# Multisystemic Therapy in the Context of Intimate Partner Violence: Parents' and Practitioners' Experiences

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## Table of contents

# Lay Summary

**Introduction:** Intimate partner violence (IPV) is behaviour committed by a partner or ex-partner that causes physical, sexual or psychological harm. Children who witness IPV are more likely to have mental health difficulties and are at a higher risk of committing or experiencing bullying or IPV. This thesis looks at systemic interventions for children and families who have experienced IPV.

**Systematic review**

**Introduction:** This review focuses on interventions for IPV-exposed children and their non-abusive parent. Previous reviews have found systemic interventions to be effective, however most have only included quantitative control studies. Families who have experienced IPV are a complex and vulnerable group, therefore this review hopes to increase the generalisability of the findings by including interview data as well as uncontrolled studies. This review aims to build on the existing literature by exploring how interventions work and for whom.

**Method:** A systematic review was conducted to determine the effectiveness of systemic interventions for IPV-exposed children. This review grouped interventions according to delivery mode, which included joint parent and child interventions, separately delivered but concurrent parent and child interventions or a combination of both. It also explored what might impact the strength and direction of the effect as well as how the interventions might work. After screening 2,662 studies 23 met the inclusion criteria and were reviewed.

**Results**

- Jointly delivered interventions had a significant impact on reducing child behaviour problems

- Mixed results were found for separately delivered interventions. More evidence was found for interventions to be slightly effective at internalising problems (e.g. depression and anxiety). However, this was more so for girls, and the effect was not maintained at long term follow-up.
- Combined interventions were more consistent and demonstrated improving a larger variety of child wellbeing outcomes such as trauma
- Extent of exposure showed inconsistency in its moderation of the effect, however interviews showed that increased time since exposure improved engagement in interventions
- Child demographic variables varied in terms of their moderation of the effect of interventions. Ethnicity and income were found to have no impact. Boys' behaviour changed to a greater extent following intervention than girls, and younger girls showed greater change in their internalising problems.
- Changes in mothers' depression following intervention was not associated with changes in children. However, more consistent were changes in mothers' trauma symptoms; greater reductions in maternal trauma symptoms led to greater reductions in child internalising problems.
- Changes in positive parenting behaviours (e.g. praise) were not associated with child outcomes. However, change in negative parenting behaviours (e.g. harsh or inconsistent parenting) did mediate change in child outcomes following intervention.
- Changes to the parent-child relationship were not associated with child outcomes, however in interviews parents felt interventions improved their relationships with children which they linked to improving child outcomes.

**Conclusions:** This review has contributed to the understanding of effectivenss of systemic interventions. There is tentative support for jointly delivered interventions being effective for externalising child difficulties, separately delivered interventions being effective for internalising difficulties and combined interventions being effective for a wider array of child difficulties. Tentative conclusions can be made about the impact of continued perpetrator contact on intervention engagement and the mediating roles of maternal PTSD and reductions in negative parenting strategies. More rigorous research is required to reach more definite conclusions.

**Empirical Paper**

**Introduction:** Systemic interventions that only include the non-abusive parent and child predominantly occur between mothers and children. However, perpetrators are often parents and usually either live with the family or have continued child contact. Excluding abusive parents from intervention impacts the effectiveness of interventions. Interventions with the whole family could mitigate this and have been found to be effective at improving child outcomes whilst not increasing risk. Multisystemic therapy (MST) is a whole family intervention for children who present with sever antisocial behaviour. Despite not being designed specifically for families experiencing IPV, child behavioural problems and family violence frequently co-occur therefore MST practitioners often work with families in the context of IPV. This study investigated how MST can best meet the needs of such families.

**Method:** Eight MST practitioners and four parents who had received MST were recruited from five MST teams across the UK and interviewed about their delivery and experience of MST in the context of IPV. Interview schedules were co-created with experts-by-experience. Interviews were transcribed, analysed and conceptualised into themes.

**Results:** Three themes and nine sub-themes were created and contextualised in relation to the different temporal and characteristics of IPV presentations.

- Theme 1: Barriers to the MST process were described in relation to the barriers posed by the impact of IPV on parents, impact of IPV on the family, and the impact of IPV on the MST process.
- Theme 2: Facilitators to change included the sub-themes of principles of MST and MST practitioners experienced as containers.
- Theme 3: Amendments, which described the changes made by practitioners to meet the needs of families. This consisted of hypervigilance to increasing risk, safety planning on-going IPV risk, increased multi-agency working and increased length of intervention.

**Impact, Integration and Dissemination Plan:** Both papers focused on systemic interventions for young people exposed to IPV. However, the systematic review synthesised interventions that excluded perpetrators and demonstrated the need for more research into understanding mediators and moderators of intervention effectiveness. It also showed some evidence that continued contact with perpetrators attenuates intervention effectiveness, which provided a rationale for the empirical paper to investigate whole family approaches. This paper highlighted acceptability of MST for this population and described some of the facilitators and barriers to the MST process as well as amendments made by practitioners. The findings are important not just for MST practitioners and families undergoing MST but provide insight to all professionals working with the population. A summary of the findings will be shared with parents and practitioners, as well as the wider MST-UK and Ireland and European teams. The project will also be submitted to peer-reviewed journals to ensure a wide impact.

# Chapter 1: Systematic Review

## Examining the Effectiveness of Systemic Interventions for Children Exposed to Intimate Partner Violence: A Mixed-Methods Systematic Review

## Abstract

The existing evidence base for interventions for children exposed to intimate partner violence (IPV) largely consists of controlled studies focused on improving the relationship between the non-abusive parent and child. This review built on the existing literature examining the effectiveness of systemic interventions and delivery modes on child outcomes and incorporated empirical research that was not restricted to RCTs or quantitative studies. Theory of change research is also limited (Anderson & van Ee, 2018; Austin et al., 2019) therefore this review sought to gain insight into the mechanisms underpinning interventions as well as moderators. Searches were carried out on three data bases and after screening 23 studies remained. Due to the heterogeneity of interventions, studies were categorised by intervention delivery mode and intervention type. Quantitative results found jointly delivered interventions had a consistent impact on reducing child behaviour problems, separately delivered interventions were less consistent but tentative evidence for reducing predominantly child internalising problems, and combined interventions demonstrated improvements in a wider array of child outcomes. Qualitative research found that time since violence stopped improved intervention effectiveness and engagement and continued perpetrator contact negatively impacted child outcomes. Limited evidence was found for the moderating impact of demographic variables on intervention effectiveness. Limited evidence was found for the mediating role of maternal depression however maternal PTSD symptoms significantly mediated changes in children's' internalising outcomes. Only changes in negative parenting practices were found to mediate change following parenting interventions. Qualitative studies found that change in parent-child relationship was a potential mediator however this was not supported by the quantitative findings.

Overall, the studies ranged in quality, however studies tended to have high attrition rates. More research is required with a focus on mediators and moderators in order to produce more definitive conclusions.

# Introduction

The World Health Organisation defines intimate partner violence (IPV) as behaviour perpetrated by a partner or ex-partner that causes physical, psychological or sexual harm (WHO, 2021). Despite perpetration spanning across gender, women are more likely to be injured by men and require medical input or hospitalisation (Office for national Statistics, 2022). Documenting children's exposure to IPV has gained attention and is identified as a form of child maltreatment (MacMillan et al., 2009). Defining child exposure has lacked consistency, but can include: directly observing, intervening or indirect exposure to abuse (Romano et al., 2021). United Kingdom prevalence data varies depending on exposure definitions, however a large-scale study estimated that 12% of children below 11 years and 18.4% children aged between 11-17 years had witnessed at least one IPV incident in their lifetime (Radford et al., 2011).

The impact of IPV on women is pervasive and well documented: ranging from physical injuries, long-term health difficulties to the development of mental health difficulties (Anderson & van Ee, 2018; Cafferky et al., 2018; Spencer et al., 2019). The negative effects of child IPV exposure have also been considerably investigated and outcomes are similar to children who have been directly abused (Kitzmann et al., 2003). Child impairment can manifest across multiple domains including: internalising, externalising, attachment difficulties as well as pro-social difficulties (Noonan & Pilkington, 2020; Vu et al., 2016); children are also at an increased risk of perpetration or being victim to, bullying and IPV perpetration (Carlson et al., 2019; Karlsson et al., 2016; Knous-Westfall et al., 2012).

The literature around age of exposure and sex moderating the effects of child outcomes is mixed. Despite younger children being disproportionately exposed to

IPV, studies remain inconclusive regarding whether younger children are more likely to suffer adverse effects than older children (Graham-Bermann et al., 2009). Sternberg et al. (2006) found that older children had an increased risk of developing internalising difficulties, however age did not have a moderating impact on externalising difficulties. Similarly inconclusive is gender, however some studies have demonstrated a relationship between IPV exposure and internalising difficulties being stronger in girls and externalising problems stronger in boys (Holmes et al., 2022). Another moderator frequently cited is level of IPV exposure, Graham-Bermann et al. (2009) found that children who witnessed more violence were more likely to demonstrate poorer outcomes.

It is evident that children exposed to IPV are a heterogenous group demonstrating an array of effects, therefore in order to account for this complexity, interventions are also diverse in their focus and delivery. Various types of interventions either target children individually or through caregivers. Due to the National Institute for Health and Care Excellence guidelines recommending interventions that aim to strengthen the relationship between the non-abusive parent and child (NICE, 2014), this review focuses on systemic interventions and excludes interventions that focus solely on the child. Despite differences in delivery mode, Rizo et al. (2011) noted in their systematic review that interventions shared general aims; aims for children included: learning about IPV, safety planning, reducing the psychological impact and enhancing well-being, increasing communication and social support. Common aims for parents included: enhancing understanding of the impact of IPV on children, improving parenting skills and social support, reducing psychological impact of IPV and increasing well-being.

Systemic interventions for IPV exposed children have been hypothesised to work in a myriad of ways. Anderson and Vn Ee (2018) found that forming positive reciprocal relationships between the non-abusive parent and child is key to promoting recovery; and Austin et al. (2019) demonstrated that a positive parent-child relationship is a protective factor in buffering the negative effects of child IPV exposure.

Similarly, parenting practices have also consistently been postulated to be a salient factor. Positive parenting consists of authoratitive parenting which entails good communication and high warmth whilst enforcing boundaries whereas, negative parenting styles consist of authoritatian, permissive or neglectful parenting practices (Baumrind, 1991). The evidence for the impact of IPV on mothers' parenting is mixed: some findings demonstrate the negative effect it can have and hypothesise that mothers' stress and fear associated with IPV compromise mothers' ability to meet children's needs (Lapierre, 2008); contrastingly, a longitudinal study found that IPV impacted mothers were more likely to demonstrate positive discipline, warmth and consistency compared to non-IPV impacted mothers (Letourneau et al., 2007). Positive parenting practices, has been consistently associated with better child outcomes in comparison to children who experienced negative parenting styles such as: executive functioning (Gustafsson et al., 2015); fewer behavioural and emotional difficulties (Carlson et al., 2019); and lower adolescent dating violence and victimisation (Garrido & Taussig, 2013). Punitive parenting practices in IPV exposed mothers have been postulated to be a way in which mothers ensure positive child behaviour to avoid aggregation of the abuser, but has been associated with greater behavioural and emotional child problems (Anderson & van Ee, 2018; Jouriles et al., 2018). Howarth et al. (2016) qualitative synthesis found that positive child outcomes

following parenting skills interventions were linked to parent reported increases in sensitive parenting and quality of the parent-child relationship; parenting seems to play a mediating role on child adjustment post IPV exposure and could contribute to increased resilience.

Another potential mediating factor in the relationship between IPV exposure and child outcomes is parental mental health. There is an increased risk of developing maternal mental health difficulties following IPV exposure (Cafferky et al., 2018; Spencer et al., 2019). Parental mental health and parenting practices are not necessarily distinct from one another, as poorer mental health such as depression has been associated with poorer parenting practices (Anderson & van Ee, 2018; Postmus et al., 2012). However, the effects of poor parental mental health on child outcomes have been well documented, and have been associated with increased likelihood of child maltreatment (Ayers et al., 2019), internalising and externalising problems (Howell, 2011). Conversely, mothers who showed fewer mental health struggles following IPV mitigated the negative effects of IPV on children (Howell, 2011). Graham-Bermann et al. (2009) cluster analysis found children with severe problem behaviours had mothers with higher trauma and depression scores than the resilient children; demonstrating its potential mediating role in child resilience.

Interventions focused on improving child outcomes following IPV exposure remains a highly saturated research area. Rizo et al. (2011) review on family interventions recognised the aforementioned common goals associated with four various types of interventions which included: therapy, outreach, parenting and multi-component interventions; however, the review was unable to conclude the most efficacious type of intervention. Following on from this, there have been six iterations of Rizo et al's. (2011) review to note.

Howarth et al. (2016) reviewed controlled trials and divided studies into parenting skill training, psychoeducation, advocacy and psychotherapy and found improvements in child outcomes with modest effect sizes. This review found that psychoeducation interventions delivered in a group were most effective, however authors described large uncertainty due to the high risk of bias (Howarth et al., 2016). Howarth et al. (2016) qualitative synthesis also found that changes to parental mental health and parenting skills impacted children's outcomes, which consisted of improved self-esteem, mental health and decreases in behaviour problems. Hackett et al. (2016) systematic review investigated mother-child joint interventions, and found medium effect sizes across child wellbeing variables (d= .52), and small effect sizes for family relationship variables (d=.18). Anderson and Van Ee (2018) systematic review found separate, joint, and combined interventions improved externalising, internalising and trauma symptoms. Authors noted that combined intervention delivery was the most effective at improving a wider range of child-outcomes. Austin et al. (2019) focused solely on parenting interventions, and made no conclusions on the types of interventions that are most effective due to considerable heterogeneity.

Latzman et al. (2019) synthesised the results of eight randomised control trials (RCT's) and divided the studies by modality, theoretical approach and setting. Results showed that home interventions had the largest effect sizes on child externalising problems (d=-.38). Interventions targeting mothers only had the highest pooled effect size (d=-.38), followed by joint interventions (d=-.25), and the smallest effect size for separate interventions (d=-.08). However, authors noted that the mothers only intervention had an inactive control group which potentially led to inflated effect sizes, therefore concluded that it was unclear what circumstances

were most efficacious. Finally, Romano et al. (2021) synthesised data from the aforementioned reviews and found immediately after intervention of any kind the average effect size was moderate (d=.49), however this varied depending on outcome. Follow up effect sizes were attenuated for externalising and trauma symptoms but remained in the small-moderate range (d=.36 – d=.44), however internalising remained stable (d=.41). There was no significant moderating effect for age, setting, or delivery mode. Intervention type did appear to have significant differences, with non-trauma specific interventions demonstrating significantly larger effect sizes. However, all studies included were rated between moderate to high levels of bias, and effect sizes were significantly larger in studies with higher levels of bias.

This review aims to build on the existing literature by further exploring the effectiveness of systemic interventions on outcomes for IPV-exposed children. The latest database search for studies in the aforementioned reviews was conducted in 2016, and the majority of reviews only included control trials. This review hopes to build upon Rizo et al. (2011) review by synthesising the literature from the last twelve years and incorporating empirical research that is not restricted to RCT's or quantitative studies. Families impacted by IPV are a complex group who demonstrate high attrition rates and interventions mostly occur in shelters where control is challenging (Howarth et al., 2016; Latzman et al., 2019; Romano et al., 2021), therefore also including uncontrolled studies and qualitative studies in this review aims to increase generalisability. There remains a lack of reporting on theory of change (Anderson & van Ee, 2018; Austin et al., 2019), subsequently this review seeks to explore mediator and moderator variables to gain insight into the mechanisms underpinning interventions. The current review seeks to:

1. Evaluate the effectiveness of systemic interventions and delivery modes on child outcomes
2. Examine the mediators and moderators of intervention effectiveness on child outcomes

# Method

This review adhered to the updated Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-P) guidelines (Page et al., 2021).

## Study Eligibility Criteria

Inclusion and exclusion criteria were applied to the search to ensure the determination of study eligibility was rigorous and transparent. The inclusion criteria consisted of:

1. Empirical research examining the use of systemic interventions for victims of IPV with a focus on children.
2. Systemic interventions include: family interventions, parenting programmes, parent-child joint sessions, and parent and child separate but concurrent sessions.
3. Interventions with the non-abusive parent.
4. Children exposed to IPV between the ages of 2-18 years of age.
5. The study included child outcome measures related to associated problems of IPV exposure e.g., mental health problems, behaviour problems, social competency, and emotional regulation.
6. Quantitative or qualitative data.
7. Empirical in nature e.g., the study collected and analysed data as opposed to commentaries.
8. Empirical study designs included randomised control trials, quasi-experimental designs, cohort analytic.
9. Comparators could include: waitlist, no intervention, or another intervention.
10. The study was reported in, or translated into English.

11. Studies published beyond 2010, building on the existing literature by expanding upon Rizo et al. (2011) review.

The exclusion criteria for studies consisted of:

1. Interventions with children under the age of 2 years only.
2. Interventions where child outcomes are not targeted.
3. Studies with interventions with children as direct victims of violence. Despite child abuse and IPV-exposure often co-occurring (Hamby et al., 2010), this review seeks to understand interventions that are effective for the unique effects of the relational trauma specific to witnessing IPV as opposed to trauma after experiencing direct abuse.
4. Interventions that include parents with substance misuse problems as it is difficult to disentangle the potential contributing role to IPV situations and would require an additional level of intervention.
5. Studies investigating systemic interventions that only report parent outcomes e.g., parent mental health or parenting outcomes.
6. Qualitative studies that only report on clinician interview data.
7. Case studies or protocols for interventions.
8. Grey literature such as commentaries, theses and books or chapters.

**Search Strategy**

Studies were identified following the systemic search of electronic databases. Searches were carried out in July 2022 on three electronic databases: PsychINFO, Web of Science and Sociological Abstracts. Reference lists from eligible papers and key existing meta-analyses were also reviewed for additional relevant studies. The search terms for each concept were defined from derivatives generated from

common terminology used in the literature and after librarian consultation. Boolean operators and truncations were utilised in order to account for variations in terminology. In order to optimise the search relevancy, searches were conducted in "Title" and "abstract" fields where possible. Database searches were conducted using the following terms:

"Young people" OR "teen*" OR "adolescen*" OR "young person*" OR "child*" OR "youth" OR "juvenile"

AND

"Domestic violen*" OR "partner violen*" OR "intimate partner violen*" OR "spous* abuse" OR "battered wom*" OR "marital violen* " OR "IPV"  OR "DV"

AND

"Famil* therap*" OR "famil* intervention" OR "famil* work*" OR "family focused intervention" OR "functional family therapy" OR "FFT" OR "systemic therap*" OR "multi systemic therap*" OR "MST" OR "systemic" OR "parent* program*" OR "parent* intervention"

**Study Selection**

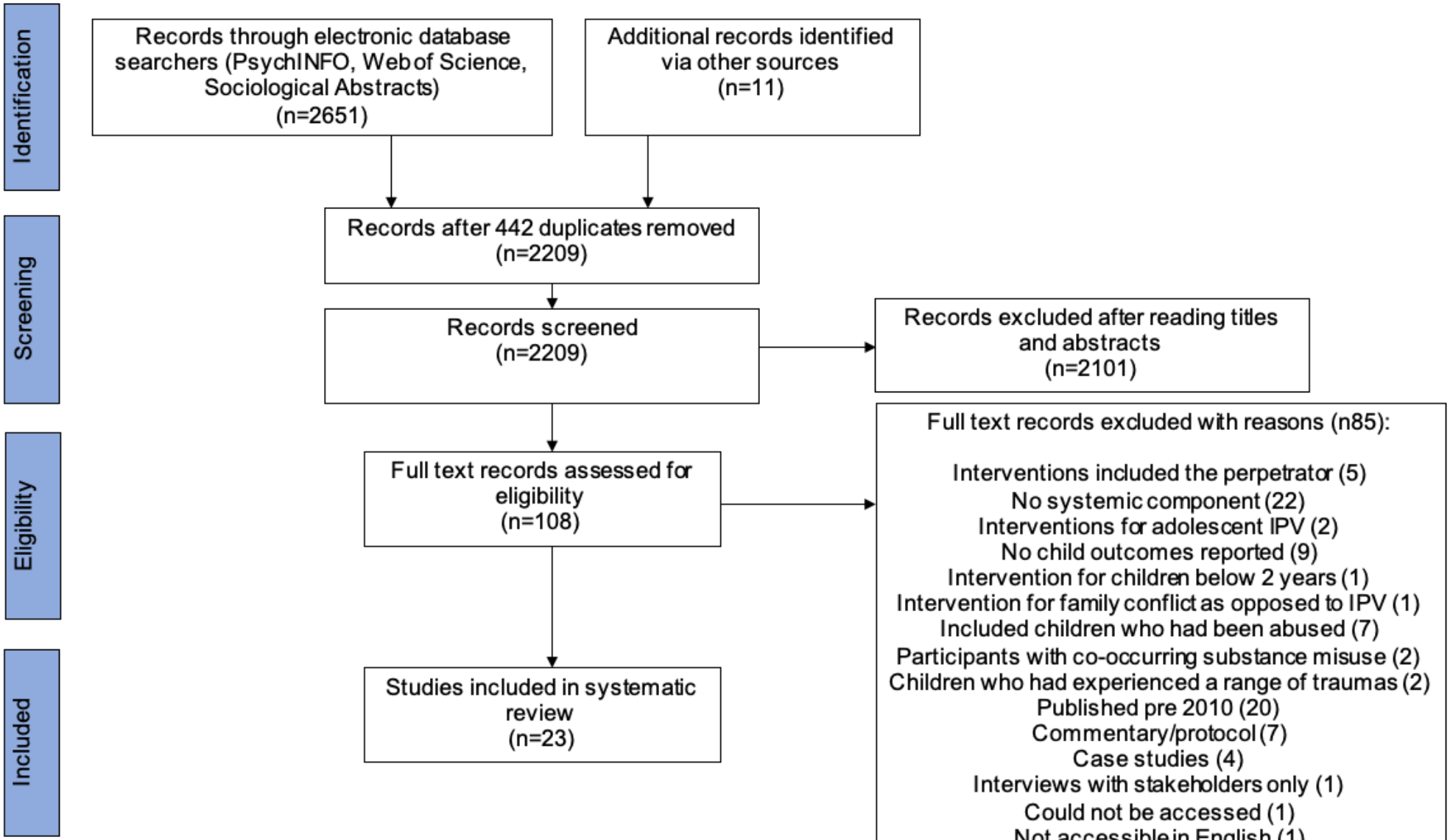
In line with PRISMA-P (Page et al., 2021) guidelines, study selection included a process entailing screening titles followed by a full text review. The electronic database search identified 2651 studies and 11 studies were identified via other sources. References were imported into Rayyan referencing management software

to remove duplicates and screen studies. As shown in Figure 1, 442 duplicates were removed and the remaining 2220 papers were screened by title and abstract against the eligibility criteria. Potential studies (108) were reviewed at full text, of which 23 studies met the inclusion criteria. Figure 1, describes the reasons for the exclusion of 85 studies. Multiple studies used duplicate samples: Howell et al. (2013), Galano et al. (2022), Clark et al. (2021), utilised a secondary analysis methodology of data obtained from Graham-Bermann et al. (2015) randomised control trial; McDonald et al. (2011) utilised data obtained from Jouriles et al. (2009) RCT; and Overbeek et al. (2017) utilised data obtained from Overbeek et al. (2013). These studies were retained on the basis that each study had a unique question or added to the data set, therefore independently contributed to the focus of the systematic review.

In order to enhance rigour and reduce potential selection bias 30% of papers screened at full text were randomly selected for screening by an independent researcher. The researcher and the reviewer had a 95% agreement rate, the two papers that were discrepant were resolved through discussion.

**Figure 1**

*PRISMA flow diagram showing the study selection process*



## Data Extraction

An in-depth examination of the 23 studies meeting the full eligibility criteria was conducted and relevant findings were extracted. For quantitative studies and the quantitive component of mixed methods studies this included: study design, setting, number of participants, child age, the intervention, intervention delivery, intervention aims and focus, control group and type of control group, time points of measures completion and completion rates, child outcome measures, and IPV measures. For qualitative studies, only the relevant data was extracted and included: setting, participants, intervention, intervention delivery method, intervention aims and focus, data collection method and analysis. Themes and subthemes were extracted, however themes derived from clinicians and practitioners around processes and intervention delivery were excluded.

## Quality Appraisal

Due to the range in methodologies in the 23 selected studies, different quality assessment tools were utilised to appraise each respectively. Using critical appraisal tools instead of a more general tool that could encapsulate all designs was considered most appropriate due to it generating a more transparent and thorough assessment. The Quality of Assessment Tool for Quantitative Studies (QATQ; National Collaborating Centre for Methods and Tools, 2008) was used to assess quantitative studies. This tool provides a standardised assessment of key aspects of study design that could introduce bias and impact conclusions. It was selected due to it being rated one of the top tools available in a review of appraisal tools (Deeks et al., 2003). It measures study quality in the following methodological areas: design, the level of control of cofounders, blinding, validity in data collection methods,

attrition rate, intervention integrity and analysis. Qualitative studies were assessed using the Critical Appraisal Skills Qualitative Programme (CASP; 2018). This tool was selected as it is the most commonly utilised tool for quality appraisals of qualitative health-related reviews (Hannes & Macaitis, 2012) and is endorsed by the World Health Organisation and Cochrane (Long et al., 2020; Noyes et al., 2018). Finally, the mixed method studies were assessed using the Mixed Methods Appraisal Tool (MMAT: Hong et al., 2018) which separately appraises the quality of the different aspects of the study as well as the integration quality. The MMAT was used as it has been found to be reliable and efficient (Pace et al., 2012). Each tool utilised was accompanied by a comprehensive guide outlining the process.

The QATQ tool (National Collaborating Centre for Methods and Tools, 2008) assigns a global score rating for each study depending on the number of assigned strong, moderate or weak ratings. The CASP (2018) and the MMAT (Pace et al., 2012) do not include a global score in their appraisals, therefore the QATQ criteria was applied and a global rating was produced to allow for study comparison (see Appendix A). Two assessors independently appraised 35% (8) of the studies. Inter-rater reliability checks consisted of studies from each of the assessment tools. There was an 92% agreement rate and discrepancies were resolved via discussion.

Although global ratings can be used to adjust results according to study design rigour, Mueller et al. (2018) describe global ratings as arbitrary and argue that different study characteristics related to quality are not interchangeable or equal in importance and therefore cannot be measured in a simple score. Therefore, no studies were excluded based on their global quality rating score.

**Data Synthesis**

Due to the heterogeneity of study designs a parallel-results convergent method was utilised to synthesise the quantitative and qualitative data. This involves qualitative and quantitative data analysed and presented separately and integrated during the interpretation of the results and the discussion (Hong et al., 2017).

The quantitative studies were synthesised using narrative synthesis, which is considered appropriate for interpreting results from a range of designs (Popay et al., 2006). Popay et al. (2007) protocol guided the synthesis in order to achieve a more systematic narrative synthesis. It entails four key elements: including the theory of how and why interventions works and for whom; developing a preliminary synthesis of findings, exploring the relationships in the data; and finally including an assessment of data quality in the synthesis. The results from each of the studies are presented using Anderson and Van Ee (2018) categorisation, which groups interventions by delivery mode: joint parent and child sessions; separate; and combined. Interventions were categorised as there were not enough studies per intervention to make meaningful comparisons. Findings are described in accordance with quality of each study, whereby higher-ranking studies are reported first.

The qualitative studies were synthesised using Thomas and Harden, (2008) three stage method. This process entails: the coding line-by-line of the results of each study; the development of descriptive themes which are close to the data; and finally, the production of analytical themes which generate interpretive constructs (Thomas & Harden, 2008). Study results were imported into NVivo20 to facilitate analysis.

# Results

## Overview of Reviewed Studies

The review identified 23 studies that fitted the eligibility criteria. Fourteen distinct systemic interventions for children who have witnessed IPV were included, spanning 12 years from 2010-2022. As demonstrated in Table 1, interventions were categorised by delivery mode: joint, separate, combined and an individual parent group was added as this could not be summarised by Anderson and Van Ee. (2018) categorisation. Interventions were also grouped into intervention type: psychotherapy; parent training; psychoeducation; advocacy. Definitions are presented in Table 2, and were attained from Howarth et al. (2016) review.

**Table 1**

*Definitions of Delivery Mode of the systemic interventions*

| Delivery Mode Category | Definition |
|---|---|
| Joint | Parent and child share a joint intervention, attend together and do not receive independent support. |
| Separate | Interventions take place in parallel, and often but not always, simultaneously. |
| Individual Parent Group | Parents receive the intervention; however, the child does not receive any support directly but benefits indirectly. |
| Combined | Separate interventions for parent and children that are supplemented with joint sessions. |

**Table 2.**

*Definitions of Intervention Types*

| Intervention Type | Description of Definition |
|---|---|
| Psychotherapy | *Using the therapeutic relationship or play to enhance greater insight about themselves, relationships, patterns of behaviour. Can be applied to parents, children and families. Usually manualised but can be adapted to meet individual needs.* |
| Psychoeducation | *Aimed at changing attitudes, building resilience through increasing understanding of information.*<br>*Often delivered in a didactic format within a group context with facilitated discussions, modelling or role play.* |
| Parent Skills Training | *General aims include: increasing parental understanding of child, change parenting behaviours to reduce coercive parenting, increase child management skills, improve communication and the parent-child relationship.* |
| Advocacy | *Helps women and families with: social and emotional support, develop a network, housing, navigate the legal system, obtain financial support and childcare.* |

This review identified five distinct joint interventions, these included: Parent-Child Interaction Therapy (PICT: Herschell et al., 2017); Project Support (McDonald et al., 2011); Talking With My Mum (Humphreys et al., 2011); Brief Relational Intervention and Screening (BRISC: Fogarty et al., 2020); and Restoring Childhood Programme and Screening (Fogarty et al., 2022) which is based on Child-Parent Psychotherapy (Lieberman et al., 2005). All of these interventions share a further sub-categorisation of being predominantly psychotherapy interventions. BRISC, Project Support and PICT also include parent training and Project Support also includes advocacy aspects. Table 3, summarises quantitative studies with joint interventions.

**Table 3**

*Summary of Quantitative Studies with a Joint Intervention Delivery Mode*

| Author & Year | Study Design | Setting | Participants | Intervention | Delivery Mode | Intervention type & Aim | Control Group | Time Points & Completion Rate | Child Outcome Measures | IPV Measure | Global Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Herschell et al. (2017) | Cohort (one group pre-post) | Community Women's Shelter.<br><br>USA | 21 mother-child dyads<br><br>Child Age: 2-7 | Parent-child Interaction Therapy (PCIT) | **Joint parent-child sessions**<br><br>12 to 20 weekly, one-hour sessions | **Manualised psychotherapy & parent training**<br><br>Aimed at mother-child relationship enhancement & effective discipline and limit setting and reducing disruptive behaviours. Grounded in attachment and social learning theory. | None | Pre, mid & post treatment<br><br>43% (n9) completed treatment & 23% (n5) completed measures | The Eyberg Child Behaviour Inventory (ECBI), & Range of parent measures | The Life Stressors Checklist-Revised (LSC-R) | Weak |
| Timmer et al. (2010) | Quasi-experimental | University hospital-based outpatient clinic<br><br>USA | 129 mother-child dyads<br><br>62 IPV-exposed & 67 nonexposed<br><br>Child Age: 2-8 | Same as above (PICT) | As Above | As Above | Mother –child dyads not exposed to IPV | Pre/post 37% dyads completed measures | As above & Child Behaviour Checklist (CBCL) | Reviewed child clinical file e.g., court records | Weak |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| McDonald et al. (2011) | RCT | Community Family Home<br><br>USA | 66 mother-child dyads (32 EC, 34 CC)<br><br>Child Age 4-9 | Project Support | **Joint parent-child sessions**<br><br>12-month, weekly home visits, family intervention | **Manualised, Psychotherapy & Parent training & Advocacy**<br><br>Aimed at reducing child conduct problems, improve mother-child relationship enhancement and reducing mothers' mental health difficulties | Monthly phone calls | Baseline, 4, 8, 12, 16, & 20-months FU<br>84% Completion rate | Child Psychopathy Screening Device (PSD); Externalizing Problems Scale CBCL; & parent measures | IPV shelter assessment: at least one IPV act from a male partner in last 12 months, The Conflict Tactics Scale – Revised (CTS-2) | Strong |
| Draxler et al. (2019) | Cohort (one group pre-post) | Family Home<br><br>Sweden | 35 parent-child dyads (34 mothers, 1 father)<br>Child age 3-9 | Project Support | As above | As above | None | Pre/post<br>80% Completion rate | ECBI, Strength and Difficulties Questionnaire–Parent (SDQ-P); CBCL; & Range of parent measures | CTS-2 | Weak |

Note. EC: experimental condition; CC: control condition, FU: follow up

This review identified six interventions for children who witnessed IPV that were delivered separately, these included: Preschool Kids Club (PKC: Graham-Bermann et al., 2015) & Mothers Empowerment Program (MEP); Kids club (KC) & MEP (Graham-Bermann et al., 2011); It's My Turn Now (Overbeek et al., 2013); Child Witness to Domestic Violence (CWDV) Program (Schubert, 2021); an unnamed program (Renner et al., 2022) that matched the description of CWDV; and Group delivered Trauma-Focused cognitive behaviour therapy with art and play therapy (TF-CBT: Woollett et al., 2020). PKC is an adapted version of the Kids Club but for younger children, and 'It's my turn now' is an adaptation of Kids Club for Swedish families. Therefore, despite the six interventions named, they are not entirely distinct from one another. All of the listed interventions have in common intervention type, which consist of: psychoeducation, and parenting skills interventions. Table 4 summarises quantitative studies whereby interventions were delivered separately as well as summarising the sole individual parenting group intervention Emotion Coaching (EC) Parenting Intervention (Katz et al., 2020) due to their theoretically similar underpinnings.

**Table 4.**

*Summary of Quantitative Studies with a Separate Intervention Delivery Mode and Individual Parent Group Delivery Mode*

| Author & Year | Study Design | Setting | Participants | Intervention | Delivery Mode | Intervention Type & Aim | Control group | Time points & Completion Rate | Child Outcome Measures | IPV Measure | Global Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Graham-Berman et al. (2015 | RCT | Community IPV shelter<br><br>USA & Canada | 120 mother-child dyads (53 EC, 67 CC)<br><br>Child Age 4-6 | Preschool Kids' Club (PKC) & Mothers Empowerment Program (MEP) | **Separate sessions**<br><br>Parallel parent & child groups, each 10 sessions over 5 weeks | **Parenting & Psychoeducation**<br>Aimed at: emotional regulation; maladaptive cognitions, safety planning; conflict resolution skills.<br><br>Mothers to enhance social and emotional adjustment, parenting skills and social support | Waitlist | Pre/post & 8 months FU<br><br>71% completion rate at 8-month FU | CBCL: internalising only | The Conflict Tactics Scale Revised (CTS-2) | Moderate |
| Howell et al. (2013) | RCT | As above | As above | PKC& MEP | As above | As above | As above | Pre & post<br><br>Completion rate 82.5% | As above + The Social Competence Scale (SCS) | As above | Moderate |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Galano et al. (2022) | RCT | As above | As above | PKC& MEP | As above | As above | As above | Pre/post & 8 months FU & 8 years FU<br><br>Completion rate at 8-year FU 57% | As above | As above | Weak |
| Clark et al. (2021) | RCT | As above | As above | Same as above PKC& MEP | As above | As above | As above | As above | Attention Problems (AP) subscale of the CBCL | As above | Weak |
| Graham-Berman n et al. (2011) | RCT | Community IPV shelters<br><br>USA | 180 Mother-child dyads (120 EC, 60 CC)<br><br>Child Age 6-12 | Kids club (KC) & MEP | **Separate sessions**<br><br>Parallel mother & child groups, each 10 sessions | **Parenting & Psychoeducation** Children's knowledge, and beliefs about IPV, emotional & social adjustment. Mothers to enhance social and emotional adjustment, parenting skills and social support | Waitlist | Pre/post<br><br>96% completion n rate | CBCL;<br>&<br>Range of parent measures | CTS-2 | Moderate |
| Schuber, (2021) | Quasi-experimental | Community Family Peace Centre<br><br>USA | 149 children & 72 mothers.<br>EC: 69 children & 33 mothers,<br>CC: 80 children & 39 mothers.<br>Child Age: 2-17 | Child Witness to Domestic Violence (CWDV) Program | **Separate sessions**<br><br>Parallel parent & child groups<br><br>12 weekly sessions | **Psychoeducation**,<br><br>Aimed at: parent and child wellbeing, and improve relationships among families. | Adult-focused DV services e.g., adult support group | Pre/post<br><br>Completion rate not reported | SDQ | Not stated | Weak |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Woollett et al. (2020) | Cohort (one group pre-post) | IPV shelters<br><br>USA & South Africa | 37 participants (21 children & 16 mothers)<br><br>Child Age 5-14 | Trauma-Focused cognitive behaviour therapy (TF-CBT) with art and play therapy | **Separate sessions**<br>Children participated in a 12, weekly group 2 hr session & mothers received 3 group sessions. | **Psychoeducation, Parenting**<br>Aimed at affect regulation skills, cognitive processing of trauma and enhancing safety<br><br>Information delivered didactically, role plays, and modelling | None | Pre/Post<br><br>29% (n11) completed measures | Parent and child versions of the Post-Traumatic Stress Disorder Reaction Index (PTSD-RI); child reported Children's Depression Inventory (CDI) | Living in a shelter- not formally assessed | Weak |
| Overbeek et al. (2013) | RCT | Community<br><br>Netherlands | 164 Parent-child dyads (108 EC, 56 CC)<br><br>Child Age 6-12 yrs | "It's my turn now" parenting intervention | **Separate sessions**<br><br>9, 90 min parallel parent & child group intervention | **Parenting & Psychoeducation**<br>Aimed at responses to trauma-related thoughts and memories; emotion regulation; safety and social skills. Parent aim to enhance emotional adjustment & recognition of child's emotions | Control intervention based on non-trauma specific factors- e.g., play for children, & social contact for parents | Pre, post & 6-month FU<br><br>Completion rate 81.7% | CBCL; CDI; Trauma Symptom Checklist for Young Children (TSCYC); Trauma Symptom Checklist for Children (TSCC) | CTS-2 | Moderate |
| Overbeek et al. (2017) | RCT | As above | As above | It's my turn now" parenting intervention | As above | As above | As above | As above | As above + Emotions subscale of the Emotion Awareness Questionnaire; How I Coped Under Pressure Scale, Parenting Stress Index; Impact of Events Scale–Revised; The Family Interaction Task | CTS-2 | Moderate |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Katz et al. (2020) | Quasi-experimental | Community IPV centre<br><br>USA | 50 mother-child dyads (23 EC, 27 CC)<br><br>Child Age 6-12 | Emotion Coaching (EC) Parenting Intervention | **Individual Parent Session**<br><br>12-week skills-based parenting program | **Parenting & Psychoeducation**<br><br>Emotion regulation, minimise harsh parenting behaviour, parent-child relationship | Waitlist control group | Pre/post therapy<br><br>Completion rate 67% | Child Regulation Index (CRIC); Respiratory sinus arrhythmia (RSA); CDI; Child posttraumatic stress symptoms (PTSS), Children's Posttraumatic Stress Symptoms Scale (CPSS) Parent & Child Coding System (PACCS) | CTS-2 | Moderate |

Note. EC: experimental condition; CC: control condition, FU: follow up.

This review identified studies that used a total of three combined interventions for children who had witnessed IPV, these included: Trauma- Focused Cognitive Behaviour Therapy (TF-CBT Cohen et al., 2011); Emotion Focused and Goal Oriented Cognitive Behavioural Interventions (EF&GO CBT McWhirter, 2011); and Domestic Abuse Recovering Together (DART: Smith et al., 2015). All of these interventions shared the sub-categorisation of being predominantly psychotherapies, with DART including a parent training aspect, and the EF&GO-CBT including a psychoeducation aspect. Table 5, summarises quantitative studies whereby interventions were delivered in a combined mode.

Table 6, includes the qualitative studies whereby interventions were delivered jointly, separately and combinedly to parents and children.

**Table 5**

*Summary of Quantitative Studies with a Combined Intervention Delivery Mode*

| Author & Year | Study Design | Setting | Participants | Intervention | Delivery Mode | Intervention Type & Aims | Control group | Time Points & Completion Rate | Child Outcome Measures | IPV Measure | Global Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cohen et al. (2011) | Randomised control trial (RCT) | Community IPV centre<br><br>USA | 124 children randomised. (64 EC, 60 CC)<br><br>Child Age 7-14 | Trauma-Focused Cognitive Behaviour Therapy (TF-CBT) | **Combined sessions**<br><br>Child & parent parallel 45 min individual therapy. Two joint sessions. 8 sessions each | **Psychotherapy Psychoeducation,**<br><br>Reduce trauma symptoms by: increasing sense of safety, addressing maladaptive cognitions, discriminate between real danger and generalised fears. | Child-centred therapy | Pre/post therapy<br><br>Completion rate 60.5% | K-SADS-PL structured diagnostic interview; Reaction Index (RI) self-report, Child Anxiety Related, Emotional Disorders (SCARED); CDI; CBCL | Interview screen: children had <5 IPV-related PTSD symptoms | Strong |
| McWhirte, (2011) | Randomised two group intervention | Family homeless shelter<br><br>USA | Children: 48<br>Mothers: 46<br>Mothers 22 EC, 24 CC<br>Child Age 6-12 | Emotion Focused & goal oriented Cognitive Behavioural interventions | **Combined sessions**<br><br>5 parallel 1hour mother & child groups + 60min joint mother-child session. | **Psychotherapy Psychoeducation**<br>Both CBT: Emotion focused group aimed to decrease relational nonadaptive coping. Goal orientated integrated motivational interviewing to increase internally guided goal-oriented change. | Active control | Pre/post<br><br>95.7% completion rate | Child self-report on a non-standardised visuographic barometer of emotional wellbeing. Children's peer conflict, family conflict, and self-esteem measured using self-report 5pt Likert scales | Score 15> on HITS (hurt-insult-threaten-scream) | Weak |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Smith et al. (2015) | Quasi-experimental | Community<br><br>England & Wales | 176 mother-child dyads (158 EC,18 CC)<br><br>Child Age 7-11 | Domestic Abuse Recovering Together (DART) | **Combined sessions**<br><br>10-week, 2.5-hour groups. Half parallel, half joint mother & child | **Psychotherapy, Parenting**<br><br>Improve the mother-child relationship, increase confidence in parenting abilities, and reduce child emotional & behavioural difficulties | Play therapy (mean 15 sessions) | Pre, post & 6-month FU<br><br>64% completion rate at time two, & 18% at 6-month FU | Rosenberg self-esteem scale; SDQ; & parent measures | Not stated | Weak |

Note. EC: experimental condition; CC: control condition, FU: follow up.

**Table 6.**

*Summary of qualitative study details in order of delivery mode, starting with joint, separate and combined.*

| Author & Year | Setting | Respondents | Intervention | Delivery Mode | Intervention Type & Aims | Data Collection & Analysis |
|---|---|---|---|---|---|---|
| Humphreys et al. (2011) | IPV shelter<br><br>UK | 27 mother-child dyads<br><br>Child Age 5-16 | "Talking with my Mum" | **Joint**<br><br>Strength-based activities with mother-child dyads, a mixture of practitioner facilitated/ self-guided delivered | **Psychotherapy**<br><br>Improve mother–child communication | Focus group with practitioners, interviews with mothers & children<br><br>Constructivist Grounded Theory |
| Fogarty et al. (2020) | "Real world community setting"<br><br>Australia | 16 Mothers<br><br>Child Age 6-12 | Brief Relational Intervention and Screening (BRISC) | **Joint**<br><br>4 session parent & joint parent-child sessions | **Psychotherapy & Parent training**<br><br>Reduce children's trauma responses, increase mother's self-efficacy & reflective functioning. Psychoeducation, parenting skills training and play. Also aims to identify children with persistent trauma who require more intensive treatment. | Semi-structured interviews, Thematic analysis |
| Fogarty et al. (2022) | Family Home<br><br>Australia | 5 Mothers<br><br>Child age 2-12 | Restoring Childhood programme (based on Child-Parent Psychotherapy: Lieberman et al., 2005) | **Joint**<br>Parent-child dyads. Conducted via telehealth during the COVID-19 pandemic | **Psychotherapy**<br><br>Aimscto strengthen parent-child relationship, increase parent self-efficacy, reduce children's trauma symptoms, and to promote increased understanding of the impact of IPV. After screening | Semi-structured interviews,<br><br>Thematic analysis |

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|---|---|---|---|---|---|---|
| | | | | | parent-child dyads undergo a medium- longer term Child-Parent Psychotherapy or individual and relational therapies that integrate Eye Movement Desensitization Reprocessing. | |
| Draxler et al. (2020) | Family Home<br><br>Sweden | 11 Mothers<br>Child Age 3-9<br><br>13 Practitioners | Project Support | **Joint**<br>12-month, weekly home visits, family intervention | **Psychotherapy & Parent training & Advocacy**<br><br>Aim to reduce child conduct problems through parent training, child management skills & provide emotional support to mothers | Semi-structured interviews,<br><br>Thematic analysis |
| Renner et al. (2022) | Community based agency,<br><br>USA | 11 mothers<br>Child Age 5-12 | Not named | **Separate**<br>12- 2hr parent group & parallel child therapy groups with additional combined sessions | **Psychoeducation & Parent Training**<br><br>Parent skills training with the aim to enhance the mother-child relationship & for parents to increase their understanding of how IPV impacts on their children. The child group format included directive play therapy & psychoeducation. | Semi-structured interviews at 3 months FU |
| Woollett et al. (2020) | IPV shelters USA & South Africa | 8 Mothers & 11 children<br><br>Child Age 6-14 | Trauma-Focused cognitive behaviour therapy (TF-CBT) with art and play therapy | **Separate**<br>Children participated in a 12, weekly group 2 hr session & mothers received 3 group sessions. | **Parent Training & Psychoeducation**<br><br>Psychoeducation, parenting skills, Relaxation & affect regulation skills, cognitive processing of trauma and to Enhance safety | Semi-structured interviews, Thematic analysis |
| McManus et al. (2013) | Community charity<br><br>England & Wales | 15 mothers & 11 children<br><br>Child Age 7-11 | Domestic Abuse Recovering Together (DART) | **Combined**<br><br>10-week, 2.5-hour groups. Half parallel, half joint mother & child | **Psychotherapy & Parent training**<br><br>Improve the mother-child relationship, increase mothers' confidence in parenting abilities, and reduce child emotional & behavioural difficulties | Semi-structured Interviews<br><br>Framework approach for analysis |

### *Sample Characteristics*

*Quantitative and Mixed Studies*

Overall, there was a total of 13 distinct samples which entailed 1283 child participants, and samples ranged from 21-180. Of these children 495 were girls and 564 boys, and 224 gender was not described. The mean age was 7.6 years (2-17 years). Children's ethnicity was not described in three of the samples, however of those reported: 53.1% were Caucasian; 26.9 % were Black, 12.1% were mixed race or other, and 7.9% were Latino. Samples were recruited predominantly from the USA (n=9), and another sample also included South Africa. The remaining three samples were recruited from Europe: Sweden (n=1), the Netherlands (n=1), and England and Wales (n=1). The total sample size of parents was 1199 (n=1 father), and the mean age was 33.1 years (18-55).

*Qualitative Studies*

Of the six distinct samples, three interviewed children. These studies consisted of 74 children, and the sample size ranged from 11-52. Thirty-one children were girls and 43 were boys, and their mean age was 9.6 years (2-16). Three studies reported on ethnicity: 80% were Caucasian; 4.4% were Black; 13.3% were Asian; and 2.3% mixed-race. The total sample size of mothers interviewed was 103, the mean age was 35.6 years (27-41). Samples were recruited from: USA (n=1), Sweden (n=1), UK (n=2), and Australia (n=2).

### *IPV and Child Outcome Measures*

The majority (76%) of the 17 quantitative (15 quantitative and 2 mixed) studies utilised validated measures to assess forms of IPV and the frequency of its occurrence. As seen in Tables 3, 4, and 5 the most common measure used (n=10) was The Conflict Tactics Scale–Revised (CTS-2: Straus et al., 1996) which has good

internal consistency and construct validity (Straus et al., 1996) and is the most widely used measure within the literature (Lehrner & Allen, 2014). Three quantitative studies and none of the qualitative studies formally measured IPV. Studies utilised a range of behavioural, trauma-related and mental health measures. McWhirter (2011) was the only study to not use standardised measures, a visuographic barometer was used to measure child emotional wellbeing. As seen in Tables 3, 4, and 5 the Child Behaviour Checklist (CBCL: Achenbach, 1994) was the most common measure and featured in 11 (58%) quantitative studies.

### *Intervention Settings and Recruitment*

Out of the 19 distinct samples, the majority (n=13) of the intervention settings took place in community IPV shelters. Other settings included family homes (n=4), and university hospital-based outpatient clinic (n=1). Most of the studies recruited participants through self-referral methods via responding to adverts within IPV shelters (n=11) and some recruited through adverts in the community (n=2). Other studies recruited through shelter staff or other agency referrals (n=8).

### *Study Quality*

Of the 15 quantitative papers, two studies received a rating of strong, six received moderate, and seven received a weak rating using the Quality of Assessment Tool for Quantitative Studies tool (QATQ: National Collaborating Centre for Methods and Tools, 2008). Appendix A, outlines the study scores. None of the studies achieved a likely representative sample of the target population, attained through random selection. Therefore, none of the studies ascertained a strong score for minimising sampling bias. Another primary reason for studies to be rated weak or moderate was the high participant attrition rates.

All six of the qualitative papers received a rating of moderate using the Critical Appraisal Skills Qualitative Programme (CASP: 2018; Appendix B). None of the papers considered the relationship between researcher and participant adequately. Appendix C demonstrates quality assessments for the mixed method studies using the Mixed Methods Appraisal Tool (MMAT: 2018) which produced two weak global score ratings. This was due to the quantitative sections of the papers having key methodological flaws. More specifically, Smith et al. (2015) failed to recruit a representative sample of the population, did not account for cofounders, had high attrition rates and did not report on intervention fidelity or number of sessions attended. Woollett et al. (2020) failed to recruit a representative sample and had high attrition rates. Appendix C, describes the rating appraisal process for the MMAT (2018). The results to research questions 1 and 2 will be presented with the highest rating papers first to aid in an integrated narrative that allows for quality of study findings to be weighted in favour of the strongest evidence.

## The Effectiveness of Systemic Interventions and Delivery Modes on Child Outcomes

### *Joint Interventions: Quantitative Studies*

One joint study (McDonald et al., 2011) obtained a strong rating and utilised a randomised control trial (RCT) with 20 month follow up data. The other three studies obtained weak ratings; Herschell et al. (2017) and Draxler et al. (2019) utilised cohort one group pre-post designs with small sample sizes: 21 dyads and 35 dyads respectively. Timmer et al. (2010) utilised a quasi-experimental design however obtained its weak rating due to its high attrition rates (63%).

Jointly delivered interventions had a significant impact on reducing child behaviour problems. McDonald et al. (2011) found that in comparison to controls, children in the Project Support group demonstrated greater reductions in conduct problems as measured using the CBCL and PSD. This was maintained at 20 months follow up with a large effect size (Cohen's d=.89). This is similar to Draxler et al. (2019) which found significant reductions in children's SDQ rated total problems (Cohen's d=.67), conduct problems (Cohen's d=.76), hyperactivity (Cohen's d=.34), and emotional symptoms (Cohen's d=.74). Timmer et al. (2010) and Herschell et al. (2017) found that Parent-child Interaction Therapy (PICT) was effective at significantly reducing child behaviour problems. ECBI scores significantly reduced on the intensity ($\eta^2$=.24) and problem scales ($\eta^2$=.27) and on all CBCL scales ($\eta^2$=.16), producing large effect sizes. However, the latter three studies did not have an active control group, therefore effect sizes may be inflated. Nevertheless, intervention effects seem to be comparable between McDonald et al. (2011) more rigorous study and the three weaker studies demonstrating that child externalising problems in particular reduce after joint mother and child psychotherapeutic interventions.

***Joint Interventions: Qualitative Studies***

As demonstrated in Table 6, four of the qualitative studies were joint. Parents reported similar outcomes to those found in the quantitative studies. Joint psychotherapy and parent training interventions had a described impact on children's emotion identification and regulation: *"He always was a very quiet, cautious and shy boy. He's definitely come out of his shell a lot. Definitely able to communicate his feelings more effectively and identify his own emotions"* (Fogarty et al., 2022, p.7). Parents also described notable improvements in their child's externalising behaviours: *"I feel like he's definitely not as aggressive anymore… it's still there, but*

*he calms down a lot quicker"* (Fogarty et al., 2022, p.7). The qualitative studies demonstrate similar findings to the quantitative results, and show mother reported child improvements in externalising behaviours predominantly, as well as showing improvements in children's emotional regulation abilities.

### *Separate Interventions and Individual Parent Group: Quantitative Studies*

Overall, the quality of studies for Preschool Kid's Club and Mothers' Empowerment Program (PKC/KC & MEP) and its Swedish equivalent 'It's My Turn Now' rated predominantly moderate with two weak ratings on the QAQT. All of the studies used convenience sampling, therefore had high likelihood of sampling bias. Galano et al. (2022) and Clark et al. (2021) received weak ratings due to higher attrition rates (43%) at the 8-year follow up. All of the studies utilised an RCT design; Overbeek et al. (2013) used an active control group and Graham-Bermann et al., (2011; 2015) used waitlist controls. Schubert's (2021) quasi-experimental study obtained a weak rating, due to not reporting on attrition rates or fidelity checks and having a high chance of selection bias. Woollett et al. (2020) cohort study had a small sample size and a high dropout rate (71%) therefore obtained a weak rating.

Overall, mixed results were found for the seven studies investigating the effectiveness of separately delivered interventions. Graham-Bermann et al. (2015) intention to treat analysis showed that only girls internalising symptoms significantly reduced at eight months post intervention as measured on the CBCL internalising scale, and produced a small effect size (Cohen's d= .18). Immediately following the intervention, Howell et al. (2013) found that children's prosocial skills in the intervention group increased to a greater extent than the control (Cohen's d= .32). Graham-Bermann et al. (2011) found that KC & MEP significantly reduced

internalising and externalising behaviours to a greater extent than waitlist controls (Cohen's d=.23; Cohen's d=.29). However, when the intervention was compared to an active control group there were no significant differences between the intervention and controls on the internalising, externalising or trauma measures (Overbeek et al., 2013; 2017). Additionally, at eight years follow up there was no significant difference between waitlist control group and PKC & MEP intervention group on internalising, externalising scores (Galano et al., 2022) or attention problems (Clark et al., 2021).

Schubert (2021) did show that the Child Witness to Domestic Violence (CWDV) intervention improved child outcomes to a greater extent than controls, however effect sizes were small (pooled Cohen's d=.17). Woollett et al. (2020) found that children's depression scores significantly reduced after the intervention (Cohen's d=.73) however PTSD scores failed to reach significance. These results should be interpreted with caution due to their weak designs, small samples and increased likelihood of producing false positives.

Overall, the findings for separate psychoeducation and parent training interventions have shown to produce small effect sizes at improving predominantly internalising child outcomes at best, and no significant difference in increasing child wellbeing in comparison to controls at long-term follow up.

Similarly, Katz et al. (2020) used a quasi-experimental design to assess the effectiveness of an emotion coaching parenting skill and psychoeducation group. However, it differed to the above interventions as it was delivered to mothers only. The study obtained a moderate rating on the QATQ. It utilised self-report measures as well as objective measures for emotional regulation. However, researchers were not blind to conditions, it had a relatively small sample size and only 67% completed measures. Overall, children of mothers in the experimental group showed

significantly improved ability to self-regulate on the self-reported measure of emotional regulation (medium effect size, ($\eta^2$=.105) and a small effect size on objective measure of ER ($\eta^2$=.019) relative to controls. However, results should be interpreted with caution due to the moderate design and the potential for inflated effect sizes.

### *Separate Interventions: Qualitative Studies*

As demonstrated in Table 6, two separate intervention studies utilised a qualitative methodology. Woollett et al. (2020) ascertained child outcomes by interviewing children. Children described having an improved ability to identify and regulate their emotions after the intervention: *"It helped me with being scared… when we are angry or sad what we can do"* (Woollett et al., 2020, p. 6). Children also reported that the group helped them with externalising problems:*"The group helped me with controlling myself and thinking first. It changed our behaviour to be better behaviour"* (Woollett et al., 2020, p. 7).

Renner et al. (2022) predominantly reported on outcomes for parents, such as parenting outcomes, as opposed to child specific outcomes. When considering both quantitative and qualitative findings for separate interventions the outcomes remain promising but varied, leading to an overall inconclusive understanding of their impact on child outcomes.

### *Combined Interventions: Quantitative Findings*

Studies in the combined delivery mode ranged in quality. Cohen et al. (2011) received a strong quality rating: it used an RCT design, active control group, used intention to treat analysis, performed fidelity checks and had moderate dropout rates. It found that in comparison to the control group, trauma-focused cognitive behaviour therapy (TF-CBT) participants reported greater reductions in total trauma symptoms

(Cohen's d=.48), hyperarousal and avoidance (Cohen's d=.47), anxiety (Cohen's d=.27) and externalising behaviours (Cohen's d=.1) Furthermore, significantly more children in the TF-CBT group moved from the clinical range to the reference range on outcome measures in comparison to controls.

McWhirter, (2011) received a weak global rating on the QATQ, despite it having a somewhat rigorous design, the study did not use standardised measures to assess child outcomes. It found that there was no significant difference between interventions, and children in both groups significantly improved on the emotional barometer measure ($\eta 2 = .13$), self-esteem ($\eta 2 = .24$), and significantly reduced on peer conflict ($\eta 2 = .16$), and family conflict ($\eta 2 = .43$) measures. However, these constructs were assessed using a single item likert scale, therefore the already small to medium effect sizes are likely to be inflated due to the lack of standardised measures and weak construct validity. Perhaps if validated measures had been utilised a possible difference between intervention groups would have been detected.

Smith et al. (2015) received a weak global rating on the MMAT, due to not controlling for co-founders, a lack of fidelity measures, and not reporting on percentages of attendance of treatment sessions. However, children in the Domestic Abuse Recovering Together (DART) group demonstrated significantly reduced conduct (Cohen's d=.48), emotional (Cohen's d=.72), and total problems (Cohen's d=.61) on the SDQ between pre-intervention scores and at six month follow up. Despite reporting that these reductions were to a greater extent than the control group, no statistical tests were reported comparing the groups.

Overall, all three interventions demonstrated improvement in a variety of child wellbeing outcomes after a combined parent-child IPV intervention.

### *Combined Interventions: Qualitative Findings*

Only one combined intervention for IPV ascertained qualitative outcomes. McManus et al. (2013) interviewed mothers and children between one to six months following the DART programme. Children described an improved sense of wellbeing by being able to talk and process the abuse:

> *"We had to watch videos of people like arguing and talk about it. I thought that was quite good because you get to tell the truth to everybody. [It was] a little bit hard but I felt quite good about myself because I let it all out. [Before DART] I kept it to myself . . . All the bad things were in my brain and now it's turned good."* (McManus et al., 2013, p. 299)

Children also reported an improved ability to emotionally regulate following DART: *"I go and shout in a cushion now . . . because you're kind of getting all your anger out and making the cushion feel unhappy and not anybody else*" (McManus et al., 2013, p. 305). Mothers described that this had a positive impact on children's behaviour: *"Now [he is] on top form. He's got certificates [for good behaviour at school] and that's from coming to the group"* (McManus et al., 2013, p. 299).

These findings supplement the aforementioned quantitative findings of the DART programme (Smith et al., 2015) and demonstrate promising results for the intervention at improving child outcomes.

## Mediators and Moderators of Intervention Effectiveness on Child Outcomes

Several studies in this review investigated mediator and moderator variables on child outcomes to varying degrees of rigour. Six qualitative studies and one mixed methods study (Woollett et al., 2020) asked parents about their experiences of

interventions which contributed to the derivation of moderator and mediator themes. Four quantitative studies ascertained simple pre-post parent and family outcomes and inferred potential mediation pathways on the child outcomes. Finally, eight studies utilised a more rigorous regression analysis to account for mediators and moderator variables.

The following synthesis will exclude the four quantitative studies that did not use viable mediation analysis (Herschell et al., 2017; Katz et al., 2020; McWhirter, 2011; Smith et al., 2015) due to potentially making unwarranted inferences. Seven of the eight quantitive studies included measured the effectiveness of the separate psychoeducation and parenting skills intervention ‘Pre-Kids Club’ and its various iterations. The other quantitative study analysed Project Support, a joint session psychotherapy, parent training and advocacy intervention McDonald et al. (2011). Therefore, it is important to note that most inferences made from quantitive studies will be predominantly based on separate interventions which were rated moderate to weak in quality.

Table 7, exhibits the analytical and descriptive themes and the number of studies that contributed. Four of these interventions were delivered jointly, two separately and one was combined, however the data was analysed together for succinctness.

**Table 7.**

*Themes Derived from QualitativeDdata.*

| Analytical Themes | Descriptive Theme | Number of Studies Theme Appeared |
|---|---|---|
| Moderators | Timing & extent of exposure | 2 |
| | Contact with perpetrator | 3 |
| Mediators | Improved parent-child communication & relationship | 5 |
| | Improved awareness of Impact of IPV on child | 4 |
| | Improved confidence in parenting | 3 |
| | Improved parental mental health | 3 |

### *Moderators: What Impacts the Strength and Direction of the Effect?*

A common moderator variable inputted into regression models was the level of child exposure to IPV. Moderation effects of IPV exposure appears to be inconsistent between studies. Graham-Bermann et al. (2011) found that greater exposure to IPV was associated with greater reductions in child internalising problems in the intervention group. Similarly, Clark et al. (2021) found that higher levels of IPV exposure led to improved intervention effects on attention problems at eight-year follow up compared to lower levels of exposure. In comparison, Howell et al. (2013) found the opposite effect whereby increased IPV exposure predicted reduced change in pro-social skills in intervention group children. These discrepancies could be attributed to the differences between internalising and externalising child outcomes however, Galano et al. (2022) found there to be no significant moderation effect of level of IPV exposure on internalising and externalising outcomes at eight-year follow up.

Similar to IPV exposure, Overbeek et al. (2013) measured time since IPV stopped and found there to be no moderation effects on child outcomes. This is in

contrast to qualitative findings, whereby time since violence was reported by parents to impact the effectiveness of interventions. Mothers described their ability to engage in the intervention was dependent on moving from an initial state of crisis to stability and primarily after leaving abusive partners mothers were not emotionally ready:

> *"When you first come here [refuge] you're frightened, very insecure and everything. A couple of months down the line you feel completely different again … So yer, I think you know you need time to experience a bit of life in a Refuge first… Because you have to have time to reflect."* (Humphreys et al., 2011, p. 176)

The initial period after separation was not only an emotionally vulnerable time but also a period with a lot of competing demands and appointments, which further constrained family's ability to engage:

> *"Perhaps before I wouldn't have done it because I didn't have the time. I was going to court quite a lot, had a lot of problems so I just didn't have time to spend on things like this, that I could sit and think about my kids."* (Humphreys et al., 2011, p. 176)

Mothers described that intervention engagement was more difficult if they were still with the perpetrator as they lacked a sense of safety. Child outcomes were also dependent on contact with the perpetrator, whereby after contact any progress observed after intervention was diminished and behaviours reverted:

> *My daughter picked up, we got on really well for months…Then I started seeing [the perpetrator] again, just for two weeks and he smacked me in the jaw and strangled me. My daughter saw….this is when she started getting really violent again…and crying constantly."* (McManus et al., 2013, p. 306)

This complex picture of the impact of level of IPV exposure and time since exposure elucidates the need for more rigorous studies to investigate outcome moderators. This population tends to have high intervention attrition rates, potentially timing of interventions offered to families and child contact with perpetrators encapsulates reasons why initial and continued engagement might be hard.

Other moderator variables measured were child demographic variables such as gender, ethnicity, age and household income. A more succinct understanding seemed to be present. Child ethnicity and household income demonstrated to have no moderating effect of the intervention on a range of internalising and externalising outcomes (Clark et al., 2021a; Galano et al., 2022; Graham-Bermann et al., 2011; Howell et al., 2013). Child gender was found to have a moderating impact on outcomes: Graham-Bermann et al. (2011) found that in children aged 6-12 gender significantly predicted change in externalising outcomes after intervention, with boys demonstrating larger change scores than girls. However, the moderating impact of gender failed to reach significance for internalising outcomes. Graham-Bermann et al. (2015) found that in children aged 4-6 years gender significantly moderated internalising problems, with girls showing significantly greater decreases in internalising outcomes than boys: this effect remained at eight-year follow up (Galano et al., 2022). Finally, age was only found to significantly moderate outcomes for one study; Howell et al. (2013) found that older children increased pro-social behaviour post-intervention to a greater extent than younger children. More research is needed for more conclusive inferences to be made.

### *Mediators: How Do Interventions Work?*

A hypothesised mechanism of change is that child outcomes are mediated by parental mental health change. Mental health variables commonly inputted into

models were maternal depression and post-traumatic stress disorder (PTSD). Higher maternal depression and PTSD were associated with increased psychopathology in children (Galano et al., 2022; Graham-Bermann et al., 2011; Howell et al., 2013; Overbeek et al., 2017). However, maternal depression consistently failed to significantly mediate intervention trajectories on child outcomes (Galano et al., 2022; Howell et al., 2013; Overbeek et al., 2017). Maternal PTSD was significantly associated with internalising and externalising difficulties in children, however, it also failed to impact slopes of child outcomes and mediate intervention trajectories (Galano et al., 2022). However, in slightly older children aged 6-12, changes in maternal PTSD significantly mediated changes in child internalising outcomes (Graham-Bermann et al., 2011); whereby, greater reductions in maternal PTSD led to greater reductions in child internalising problems in the intervention group. In three qualitative studies, the theme of improved parental mental health emerged. One parent described that the group helped her express her emotions which reduced her anxiety: *"Before I was more down, always depressed, worrying about what other people were thinking about me. Now I express my feelings, what I have inside…I'm not ashamed of what happened to me"* (McManus et al., 2013, p. 301).

Other hypothesised mediator variables are changes to positive parenting practices, and decreases in negative parenting behaviours. Mixed results were found for parenting mediating effects on child outcomes. Graham-Bermann et al. (2011) and Howell et al. (2013) found there to be no relationship between parenting and child outcomes. Whereas, Galano et al. (2022) found that increased negative parenting was associated with poorer emotional regulation in children, and higher externalising problems at eight-year follow-up but no relationship between positive parenting and child outcomes was found. Further analysis revealed that these

significant predictors did not mediate the slope of outcome trajectories, therefore the rate of change in child outcomes did not vary as a function of negative parenting practices.

However, Project Support (a more intensive parenting intervention taking place over a year as opposed to five weeks) appeared to show evidence of parenting practices as a mediator. Harsh and inconsistent parenting (negative parenting styles) accounted for 35% of variance in decreases of externalising difficulties in children after intervention (McDonald et al., 2011). Harsh and inconsistent parenting also was found to mediate the relationship between the Project Support and control group: the rate of decrease in conduct problems over time, accounted for 34% of variance in difference between treatment conditions over time.

Overall, changes in negative parenting in particular appears to be a promising mediator variable in the effect of interventions on child outcomes. This was further corroborated in the qualitative studies, whereby confidence in parenting emerged as a theme in three of the studies: *"That feeling of constant dread isn't there. And feeling like when these things come up I feel calm and okay to handle them. It's not like I felt like before"* (Renner et al., 2022, p. 254).

One mother specifically referred to her change in her parenting style away from the negative parenting style of being passive aggressive:

> *"I feel like I have a better control of diffusing incidents ahead of time, and finding a way to open up, just trying to let them express…we can resolve issues without being passive aggressive... we resolve without letting either of us get pushed into anger*." (Renner et al., 2022, p. 254)

Another possible mediator variable explored in studies is the change in parent-child relationship. Overbeek et al. (2017) found that parent-child interactions were not significantly associated with changes in child trauma symptoms. However, it could be hypothesised that change in parenting style might be associated with change in relationship therefore perhaps some of the variance explained in McDonald et al. (2011) model could be partially accounted for by relationship. The lack of quantitative data on relationship as a mediator is not in accordance with qualitative findings, whereby mothers reported improvements in parent-child relationship and communication consistently: *"I have learnt to communicate with S [ten-year-old boy]. There was such a of lack of communication before… and I just think everything since has got better and better. I do think it did bring me and S closer."* (Humphreys et al., 2011, p.178)

Improved communication seemed to be the mechanism through which mothers reported feeling closer to their children: *"I think that we had so many more tools coming out of this and that platform to start on to start talking and open up that dialog with each other" (*Renner et al., 2022, p. 254).

None of the quantitative papers investigated changes in parental level of awareness of impact of IPV on children as a possible mediator. However, in four qualitative studies mothers spoke of their enhanced insight into the impact of the trauma on children which in turn had a positive impact on child behaviours:

> *I've gotten an understanding of the little triggers from domestic violence and the trauma it has on your kids. I never seen it as anything, now I realise the affects it then has on your child growing up… I would never have thought that anything that I had gone through had anything to do with [Child]" (*Fogarty et al., 2022, p.6).

# Discussion

The objective of this review was to examine the effectiveness of systemic interventions on child outcomes for IPV-exposed children, and examine the mediators and moderators of intervention effectiveness. Unlike previous reviews, it included qualitative, controlled and uncontrolled studies. The review identified 23 studies that met the inclusion criteria, 13 of which were unique to this review. Tentative conclusions can be drawn that jointly delivered interventions had the largest effect on child externalising outcomes, separately delivered on internalising child outcomes and combined on a wider array of outcomes including trauma. Mixed results were found for moderator and mediator variables, the review generally found limited impact of increased IPV exposure and demographic variables on intervention outcomes. However qualitative findings suggested increased time since exposure and reduced contact with the perpetrator afforded better outcomes for children. Only parental PTSD was found to mediate child outcomes for slightly older children, and only reductions in negative parenting following interventions were associated with better child outcomes. This contrasted with qualitative findings whereby parents reported improvement in their parenting skills and confidence.

## Main Findings

### *The Effectiveness of Systemic Interventions on Child Outcomes*

Jointly delivered interventions were predominantly psychotherapies demonstrating efficacy at reducing children's behaviour problems, and children's ability to emotionally regulate (Fogarty et al., 2022). The effect sizes found in this review were larger than previous reviews which found reductions in externalising symptoms to be in the small to moderate effect range (d=.36 – d=.44: Romano et al., 2021). Perhaps this possible effect size inflation was due to introducing more risk of

bias in this review as only one of the joint intervention studies was an RCT (McDonald et al., 2011). However, Project Support was conducted in the family home setting therefore the larger effect sizes corroborate with Latzman et al. (2019) finding that home interventions produced the largest effect sizes for reducing externalising problems.

Separately delivered interventions had the most impact on child internalising outcomes. However the efficacy of separately delivered group interventions with a psychoeducation and parenting skills focus seemed to be weak, and improvements were not sustained over time. This is particularly pertinent as Romano et al. (2021) found that reductions in internalising symptoms following intervention are the least impervious to time in comparison to other outcomes. These findings are in contrast to Howarth et al. (2016) review, whereby separately delivered groups were the most efficacious intervention. However, findings are similar to Latzman et al. (2019) meta-analysis findings which produced the smallest pooled effect size (d=-.08). Similarly to previous reviews, studies investigating separately delivered interventions are weak in quality and have a high chance of bias (Anderson and Van Ee., 2018; Austin et al.,2019; Howarth et al.,2016; Latzman et al., 2019; Romano et al., 2021). Therefore, it is challenging to definitively make comparisons without more rigorous studies.

Combined interventions were heterogenous in their delivery format and ranged in quality, with only one study receiving a strong QATQ rating (Cohen et al., 2011). Overall, the combined interventions provided tentative evidence for being effective at improving a wider array of outcomes than the aforementioned joint or separate interventions. These included reductions in trauma symptoms such as hyperarousal and avoidance, anxiety and externalising behaviours. The finding that trauma specific interventions produced smaller effect sizes in comparison to non-

trauma specific interventions (Romano et al., 2021) was not corroborated, as TF-CBT (Cohen et al., 2011) produced similar effect sizes to studies of similar rigour (McDonald et al., 2011).

### *Mediators and Moderators*

The moderating impact of level of IPV exposure on child outcomes after intervention was mixed. Two studies found greater reductions in attention and internalising problems after greater IPV-exposure (Clark et al., 2021; Graham-Bermann et al., 2011), whereas Howell et al. (2013) found greater exposure led to reduced change in pro-social skills and Galano et al., 2022 found no moderating impact at eight-year follow up. Themes that emerged from qualitative studies were different but conceptually similar to level of IPV exposure (Humphreys et al., 2011; McManus et al., 2013). Parents reported that increased time since exposure and reduced contact with the perpetrator afforded better outcomes for parents and children. It is challenging to situate these findings within the literature as no previous quantitative reviews have investigated the moderating impact of level of exposure on child outcomes. Kitzmann et al. (2003) meta-analysis found that increased child exposure to violence led to increased child internalising and externalising problems, however this was not investigated in relation to intervention receptibility. Lindhorst and Beadnell (2011) longitudinal study found differing levels of exposure and types of abuse predicted psychological outcomes in children after intervention, however at long-term follow up there was no significant difference between groups, indicating that time since abuse affected adjustment. Furthermore, Howarth et al. (2019) qualitative synthesis found that a factor impacting intervention engagement was whether families were out of crisis, and continual child contact with the perpetrator acted as a barrier to intervention effectiveness. More research is needed on the

moderating effects of extent, type and time since IPV exposure on outcomes following intervention.

The moderating impact of demographic variables on child outcomes also has a limited evidence base. This review found tentative evidence that gender might moderate intervention efficacy, with boys demonstrating increased reductions to externalising (Graham-Bermann et al., 2011) and girls internalising problems (Graham-Bermann et al., 2015). One study found evidence that age of IPV-exposure might play a moderating role on intervention efficacy, with older children demonstrating an increase in pro-social behaviour (Howell et al., 2013). The seemingly limited moderating impact of age, family income, and ethnicity should be held tentatively due to the lack of diversity in the sample which was predominantly Caucasian American. The findings are consistent with previous reviews (Howarth et al., 2016; Latzman et al., 2019a; Romano et al., 2021), however all moderator variables need to be explored further with a more diverse sample.

The mediating role of maternal mental health proved to demonstrate contradicting results between qualitative and quantitative findings. The theme emerged in three qualitative studies, whereas only reductions in maternal PTSD symptoms significantly mediated reductions in children's internalising symptoms (Graham-Bermann et al., 2011) and depression symptoms consistently failed to mediate child outcomes (Galano et al., 2022; Graham-Bermann et al., 2011; Howell et al., 2013; Overbeek et al., 2017). None of the previous systematic reviews synthesised it as a possible mediating role, however another RCT not included in this review, due to it's publication date, found that improved parental mental-health mediated the link between intervention and decreases in child PTSD symptoms (Jouriles et al., 2009). Similarly, this review found limited evidence for changes in the

parent-child relationship mediating intervention effectiveness of child outcomes, with the theme mostly appearing in qualitative findings as opposed to the quantitative studies. Changes in parental mental health and the quality of the relationship were often stated as intervention aims in the studies included in this review and previous reviews (Rizo et al., 2011). Our understanding of child outcomes relationship to attachment styles (Ainsworth et al., 1978; Bowlby,1973) and the instrumental role of parental mental health and availability can have on forming attachment styles (Risi et al., 2021) makes conceptual sense for parental mental health and parent-child relationship to play a mediating role in systemic interventions; however, more research, with an emphasis on theory of change is required in order to fully understand this.

Enhancing positive parenting skills and reducing harsh and inconsistent parenting practices was a common goal in interventions as well as in previous research (Rizo et al., 2011). However, positive parenting consistently failed to significantly relate to child outcomes, let alone mediate changes in child outcomes. Only changes to negative parenting was associated with child outcomes and mediated the relationship between Project Support participation and child outcomes (McDonald et al., 2011). Three qualitative studies found that parents reported an improvement in their parenting skills and confidence (Fogarty et al., 2022; McManus et al., 2013; Renner et al., 2022) and had more of an understanding of the impact of IPV on their child post intervention. This is in line with Howarth et al. (2016) qualitative synthesis whereby increases in sensitive parenting following interventions were reported by parents. However, the lack of quantitative evidence for systemic interventions enhancing parenting skills is concerning given the emphasis on parenting in many of the interventions and the hypothesis of parenting skills being a

theory of change in systemic interventions (Anderson & van Ee, 2018; Austin et al., 2019).

**Methodological Issues of Included Studies**

The overall quality of evidence in this review was low, with the majority of studies being ranked weak to moderate with high levels of likely bias. One major contributing factor was biased sample selection, as most consisted of convenience sampling obtained via connections to IPV shelters. Such samples impede the generalisability of study results as approximately two percent of children exposed to IPV live in shelters (Anderson & van Ee, 2018). Therefore, IPV victims known to local services or seeking support may differ in important ways to those that do not, this could be with respect to: severity of violence, child difficulties, and parental mental health (Austin et al., 2019). Furthermore, despite extensive evidence suggesting IPV affects communities worldwide (Sardinha et al., 2022), samples were predominantly Caucasian and from the USA, therefore findings are not entirely generalisable and suggests recruitment ought to include a wider outreach. Another contributing factor to the high risk of bias was the high levels of participant attrition (lowest retention rate 23%). Such rates are typical for intervention studies with vulnerable people (Ellard-Gray et al., 2015). However, the attrition rates impacted studies ability to detect meaningful differences between intervention and comparison groups. The high attrition rates may reflect the chaotic lifestyles associated with families moving away from abusive relationships into shelters (Latzman et al., 2019) and further signifies the need for broader participant selection procedures. Despite these methodological challenges, effects were identified and highlight the importance of these findings.

Another limitation of the studies was the lack of RCTs. Though many of the studies found changes in outcomes, it was not always possible to determine whether these were due to interventions or other factors such as time or non-intervention specific factors; indeed when Overbeek et al. (2013) compared the intervention to a non-trauma specific general social group, child outcomes decreased equally across groups suggesting that the social contact of the play group could be equally beneficial to children than the more resource intensive IPV intervention. Perhaps the prominent use of cohort study designs and pilot studies is more ecologically valid and representative of the challenges of conducting empirical research in community-based settings and engaging with the IPV-exposed population.

Furthermore, there was considerable heterogeneity in relation to target child outcomes and measures used. Seven different outcome categories were identified and a total of 18 different instruments to calibrate them. Not all intervention modes tested the same concepts which meant identifying differentiating efficacy levels between intervention modes and possible change mechanisms difficult to authentically compare. There was also a lack of standardisation in defining IPV exposure, as this captures varying levels of severity from single incidents to persistent exposure as well as varying types of IPV. Also, not all studies defined IPV-exposure or utilised standardised tools to measure it. This makes inferences about the group challenging as IPV exposure is not homogenous and intervention responses may vary depending on IPV type (Halford & Smith, 2022). Despite this review grouping studies via delivery and modality, there remained a considerable degree of heterogeneity in terms of intervention delivery and content even within categories. This might reflect the numerous psychological impacts of IPV on families

however could also depict the lack of consensus among the literature regarding how to best support families (Anderson & van Ee, 2018).

**Strengths and Limitations of Review**

This review has contributed to the understanding of the impact of systemic interventions on child outcomes and identified 13 studies not included in other reviews. The inclusion criteria were less stringent than previous reviews, as they permitted uncontrolled and qualitative studies; this made findings more ecologically valid and representative of community based interventions for a particularly hard to retain group. This review also sought to build upon previous reviews' recommendations by seeking to understand mechanisms of change (Howarth et al., 2016; Romano et al., 2021). Conducting searches using three major databases within the field, increased the likelihood of capturingthe relevant studies. However, by excluding grey literature, and the publication process itself demonstrating a bias towards significant results, there was a potential for an incomplete dataset with a positive data skew. Using a second reviewer to screen a percentage of papers and review the methodological quality enhanced reliability of the review, and the high inter-rater reliability attained signifies the feasibility for replication.

A limitation of the review was the exclusion of parents with substance misuse difficulties and children as direct victims of violence. Distinguishing between children who witnessed and direct victims of IPV is arbitrary as both often co-occur, and substance misuse plays a role in many families' experiences of IPV and parenting (Anderson & Van Ee, 2018).

Another limitation of this review was the limited number of quantitative papers exploring mediators and moderators. The majority of inferences were made from weak to moderate studies investigating the separately delivered psychoeducation

parenting group PKC & MEP (Graham-Bermann et al., 2011). Other studies measured different outcomes such as parent and family outcomes however due to weaker methodologies did not use multivariable modelling to ascertain mediation and moderation effects. The themes derived from the qualitative papers signify that parents felt that changes in their parent-child relationships, parenting and mental health were all important factors in their noted improvements in their children's behaviour; however more rigorous studies utilising regression analysis are required with larger samples to ascertain the extent.

**Clinical Implications**

The findings from this review provide insight into various systemic interventions for families exposed to IPV, however clinical implications must be viewed in light of these limitations. Similarly to previous reviews (Howarth et al., 2016; Latzman et al., 2019), this review cannot definitively recommend any one type of intervention over and above another; however, there is tentative support for jointly delivered interventions being effective for externalising child difficulties, separately delivered interventions being effective for internalising difficulties and combined interventions being effective for a wider array of child difficulties such as trauma. However, findings from mediator and moderator analysis indicate that it is largely unclear as to how and for whom systemic interventions promote well-being among children exposed to IPV.

**Future Research**

There are many possibilities for future research to increase and consolidate the evidence base to better understand systemic interventions for IPV exposed families. This review recommends the replication of current interventions in more

diverse populations recruited from outside of shelters, with larger sample sizes that will afford more rigorous and complex analysis such as multilevel modelling to ascertain mediator and moderator variables. Exploring this is crucial to potentially understand the high attrition rates as previous research has noted a complex array of added adversities that could potentially influence intervention receptiveness such as: level of IPV, mental health, lack of support, financial concerns, continued perpetrator contact (Austin et al., 2019). More consistent and detailed assessment of the nature and extent of IPV subtypes is therefore required. Also, a focus on theory of change is needed to elucidate the mechanism by which interventions are effective, potentially leading to an enhanced understanding for the varying levels of effectiveness of interventions and their delivery modes for certain child outcomes; as particular interventions such as short term psychoeducation groups like the Kids Club (Graham-Bermann et al., 2011) are more cost effective than the resource intensive 12-month weekly home visit model such as Project Support (McDonald et al., 2011), so knowing what works for whom and why could be vital to maximise clinical effectiveness and cost efficiency.

Finally, a large contributing factor to the inability to ascertain definitive conclusions from the literature is the high level of bias that permeates many of the studies. As mentioned, an emphasis on participant selection and randomisation, comparison groups and long term follow up is needed to determine less biased and inflated effect sizes. However, the complexities of the population might serve as a limiting factor in carrying out more rigorous RCTs, therefore focusing on just one of these elements in conjunction with continued qualitative data collection to supplement findings might serve to detect more meaningful effects.

## Conclusions

This review synthesised the available empirical research evaluating systemic interventions for families exposed to IPV over the last twelve years. The evidence base has made limited progress with conclusions similar to previous reviews in that more rigorous evaluations are needed (Anderson & van Ee, 2018; Austin et al., 2019; Howarth et al., 2016; Latzman et al., 2019; Rizo et al., 2011; Romano et al., 2021). The findings show direct comparisons of differing levels of efficacy between combined, jointly, and separately delivered interventions are hard due to their considerable heterogeneity. Tentative evidence was found for joint interventions being most efficacious for improving child externalising outcomes, separately delivered interventions for internalising outcomes and combined for a wider array of outcomes. Tentative conclusions can also be made about the moderating role of continued perpetrator contact and mediating roles of reductions in maternal PTSD and negative parenting strategies after intervention. More rigorous research with a focus on moderator and mediator variables are needed.

# Chapter 2: Empirical Paper

## Multisystemic Therapy in the Context of Intimate Partner Violence: Parents' and Practitioners' Experiences

## Abstract

Interventions for children impacted by intimate partner violence (IPV) predominantly focus on improving the relationship between non-abusive parents and their child. However, abusive parents often live with their children or have continued contact; this has been found to impede intervention effectiveness. Whole family interventions for IPV impacted families are gaining traction and are a recommended area for research in the National Institute for Health and Care Excellence (NICE) guidelines for multi-agency working with domestic violence (NICE, 2014). Multisystemic Therapy (MST) is an intensive whole family intervention designed for children who present with antisocial behaviour. As child behaviour problems frequently co-occurs with family violence (Van Eldik et al., 2020) MST practitioners often work in the context of IPV. To date MST has not been researched specifically in relation to IPV. This study investigated how MST can best meet the needs of families where there are concerns of IPV. A sample of eight MST practitioners and four parents were interviewed using semi-structured interviews. Interviews were analysed using reflexive thematic analysis and produced three themes and nine sub-themes. Theme one was barriers to MST process and consisted of barriers posed by the impact of IPV on parents, impact of IPV on the family, and the impact of IPV on the MST process. Theme two was facilitators to change and included the sub-themes of principles of MST and MST practitioners experienced as containers. Theme three was amendments which described the changes made by practitioners to meet the needs of families. This consisted of hypervigilance to increasing risk, safety planning on-going IPV risk, increased multi-agency working and increased length of intervention. The study demonstrated the acceptability of MST for working with families impacted by IPV and gives credence to the systemic perspective of the inclusion of abusive parents.

# Introduction

The Domestic Abuse Act (2021) recognised children as victims of domestic abuse (DA) if they witness or experience the effects of DA, and outlines DA behaviours as: physical or sexual abuse; violent or threatening behaviour; coercive behaviour; financial abuse; and emotional abuse. However, the term intimate partner violence (IPV) will be used throughout this paper as it denotes violence that occurs between romantic partners irrespective of whether they live in the same household or not, whereas DA can reflect abuse in non-intimate relationships (e.g. adult children and elderly parents). IPV is a pervasive issue. The Crime Survey for England and Wales estimated that 2.4 million adults experienced IPV in the year ending March 2022 (Office for National Statistics, 2022). Children are hugely impacted by IPV, with a Women's Aid audit revealing that 62% of their service users had children (2023) and was the most frequent factor identified in children in need assessments (49.6%: Department for Education 2016). The impact of IPV on the non-abusive partner and children are far reaching and pervasive: children are more likely to suffer from maltreatment, demonstrate internalising, externalising and attachment difficulties, as well as be at an increased risk of perpetrating or becoming a victim of bullying and IPV (Carlson et al., 2019; Karlsson et al., 2016; Noonan & Pilkington, 2020; Vu et al., 2016).

IPV perpetration is a considerably heterogenous phenomenon, therefore differentiations have been made with respect to context, partner dynamics and consequences (Holtzworth-Munroe & Stuart, 1994). Kelly and Johnson (2008) built upon Holtzworth-Munroe's typologies of IPV, and theorised patterns of violence categorisation. Two of these typologies include coercive controlling violence (formerly intimate terrorism) and situational couple violence which are most

frequently cited (Potter et al., 2021). The former is driven by positive attitudes and beliefs about violence and is characterised by severe one-sided violence underlined by control. Perpetrators are commonly described as batterers and are often the partners of women in refuges (Kelly & Johnson, 2008). Situational couple violence refers to couples where mild-moderate violence is reciprocal and lacks control and domination as motivation, it arises from situational stressors whereby violence is used as a problem-solving strategy (Kelly & Johnson, 2008). The IPV typologies have been useful in understanding the pattern of differing gender rates of IPV perpetrators between community samples and refuge samples; gender rates are more symmetrical in community samples where situational couple violence is more common, and asymmetrical in refuge samples such as a Women's Aid audit (2023) whereby perpetrators were 94.3% male and more likely to represent the coercive controlling violence subtype.

Different theories about IPV have contributed to the numerous interventions for perpetrators, non-abusive partners and children. Feminist theory understands IPV through the lens of patriarchy and the gender inequalities of power that contribute to men becoming violent; it proposes that men are socialised to utilise violence as a means of maintaining privilege (Jenkins, 1990). This informed the development of the Duluth Model (Pence & Paymar, 1993) which assumes a unidirectional approach where men are perpetrators of IPV and require separate interventions to their female partners such as batterer interventions. Separate interventions proposed by feminist theory also extend to the parent-child interventions whereby only the non-abusive partner, predominantly mothers, take part and there is an emphasis on enhancing the parent-child relationship (Anderson & van Ee, 2018; Howarth et al., 2016; Latzman et al., 2019; Rizo et al., 2011; Romano et al., 2021). The National Institute

for Health and Care Excellence (NICE) guidelines for multi-agency working with domestic violence recommended pathway seems to be informed by feminist theory (NICE, 2014). It recommends interventions for perpetrators' should be separate with goals entailing attitudinal change and accepting accountability (NICE, 2014).

However, the evidence base for separate interventions such as batterer interventions based on the Duluth model is poor and demonstrates high drop-out rates (Armenti & Babcock, 2016). A meta-analysis found interventions to have no effect on recurrence of physical violence as reported by victims (d= .01) and a small effect on official recidivism rates (d=.26; Eckhardt et al., 2013). One contributing factor could be that batterer interventions are a one size fits all approach for a heterogenous group as they assume a universal unidirectional pattern of violence by men underscored by control (McCollum & Stith, 2008). This approach neglects to consider Kelly and Johnson's (2008) and Holtzworth-Munroe & Stuart (1994) other theorised 'types' of perpetrators such as situationally violent couples and violent resistant. Treating perpetrators in isolation as a homogenous group fails to address the underlying relationship dynamics that could contribute to situationally violent couples and conjoint therapy potentially would mitigate such stressors and prove more effective (Hurless & Cottone, 2018).

Furthermore, perpetrators that are excluded from interventions are often men, many of whom are fathers; a UK evaluation study found that two thirds of referrals to male batterer interventions were from child social services or Children and Family Court Advisory and Support Service (Hilder & Freeman, 2016). Evidence suggests that where there is IPV couples often remain together or it can take on average seven attempts to separate (Karakurt et al., 2013). Separation is not only a particularly risky time period for violence escalation, there also remain many

logistical barriers such as isolation, limited resources and continued child contact with perpetrators (Stanley & Humphreys, 2017). However, child protection social work almost exclusively focuses on children and mothers and fails to engage abusive fathers, positioning mothers in a negative light and facing scrutiny from services for staying with abusive partners which can lead to the alienation of families (Stanley & Humphreys, 2017). If couples do separate, continued and often court mandated unsupervised child contact with fathers exposes children to potential abuse and can also cause the continuation of IPV perpetuation in a different form (Heward-Belle, 2018). Furthermore, despite the evidence base for non-abusive parent-child interventions being promising with effect sizes ranging between small to moderate (Latzman et al., 2019; Romano et al., 2021), continual contact with fathers has been found to act as a barrier to intervention effectiveness (Howarth et al., 2016). Mohaupt and Duckert (2023) interviewed violent and non-violent men and examined their descriptions of their co-parenting mothers and children; in comparison to non-violent fathers, violent fathers struggled to mentalise their children and their descriptions of co-parents were often negative, lacked respect or mutuality and described undermining behaviours as well as an inflated perception of their own parenting competency. Violent fathers have been documented to utilise over-controlling behaviours as well as the overuse of physical forms of discipline (Humphreys & Campo, 2017). Furthermore, Hardesty and Ganong (2006) interviewed women whose ex-partners were abusive and found: women described ex-partners to be exhibiting controlling behaviours post separation which often centred around co-parenting arrangements; they were parenting in the context of fear; conflict existed around general parenting differences such as household rules and routines; and women tried to create boundaries and regain control by limiting

communication with ex-partners as much as possible (Hardesty & Ganong, 2006). Collectively, this provides a compelling argument for children exposed to IPV mental health interventions to include abusive parents in some capacity.

The systemic perspective does so and considers the overall functioning of the family system (Stith et al., 2012). Within this perspective, conflict theory understands violence to be a type of behaviour used to achieve a goal and explains power struggles within relationships. Contemporary systemic theories also consider the wider context of culture, gender and power on the family system (Oka & Whiting, 2011). In contrast to the Deluth model, systemic theories take into account that IPV within families can occur in a myriad of ways and perpetrators are not necessarily solely categorised as the intimiate terrorism/ coercive controlling (Holtzworth-Munroe & Stuart, 1994; Kelly & Johnson's, 2008). Systemic theories advocate for the need to intervene with families and couples as a whole in the context of IPV, as opposed to separate interventions informed by the Deluth model.

Concerns about whole family approaches or conjoint couple interventions in the context of IPV are well documented, and mainly consist of worries regarding safety during, and escalation of violence after sessions (Todahl et al., 2012). The inherent power imbalance regarded in certain typologies of IPV and the fear of retribution from partners undermine the pre-requisite for safe therapy which is the ability to speak freely (Humphreys & Campo, 2017); leading to possible victim minimisation and suppression of their needs during therapy to appease perpetrators (Todahl et al., 2012). Interviews with women who experienced couples therapy in this context found that there was not only a lack of safety and an inability to speak openly but also a sense of feeling afraid which was not discussed with therapists due to perpetrator intimidation (Jory et al., 1997). Besides the pragmatic difficulties

around safety, there remains a theoretical opposition to conjoint therapy in the context of IPV; formulating systemically using circular causualty dilutes the responsibility of the perpetrator and implicates victims as partly responsible for the violence (Stith & McCollum, 2011). These concerns are legitimate and require deliberation.

Therefore inline with these considerations guidelines for clinicians have been produced to safely work with couples or families where there is IPV (Humphreys & Campo, 2017; McCollum & Stith, 2008). Primarily, guidelines refer to the requirement of a rigorous assessment of couples to ensure IPV is not characterised as the coercive controlling type (Kelly & Johnson, 2008), one partner is not fearful, there is the potential for violence escalation or where there is serious substance misuse. Tools suggested to help identify the characteristics of the violence are the Conflict Tactics Scale (Straus et al., 1996) and the Situational Violence Screening Tool (SVST; Friend et al., 2011). Guidelines also suggest considerable assessment and ensuring that couples are assessed individually (Humphreys & Campo, 2017). A second guideline referred to the need for an enhanced focus on safety throughout the intervention; this includes on-going safety planning and constant risk assessment, modifying interventions to include the teaching of violence de-escalation skills such as time-outs. Finally, another consistent suggestion is the need for enhanced multi-agency working with an aim of increasing the family's connectivity to wider systems (Humphreys & Campo, 2017; McCollum & Stith, 2008). Humphreys and Campo (2017) suggested best practice guidelines also include keeping the intervention focused on parenting as opposed to the couple and explicitly addressing IPV in relation to their children. Other suggestions included contracting no violence

from the outset, including the goal of stopping violence and the requirement of therapists to receive additional IPV training.

There is a growing evidence base for couple and whole family interventions in the context of IPV. Armenti and Babcock's (2016) systematic review examining the effectiveness of conjoint interventions identified eight experimental studies and found that for assessed couples exhibiting situational violence there were equal reductions in physical violence compared to treatment as usual, increased couple satisfaction, and no violence escalation post sessions. The review concluded that conjoint interventions for situationally violent couples exhibiting mild-to-moderate violence are safe and the field can move beyond intervening solely from a Duluth model perspective (Armenti & Babcock, 2016). Furthermore, Humphreys and Campo (2017) scoping review of whole family approaches with mothers and fathers either living together or co-parenting separately, identified a range of interventions. Those that were evaluated demonstrated interventions to increase family safety to a greater extent than controls (May et al., 2016) and reduced IPV (Stover, 2015). Working with families in the context of IPV has increasingly been prioritised within the UK, demonstrated by the funding of the Troubled Families Intervention; although not the only intervention target, it identified IPV as pervasive and recognised whole family, multi-agency working as crucial for interventions (Day et al., 2016). Another whole family programme in the UK is the Growing Futures programme (McCracken et al., 2017) which is specifically designed for families experiencing IPV and is a multi-agency service, coordinated to provide therapeutic intervention to children, victims and perpetrators of IPV with a focus on risk reduction. It found that repeat referrals to Multi-Agency Risk Assessment Conference (MARAC) reduced by 36.4% following programme completion (McCracken et al., 2017). There clearly is an appetite for

family interventions in the context of IPV, however despite the evidence base growing, it remains an under-researched area.

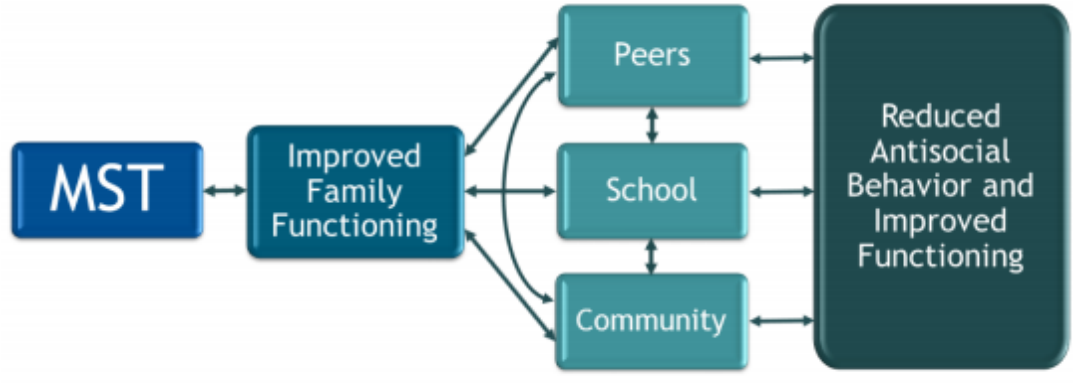
A limited number of qualitative studies have captured some experiences of therapists' and parents' experiences of delivering or receiving couple and family interventions in the context of IPV. Karakurt et al. (2013) interviewed family therapists and found: therapists experienced systemic principles such as cycle work useful in conceptualising violence; fears of increasing violence; treatment focus was dependent on the level of risk with more violent couples having to spend more time on safety planning, paying attention to ground rules and having some 'no discussion' topics; and therapists expressed a desire for more training specifically around safety planning (Karakurt et al., 2013). Stanley and Humphreys (2017) interviewed parents and therapists in the Growing Futures whole family intervention (McCracken et al., 2017) and found: engagement was facilitated by the service offering a different nature of relationship in comparison to other services such as social care; flexibility was paramount to engagement; offering different clinicians if separated couples did not want to work with the same clinician; engaging perpetrators was harder and was achieved in just over half of the cases; working in dyads was helpful and allowed for a 'good cop bad cop' approach or for each clinician advocating for either parent; engagement was enabled by keeping interventions child focused such as on parenting skills and strength based; helpful intervention focused on empowerment and repairing families' relationships with the wider system and whole system; and finally a huge amount of work was dedicated to risk assessment and safety planning (Stanley & Humphreys, 2017).

The present study aims to advance the field of family-based treatments in the context of IPV by investigating the family intensive intervention Multisystemic

Therapy (MST:Henggeler & Borduin, 1990). MST is an evidence-based ecologically valid family intervention developed for young people aged 11-17 who are at risk of custody or out-of-home placement due to severe antisocial behavioural problems. It is an intensive home-based intervention based on Bronfenbrenner's (1979) social-ecological conceptualisation of human development which proposes that behaviour is influenced by the multiple systems in which young people are embedded (family, peer, education and community systems). As shown in Figure 2, MST aims to affect the multiple systems that surround the young person by primarily working with caregivers to 'improve family functioning' and empower caregivers with resources and skills to manage the behaviours (Henggeler et al., 2009). MST is delivered across 3-5 months and practitioners are available 24-hours a day seven days a week. It is tailored to address families' individual needs through continual assessment and formulation following the 'do loop' process. This starts with identifying and prioritising the main drivers of behaviour, weekly evaluation of the progress made towards identified goals, trying out various interventions, and finally identifying the advances and barriers to change. MST uses an amalgamation of evidence-based approaches for intervention such as cognitive behavioural therapy (CBT), family therapy, behavioural and parent management training (Ashmore & Fox, 2011).

**Figure 2**

*MST Model of Change (MST Services, 2017)*



MST has a large international evidence base, a recent meta-analysis which included 22 RCTs found that MST was effective at reducing antisocial and offending behaviour (Van der Stouwe et al., 2014). MST was also found to be effective at improving family factors (mean *d*= .143; Van der Stouwe et al., 2014), which included parental mental health and parenting. However, results have not been ubiquitous as larger effect sizes were found for RCTs that took place in America (Van der Stouwe et al., 2014), and Fonagy et al. (2020) large scale UK based RCT found no significant difference in the proportion of offending between treatment as usual and MST at 18-months follow-up.

MST does have multiple adaptations to meet the unique needs of different populations. One being MST for Child Abuse and Neglect (MST-CAN: Swenson & Schaeffer, 2018) which is for families where there are children aged 6-17 who experience physical abuse and neglect and are under the guidance of Child Protective Services (CPS). However, not all families where there is IPV present meet the inclusion criteria for MST-CAN and MST-CAN is not as widely delivered as standard MST. The presence of IPV within families is not part of the standard MST exclusion criteria and child behavioural problems and family violence frequently co-occur (Skinner et al., 2019; Van Eldik et al., 2020). Therefore despite MST not being an IPV specific intervention, MST practitioners often work with IPV impacted families and directly address violence. MST shares multiple key aspects of the aforementioned family interventions for IPV and best practice guidelines (Humphreys & Campo, 2017; McCollum & Stith, 2008; Stanley & Humphreys, 2017) that make it

an appropriate whole family intervention for IPV impacted families. These include: multi-agency working; engaging, where possible, everyone in the family system; child and parent skills focused; strength-based; flexible; and incorporates safety planning and de-escalation. However, despite family functioning being a prominent intervention target in MST, to date MST has not been researched specifically in relation to IPV. An MST-IPV intervention (Swenson & Schaeffer, 2018) is currently being piloted with a goal of helping partners interact safely (Swenson & Schaeffer, 2018). This MST adaptation will differ in regards to standard MST as it will have a more extensive assessment process to ensure safety in working with couples conjointly, more intensive safety planning and a written commitment to non-violence, incorporate domestic violence-focused couples therapy (Stith et al., 2011) as well as the psychoeducation and acceptance of responsibility of the impact of IPV on children. As MST-IPV remains in development this study hopes to contribute to its formation. However, the availability of MST-IPV within the UK will be limited, and many MST teams will have to apply standard MST to families who experience IPV. Little is known about clients' or practitioners' experiences of MST when IPV is or has been a concern. Therefore, this study also hopes to contribute to the wider literature surrounding experiences of undergoing and delivering family interventions in the context of IPV. To the researcher's knowledge, only one study has interviewed both parents and practitioners experiencing family therapy in the context of IPV (Stanley & Humphreys, 2017). This study hopes to build on this and investigate how MST can best meet the needs of families where there are concerns of IPV, but for which this is not the specific aim of intervention.

**Aim**

To understand the impact of IPV on the delivery and implementation of MST in order to best meet the needs of families where there are concerns around current or historic IPV.

### Research Questions

1. What is the perceived impact of IPV on parents' experiences and practitioners' delivery of MST?
2. Which MST intervention components are perceived as effective at addressing the needs of parents impacted by IPV?

## Methodology

### Design

A qualitative methodology with a semi-structured interview design was utilised as the research was exploratory and interested in participants' nuanced experiences.

### Ethics

The research was granted full ethical approval by Royal Holloway University of London Ethics Committee (REC Project ID 3154) on 7th July 2022 (see Appendix D). Further approval from the Health and Research Authority within the NHS was not necessary to obtain due to MST recruitment sites being charities or local authorities. The separate sites required further ethical approval via either their leadership or research governance teams. E-mail confirmation of approval from each participating site was received between September-December 2022 (see Appendix E). During one parent interview, a disclosure was made indicating potential harm from her ex-partner which led to an intentional breach of confidentiality due to safeguarding concerns. This was in line with the participant understanding as set out in the information sheet and consent form. The pre-determined guidelines were adhered to

and the participant consented to the sharing of the researcher's concerns with her former MST practitioner and social worker.

**Recruitment**

Participants were recruited from five MST teams across the UK spanning four regions: East and West Midlands of England, North of England and Scotland. Purposeful sampling was utilised whereby information sheets which contained the inclusion criteria were sent to MST practitioners who were then responsible for identifying and contacting suitable families to gain consent to be additionally contacted by the researcher. The parent inclusion criteria consisted of:

- Parents who had completed standard MST within the last two years who reported experiencing historic or current IPV
- Families where statutory services assessments stated the young person was able to remain at home during the MST treatment process
- IPV was addressed by the practitioners as a concern and worked on with the family during MST
- Parent spoke proficient English in order to complete the research interview

practitioners at each site were also invited to take part in the study depending whether they met the criteria of having worked with families where IPV had been a concern and worked on with the family. Purposeful sampling was also utilised with practitioners recruitment as information was sent to supervisors who encouraged practitioners to contact the researcher.

**Procedure**

Once practitioners or parents had been identified, the researcher emailed all participants with the research information, consent forms and demographic forms. Two information forms were developed providing details about the research,

researcher and supervisor contact information, what participation would entail, confidentiality and anonymity, limits of confidentiality, the data storage plan and participants' ability to withdraw (see Appendix F and G). All 12 interviews were conducted online via Microsoft Teams between September 2022-March 2023. Interviews were audio recorded via teams and transcribed by the researcher. To ensure anonymity, interviews were only accessible to the researcher and stored separately to consent and demographic forms. Anonymised transcripts were stored using RHUL Dropbox for Business and supervisors could access anonymised transcripts via an MST secure file transfer system.

Consent and demographic forms were emailed to the researcher prior to the interviews. Additionally, informed consent was attained prior to starting the interview, this entailed checking participants understanding of what they had consented to by asking a short series of questions. The researcher further re-iterated the limits of confidentiality around risk or safeguarding disclosures and the procedures that would be followed, and their ability to withdraw. Participants were also offered the opportunity to ask the researcher questions. No participants withdrew, however one interview terminated earlier due to a parent having to pick up their child early due to sickness. The duration of interviews varied from 40 to 70 minutes. Parents were re-imbursed £10 for their participation in the study. A debrief information sheet (see Appendix H, I) was emailed to participants post- interview which provided another summary of the research, contact details and a list of website links and telephone numbers to organisations that support victims of IPV.

**Materials**

Two draft semi-structured interview schedules for practitioners and parents were created based on the research questions, existing literature and supervisors'

recommendations. The practitioners interview was adapted from Karakurt et al. (2013) interview schedule around investigating experiences of family therapists working with IPV, however was modified to be specific to MST and the research questions. During the draft phase, two practitioners and one parent (experts by experience) were consulted on their understanding of the questions, views on format, breadth and sequence of questions, language used and whether the questions were accessible and answerable. The feedback was consulted on with supervisors and the order of questions was changed to ensure that the more sensitive questions appeared slightly further down the interview schedule to allow for the development of rapport between researcher and interviewee. The final interview schedules (see Appendix J) were designed to be open-ended with the use of additional prompts if needed. The parent interview schedule entailed nine questions and was organised into pre-MST questions surrounding circumstances of young person and IPV relationship; intervention questions exploring their experiences of MST in the context of IPV; and post-MST exploring the impact of MST and whether COVID-19 had impacted on their experience. Practitioners interviews also consisted of nine questions enquiring about: the type and prevalence of IPV they come across; impact on delivery; difficulties and facilitators; recommendations or adaptations; and their confidence.

Demographic questionnaires pertaining to age, gender, and ethnicity was also developed with supervisor input. Parents were further asked about the circumstances around timing of IPV in relation to their MST participation, whether they completed MST and under what circumstances in relation to the COVID-19 pandemic (see Appendix J). Practitioners were asked about their length of time working for MST (see Appendix K).

**Sample**

The sample consisted of four parents and eight practitioners (two supervisors, six therapists). The researcher is not aware of the exact number of parents were approached to take part in the study. Nevertheless, the researcher is aware of 12 parents that were identified by practitioners as possible participants, of which: three parents did not fully meet the inclusion criteria; three parents declined to take part in the research; and two parents consented to being contacted and interviewed but did not proceed. Informed by Braun and Clark (2022) guidance the concept of 'information power', which considers sample specificity, interview quality and analysis strategy (Malterud et al., 2016), was utilised to determine sample size as opposed to sample saturation. A total sample of 12 was deemed appropriate due to the richness of the information obtained from the interviews as well as sample size guidance for reflexive thematic analysis. In order to contextualise the sample and allow for the consideration of the transferability of the findings, parent demographic information is provided in Table 8. All parents were White British mothers, and their mean age was 41.25 years. All but one young people was male, and their mean age was 13 years. None of the sample participated in MST at the time of the COVID-19 pandemic therefore MST was delivered in homes. The mean length of time working in MST for practitioners was 4.6 years, and all except one practitioners was female. Six practitioners were white, one identified as Asian British, and another practitioner identified was Black British.

Due to IPV being such a heterogenous experience, Table 9 provides brief information regarding parents' experiences of IPV at the time of their taking part in MST in order to better 'situate the sample' (Elliott et al., 1999).

**Table 8**

*Parent Demographic Information*

| Participant | Gender | Age | Gender of referral young person | Age of young person at time of MST | MST Outcome |
|---|---|---|---|---|---|
| Parent 1 | Female | 30-35 | Male | 10-15 | Completed |
| Parent 2 | Female | 36-40 | Male | 10-15 | Completed |
| Parent 3 | Female | 45-50 | Male | 10-15 | Completed |
| Parent 4 | Female | 45-50 | Female | 10-15 | Completed |

**Table 9**

*Brief overview of parents' experiences of IPV and relationship to perpetrator during MST*

| Participant | Experience of IPV at the time of MST |
|---|---|
| Parent 1 | Experienced IPV with referred young person's father. At the time of MST parents were separated but co-parenting, however the participant was living with a new partner who was emotionally abusive and controlling. |

| | |
|---|---|
| Parent 2 | Experienced IPV with referred young person's father. At the time of MST parents were separated but co-parenting. However, since separating and during MST involvement the participant referred to being stalked and harassed by her ex-partner. |
| Parent 3 | Experienced IPV with referred young person's father. At the time of MST parents were separated but co-parenting however during the interview referred to the continued experience of controlling behaviour and harassment. |
| Parent 4 | Living with partner who can be emotionally and physically abusive when drinking. Described physical aggression can be exhibited by both parents. |

**Analytic Approach**

Reflexive thematic analysis (TA) was considered to be the most appropriate qualitative approach over and above interpretative phenomenological analysis (IPA). IPA has a more ideographic focus with an in-depth scrutiny of the narrative of individual participants (Tindall, 2009); whereas this research was interested in the patterned meaning of practitioners' and parents' experiences whilst giving prominence to the subjective experience of the researcher and how that shapes the findings (Braun & Clarke, 2022). Furthermore, the relatively heterogenous experience of IPV and the sampling of both practitioners and parents was less compatible with the IPA approach which requires a more homogenous sample (Tindall, 2009).

TA enabled the researcher to take an inductively-orientated experimental position for the analysis which primarily grounds the themes within the data and explores participants own understandings as opposed to pre-existing theories; this flexibility meant that the researcher was less informed by the multiple, and at times conflicting theories relating to IPV such as feminist, power, and ecological theories; permitting for the possibility of contradictory findings that would better encapsulate the heterogenous experience of IPV. Furthermore, the flexibility afforded by TA meant that the researcher could occupy both latent and semantic approaches,

offering both descriptive and interpretive portrayals of the data remaining close to the data whilst offering interpretations indicating participants' wider social contexts. Finally, the researcher adopted a relativist ontological position meaning the findings were inherently contextually situated, and a constructivist epistemological stance meaning findings were produced and co-created by researcher and participants (Braun & Clarke, 2022).

Braun and Clarke's (2022) six stage iterative process to reflexive TA was implemented. Data familiarisation entailed transcribing verbatim all interviews and re-reading transcripts to identify possible points of analytic interest. Data was then uploaded onto NVivo (version 12) to perform the second stage of coding the data into meaningful chunks, this produced over one hundred codes capturing micro differences within the dataset. Supervisors reviewed two coded transcripts to ensure process fidelity. Initial theme generation entailed the researcher clustering codes into a more meaningful number of four boarder themes linked to the research questions. Theme development involved the researcher and a practitioner independently clustering and connecting themes into a thematic map, the collaboration on themes was to further enhance understanding and interpretations as opposed to reaching consensus. Supervisors were consulted on for defining and naming themes to ensure that the themes produced were succinct and coherent. Finally, themes were written up, which entailed the difficult process of selecting participant quotes that best represented the themes that formed the analytic narrative.

**Reflexivity**

The researcher's ontological and epistemological stance of research being inherently subjective and co-created meant that personal values and politics, and social positions of privilege and marginality both visibly and invisibly inform the

research process. Therefore, a reflexive journal was kept throughout to reflect on how these identities informed the researcher's: assumptions; questions asked, how the researcher related to participants; participants' possible perceptions of the researcher; and what the researcher might have paid particular attention and inattention to. The researcher holds many positions of privilege including: white British, middle-class, able bodied, cis-gendered, and a Trainee Clinical Psychologist. The researcher also holds positions of marginality including being a woman and gay, this, in combination with being a feminist, perhaps invariantly shaped the researcher's assumptions about IPV and paying more attention to women as victims and men as perpetrators of IPV which is more in line with feminist researchers as opposed to the family conflict researchers (Burelomova et al., 2018).

**Quality Assurance**

Elliot et al's (1999) guidelines for optimal quality in psychological qualitative research were adhered to throughout the research process. The researcher's perspective was owned and orientated to from the outset, and using the reflective journal enabled the continual reflection process on how the theoretical stance and socially privileged and minoritised positions shaped the research. The sample were situated by reporting on the IPV characteristics and demographic information in order to contextualise the findings so that the transferability of the findings could be considered. Themes were grounded in examples by providing rich direct quotations from interviews, and the inclusion of a co-created thematic map to aid the development of a coherent analytic narrative for the reader to resonate with. Credibility checks were continual and involved a practitioner expert-by-experience co-create the theme development, as well as supervisors reviewing transcripts, coding and feeding back on the forming of theme development and refinement to

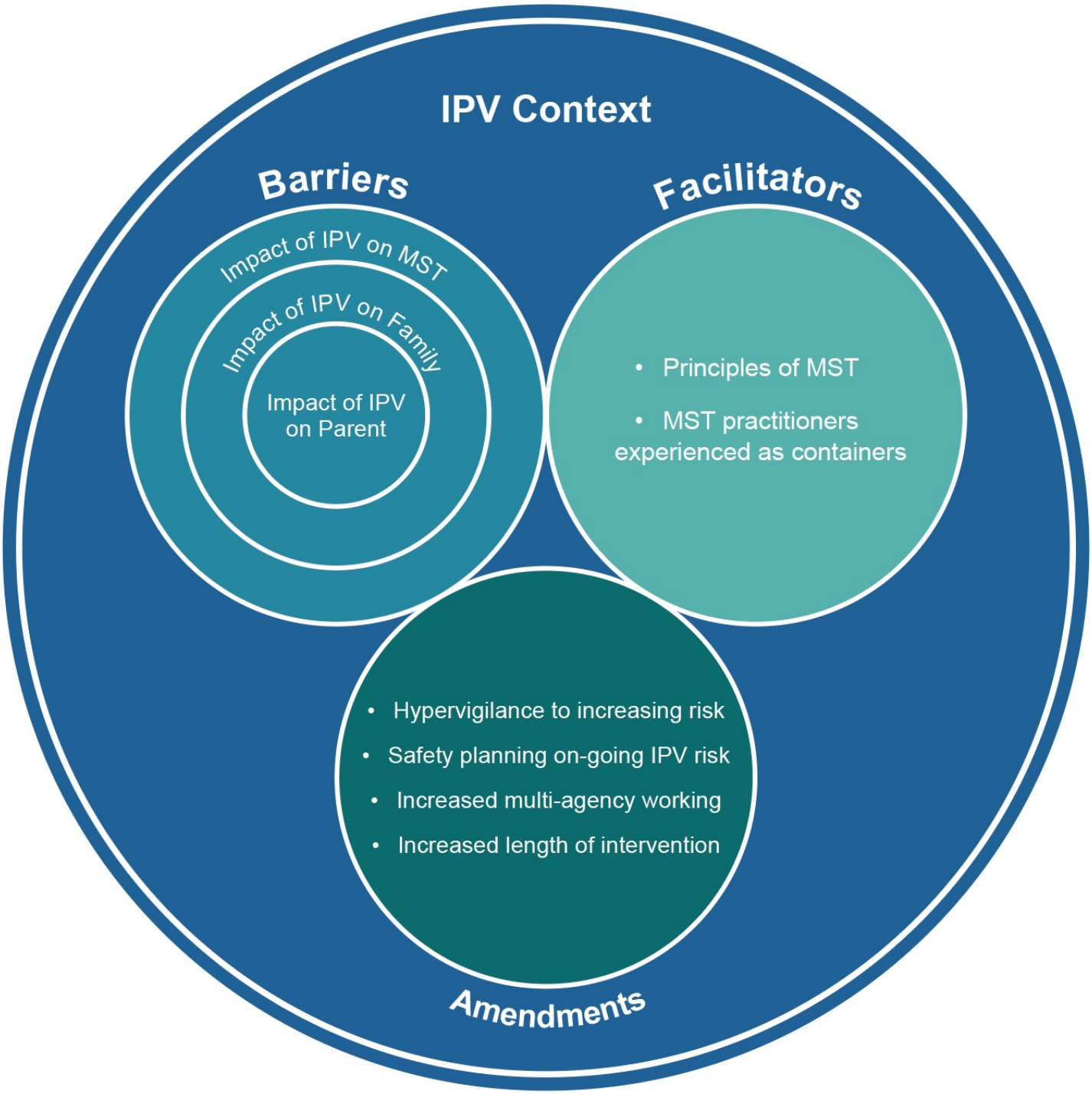
ensure themes were supported and grounded in the data. Finally, the accomplishing of general versus specific research tasks was adhered to as multiple perspectives were incorporated into the study (parents, therapists and supervisors), participants were recruited from across the UK, and the study addresses the limitations of extending the findings beyond the current context.

## Results

As demonstrated in Figure 3, three themes and nine sub-themes were identified. Despite not being a theme in itself, Intimate Partner Violence (IPV) context permeates all themes. IPV is not a homogenous experience and each participant's IPV circumstances differed, therefore the IPV context refers to the different temporal aspects and characteristics of IPV by which themes were contextualised. In this sample all parent participants described their male co-parent as physically violent and all but one co-parent's pattern of violence was best defined by the coercive controlling subtype (Kelly & Johnson, 2008). Parent four's IPV circumstances differed as IPV episodes were triggered by alcohol consumption, could be bi-directional and characterised as the situationally violent subtype (Kelly & Johnson, 2008). Parent one and four were co-habiting with violent partners and parents two and three were separated but co-parenting, however were still victim to harassment and controlling behaviours. All mothers described that their children had witnessed violence and at times experienced physical violence. All except parent four's referral child were male and were described to be exhibiting physically violent behaviours. Parent four's child was female and her mother described her being impacted by the IPV in terms of her mental health.

**Figure 3**

*Thematic Map Illustrating Themes and Subthemes Ascertained from Reflexive Thematic Analysis*



**Barriers To the MST Process**

This theme described the barriers that participants experienced as a result of engaging in MST in the context of IPV. Similar to Bronfenbrenner's (1979) ecological model, the barriers to MST progression consider the multiple levels of systems that IPV impacts, including the parent, the family system, and finally the MST process.

***Impact of IPV on Parent***

Participants provided explanations of the individual parent barriers faced following IPV that impede their ability to trust the therapist and process. Parents described how mental health difficulties were often a result of IPV experiences, and the experience of being undermined made it difficult to assimilate praise: *" When you are kind of constantly being knocked down by your partner and you're never good enough, …it's very hard to take positive feedback" (*Parent 2).

MST practitioners also described how parents' trauma, as a result of IPV, informed their responses to their children's' behaviour. Parents' fight, flight or freeze response were triggered by their child and this was reported as out of proportion to the behaviour being exhibited, stemming from unprocessed trauma:

> "*Mum just doesn't understand why she freezes, and she'll lock herself and the smaller children in a bedroom and won't come out because the older child is kicking off, even if he just starts a little bit, she'll quickly run to the bedroom and lock the door with the kids or she'll just like freeze and like phone the police*" (Practitioners 3).

Portrayal from mothers about son's behaviours tended to be framed in relation to their abusive fathers. The negative association being that they are their fathers, as

illustrated by one mother who declared her son was "*bullying*" her and: "*it just felt like I was living with his dad all over again"* (Parent 1).

Participants described how mothers' ability to move into the executive position and assert boundaries was impacted by mothers being re-triggered and reminded of their abusive partner:

> "*I think my son is a lot like his dad which does become an issue…So for me it's kind of it's a bit of a trigger, … when he's kicking off in my house and stuff it just reminds me of him so much and I think that makes it hard. So, when he's doing all this, like his dad's stuff, I don't really tell him off for the simple fact I don't want him to keep going and kind of make me have them feelings back again …. I would just say to [MST practitioner] that I had tried out her strategies but I hadn't been able to… in my head I was like, there's no way I can do that with my son because he's just going kick off* (Parent 2).

MST practitioners reflected on how mothers responded to her child's behaviour in such a way so as to not escalate: "*As soon as there were little blips of kind of violence, she went back to the default setting of pandering to him because it probably took her back to how she was when she was with her ex-partner*" (Practitioner 7).

Furthermore, IPV contextual factors impacted the extent to which parents seemed able to exert MST suggested boundaries. When parents were living with abuse, boundary enforcement difficulties were exacerbated due to the guilt of having a partner who was quick to punish:

> *"I just felt guilty over everything**…** But I found with him [current partner] quick to punish them but when they do something right, he couldn't show the other side, so it was all me. So, I think a lot of my failings were I could not put consequences in place, I couldn't because he constantly did it and I felt like*

*they were getting like consequences left, right and centre and no one was ever telling them they were doing anything right. So, I kind of had to become that person more than the bad person"* (Parent 2).

Another aspect of IPV contextual factors influencing the extent to which individual parent barriers manifested was parents' ability to connect their child's behaviours to witnessing IPV. MST practitioners referred to this being dependent on whether parents were in IPV relationships. MST practitioners inferred that this could be in relation to how much agency parents felt they had:

*"When the partner is still active in their life I think that denying kicks in. It's more when it's historic when they've got out of the situation, they're able to process it then they're able to receive it better. If they've got that insight to see their own actions and feel they have the power to change, then it can be powerful even if their partner is still there, but it can be really difficult when the partner's still there"* (Practitioner 2).

***Impact of IPV on Family***

Participants provided accounts of the impact of IPV on the family system and how it impeded MST progress. For parents who were co-parenting but separated, participants described how a lack of alignment between households was challenging and was exacerbated by their limited communication stemming from IPV. One MST practitioner described how some communication is necessary for the success of MST if parents are co-parenting:

*"The parents just argue and don't work together, which sends you know conflicting messages to the child and then it's really just not helpful…It becomes very difficult in those situations because parents don't want to*

*communicate with each other and what we're kind of saying is that you know a level of communication needs to happen"* (Practitioner 8).

As MST focuses on changing children's behaviour by changing parents', the lack of alignment between partners caused challenges. Particularly pernicious was what parents described feeling as if perpetrators were undermining their boundary enforcement as a means of exerting continued control over the household irrespective of living arrangements:

*"[ex-partner] would override a lot of the things I was trying to implement with [son], especially regarding his behaviour… So when I tried to start putting boundaries in place I'd struggle because [ex-partner] would overrule those all the time, even within my household, from a distance he would overrule them"* (Parent 3).

Another way this became a barrier to MST progression was when MST practitioners described children as utilising parental conflict to undermine MST progress:

*"We were getting somewhere with addressing her [young person] behaviour [and] she didn't like that, so she was kicking off and she decided to escalate and turn up at dads' and tell dad all the things that mum had been doing, which then led dad to react and come up to the house… That absolutely led to a complete breakdown because mum was so fearful that she couldn't follow any safety planning to keep her child safe because of the risks to herself"* (Practitioner 6).

The lack of alignment manifested differently in households where IPV was present. MST's goals were often misaligned with the perpetrators and even more so

if the partner was new. This presented as a barrier when parents acted in a way to appease their partner over and above MST:

> *"The capacity to be able to work on the pulls back home or quality time within the family home or feeling wanted in the home are all so fractured when mum is feeling so pressured to keep her current partner appeased or whatever. He tends to just want the child out because he just sees them as bringing professionals to the home and causing chaos in their life"* (Practitioner 3).

This integral difference in goals between MST and perpetrators also manifested as a barrier to family engagement. Within parent's accounts of perpetrators engagement, it was superficial engagement whereby they were attending sessions and agreeing to carry out MST strategies, however not following through: "*he was just agreeing to it and not kind of doing it*" (Parent 2). There seemed to be distrust in perpetrators when they did engage with MST. Perhaps this positioned fathers in a paradoxical position whereby engagement or lack of engagement were equally pathologised:

> *"It's a very interesting kind of dynamic and it's, you know, it's part and parcel of the perpetrators, they can be very charming and sometimes MST practitioners can kind of not get sucked in, they'll see dad in a better light because dad is really engaging with them"* (Practitioner 7).

However, IPV context played an instrumental role in family barriers to engagement as when perpetrators were in the household and fitted within the coercive controlling subtype MST practitioners' ability to engage was impacted. This manifested as cancelling sessions or withholding information. One parent attributed this to control and her partner not wanting her to be empowered by MST:

*"[Partner] would be like you don't need a call, you don't want people knowing your business. So, I kept like going along with what he was telling me to do so not saying things and like cancelling MST meetings… He just didn't want anybody around the house, he didn't want anybody knowing like our life. He just didn't want anybody imposing really. And when I look back now, I know why because for me to see the light of the things that I was actually putting up with … I think I had to split from [partner] for me to properly work with MST because I don't think if I stayed with [partner] I would have been able to do like what I've done*" (Parent 1).

MST practitioners attributed this to not wanting services to find out about the IPV and called it "*disguised compliance"* in order to avoid: "*social care being involved... [and] finding out about the abuse"* (Practitioner 5). This seemed to be particularly pertinent to "*after an incident… to take a step back from the world"* (Practitioner 4). This might represent a family's lack of trust in services as a result of their past experiences that were experienced as persecutory: "*they [social services] think it's me that's mentally unstable, me that can't cope, me that's causing the problems*" (Parent 3).

***Impact of IPV on MST***

IPV impeded on the MST process, in particular MST practitioners noted the difficulties they faced as a result of increased multi-agency working specifically after an IPV incident. One MST practitioner commented on the "*social worker's approach is different... and can go steaming in"* (Practitioner 3). Another MST practitioner found the differing levels of knowledge about IPV between services and at an individual professional level challenging: "*he [social worker] was going out and then trying to have private conversations with mum in the house while stepdad was in the kitchen,*

*and that was just a case of risk*" (Practitioner 6). However, another MST practitioner noted that this was not necessarily always a barrier as it afforded the opportunity for MST to represent something different to other services and be positioned as more aligned to the family: "*it tends to feel like that MST has your back over everybody else. So, MST fight your corner at the school, MST fight your corner with social care*" (MST practitioners 5).

However, IPV was not always disclosed to MST practitioners:

> *"It was always a grey area to everybody like what was going on here, and I just felt like trying to deal with my ex and then trying to deal with this [current abusive partner] as well, it was just too much. So, I kind of separated it and I didn't want it to be brought up. So, I think when [MST therapist] was working with me, I was like I wasn't admitting there was a problem"* (Parent 2).

This acted as a barrier to the MST process as practitioners found it challenging to fully develop formulations: "*you can't really get the true sequence of what is going on*" (Practitioner 3). However, when IPV was disclosed, MST practitioners believed that they could not always follow the MST process and hold both parents accountable as "*there was no equality*" (Practitioner 6) and a fear of increasing risk: *"There was a massive power imbalance…and we're trying to shift it so it's more equal, but then when we put it in a way where the mum will start to take more responsibility, dad didn't like it*" (Practitioner 2).

This portrayal was corroborated by parents who described joint sessions as feeling like they were in *"panic mode*" (Parent 2); fearing what the MST practitioners would ask of their partners. Parents described having to appease perpetrators after sessions for fear of the consequences of what was discussed in sessions:

> *"They [MST] were trying to explain to [ex-partner] that the money that the children were getting was for the children and it's not his. He absolutely went bonkers…and when that meeting finished, I contacted [ex-partner] because I was terrified, he was going to try and enforce support order"* (Parent 3).

**Facilitators To Change and Engagement**

Both parents and MST practitioners felt that despite IPV, MST was applicable to families and was an acceptable intervention that facilitated change and engagement. Factors that were identified to facilitate this included: the principles of MST and the MST practitioners being experienced as containers.

***Principles of MST***

This sub-theme encompasses how the principles of MST were perceived as facilitators to engagement and change for families impacted by IPV. Within this portrayal seven of the nine principles of MST were referred to by participants as facilitators, suggesting that MST's process is conducive to working with families impacted by IPV.

The flexible formulation process of MST and the principle of 'finding the fit' meant that the intervention was adaptable to individual family needs and could be tailored to integrate IPV into formulations: "*[MST] is person centred to working on the needs of the young person, the family, the systems around them to come to that shared working goal"* (Practitioner 2). MST practitioners described how the principle of 'targeting sequences' of behaviour could be directly applied to IPV incidents: *"I'd sequence an [IPV] incident"* (Practitioner 5). Practitioner eight shared a similar portrayal:

> *"I don't mean to minimise IPV in any way shape or form, but it is just behaviour. So, we would treat it different in the sense of safety elements but*

*it's a behaviour that we would manage and take through our process."* (Practitioner 8).

MST's formulation process of being 'present focused' and child centred was described by parents as offering a different experience of accessing help than to other professionals which facilitated engagement:

> *"Umm so it was a bit weird because like he doesn't like professionals being in my house, obviously because people pry … but with MST it was a little bit different like he kind of just focused on what was happening at the time with the children, so like he did engage well with like anything that was around working with [child]" (Parent 2*).

MST practitioners centred conversations around the child or parenting which enabled therapists to open up conversations around IPV. Practitioners conveyed how IPV might relate to the child's referral behaviour, referred to in MST as the 'FIT': "*using the FIT circles and the priority drivers for the child's behaviours, there would be a driver like parents did not communicate with each other*" (Practitioner 1). In IPV contexts where parents were separated but coparenting, one practitioner described how parental alignment was facilitated by "*saying the purpose why, almost say it's not about helping mum, it's about helping your child and really kind of refocus it on the child*" (Practitioner 6). Engaging perpetrators was also perceived to be driven by the MST principle of remaining 'strength focused'. Practitioners referred to offering families and perpetrators a different experience of services and to "*reinforce all systems to look at strengths…so we really try to not only focus on what dad isn't doing but also what his dad is able to do as well*" (Practitioner 7).

Within this sub-theme's portrayal were MST's principle of 'continuous effort' and 'accountability' as facilitators to engagement. This encapsulated MST

practitioners being consistent, persistent and flexible: *“She just like put everything into me really… she didn't give up on us you know like she was very persistent”* (Parent 1). Perhaps this was facilitated by MST practitioners’ lower caseloads, which allowed for the engagement of the often more complex lives of families where IPV is present. MST not being constrained to the typical parent working hours and location flexibility also enabled this:

> “*I think the flexibility of the service as well, so it's literally anytime you know. Past a certain point, it may not be ideal to have a face-to-face session, but other than that you know I have met family so like 8:30 because they've been working*” (Practitioner 1).

The principle of accountability consists of practitioners ensuring that they are responsible for doing whatever it takes to build engagement. Practitioners described this as pertinent to engaging fathers and was perceived as a demonstration of their eagerness to include them in the process irrespective of IPV:

> *“I've worked with the same dad to get him in the position where he is now and that's just through consistency and bending over backwards, really trying to do everything you can to show that even though you know they’re the one kind of doing these terrible things, we still want to help*” (Practitioner 5).

MST persistency was also encapsulated by the twenty-four-hour on-call service which offered the continuous opportunity of MST practitioner support if necessary. Isolation is common for families experiencing IPV, therefore one parent referred to the on-call system as mitigating the impact of this: “*They was always on the end of the phone, I haven't really got nobody and I made quite a close bond with [MST therapist]*” (Parent 4). The on-call system was also utilised for families in crisis which included IPV incidents:

*"On call will have a copy of the safety plan easily accessible to them that they can then talk through, whoever is struggling and if it's mum or dad or the young person to just go through the steps that they need to follow"*

(Practitioner 4).

Change was facilitated via MST's principle of 'increasing responsibility' which was experienced by parents as feeling empowered to enforce boundaries not only with their children but also in their relationships with their co-parent; this is also in accordance with the 'generalisation' principle of MST:

*If he's texting me nasty messages, don't reply to them as it's going to make him worse, so she [MST therapist] helped me break that cycle and just ignore him… it's the best thing, really… I feel that I have more control*" (Parent 3).

The parenting skills acquired via MST were transferable to all relationships including the IPV relationship, and practitioners described how this was especially thought about in relation to "*the sustainability plans because we want these families to be able to generalise the interventions to all their interactions*" (Practitioner 4). Particular skills that were highlighted as applicable to IPV relationships were:

*"The four D's technique which is about how you de-escalate situations in an effective and sort of efficient way… I think that's one of the major ones to be transferable across all the human interactions really*" (Practitioner 1).

One MST practitioner described that for some of the women she had worked with they were empowered to the point of having the courage to leave their abusive partners: "*there's a lot of empowering of the female that goes on and then they don't want them there anymore…I think that empowering the mum and making her more assertive not just with their children but with that person*" (Practitioner 3). MST practitioners described how MST's multi-agency way of working and the role MST

plays in engaging the system facilitated this process by: "*put[ting] them into contact with the right agencies where they might have been lost before*" (Practitioner 3). In cases where mothers didn't leave abusive partners, MSTs joined up way of working helped "*support systems to work better with families*" (Practitioner 2) and helped parents to: "*communicate with the school and the police*" (Parent 2).

### *MST Practitioners Experienced as Containers*

This sub-theme encapsulates how crucial the MST practitioners were at creating a containing space whereby parents felt safe enough to disclose their experiences of IPV. Parents described the "*close bond"* (Parent 4) formed with their MST practitioner, and how it was an uncommon experience for them to trust a professional:

> "*I told [MST practitioner] absolutely everything I told her the truth like and opened up and me and [MST practitioner] got like really close… And like obviously I used to have me episodes when I was down and I'd be like go from zero to like 100 but she just used to calm us straight down like I trusted her and I don't always*" (Parent 1)

Within this description the participant described the therapist's ability to assist with emotional regulation which is an instrumental part of containment (Miller-Pietroni, 1999)as well as the experience of feeling understood: "*that was good for me because I've never felt like that with another professional, I've never felt heard, listened to*" (Parent 3). Trust to disclose also resulted from practitioner competency. MST practitioners felt that their ability to pick up on IPV cues before it was disclosed related to their level of experience in working with IPV: "*brand new therapist who are just finding their feet and working through the process might not, have the capacity to pick up on different cues because they're so like focused on what they've got do*"

(Practitioner 3). Practitioners' experience enabled them to ask more difficult questions relating to IPV: "*I feel quite confident to have those difficult conversations and I don't know if that comes from a background in child protection*" (Practitioner 5). Therefore, perhaps the trust afforded to practitioners was gained by their skill and competency to pick up on IPV cues and take the 'relational risk' (Mason, 2018) to ask more challenging questions relating to IPV.

**Amendments**

Despite the applicability of the MST model to families experiencing IPV, this theme encapsulates the amendments and considerations made by practitioners to better meet the needs of families experiencing IPV. Four sub-themes were developed, these include: hypervigilance to increasing risk, safety planning on-going IPV risk, increased multi-agency working and increased length of intervention. The level of amendments to MST were often dependent on the context of IPV, with historic IPV having a limited impact:

> "*Historical [IPV] is relatively common I don't think that necessarily changes the focus, it would be a driver for why the behaviour is that way. But I think when the domestic violence is present, that's a whole different ball game*" (Practitioner 5).

Whereas the below sub-themes predominantly apply to couples living with violent partners or in joint MST sessions with co-parents where perpetrators remain threatening and controlling.

***Hypervigilance to Increasing Risk***

This sub-theme pertains to MST practitioners having to be vigilant to causing service led risk by leaving one partner vulnerable post session. This "*constantly having to be risk aware*" (Practitioner 6) manifested in a variety of slight amendments

to MST delivery. Participants described having to do more work setting up MST, which constituted having separate assessments with parents to assess the couple dynamics and the appropriateness of joint sessions: "*you would have conversations around you know, how do you feel about your ex-partner, are you scared, those kinds of conversations would happen at the very early stages when you're thinking about risk*" (Practitioner 1). One parent indicated that she would have liked more: "*maybe like more work setting up the sessions, so talking to me first or something* " (Parent 2). Within the assessment stage, practitioners described setting up the space included having conversations around planning for a session where both parents might be present: "*what is and isn't acceptable to be able to talk about in front of dad, set like those guidelines down. So, knowing what is the best thing that we can work on when he's present?"* (Practitioner 3). However, if the violence was not disclosed at assessment stage and became apparent to practitioners throughout the intervention, practitioners referred to following a similar protocol to ensure safety:

> *"If there was something that was being witnessed and not discussed, I would speak to that person in a safe way out of the family home, out of ear shot, because we don't want to put whichever partner it is in that line of jeopardy"* (Practitioner 8).

These conversations were also described to occur throughout intervention such as pre-session and included checking in around safest times to have sessions if violence occurred as a result of substance use:

> "*Speak to mum to find out when are the times when dad doesn't take drugs, doesn't drink and hasn't had a hard day, or is out the house. Check with mum when you're on the way to the house what is dad's mood like*" (Practitioner 7).

Practitioners also described creative ways to set up sessions when both parents were present to ensure safety:

> *“I do ground rules for sessions; I’ve done a WhatsApp group where I would put out the agenda for the session, the ground rules for the session that mum and dad had previously come up with, you know their own ground rules like at what point I would stop a session, what the topics that we won't discuss in session*” (Practitioner 6)

Within sessions practitioners described an awareness of their terminology to avoid risk escalation post session. Practitioners utilised: “*a different term, I say sort of parental conflict or parent arguments or parent disagreement or something. I don't go as, unless it was just the mum*” (Practitioner 3). This was to avoid triggering perpetrators and extended to other words: “*triggering words and that might be different for every situation, but particularly words like victim, perpetrate, abuse*” (Practitioner 6). The practitioner’s sensitivity to language demonstrated their hypervigilance to increasing risk and the importance of paying attention to the subtleties of differing family situations.

In families where it was agreed that separate sessions were safest but parents remained living together, practitioners would: “*plan sessions more when that person's not there*” (Practitioner 3) or: “*meet outside of the home or go meet for a coffee or meet in the children's centre”* (Practitioner 8). For families who were co-parenting and having separate sessions, participants referred to a hypervigilance around information sharing so as not to contributing to what one parent referred to as enabling the partner to have “*one over on me*” (parent 2) or to increase risk:

> *“you've got to be very careful about how you communicate with either the parent who's the victim and the parent who's the perpetrator, how you*

*communicate with the children because you're potentially putting all of these people at risk in this household"* (Practitioner 5).

***Safety Planning Ongoing IPV Risk***

Encapsulated within this sub-theme are the amendments practitioners made in order to safety plan on-going risk posed to families due to IPV. This included each family member having a plan to ensure everybody disengages:

*"Where can dad go, where can mum go if or what if dad refuses to leave, what are the protocols and where will each child go. Some families have multiple children and limited space in the house, so coming up with a new plan to say the child can't go to their room, they want to maybe avoid the room and go outside*" (Practitioner 4).

Practitioners also referred to the risk posed by safety plans whereby: "*you may not be able to give all family members copies*" (Practitioner 6) and might include making: "*another kind of plan on the side that we have with mum"* (Practitioner 5). Further amendments to the plans included having code words which families could utilise if they were in the presence of the perpetrator and were feeling unsafe and wanted to surreptitiously get support: "*if you're feeling unsafe text a safe word to this number, and we will get someone to contact you or bring you help, or come get you*" (Practitioner 5). IPV amended safety plans also consisted of: "*having a very clear focus about what point do we need to include the police. So having a very clear line with police and with the family, at what point and where's the threshold"* (Practitioner 6).

Within this sub-theme, portrayals of safeguarding practitioners were also apparent. As MST practitioners operate in the community this is always considered,

however was thought about to a greater extent when practitioners were entering homes where IPV was present:

> "*We have those conversations with our supervisor so that we feel supported and safe. We have our safety measures and our safety plans to follow. So, what if this happens, what if that happens? So, we don't go there unless we're feeling safe, because if you're, if you're feeling anxious before a session, I think the families will feed off of that*" (Practitioner 4).

Practitioners referred to having exit strategies in case of violence escalation and ensuring the: "*on-call service [are] on standby as well*" (Practitioner 8).

***Increased Multi-Agency Working***

MST's way of working entails working alongside systems around the family, offering joint sessions with other agencies and bringing the network together. However, this sub-theme encompasses how in families where IPV was present, this occurred more frequently. Communication was described as "tighter" (Practitioner 3), and MST offered more joint sessions with social care services:

> *"When there's a lot [of violence] we will definitely draw on social care more because there's a lot of things that are beyond the remit of our role. I think that's where the beauty of multi-agency working comes through because then the social work can set those expectations. For example, if there is a court order in place, they make sure that it is adhered to"* (Practitioner 2).

Increased collaboration with other agencies extended to other services such as the police and was more likely to occur: "*after an incident happens that we know about, we'd have a police report that something's gone off and we would plan sessions where we would go out with the social worker*" (Practitioner 5). Multi-agency risk meetings were described to take place for IPV cases where expectations

were outlined of the requirements from services in safety planning: "*being very clear that it's multi-agency and looking at what each agency can input, what we need from them, what they need to do in moments*" (Practitioner 6). Another practitioner described how in their team the on-call number and safety plans were shared with the police in cases of IPV to ascertain a: "*higher level of awareness from the police because we don't necessarily want them just knocking on the door to check in with mum because that could increase and make things worse*" (Practitioner 8).

***Increased Length of Intervention***

The final sub-theme relates to anticipated future amendments to MST in the context of IPV. Parents described how they wished for longer intervention and felt: "*gutted, I don't think the five months is long enough to be honest it should be a year*" (Parent 4). Another parent suggested that MST: "*should offer longer interventions for cases that are complex"* (Parent 2). Practitioners were in accordance with parents, and described needing more time for intervention for a variety of reasons. One such reason was that it was generally reported to take more time to engage and gain the trust of families where IPV was a concern: *"it takes a long time to unpick that and build trust with the family"* (Practitioner 4) as well as for therapists to get a true sense of what might be occurring: *"it takes time to… truly unravel and to be able to get to the point where you able to work on proper set of sequences or understand about what's going on in the home"* (Practitioner 3). Furthermore, participants described IPV pulling focus from parenting interventions to the relationship or safety planning: *"it took time because we were still working on the other part of me being able to say no to [ex-partner] … so it was like we were dealing with two cases"* (Parent 2). This view was shared by another parent: "*I do feel that a lot of the time that we were allocating with MST was spent trying to fix the relationship side of things rather than*

*focus on [son]*" (Parent 3). Practitioners described that this all took time due to relationship difficulties being *"ingrained"* (Practitioner 2) and: "*16 to 20 weeks isn't long enough to make the changes that we need to make*" (Practitioner 6).

## Discussion

This study explored parents' and practitioners' experiences of Multisystemic Therapy (MST) in the context of Intimate Partner Violence (IPV). The primary aim was to understand the impact of IPV on the delivery and implementation of MST in order to best meet the needs of families where there are concerns around current or historic IPV. Three main themes were developed and considered in relation to different IPV contexts: Barriers to the MST process, Facilitators to change, and Amendments. The results are discussed in line with research questions.

**What is the perceived impact of IPV on parents' experiences and practitioners' delivery of MST?**

This is most appropriately considered in relation to two themes: Barriers to MST process and the Amendments. Both themes suggest a level of impact of IPV on MST implementation. IPV was a barrier to MST progression and was considered in line with Bronfenbrenner's (1979) ecological model in which IPV impacted on multiple systems from the parent and family to the professional systems around families such as MST. The barriers are discussed in relation to the amendments made.

MST was effected by the impact of IPV on parents as it was described as a barrier to MST progress. IPV had a detrimental impact on parental mental health which led to sons' violent behaviours triggering mothers' trauma response; this impeded mothers' ability to assert boundaries and occupy the executive position for fear of violence escalation. The detrimental impact of IPV on parental mental health

is well documented, with a particularly strong association between female IPV victimisation and post-traumatic stress disorder (PTSD; Spencer et al., 2019). Rosser-limiñana et al. (2020) systematic review found an association between mothers' IPV victimisation and difficulties in establishing parenting boundaries. Pels et al. (2015) understood the impact of IPV on mothers' parenting in relation to the ecological process model of parenting (Belsky, 1984) which considers three determinants of parenting: parental wellbeing, sources of stress and support, and characteristics of the child. Pels et al. (2015) described how IPV has a detrimental impact on all three: parental and child wellbeing; is a source of stress; and impedes parents' access to support due to its isolating nature. However, the results of this study extend this hypothesis and suggests that mothers' trauma (parental well-being) informed their interpretation of their child's characteristics by viewing their sons as extensions of their abusive fathers. This was a barrier to MST progress as MST aims for parents to assume an executive position and implement boundaries. The amendment of increasing intervention length would mitigate this and allow for more time to change more entrenched trauma-based mother responses.

Within this sub-theme MST was impacted by mothers struggling to assert boundaries if they were living with an abusive partner, they described feeling guilty as a result of the often-punishing role played by their partners. This is in accordance with Pels et al. (2015) account whereby interviewed mothers described compensating as a result of feeling guilty for co-parents aggression. The finding that mothers did not believe MST practitioners' praise is in line with Buehler and Gerard (2002) spill over theory whereby the humiliation and criticism faced during IPV made mothers susceptible to a loss in self-confidence. Central to MST's theory of change is upskilling parents to improve family functioning by empowering them with

resources and skills to manage the child's behaviours (Henggeler et al., 2009). Therefore, attention to parents' mental health/trauma, IPV context, and the pernicious impact of being undermined need to be considered in MST formulations as potential barriers to change.

Within barriers to MST process was the impact of IPV on the family system. Incorporated into this theme was the barrier posed due to lack of alignment between separated but co-parenting parents. This finding is in accordance with Mohaupt and Duckert (2023) research whereby violent fathers showed a lack of respect to their co-parent as well as described actively undermining their ex-partners. The notion that mothers experienced continued control post separation and IPV perpetration in a different form (Heward-Belle, 2018) was central to this sub-theme and similar to Hardesty and Ganong (2006) findings that mothers were parenting in fear and were subject to being undermined. Participants' descriptions of the lack of alignment being exacerbated by lack of communication is noteworthy as Hardesty and Ganong (2006) found that mothers tried to regain their control by limiting their communication with abusive ex-partners. Getting the balance between boundaried communication and no communication is something MST practitioners worked towards as mothers' descriptions of MST empowerment tended to focus around gaining confidence by limiting their communication with ex-partners. The impact of this barrier to MST could be mitigated by the amendment's sub-theme 'sensitivity to increasing risk'. Specifically, MST practitioners limiting information sharing to a need-to-know basis so as not to perpetuate perpetrator control.

The impact of IPV on the family system impeded MST delivery when perpetrators were present in the household; practitioners faced difficulty in engaging families due to the contradictory goals between MST and perpetrators. Practitioners

referred to families missing appointments and perpetrators demonstrating disguised compliance. This is comparable to other studies within the literature (Labarre et al., 2016; Stover, 2013; Valdovinos & Bellamy, 2023), which suggests overcoming this barrier to engage fathers by focusing interventions on the child. However, the particular difficulty described by MST practitioners was when the perpetrator was a new partner. Soliman (2016) discussed ways of engaging perpetrators and described a tension between practitioners either colluding with or becoming accusatory of perpetrators. Similar positions could be identified within the descriptions found in this study, with one practitioner referring to this colluding position by being wary of the over-engagement of perpetrators. Soliman (2016) suggests practitioners should strike the balance and find a more constructive neutral position that allies with change. This position can be utilised when engaging new-partners and is in accordance with MST's ethos of attempting to engage the whole system around the child.

The final sub-theme within barriers was the impact of IPV on the MST process. In particular, practitioners described both the barriers and opportunity afforded by the increased multi-agency working; the barrier consisted of differing levels of IPV knowledge and ways of working between agencies and the facilitator being this difference could be utilised by MST to offer families allyship. This is what Stanley and Humphreys (2017) referred to as the benefits and barriers of working in partnership and described the 'good cop' 'bad cop' roles played by dyads to be beneficial to engagement. The amendment of 'tighter' communication between services such as social care and the police could mitigate the disparity in knowledge between services and is in accordance with Humphreys and Campo (2017) guidelines for whole family IPV interventions.

Within this sub-theme was the barrier of families not always disclosing IPV, which led to partial understanding of behaviour sequences and parents not connecting their children's behaviour with witnessing IPV. Soliman (2016) advocates for practitioners to demonstrate curiosity to overcome this barrier as often it stems from fear of consequences, and feelings of shame and guilt. MST's treatment principle of 'evaluation and accountability' is in accordance with this at it advocates for MST to be held accountable instead of labelling families as resistant to change. All mothers interviewed did disclose IPV to MST however some mothers described it taking time to gain trust in the service. Therefore, the amendment theme of increasing intervention length may allow time to overcome this barrier.

Finally, another impact on MST delivery within this sub-theme was mothers' descriptions of being fearful in joint sessions with perpetrators and practitioners not being able to hold perpetrators to account due to the lack of equality and fear of violence escalation. This is described by the feminist IPV literature as the central argument against whole family or couple IPV interventions (Jory et al., 1997; Todahl et al., 2012). However, this was not described by one parent whose IPV was categorised as situational couple violence (Kelly & Johnson, 2008). It seemed that practitioner and parent descriptions of this barrier centred around IPV characteristics pertaining to the coercive controlling type; this category or IPV is advocated for within the literature as not appropriate for joint or whole family interventions (Humphreys & Campo, 2017; McCollum & Stith, 2008). This barrier could therefore be overcome by the amendment sub-theme 'hypervigilance to increasing risk', whereby MST practitioners described an increased assessment process to clarify the nature and context of the IPV relationship. Humphreys and Campo (2017) Guidelines advocate for the administration of measures to ascertain the IPV

characteristics such as Revised Conflict Tactics Scale (CTS2; Straus et al., 1996) which could be incorporated into the MST assessment process. Another amendment mentioned within 'hypervigilance to increasing risk' sub-theme which would be applicable to ameliorating fear in sessions is the extensive setting up process by practitioners with regards to guidelines and a sensitivity to language used. These amendments were similar to those reported in Karakurt et al. (2013) interviews with family therapists who described setting out 'agreements' during the contracting stage and having some no discussion topics. Therefore, despite the aforementioned barriers having an impact on MST delivery, many of the described amendments made by practitioners contributed to their alleviation.

A final impact to MST delivery was the amendments made to the safety planning procedures. Practitioners described incorporating measures for on-going risk of IPV by integrating safety strategies for all family members when IPV arises, having a different safety plan for IPV victims, considerations of escalation thresholds and finally safeguarding therapists. These extra considerations and resources spent on safety planning is in line with other whole family IPV interventions (Karakurt et al., 2013; McCracken et al., 2017; Stanley & Humphreys, 2017) and guidelines (Humphreys & Campo, 2017; McCollum & Stith, 2008). It further exemplifies the need for extending MST to allow for the appropriate amount of time to dedicate to safety planning.

**Which MST intervention components are perceived as effective at addressing the needs of parents impacted by IPV?**

Despite MST not being designed as an IPV specific whole family intervention, the theme facilitators to change captured parents' and practitioners' portrayals of the MST components that were perceived to be effective. This research question is

discussed in relation to the facilitators to change theme which highlighted the factors of MST's processes that were conducive to working with families impacted by IPV.

Much of MST's process and treatment principles were considered to be effective for working with IPV impacted families. Similar to the IPV whole family Growing Futures intervention (McCracken et al., 2017), the MST formulation and intervention process is child-focused with an emphasis on parenting skills. This is in-line with Humphreys and Campo (2017) suggested best practice guidelines as it allows for IPV to be addressed in relation to children, which is less intensive and facilitated perpetrator engagement. However, where appropriate, practitioners could apply the MST formulation process specifically to IPV which was enabled by the flexibility of MST and 'finding the fit' principle. Other aspects which were perceived to be effective were remaining present and strength-based focused. This allowed for MST to offer families a different experience of accessing help. Similar to the Growing Futures intervention (McCracken et al., 2017) MST challenged the more uniform blaming position towards families by the wider network and instead offered a more strength-based 'whole-system change'.

Another perceived effective component of MST for working with IPV impacted families, was the continuous effort treatment principle. Within this portrayal, practitioners described being flexible and persistent in order to engage with families and particularly fathers. This flexibility and persistency enabled by MST practitioners' low caseloads appeared to have resonated with parents and promoted engagement and trust. MST's persistency in engaging fathers demonstrated MST's recognition of the instrumental role they continue to play in children's lives (Stanley & Humphreys, 2017). Continuous effort also included MST's 24-hour on-call system which particularly resonated with families who were isolated as a result of IPV. This

appeared to be unique to MST amongst other family IPV interventions (Humphreys & Campo, 2017; Stanley & Humphreys, 2017), however could be considered instrumental to MST's engagement as well as the consolidation of safety planning implementation.

MST aims to empower parents to improve family functioning by upskilling them with resources and skills to manage their child's behaviours (Henggeler et al., 2009). Also instrumental to MST's process is the principle of generalisability. Taken together, participants reported that the parenting skills acquired from MST were useful and improved parenting confidence, however certain skills such as de-escalation and conflict resolution skills were transferable to the IPV relationship. It seemed that the skills learned were appropriate for IPV and mirrored those learned on IPV couple-based violence reduction interventions (Ronan et al., 2013). Emphasising parenting skills and fostering parents use of a wide tool-box of techniques are stated as a key component of intervention guidelines (Humphreys & Campo, 2017). Parents described improved family functioning with examples of mothers feeling empowered to enforce boundaries with their abusive ex-partners, or in some cases leave their partner. Despite MST not necessarily being designed for families in the context of IPV, it demonstrates the acceptability of MST to such families.

The final sub-theme that encapsulated MST's perceived effectiveness at addressing the needs of parents impacted by IPV was MST practitioners being experienced as containers. It consistently arose in descriptions and was perceived to be different to parents' previous experiences of professionals when accessing help prior to MST. Perhaps this pertains to what is described within IPV literature as the judgment and scrutiny experienced from services for staying with abusive partners

which can cause service alienation (Stanley & Humphreys, 2017). It highlights the importance of practitioners remaining non-judgmental as this earned the trust from parents to discuss IPV. Practitioners described that their abilities to work with this population arose from experience, which is similar to reports from systemic therapists (Karakurt et al., 2013).

**Clinical Implications**

The results highlight a number of clinical implications for MST. Firstly, the findings demonstrate that standard MST interventions can be applied to families who are experiencing or have experienced IPV. MST shares core components with pre-existing IPV-specific interventions (McCracken et al., 2017) and whole family IPV intervention guidelines (Humphreys & Campo, 2017; McCollum & Stith, 2008) which make it conducive to working with this population. However, the findings also highlight clinical implications pertaining to the requirement of amendments to better meet the needs of IPV impacted families. These amendments are more pertinent to families who are living with abusive partners or are still experiencing control from a partner who they have separated from but are co-parenting with.

One major consideration is the need for more extensive setting up processes. This entails separate assessments with both partners to ascertain the extent and characteristics of current IPV. This is in accordance with guidelines that suggest using the CTS2 (Straus et al., 1996) during the assessment process. Guidelines advocate for violence characterised by a coercive controlling nature (Kelly & Johnson, 2008) as not appropriate for joint work (Humphreys & Campo, 2017). Amendments should be made to ensure MST works separately with co-parents and limits information sharing to a need-to-know basis. If co-parents live together, MST

practitioners should keep the intervention child-focused, and include in the setting up process agreed topics to avoid and contract guidelines for any joint sessions. Further amendments to MST are suggestions around the safety-planning process, which include code words, guidelines around thresholds for enlisting police involvement, being more considerate about information and safety planning sharing, and ensuring all family members have a de-escalation plan should an IPV incident arise. Adjustments to multi-agency working include tighter communication between services and more joined-up sessions, particularly after an IPV incident. The final recommended amendment is increasing intervention length where possible. This would mitigate the impact of the aforementioned barriers to MST engagement and process.

The MST-IPV adaptation (Swenson & Schaeffer, 2018) entails all of the aforementioned amendments and is six to nine months in length as opposed to Standard MST which is three to five. Therefore, the findings from this study give credence to the changes made in the MST-IPV adaptation (Swenson & Schaeffer, 2018) to better meet the needs of IPV impacted families. However, the barrier identified in this study pertaining to parental trauma as a result of IPV impeding parents' ability to occupy the executive position is not necessarily addressed in the MST-IPV adaptation. Perhaps the adaptation of including psychoeducation about the impact of IPV on children can be extended to include psychoeducation on IPV, trauma and parenting. Despite the congruency between the MST-IPV adaptations and the recommended amendments found in this study, MST-IPV also includes the integration of Domestic Violence Focused Couples Therapy (DVFCT; Stith et al., 2011). Unfortunately, due to limits in infrastructure within the UK, the likelihood of local UK teams getting funding to implement this adaptation is low. This means it is

unlikely that local authorities will have access to the adaptation, however Standard MST teams can apply the findings from this research where possible to better meet the needs of families where IPV is present. Furthermore, as child behavioural problems and family violence frequently co-occur (Skinner et al., 2019; Van Eldik et al., 2020) MST practitioners will likely be operating within families where there is IPV categorised as the coercive controlling subtype, therefore families would not meet the criteria for the MST-IPV adaptation anyway, as DVFCT would not be appropriate. Therefore, this study's findings can be used by MST practitioners as guidance as to how best operate within such circumstances.

**Strengths and Limitations**

This is the first study to explore MST delivery in the context of IPV. Having input from parents as well as practitioners enabled the client's experiences to remain at the centre of this research and provided an important understanding of this topic. Parental contributions provided valuable insight into their experiences of MST, and can be applied more broadly to whole family IPV interventions where very few studies include parents' perspectives (Humphreys & Campo, 2017). Furthermore, having an expert-by-experience and MST practitioners' input in the setting up and analysis of this study provided relevancy and credibility to the study and contributed to the enabling of the researcher to have challenging conversations in a more approachable way.

Multiple MST teams were contacted and requested to take part in this study, however only five teams were able to commit to recruitment. Despite the geographical spanning across England and Scotland, the representativeness of the sample remained low as the majority of participants were white females. The goal of reflexive TA is not one of generalisability (Braun & Clarke, 2022), however due to the

sample lacking representation from multiple ethnicities, the transferability of these findings beyond the white experience is limited. The findings lack cultural nuance, as the experience of families from ethnic minorities accessing MST in the context of IPV could be different from white families. Sociocultural factors that might have impacted the recruitment of families from minority backgrounds could include cultural stigma around help seeking and discussing family issues like violence, a lack of trust in interventions and systems, and a lack of representation in professionals. MST research has demonstrated its effectiveness for minority ethnic groups, showing similar outcomes across race and ethnicity in large diverse samples (Painter and Scannapieco, 2009). Therefore, this study's inability to access a more diverse sample could be a result of the phenomenon being investigated or the researcher's whiteness as opposed to MST's reach. Increasing representation by improving researcher and practitioner diversity could facilitate this, and mitigate the effects of the aforementioned barriers such as shame, stigma and lack of trust.

Furthermore, only mothers were interviewed and the majority of their IPV experiences were characterised by the coercive controlling subtype (Kelly & Johnson, 2008). The lack of father participation or the abusive co-parent is characteristic of research (Armenti & Babcock, 2016; Humphreys & Campo, 2017) however impedes the transferability of the research to the more gender-symmetrical rates of situationally violent couples. This might have been impacted by the researcher who identifies as female, and the majority female workforce of MST practitioners; perhaps this influenced assumptions of IPV which might have been influenced by the feminist perspective of the 'coercive controlling' male batterer and therefore informed the recruitment of families to the study. Future research should therefore aim to capture the male perspective and could better define IPV to include

all typologies when introducing the research. Furthermore, the research centres heterosexual couples and a more feminist perspective of IPV and fails to capture the experience of IPV within same-sex parenting families.

Finally, the purposeful sampling methodology used to recruit parents and therapists was a limitation of this study as it increased the likelihood of selection bias. Perhaps the parents who were put forward by MST practitioners were more likely to have had positive therapeutic relationships and positive treatment outcomes than those not identified. This could have skewed the data to over-represent a positive view of MST and over-emphasise MST's applicability to families who experience IPV. This could have been exacerbated by the sample being exclusively treatment completers. Including practitioners could have mitigated this risk slightly, as they might have offered a more balanced perspective however, they too could have been more motivated to partake in the research. Having a slightly larger sample size might have ameliorated this, however IPV being a highly emotive topic to discuss with a researcher meant that it was challenging to recruit more parents.

**Future Research**

It is recommended that future research focuses on exploring the impact of IPV on MST outcomes quantitatively to hopefully corroborate this study's qualitative findings. It is recommended that future research utilise Kelly and Johnson (2008) categories to better define the type of IPV under investigation as opposed to treating IPV as one homogenous experience. This would contribute to an enhanced understanding of what interventions are best for whom. There is a dearth of studies investigating whole family interventions for IPV, therefore more research in this field is recommended to build up the evidence base. It is hoped that this would inform further development of NICE guidelines (2016) to include intervention pathways that

do not solely separate interventions by perpetrator and victim, but include whole family IPV interventions for those characterised by a situationally violent typology.

**Conclusions**

This approach gives credence to the systemic perspective for IPV intervention (Armenti & Babcock, 2016; Humphreys & Campo, 2017) which is underpinned by the importance of including both parents where possible in interventions. It demonstrates the acceptability of MST, a non-IPV specific whole family intervention, to this population. Whilst the findings highlight some barriers and modifications to the MST model to better meet the needs of IPV impacted families, it also demonstrates the utility of MST and its congruency with whole family intervention guidelines (Humphreys & Campo, 2017; McCollum & Stith, 2008). The clinical implications of the findings will hopefully enhance practitioners' clinical practice, as well as guide the thinking about the implementation of the intervention to best meet the needs of IPV impacted families undergoing MST who have not got access to MST-IPV adaptation.

# Chapter 3: Integration, Impact and Dissemination

# Integration

The overall aim of this paper was to explore systemic interventions for families who have experienced Intimate Partner Violence (IPV). It sought to generate insight into how to best meet the needs of these families in order to inform and further develop recommendations for clinical practice. National Institute for Health and Care Excellence guidelines (NICE, 2014) recommend interventions for IPV exposed children to be aimed at strengthening the relationship between the child and non-abusive parent, and advocate for perpetrator and victim interventions to be kept separate.

The systematic review and empirical paper were somewhat related, however had distinct objectives. Both focused on systemic interventions for young people exposed to IPV that aimed at improving child outcomes and the parent-child relationship. However, the systematic review synthesised systemic interventions that excluded perpetrators and were therefore more in line with NICE guidelines for IPV exposed children. This transpired to predominantly exclude fathers and mostly included mother-child focused interventions. Whereas the empirical paper focused on Multisystemic Therapy (MST) which intervened with the whole family and included perpetrators of IPV. The rationale for the empirical paper was informed by some of the findings from the systematic review, including: the high attrition rates, qualitative studies showed engagement was reduced when mothers remained with abusive partners, and continued child contact with perpetrators negatively impacted parents engagement in interventions. This demonstrates interventions excluding perpetrators do not necessarily meet all the needs of the population and are particularly inadequate for families who have continued contact with perpetrators.

Subsequently, this provided a rationale for the exploration of alternative interventions for families impacted by IPV.

Integrating the findings from both the systematic review and the empirical study suggest that both studies demonstrate the potential effectiveness of systemic interventions for children impacted by IPV. The systematic review findings indicate that parenting interventions focused on enhancing the relationship with the non-abusive parent and child are an acceptable intervention. However, the empirical study shows that for families where children have continued contact with the perpetrator, whole family interventions are a viable intervention. Whole family interventions can assume many delivery iterations and assessments including careful consideration of the type of violence experienced by the family can determine whether joint or separate interventions with the perpetrator are appropriate.

One similar finding across the papers was the role played by parental mental health on intervention effectiveness on child outcomes. The systematic review found maternal PTSD mediated reductions in child internalising symptoms. The review hypothesised that this could be due to attachment styles and the impact on parental mental health on parental availability (Risi et al., 2021). The empirical study found that parents' mental health, in particular PTSD, impacted on MST and was conceptualised as a barrier to the MST process. However, participants reported that this had an impact on their ability to assert boundaries due to being triggered by the child's behaviour impacting their ability to adopt an executive position. This finding is particularly pertinent as it demonstrates another potential mechanism for how parental mental health might mediate treatment effectiveness and suggests the initial attachment hypothesis does not fully capture the nuance of the mediating role of maternal PTSD. Another finding of interest across both papers was the impact of

continued contact with perpetrators on intervention engagement and effectiveness. The systematic review found some evidence for reduced child contact with perpetrators afforded better child outcomes post intervention. Empirical paper findings could elucidate potential reasons for this, including the findings that perpetrators impacted family engagement in the intervention, perpetrators undermined parenting strategies implemented by their co-parent, and in separated but co-parenting couples' households were often misaligned on topics such as ground rules, discipline strategies and routines.

The empirical paper sought to rectify some of the sampling limitations highlighted in the studies included in the systematic review. Systematic review studies had a more stringent participation inclusion criterion which excluded participants if: children had experienced violence from perpetrators; or parents had substance misuse problems. This was in order to isolate the unique effects of witnessing relational trauma and control for the extraneous variables that might have influenced the outcomes. However, considering child abuse and IPV-exposure often co-occur (Hamby et al., 2010) and substance misuse is a common factor related to IPV perpetration (Gilchrist et al., 2019) their exclusion from studies limits the generalisability of the findings to a large subset of the IPV population. Their inclusion in the empirical paper adds to the ecological validity of the study, making the findings more representative of families impacted by IPV who often face multiple co-morbidities as opposed to IPV alone. Additionally, the studies included in the systematic review predominantly recruited from IPV shelters, despite the fact that approximately two percent of children exposed to IPV live in shelters (Anderson & van Ee, 2018). This impacted the reviews generalisability to IPV victims living in the community. The empirical paper managed broaden selection procedures as it

sampled from standard MST teams. This meant families who had not specifically sought help for IPV or living in shelters were sampled. This was more representative of community IPV populations where IPV is not always known by services and help seeking is generally low (Satyen et al., 2019). Reports from participants in the empirical paper described that IPV was usually disclosed to practitioners midway through interventions as opposed to parents seeking help specifically for IPV, therefore the empirical paper sample might have captured a more typical community IPV population. Furthermore, included studies in the systematic review predominantly took place in the USA, highlighting the necessity for more UK based IPV research.

**Further methodological considerations**

It was challenging to recruit parents to the study which led to a smaller than hoped for parent sample. It seemed that MST practitioners were reluctant to approach parents and stated worries about the emotionally laden topic. This is in accordance with Ellard-Gray et al. (2015) research into the challenges of recruiting IPV samples who they refer to as a vulnerable and often hidden group to discuss sensitive research connected to their vulnerable or hidden status. This was potentially exacerbated by my inclusion criteria which excluded open cases as perhaps practitioners were worried about de-stabilising closed cases. This meant that there was a slight incongruency with the reported frequency of IPV impacted families within MST and my ability to sample them. This was overcome somewhat by recruiting directly from practitioners that had been interviewed. However, this potentially skewed the data to include parents who had a more positive experience of MST or perceived by practitioners to be more stabilised. Three potential participants declined to be interviewed and an additional two participants did not

materialise into interviews due to stating not having time. However, the struggle to recruit is somewhat representative of the vulnerable population at large, as families are often difficult to identify, lead complex lives and have proven to be difficult to recruit and retain (Ellard-Gray et al., 2015). I attempted to increase parent participation by extending my recruitment time frame, as initially my allocated time for data collection was unrealistic. This led to the fruition of one more interview, and the identification of three more participants. However, they did not fit the eligibility criteria. Additionally, I was unable to triangulate my findings by interviewing fathers (or the other co-parent), or capture violence more characteristic of a situationally violent type (Kelly & Johnson, 2008). This could be a reflection of the more common understanding of IPV to be more in line with the feminist unilateral often female directed violence, which informed who MST practitioners identified as potential participants. In the future if I were to recruit IPV-impacted families again I would include information sheets which outlined all of Kelly and Johnson (2008) categories of IPV.

Data saturation is a frequently cited concept within qualitative literature and refers to an attempt to instil more rigor to the qualitative sampling process by reaching a point of information redundancy (Constantinou et al., 2017). However, within the reflexive TA framework, the analysis process cannot be completed rather, the researcher makes an informed judgement about stopping sampling (Braun & Clarke, 2022). This study's sample size was instead informed by Malterud et al. (2016) concept of 'information power' which determined that the final sample of twelve held enough relevant and rich information that the sample size sufficed.

As reflexive TA data analysis progressed the messiness of the data became apparent. This was reflective of the phenomenon under investigation, as IPV is such

a heterogenous experience. Despite having interviewed practitioners and parents, their recollections converged and the formation of the themes and sub-themes was most appropriately conceptualised as a collective. However, what was more challenging was delineating how each theme and sub-theme related to differing IPV contexts. Integrating a narrative of IPV context into the themes eventually felt the most appropriate way to handle the diverging IPV experiences. Future research into this topic could better demarcate IPV and perhaps specify from the outset which category of IPV is under investigation.

**Personal Reflections**

Due to this being my first qualitative research experience, I felt a certain amount of positivist-empiricist produced anxiety. This meant that I felt the pull towards quantifying my themes by producing a table of how many participants contributed to the theme, or the desire to ascertain inter-rater reliability. Prioritising concepts of reliability and objectivity have been ingrained in me as a result of the years learning research and statistics in psychology, therefore I found embracing my relativist ontological position and constructivist epistemological stance more challenging than anticipated. However, using my reflective journal and as the analysis process went on, I became more familiar with it and I found some freedom in accepting how I might be influencing the research process as opposed to finding ways to mitigate it. On reflection my positions of privilege and marginality did impact the research process in a multitude of ways. I am a woman, identify as a feminist and gay. This shaped what I paid more attention to in interviews and in data analysis where I predominantly centred the unilateral women-directed violence from men narrative which is more in line with feminist theories of IPV (Burelomova et al., 2018). Perhaps, if the researcher had been male, more attention would have been paid to

examples of bi-directional situational couple violence within the data. However, this might have impacted on the relationship formed with parents, as all parents interviewed were mothers and most had been subjected to coercive controlling violence from male partners; therefore, being female might have contributed to a sense of safety and trust in me to discuss the sensitive topic that might not have been afforded had I been male. Furthermore, my considerable positions of privilege also shaped the research process, particularly how participants might have related to me in interviews. Being a trainee clinical psychologist and from a middle-class background brings with it positions of power. Usually when working clinically, time spent getting to know each other can ameliorate some of the negative implications associated with holding positions of power. However, in this setting I had less time to put participants at ease and gain their trust. I relied on my clinical skills to form relationships with the participants, however the extent to which this might have affected the research is unknown.

My lack of experience in conducting interviews for qualitative research, combined with my narrow clinical experience in working with families impacted by IPV and the sensitivity of this topic may have limited the research process and negatively impacted the findings. In particular I noticed that I felt more nervous before interviews with parents than I did practitioners, and I wondered whether this might have been influenced by worries about risk disclosures. I also found it challenging to move from a position of therapist to researcher and found my curiosity at times impeded my ability to keep the interviews focused and obtain the relevant information. However, as I gained experience, I found it easier to negotiate between responding to what participants were bringing as well as following my interview schedule. Another way in which my relative inexperience in qualitative research

might have influenced the findings was that I found it easier to adopt semantic as opposed to latent interpretations of data. In particular I was conscious of over-reaching or misinterpreting interpretations that were latent. However, having my supervisors independently review the coding of some of the interviews helped me navigate this. Finally, conducting the interviews online might have negatively impacted the findings as this could have impacted my ability to form a relationship as well as respond to non-verbal cues. However online interviews afforded me the chance to reach participants from around the UK.

**Impact and Dissemination**

The empirical paper and systematic review have made significant contributions to the field of IPV and have important clinical implications. The findings provide valuable insight into intervening with a vulnerable population who are hard to recruit, engage and retain. The findings have the potential to significantly impact a variety of stakeholders including: young people and families impacted by IPV; MST practitioners; mental health practitioners; other professionals who come into contact with families such as social care, police and third sector professionals; and best practice intervention guidelines.

Young people and families will benefit from the research as it sheds light on the different systemic interventions available for families. The systematic review findings demonstrated the effectiveness of non-abusive parent child interventions on child outcomes, and gave some indication of what moderates and mediates intervention effectiveness. The empirical paper elucidated how to best meet the needs of families impacted by IPV in MST. The findings identified some amendments that could be made by MST practitioners to facilitate engagement and safety. A summary modified into lay language will be disseminated to all parents who took

part. It is hoped that further expert by experience input could be ascertained to consult on the best way to do this to ensure it is digestible to parents.

The findings could have a large impact on MST services. More specifically this study gives credence to the MST-IPV adaptation as much of the found amendments were congruent with the adaptation. However, it expands upon some adaptations and advocates for the need for parents' trauma to be brought into the formulation and intervention. In order for the findings of this study to be maximised, results will be shared with the developer of MST-IPV. However, as the majority of UK MST teams will not have access to the MST-IPV, the findings from this study demonstrate that the existing MST model can be applied to families who are experiencing or have experienced IPV. Furthermore, knowledge gained from this study pertaining to the barriers and facilitators to the MST process and the amendments that can be made to overcome these barriers can be utilised by MST practitioners so that they can best meet the needs of families experiencing IPV. In order to maximise the benefits of this study, the key findings will be presented to MST practitioners, and the MST-UK and Ireland network. A summary information sheet with the main findings will also be distributed to MST teams so that practitioners and parents can fully benefit from the findings. It is hoped that the research will be presented to an international audience at the bi-annual MST European Research Collaboration Conference. This is attended by international European MST teams as well as researchers with a special MST interest.

The findings from both papers also have the potential to have a far-reaching impact on other professional disciplines and influence the best practice guidelines for working with IPV impacted families. The findings can guide services and professionals working with this population to better meet their needs. The systematic

review highlighted that for families where children are not in contact with perpetrators, systemic interventions that enhance the parent-child relationship and parenting skills are appropriate and the type of intervention and its delivery mode could be picked depending on how the child presents. However, for children who still have contact with perpetrators, whole family interventions such as MST should be considered. Whether the intervention is delivered separately should depend on extensive assessment to ascertain the type of violence. It is hoped that more research into family interventions for families experiencing IPV is carried out which ogether with the findings from this study, would inform the development of further consideration of this type of intervention into the NICE guidance for intervening with IPV exposed children.

The research was also presented to trainee clinical psychologists and staff at Royal Holloway, University of London. It is hoped that the findings may inform future research projects. It is anticipated that they gained understanding of some of the barriers, facilitators to working with this population as well as how they could amend their practice. To further maximise the clinical and academic impact of the findings to a wider audience the systematic review and empirical study will be submitted to peer-reviewed academic journals. The submission of two separate papers will maximise the dissemination to the academic and clinical community. Impact factors and journal relevancy were taken into consideration when picking journals to submit the papers to, as those with increased number of citations would have an increased likelihood of maximising the audiences. Therefore, the subsequent journals will be approached for publication in the following order: Journal of Interpersonal Violence, Journal of Marital and Family Therapy, Clinical Child Psychology and Psychiatry, and Journal of Family Therapy. Due to many of the IPV interventions occurring in the

third sector, large organisations such as Refuge and Women's Aid will be approached by the researcher with the hope of broadening the reach of the findings and to maximise the impact.

# References

Ainsworth, M. D. S. (1978). The bowlby-ainsworth attachment theory. Behavioral and brain sciences, 1(3), 436-438. https://doi.org/10.1017/S0140525X00075828

Anderson, K., & van Ee, E. (2018). Mothers and children exposed to intimate partner violence: a review of treatment interventions. *International Journal of Environmental Research and Public Health*, *15*(9). https://doi.org/10.3390/IJERPH15091955

Armenti, N. A., & Babcock, J. C. (2016). Conjoint treatment for intimate partner violence: A systematic review and implications. *Couple and Family Psychology: Research and Practice*, *5*(2). https://doi.org/10.1037/cfp0000060

Ashmore, Z., & Fox, S. (2011). How does the delivery of multisystemic therapy to adolescents and their families challenge practice in traditional services in the criminal justice system? *British Journal of Forensic Practice*, *13*(1). https://doi.org/10.5042/bjfp.2011.0047

Austin, A. E., Shanahan, M. E., Barrios, Y. v., & Macy, R. J. (2019a). A Systematic Review of Interventions for Women Parenting in the Context of Intimate Partner Violence. In *Trauma, Violence, and Abuse* (Vol. 20, Issue 4). https://doi.org/10.1177/1524838017719233

Ayers, S., Bond, R., Webb, R., Miller, P., & Bateson, K. (2019). Perinatal mental health and risk of child maltreatment: A systematic review and meta-analysis. In *Child Abuse and Neglect* (Vol. 98). https://doi.org/10.1016/j.chiabu.2019.104172

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. The journal of early adolescence, 11(1), 56-95. https://doi.org/10.1177/027243169111100

Belsky, J. (1984). The determinants of parenting: a process model. *Child Development*, *55*(1). https://doi.org/10.1111/j.1467-8624.1984.tb00275.x

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic Treatment of Adolescent Sexual Offenders. *International Journal of Offender Therapy and Comparative Criminology*, *34*(2). https://doi.org/10.1177/0306624X9003400204

Bowlby, J. (1973). Attachment and loss. Volume II. Separation, anxiety and anger. In Attachment and loss. volume II. Separation, anxiety and anger (pp. 429-p).

Braun, V., & Clarke, V. (2022). Thematic Analysis: A Practical Guide. *QMiP Bulletin*, *1*(33). https://doi.org/10.53841/bpsqmip.2022.1.33.46

Bronfenbrenner. (1979). The Ecology of Human Development: Experiments by Nature and Design. Cambridge. *Encyclopedia of Quality of Life and Well-Being Research*.

Buehler, C., & Gerard, J. M. (2002). Marital conflict, ineffective parenting, and children's and adolescents' maladjustment. *Journal of Marriage and Family*, *64*(1). https://doi.org/10.1111/j.1741-3737.2002.00078.x

Burelomova, A. S., Gulina, M. A., & Tikhomandritskaya, O. A. (2018). Intimate Partner Violence: An overview of the existing theories, conceptual frameworks, and definitions. *Psychology in Russia: State of the Art*, *11*(3). https://doi.org/10.11621/pir.2018.0309

Critical Appraisal and Skills Programme. (2018). CASP Qualitative Checklist. https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2018). Substance use and intimate partner violence: A meta-analytic review. *Psychology of Violence*, *8*(1). https://doi.org/10.1037/vio0000074

Carlson, J., Voith, L., Brown, J. C., & Holmes, M. (2019). Viewing Children's Exposure to Intimate Partner Violence Through a Developmental, Social-Ecological, and Survivor

Lens: The Current State of the Field, Challenges, and Future Directions. *Violence Against Women*, *25*(1). https://doi.org/10.1177/1077801218816187

Clark, H. M., Galano, M. M., Grogan-Kaylor, A. C., Stein, S. F., & Graham-Bermann, S. A. (2021). Treating attention problems in children exposed to intimate partner violence: Evaluating the Preschool Kids' Club. *Children and Youth Services Review*, *128*. https://doi.org/10.1016/j.childyouth.2021.106138

Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatrics and Adolescent Medicine*, *165*(1), 16–21. https://doi.org/10.1001/ARCHPEDIATRICS.2010.247

Constantinou, C. S., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes saturation (CoMeTS) in qualitative interviews. *Qualitative Research*, *17*(5). https://doi.org/10.1177/1468794116686650

Day, L., Bryson, C., & White, C. (2016). National evaluation of the troubled families programme: final synthesis report. https://www.niesr.ac.uk/wpcontent/uploads/2021/10/Troubled_Families_Evaluation_Synthesis_Report.pdf. Accessed January, 2023.

Deeks, J. J., Dinnes, J., D'Amico, R., Sowden, A. J., Sakarovitch, C., Song, F., Petticrew, M., & Altman, D. G. (2003). Evaluating non-randomised intervention studies. In *Health Technology Assessment* (Vol. 7, Issue 27). https://doi.org/10.3310/hta7270

Department for Education. (2016). Characteristics of children in need: 2015 to 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/564620/SFR52-2016_Main_Text.pdf .Accessed January, 2023.

Domestic Abuse Act 2021. https://www.lawsociety.org.uk/en/topics/family-and-children/domestic-abuse-act-2021. Accessed January, 2023.

Draxler, H., Hjärthag, F., & Almqvist, K. (2019). Replicability of Effect when Transferring a Supportive Programme for Parents Exposed to Intimate Partner Violence and Their Children from the US to Sweden. *Child Care in Practice*, *25*(4). https://doi.org/10.1080/13575279.2018.1463968

Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The Effectiveness of Intervention Programs for Perpetrators and Victims of Intimate Partner Violence. *Partner Abuse*, *4*(2). https://doi.org/10.1891/1946-6560.4.2.196

Ellard-Gray, A., Jeffrey, N. K., Choubak, M., & Crann, S. E. (2015). Finding the Hidden Participant: Solutions for Recruiting Hidden, Hard-to-Reach, and Vulnerable Populations. *International Journal of Qualitative Methods*, *14*(5). https://doi.org/10.1177/1609406915621420

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*. https://doi.org/10.1348/014466599162782

Fogarty, A., Savopoulos, P., Seymour, M., Cox, A., Williams, K., Petrie, S., Herman, S., Toone, E., Schroeder, K., & Giallo, R. (2022). Providing therapeutic services to women and children who have experienced intimate partner violence during the COVID-19 pandemic: Challenges and learnings. *Child Abuse and Neglect*, *130*. https://doi.org/10.1016/j.chiabu.2021.105365

Fogarty, A., Treyvaud, K., Savopoulos, P., Jones, A., Cox, A., Toone, E., & Giallo, R. (2020). Facilitators to Engagement in a Mother–Child Therapeutic Intervention Following Intimate Partner Violence. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260520926316

Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., Fuggle, P., Kraam, A., Byford, S., Wason, J., Smith, J. A., Anokhina, A., Ellison, R., Simes, E., Ganguli, P., Allison, E., & Goodyer, I. M. (2020). Multisystemic therapy compared with management as usual for adolescents at risk of offending: the START II RCT. *Health Services and Delivery Research*, *8*(23). https://doi.org/10.3310/hsdr08230

Friend, D. J., Bradley, R. P. C., Thatcher, R., & Gottman, J. M. (2011). Typologies of Intimate Partner Violence: Evaluation of a Screening Instrument for Differentiation. *Journal of Family Violence*, *26*(7). https://doi.org/10.1007/s10896-011-9392-2

Galano, M. M., Stein, S. F., Clark, H. M., Grogan-Kaylor, A., & Graham-Bermann, S. A. (2022). Eight-year trajectories of behavior problems and resilience in children exposed to early-life intimate partner violence: The overlapping and distinct effects of individual factors, maternal characteristics, and early intervention. *Development and Psychopathology*. https://doi.org/10.1017/S0954579422000104

Garrido, E. F., & Taussig, H. N. (2013). Do parenting practices and prosocial peers moderate the association between intimate partner violence exposure and teen dating violence? *Psychology of Violence*, *3*(4). https://doi.org/10.1037/a0034036

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L. M., & Gadd, D. (2019). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy*, *65*. https://doi.org/10.1016/j.drugpo.2018.12.009

Graham-Bermann, S. A., Gruber, G., Howell, K. H., & Girz, L. (2009). Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV). *Child Abuse and Neglect*, *33*(9). https://doi.org/10.1016/j.chiabu.2009.01.002

Graham-Bermann, S. A., Howell, K. H., Lilly, M., & DeVoe, E. (2011). Mediators and moderators of change in adjustment following intervention for children exposed to intimate partner violence. *Journal of Interpersonal Violence*, *26*(9), 1815–1833. https://doi.org/10.1177/0886260510372931

Graham-Bermann, S. A., Miller-Graff, L. E., Howell, K. H., & Grogan-Kaylor, A. (2015). An Efficacy Trial of an Intervention Program for Children Exposed to Intimate Partner Violence. *Child Psychiatry and Human Development*, *46*(6), 928–939. https://doi.org/10.1007/S10578-015-0532-4

Gustafsson, H. C., Coffman, J. L., & Cox, M. J. (2015). Intimate partner violence, maternal sensitive parenting behaviors, and children's executive functioning. *Psychology of Violence*, *5*(3). https://doi.org/10.1037/a0037971

Hackett, S., McWhirter, P. T., & Lesher, S. (2016). The Therapeutic Efficacy of Domestic Violence Victim Interventions. *Trauma, Violence, and Abuse*, *17*(2). https://doi.org/10.1177/1524838014566720

Halford, E., & Smith, J. (2022). Operation provide: a multi-agency response to increasing police engagement in cases of intimate partner violence during the COVID-19 pandemic. *Police Practice and Research*, *23*(5). https://doi.org/10.1080/15614263.2022.2033621

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse and Neglect*. https://doi.org/10.1016/j.chiabu.2010.03.001

Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: Update on a review of published papers. *Qualitative Research*, *12*(4). https://doi.org/10.1177/1468794111432992

Hardesty, J. L., & Ganong, L. H. (2006). How women make custody decisions and manage co-parenting with abusive former husbands. *Journal of Social and Personal Relationships*, *23*(4). https://doi.org/10.1177/0265407506065983

Henggeler, S., & Borduin, C. M. (1990). Family therapy and beyond: A multisystemic approach to treating the behavior problems of children and adolescents. Brooks/Cole.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic therapy for antisocial behavior in children and adolescents, 2nd ed. In *Multisystemic therapy for antisocial behavior in children and adolescents, 2nd ed.*

Herschell, A. D., Scudder, A. B., Schaffner, K. F., & Slagel, L. A. (2017). Feasibility and Effectiveness of Parent–Child Interaction Therapy with Victims of Domestic Violence: A Pilot Study. *Journal of Child and Family Studies*, *26*(1), 271–283. https://doi.org/10.1007/S10826-016-0546-Y

Heward-Belle, S. (2018). Domestic Violence and Protecting Children: New Thinking and Approaches. *Australian Social Work*, *71*(1). https://doi.org/10.1080/0312407x.2016.1259977

Hilder, S., & Freeman, C. (2016). Working with perpetrators of domestic violence and abuse: The potential for change. In *Domestic Violence: Interdisciplinary Perspectives on Protection, Prevention and Intervention*. https://doi.org/10.1057/978-1-137-52452-2_13

Holmes, M. R., Berg, K. A., Bender, A. E., Evans, K. E., O'Donnell, K., & Miller, E. K. (2022). Nearly 50 Years of Child Exposure to Intimate Partner Violence Empirical Research: Evidence Mapping, Overarching Themes, and Future Directions. In

*Journal of Family Violence* (Vol. 37, Issue 8). https://doi.org/10.1007/s10896-021-00349-3

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of Male Batterers: Three Subtypes and the Differences Among Them. *Psychological Bulletin*, *116*(3). https://doi.org/10.1037//0033-2909.116.3.476

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M. P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. C., Vedel, I., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4). https://doi.org/10.3233/EFI-180221

Hong, Q. N., Pluye, P., Bujold, M., & Wassef, M. (2017). Convergent and sequential synthesis designs: implications for conducting and reporting systematic reviews of qualitative and quantitative evidence. In *Systematic reviews* (Vol. 6, Issue 1). https://doi.org/10.1186/s13643-017-0454-2

Howarth, E., Moore, T. H. M., Stanley, N., MacMillan, H. L., Feder, G., & Shaw, A. (2019). Towards an ecological understanding of readiness to engage with interventions for children exposed to domestic violence and abuse: Systematic review and qualitative synthesis of perspectives of children, parents and practitioners. In *Health and Social Care in the Community* (Vol. 27, Issue 2). https://doi.org/10.1111/hsc.12587

Howarth, E., Moore, T. H., Welton, N. J., Lewis, N., Stanley, N., MacMillan, H., Shaw, A., Hester, M., Bryden, P., & Feder, G. (2016). IMPRoving Outcomes for children exposed to domestic ViolencE (IMPROVE): an evidence synthesis. *Public Health Research*, *4*(10). https://doi.org/10.3310/phr04100

Howell, K. H. (2011). Resilience and psychopathology in children exposed to family violence. In *Aggression and Violent Behavior* (Vol. 16, Issue 6). https://doi.org/10.1016/j.avb.2011.09.001

Howell, K. H., Miller, L. E., Lilly, M. M., & Graham-Bermann, S. A. (2013). Fostering social competence in preschool children exposed to intimate partner violence: Evaluating the preschool kids' club intervention. *Journal of Aggression, Maltreatment and Trauma*, *22*(4). https://doi.org/10.1080/10926771.2013.775986

Humphreys, C., & Campo, M. (2017). Fathers who use violence: Options for safe practice where there is ongoing contact with children. *CFCA Paper No. 43.*, *43*.

Humphreys, C., Thiara, R. K., & Skamballis, A. (2011). Readiness to change: Mother-child relationship and domestic violence intervention. *British Journal of Social Work*, *41*(1). https://doi.org/10.1093/bjsw/bcq046

Hurless, N., & Cottone, R. R. (2018). Considerations of Conjoint Couples Therapy in Cases of Intimate Partner Violence. *Family Journal*, *26*(3). https://doi.org/10.1177/1066480718795708

Jenkins, A. (1990). Invitations to responsibility: The therapeutic engagement of men who are violent and abusive. In *Australian and New Zealand Journal of Family Therapy* (Vol. 11, Issue 2). https://doi.org/10.1002/j.1467-8438.1990.tb00796.x

Jory, B., Anderson, D., & Greer, C. (1997). Intimate justice: Confronting issues of accountability, respect, and freedom in treatment for abuse and violence. *Journal of Marital and Family Therapy*, *23*(4). https://doi.org/10.1111/j.1752-0606.1997.tb01053.x

Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. C. (2009). Reducing Conduct Problems Among Children Exposed to Intimate Partner Violence: A Randomized Clinical Trial Examining Effects of Project Support.

*Journal of Consulting and Clinical Psychology*, *77*(4). https://doi.org/10.1037/a0015994

Jouriles, E. N., Rosenfield, D., McDonald, R., Vu, N. L., Rancher, C., & Mueller, V. (2018). Children exposed to intimate partner violence: Conduct problems, interventions, and partner contact with the child. *Journal of Clinical Child and Adolescent Psychology*, *47*(3), 397–409. https://doi.org/10.1080/15374416.2016.1163706

Karakurt, G., Dial, S., Korkow, H., Mansfield, T., & Banford, A. (2013). Experiences of marriage and family therapists working with intimate partner violence. *Journal of Family Psychotherapy*. https://doi.org/10.1080/08975353.2013.762864

Karlsson, M. E., Temple, J. R., Weston, R., & Le, V. D. (2016). Witnessing Interparental Violence and Acceptance of Dating Violence as Predictors for Teen Dating Violence Victimization. *Violence Against Women*, *22*(5). https://doi.org/10.1177/1077801215605920

Katz, L. F., Gurtovenko, K., Maliken, A., Stettler, N., Kawamura, J., & Fladeboe, K. (2020). An emotion coaching parenting intervention for families exposed to intimate partner violence. *Developmental Psychology*, *56*(3), 638–651. https://doi.org/10.1037/DEV0000800

Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review*, *46*(3). https://doi.org/10.1111/j.1744-1617.2008.00215.x

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*(2). https://doi.org/10.1037/0022-006X.71.2.339

Knous-Westfall, H. M., Ehrensaft, M. K., Watson MacDonell, K., & Cohen, P. (2012). Parental Intimate Partner Violence, Parenting Practices, and Adolescent Peer Bullying: A Prospective Study. *Journal of Child and Family Studies*, *21*(5). https://doi.org/10.1007/s10826-011-9528-2

Labarre, M., Bourassa, C., Holden, G. W., Turcotte, P., & Letourneau, N. (2016). Intervening with fathers in the context of intimate partner violence: An analysis of ten programs and suggestions for a research agenda. *Journal of Child Custody*, *13*(1). https://doi.org/10.1080/15379418.2016.1127793

Lapierre, S. (2008). Mothering in the context of domestic violence: The pervasiveness of a deficit model of mothering. *Child and Family Social Work*, *13*(4). https://doi.org/10.1111/j.1365-2206.2008.00563.x

Latzman, N. E., Casanueva, C., Brinton, J., & Forman-Hoffman, V. L. (2019a). The promotion of well-being among children exposed to intimate partner violence: A systematic review of interventions. In *Campbell Systematic Reviews* (Vol. 15, Issue 3). https://doi.org/10.1002/cl2.1049

Lehrner, A., & Allen, N. E. (2014). Construct validity of the conflict tactics scales: A mixed-method investigation of women's intimate partner violence. *Psychology of Violence*, *4*(4). https://doi.org/10.1037/a0037404

Letourneau, N. L., Fedick, C. B., & Willms, J. D. (2007). Mothering and domestic violence: A longitudinal analysis. *Journal of Family Violence*, *22*(8). https://doi.org/10.1007/s10896-007-9099-6

Lieberman, A. F., van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(12), 1241–1248. https://doi.org/10.1097/01.CHI.0000181047.59702.58

Lindhorst, T., & Beadnell, B. (2011). The long arc of recovery: Characterizing intimate partner violence and its psychosocial effects across 17 years. *Violence Against Women*, *17*(4). https://doi.org/10.1177/1077801211404548

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1). https://doi.org/10.1177/2632084320947559

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. In *The Lancet* (Vol. 373, Issue 9659). https://doi.org/10.1016/S0140-6736(08)61708-0

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13). https://doi.org/10.1177/1049732315617444

Mason, B. (2018). Relational risk-taking and the therapeutic relationship. In *The Space Between: Experience, Context, and Process in the Therapeutic Relationship*. https://doi.org/10.4324/9780429483295-11

May, F., F. Shackleton, E. Avdagic, C. Wade, and C. Michaux. "Evaluating the implementation of Uniting's Working with Families Experiencing Domestic Violence Practice Framework: Qualitative evaluation report." Unpublished report. Melbourne: Uniting & Parenting Research Centre (2016).

McCollum, E. E., & Stith, S. M. (2008). Couples treatment for interpersonal violence: A review of outcome research literature and current clinical practices. In *Violence and Victims* (Vol. 23, Issue 2). https://doi.org/10.1891/0886-6708.23.2.187

McCracken, K., FitzSimons, A., Priest, S., Bracewell, K., & Stanley, N. (2017). Evaluation of Growing Futures. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/600952/Evaluation_of_Growing_Futures.pdf . Accessed January, 2023.

McDonald, R., Dodson, M. C., Rosenfield, D., & Jouriles, E. N. (2011). Effects of a parenting intervention on features of psychopathy in children. *Journal of Abnormal Child Psychology*, *39*(7), 1013–1023. https://doi.org/10.1007/S10802-011-9512-8

McManus, E., Belton, E., Barnard, M., Cotmore, R., & Taylor, J. (2013). Recovering from Domestic Abuse, Strengthening the Mother-Child Relationship: Mothers' and Children's Perspectives of a New Intervention. *Child Care in Practice*, *19*(3). https://doi.org/10.1080/13575279.2013.785933

McWhirter, P. T. (2011). Differential therapeutic outcomes of community-based group interventions for women and children exposed to intimate partner violence. *Journal of Interpersonal Violence*, *26*(12). https://doi.org/10.1177/0886260510383026

Miller-Pietroni, M. (1999). Containment in theory and practice. *Psychodynamic Counselling*, *5*(4). https://doi.org/10.1080/13533339908404980

Mohaupt, H., & Duckert, F. (2023). Partner-violent and non-violent fathers' descriptions of co-parenting. *Journal of Gender-Based Violence*, *7*(1). https://doi.org/10.1332/239868021X16430290579843

Multisystemic Therapy Services. (2017). Multisystemic Therapy. Adaptations Pilot Studies to Large- Scale Dissemination. http://www.mstservices.com/mst-whitepapers. Accessed January, 2023.

Mueller, M., D'Addario, M., Egger, M., Cevallos, M., Dekkers, O., Mugglin, C., & Scott, P. (2018). Methods to systematically review and meta-analyse observational studies: A

systematic scoping review of recommendations. In *BMC Medical Research Methodology* (Vol. 18, Issue 1). https://doi.org/10.1186/s12874-018-0495-9

National Collaborating Centre for Methods and Tools (2015). Appraising Qualitative, Quantitative, and Mixed Methods Studies included in Mixed Studies Reviews: The MMAT. Hamilton, ON: McMaster University. http://www.nccmt.ca/resources/search/232. Accessed January, 2023.

National Institute of Clinical Excellence (2014). Domestic violence and abuse: multi-agency working [NICE Guideline PH50]. https://www.nice.org.uk/guidance/ph50. Accessed January, 2023.

Noonan, C. B., & Pilkington, P. D. (2020). Intimate partner violence and child attachment: A systematic review and meta-analysis. In *Child Abuse and Neglect* (Vol. 109). https://doi.org/10.1016/j.chiabu.2020.104765

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology*, *97*. https://doi.org/10.1016/j.jclinepi.2017.06.020

Office for national Statistics (2022) Domestic abuse in England and Wales overview: November 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022. Accessed January, 2023.

Oka, M., & Whiting, J. B. (2011). Contemporary mft theories and intimate partner violence: A review of systemic treatments. In *Journal of Couple and Relationship Therapy* (Vol. 10, Issue 1). https://doi.org/10.1080/15332691.2011.539173

Overbeek, M. M., de Schipper, J. C., Lamers-Winkelman, F., & Schuengel, C. (2013). Effectiveness of specific factors in community-based intervention for child-witnesses of interparental violence: A randomized trial. *Child Abuse and Neglect*, *37*(12), 1202–1214. https://doi.org/10.1016/J.CHIABU.2013.07.007

Overbeek, M. M., de Schipper, J. C., Willemen, A. M., Lamers-Winkelman, F., & Schuengel, C. (2017). Mediators and Treatment Factors in Intervention for Children Exposed to Interparental Violence. *Journal of Clinical Child and Adolescent Psychology*, *46*(3), 411–427. https://doi.org/10.1080/15374416.2015.1012720

Pace, R., Pluye, P., Bartlett, G., Macaulay, A. C., Salsberg, J., Jagosh, J., & Seller, R. (2012). Testing the reliability and efficiency of the pilot Mixed Methods Appraisal Tool (MMAT) for systematic mixed studies review. *International Journal of Nursing Studies*, *49*(1). https://doi.org/10.1016/j.ijnurstu.2011.07.002

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. In *The BMJ* (Vol. 372). https://doi.org/10.1136/bmj.n71

Painter, K., & Scannapieco, M. (2009). Part I: A review of the literature on multisystemic treatment within an evidence-based framework: Implications for working with culturally diverse families and children. Journal of Family Social Work, 12(1), 73-92. https://doi.org/10.1080/10522150802654302

Pels, T., van Rooij, F. B., & Distelbrink, M. (2015). The Impact of Intimate Partner Violence (IPV) on Parenting by Mothers Within an Ethnically Diverse Population in

the Netherlands. *Journal of Family Violence*, *30*(8). https://doi.org/10.1007/s10896-015-9746-2

Pence, E., & Paymar, M. (1993). Education groups for men who batter: The Duluth model. In *Education groups for men who batter: The Duluth model.*

Popay, J., Roberts, H., Sowden, A., … M. P.-A. product from the, 2006, U., Baldwin, S., Arai, L., Britten, N., Petticrew, M., Rodgers, M., & Sowden, A. (2007). Guidance on the Conduct of Narrative Synthesis in Systematic Reviews. *ESRC Methods Programme*, *January*.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., & Britten, N. (2006). Narrative Synthesis in Systematic Reviews: A Product from the ESRC Methods Programme. *ESRC Methods Programme*, *2006*.

Postmus, J. L., Huang, C. C., & Mathisen-Stylianou, A. (2012). The impact of physical and economic abuse on maternal mental health and parenting. *Children and Youth Services Review*, *34*(9). https://doi.org/10.1016/j.childyouth.2012.06.005

Potter, L. C., Morris, R., Hegarty, K., García-Moreno, C., & Feder, G. (2021). Categories and health impacts of intimate partner violence in the World Health Organization multi-country study on women's health and domestic violence. International journal of epidemiology, 50(2), 652-662. https://doi.org/10.1093/ije/dyaa220

Radford, L. Corral, S. Bradley, C. Fisher, H, Collishaw, S. Bassett, C. and Howat, N. (2011), Child Abuse and Neglect in the UK Today, London: NSPCC

Renner, L. M., Driessen, M. C., & Lewis-Dmello, A. (2022). An Evaluation of a Parent Group for Survivors of Intimate Partner Violence. *Journal of Family Violence*, *37*(2). https://doi.org/10.1007/s10896-021-00270-9

Risi, A., Pickard, J. A., & Bird, A. L. (2021). The implications of parent mental health and wellbeing for parent-child attachment: A systematic review. In *PLoS ONE* (Vol. 16, Issue 12 December). https://doi.org/10.1371/journal.pone.0260891

Rizo, C. F., Macy, R. J., Ermentrout, D. M., & Johns, N. B. (2011). A review of family interventions for intimate partner violence with a child focus or child component. In *Aggression and Violent Behavior*. https://doi.org/10.1016/j.avb.2011.02.004

Romano, E., Weegar, K., Gallitto, E., Zak, S., & Saini, M. (2021). Meta-Analysis on Interventions for Children Exposed to Intimate Partner Violence. In *Trauma, Violence, and Abuse* (Vol. 22, Issue 4). https://doi.org/10.1177/1524838019881737

Ronan, G. F., Maurelli, K., & Holman, K. M. (2013). A Couples-Based Violence Reduction Approach to Curbing Intimate Partner Assault. In *Forensic CBT*. https://doi.org/10.1002/9781118589878.ch11

Rosser-limiñana, A., Suriá-martínez, R., & Pérez, M. Á. M. (2020). Children exposed to intimate partner violence: Association among battered mothers' parenting competences and children's behavior. *International Journal of Environmental Research and Public Health*, *17*(4). https://doi.org/10.3390/ijerph17041134

Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet*, *399*(10327). https://doi.org/10.1016/S0140-6736(21)02664-7

Satyen, L., Rogic, A. C., & Supol, M. (2019). Intimate Partner Violence and Help-Seeking Behaviour: A Systematic Review of Cross-Cultural Differences. In *Journal of Immigrant and Minority Health* (Vol. 21, Issue 4). https://doi.org/10.1007/s10903-018-0803-9

Schubert, E. C. (2021). Supporting Children Who Experience Domestic Violence: Evaluating the Child Witness to Domestic Violence Program. *Journal of Interpersonal Violence*. https://doi.org/10.1177/08862605211035874

Skinner, L., Gavidia-Payne, S., Brown, S., & Giallo, R. (2019). Mechanisms underlying exposure to partner violence and children's emotional-behavioral difficulties. *Journal of Family Psychology*. https://doi.org/10.1037/fam0000532

Smith, E., Belton, E., Barnard, M., Fisher, H. L., & Taylor, J. (2015). Strengthening the Mother-Child Relationship Following Domestic Abuse: Service Evaluation. *Child Abuse Review*, *24*(4). https://doi.org/10.1002/car.2405

Soliman, F. (2016). Engaging with Perpetrators of Domestic Violence: Practical Techniques for Early Intervention, Kate Iwi and Chris Newman. *British Journal of Social Work*, *46*(2). https://doi.org/10.1093/bjsw/bcw011

Spencer, C., Mallory, A. B., Cafferky, B. M., Kimmes, J. G., Beck, A. R., & Stith, S. M. (2019). Mental health factors and intimate partner violence perpetration and victimization: A meta-analysis. *Psychology of Violence*, *9*(1). https://doi.org/10.1037/vio0000156

Stanley, N., & Humphreys, C. (2017). Identifying the key components of a 'whole family' intervention for families experiencing domestic violence and abuse. *Journal of Gender-Based Violence*, *1*(1). https://doi.org/10.1332/239868017X14913081639164

Sternberg, K. J., Baradaran, L. P., Abbott, C. B., Lamb, M. E., & Guterman, E. (2006). Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis. *Developmental Review*, *26*(1). https://doi.org/10.1016/j.dr.2005.12.001

Stith, S. M., & McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. In *Aggression and Violent Behavior* (Vol. 16, Issue 4). https://doi.org/10.1016/j.avb.2011.04.012

Stith, S. M., Mccollum, E. E., Amanor-Boadu, Y., & Smith, D. (2012). Systemic Perspectives on Intimate Partner Violence Treatment. In *Journal of Marital and Family Therapy* (Vol. 38, Issue 1). https://doi.org/10.1111/j.1752-0606.2011.00245.x

Stith, S. M., McCollum, E. E., & Rosen, K. H. (2011). Couples therapy for domestic violence: Finding safe solutions. In *Couples therapy for domestic violence: Finding safe solutions.* https://doi.org/10.1037/12329-000

Stover, C. S. (2015). Fathers for Change for Substance Use and Intimate Partner Violence: Initial Community Pilot. *Family Process*, *54*(4). https://doi.org/10.1111/famp.12136

Straus, M. A., HAMBY, S. L., BONEY-McCOY, S., & SUGARMAN, D. B. (1996). The Revised Conflict Tactics Scales (CTS2). *Journal of Family Issues*, *17*(3). https://doi.org/10.1177/019251396017003001

Swenson, C. C., & Schaeffer, C. M. (2018). A Multisystemic Approach to the Prevention and Treatment of Child Abuse and Neglect. *International Journal on Child Maltreatment: Research, Policy and Practice*, *1*(1), 97–120. https://doi.org/10.1007/S42448-018-0002-2

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*. https://doi.org/10.1186/1471-2288-8-45

Timmer, S. G., Ware, L. M., Urquiza, A. J., & Zebell, N. M. (2010). The effectiveness of Parent-Child Interaction Therapy for victims of interparental violence. *Violence and Victims*, *25*(4), 486–503. https://doi.org/10.1891/0886-6708.25.4.486

Tindall, L. (2009). J.A. Smith, P. Flower and M. Larkin (2009), Interpretative Phenomenological Analysis: Theory, Method and Research . . *Qualitative Research in Psychology*. https://doi.org/10.1080/14780880903340091

Todahl, J., Linville, D., Tuttle Shamblin, A. F., & Ball, D. (2012). Client Narratives About Experiences With a Multicouple Treatment Program for Intimate Partner Violence. *Journal of Marital and Family Therapy*, *38*(SUPPL.1). https://doi.org/10.1111/j.1752-0606.2011.00273.x

Valdovinos, M. G., & Bellamy, J. L. (2023). Engaging Fathers in Intimate Partner Violence Interventions. In *Social Work Practice with Fathers*. https://doi.org/10.1007/978-3-031-13686-3_15

Van der Stouwe, T., Asscher, J. J., Stams, G. J. J. M., Deković, M., & van der Laan, P. H. (2014). The effectiveness of multisystemic therapy (MST): A meta-analysis. In *Clinical Psychology Review* (Vol. 34, Issue 6). https://doi.org/10.1016/j.cpr.2014.06.006

Van Eldik, W. M., de Haan, A. D., Parry, L. Q., Davies, P. T., Luijk, M. P. C. M., Arends, L. R., & Prinzie, P. (2020). The Interparental Relationship: Meta-Analytic Associations With Children's Maladjustment and Responses to Interparental Conflict. *Psychological Bulletin*. https://doi.org/10.1037/bul0000233

Vu, N. L., Jouriles, E. N., McDonald, R., & Rosenfield, D. (2016). Children's exposure to intimate partner violence: A meta-analysis of longitudinal associations with child adjustment problems. In *Clinical Psychology Review* (Vol. 46). https://doi.org/10.1016/j.cpr.2016.04.003

Women's Aid. (2023) The Domestic Abuse Report 2023: The Annual Audit, Bristol: Women's Aid. https://www.womensaid.org.uk/wp-content/uploads/2023/01/The-

Domestic-Abuse-Report-2023-The-Annual-Audit-FINAL.pdf. Accessed January, 2023.

Woollett, N., Bandeira, M., & Hatcher, A. (2020). Trauma-informed art and play therapy: Pilot study outcomes for children and mothers in domestic violence shelters in the United States and South Africa. *Child Abuse and Neglect*, *107*. https://doi.org/10.1016/J.CHIABU.2020.104564

World Health Organisation (2021). Violence against women. https://www.who.int/news-room/fact-sheets/detail/violence-against-women#:~:text=Introduction&text=Intimate%20partner%20violence%20refers%20to,psychological%20abuse%20and%20controlling%20behaviours. Accessed January, 2023.

# Appendices

**Appendix A**: *Quality assessment of quantitative studies using the QATQ (National Collaborating Centre for Methods and Tools, 2008)*

| **Study** | Selection Bias | Study Design | Cofounders | Blinding | Data collection Methods | Withdrawals & Drop-outs | Intervention Integrity Treatment fidelity | Analysis | Global Rating |
|---|---|---|---|---|---|---|---|---|---|
| Herschell et al. (2017) | Weak | Moderate | Weak | Weak | Strong | Weak | Moderate | Moderate | **Weak** |
| Schubert, (2021) | Weak | Strong | Strong | Weak | Strong | Weak | Weak | Moderate | **Weak** |
| Cohen et al. (2011) | Moderate | Strong | Strong | Moderate | Strong | Moderate | Strong | Strong | **Strong** |
| Katz et al. (2020) | Moderate | Strong | Strong | Weak | Strong | Moderate | Strong | Moderate | **Moderate** |
| Graham-Bermann et al. (2015) | Weak | Strong | Strong | Moderate | Strong | Moderate | Strong | Strong | **Moderate** |
| Howell et al. (2013) | Weak | Strong | Strong | Moderate | Strong | Moderate | Strong | Strong | **Moderate** |
| Galano et al. (2022) | Weak | Strong | Strong | Moderate | Strong | Weak | Strong | Strong | **Weak** |
| Clark et al. (2021) | Weak | Strong | Strong | Moderate | Strong | Weak | Strong | Strong | **Weak** |
| McWhirter, (2011) | Weak | Strong | Strong | Moderate | Weak | Strong | Moderate | Strong | **Weak** |
| Graham-Bermann et al. (2011) | Weak | Strong | Strong | Moderate | Strong | Strong | Strong | Strong | **Moderate** |
| (Timmer et al., 2010) | Weak | Moderate | Strong | Moderate | Strong | Weak | Strong | Strong | **Weak** |
| McDonald et al. (2011) | Moderate | Strong | Strong | Moderate | Strong | Strong | Strong | Strong | **Strong** |
| Draxler et al. (2019) | Weak | Moderate | Weak | Weak | Strong | Strong | Strong | Moderate | **Weak** |
| Overbeek et al. (2013) | Weak | Strong | Strong | Moderate | Strong | Moderate | Moderate | Strong | **Moderate** |
| Overbeek et al. (2017) | Weak | Strong | Strong | Moderate | Strong | Moderate | Moderate | Strong | **Moderate** |

**Appendix B:** *Articles excluded at full text from systematic review and reasons for exclusion*

| CASP Item | Humphreys et al. (2011) | McManus et al. (2013) | Draxler et al. (2020) | Fogarty et al. (2020) | Fogarty et al. (2022) | Renner et al. (2022) |
|---|---|---|---|---|---|---|
| Clear statement of the aims of research? | Yes | Yes | Yes | Yes | Yes | Yes |
| Is a qualitative methodology appropriate? | Yes | Yes | Yes | Yes | Yes | Yes |
| Was the research design appropriate to address the aims of the research? | Yes | Yes | Yes | Yes | Yes | Yes |
| Was the recruitment strategy appropriate to the aims of the research? | Can't tell | Yes | Yes | Yes | Yes | Yes |
| Was the data collected in a way that addressed the research issue? | Yes | Yes | Yes | Yes | Yes | Yes |
| Has the relationship between research and participants been adequately considered? | No | No | No | No | No | No |
| Have ethical issues been taken into consideration? | Yes | Yes | Yes | Yes | Yes | Yes |
| Was the data analysis sufficiently rigorous? | Yes | Yes | Yes | Yes | Yes | Yes |
| Is there a clear statement of findings? | Yes | Yes | Yes | Yes | Yes | Yes |
| Global rating | Moderate | Moderate | Moderate | Moderate | Moderate | Moderate |

**Note.** Global ratings were assigned using an adapted version of the global rating criteria on the QATQ. Strong was assigned to studies with zero "No" ratings. Moderate was assigned to studies with one "No' and/or one "Can't tell" ratings. Weak was assigned to studies with two or more No' and/or one "Can't tell" ratings.

***Appendix C:*** *Quality assessment of mixed method studies using the MMAT (2018)*

| Study | 1. Are there clear research questions? | 2.Do the collected data allow the research questions to be addressed? | 3. Is there an adequate rationale for using a mixed methods design to address the research question? | 4. Are the different components of the study effectively integrated to answer the research question? | 5. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? | 6. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? | 7. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? | Global Rating |
|---|---|---|---|---|---|---|---|---|
| Smith et al. (2015) | Yes | Yes | Yes | Yes | Yes | Yes | No | Weak |
| Woollett et al. (2020) | Yes | Yes | Yes | Yes | Yes | Yes | No | Weak |

**Note.** Global rating system used the same criteria as Table 8.

**Appendix D:** *Royal Holloway University of London Ethics Approval*

## [EXT] RE: Result of your application to the Research Ethics Committee (application ID 3154)

ES

Ethics Application System <ethics@rhul.ac.uk>

To: Kearney, Lucy (2020); Glorney, Emily; Ethics

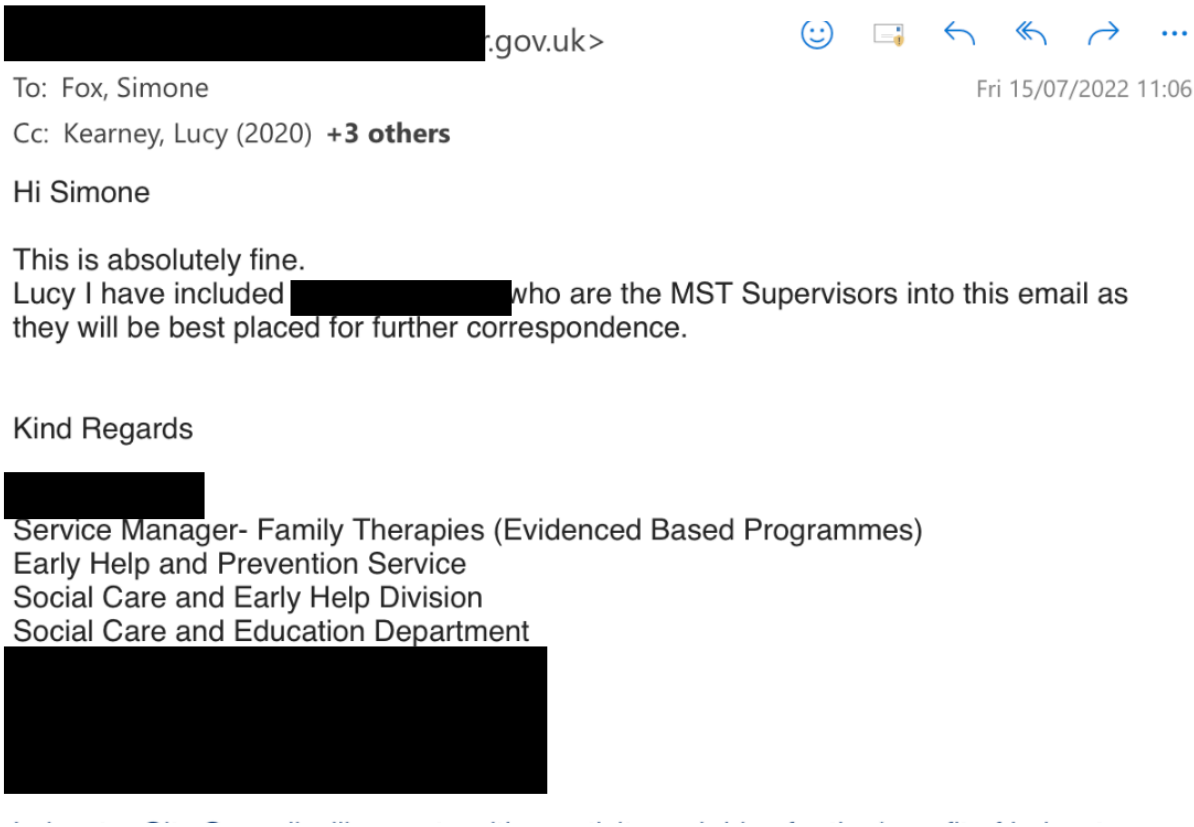
Thu 07/07/2022 13:05

PI: Emily Glorney
Project title: Caregivers' and therapists' perspective on experiences of Multisystemic Therapy in the context of intimate partner violence

REC ProjectID: 3154

Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

**Appendix E:** *Example of local recruitment site ethical approval*



[redacted].gov.uk>

To: Fox, Simone

Fri 15/07/2022 11:06

Cc: Kearney, Lucy (2020) **+3 others**

Hi Simone

This is absolutely fine.
Lucy I have included [redacted] who are the MST Supervisors into this email as they will be best placed for further correspondence.

Kind Regards

[redacted]
Service Manager- Family Therapies (Evidenced Based Programmes)
Early Help and Prevention Service
Social Care and Early Help Division
Social Care and Education Department
[redacted]

**Appendix F:** *Parent Information Sheet*

Department of Psychology
Royal Holloway, University of London
Egham, Surrey, TW20 0EX
www.royalholloway.ac.uk/psychology

**Information Sheet for Caregivers**
**Royal Holloway University**

**Study Title:** Caregivers' and therapists' perspective on experiences of Multisystemic Therapy in the context of intimate partner violence

**Introduction**
My name is Lucy Kearney and I am a Trainee Clinical Psychologist undergoing a doctorate in clinical psychology at Royal Holloway, University of London. I am working on a study which is interested in asking caregivers who have experienced intimate partner violence about their experiences of Multisystemic Therapy (MST).

**The Study**
This study is interested in exploring your experiences of MST and whether it was impacted by your experience of intimate partner violence. Intimate partner violence or domestic violence is defined by the Domestic Abuse Act (2021) as the behaviour of a person towards another that is abusive, this includes: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; and psychological, emotional or other abuse. This research aims to understand how MST can best meet the needs of families where there are concerns of intimate partner violence.

**Who can take part in this study?**
You can take part in this study if you have:

- Completed MST within the last two years
- Have experienced intimate partner violence at the time of MST or prior to taking part in MST
- Intimate partner violence was discussed with your MST therapist
- You speak enough English to participate in the interview, as interviews are unable to be conducted in other languages

**What will I have to do if I take part?**
If you agree to take part in this study, I would like to talk to you about your personal experiences of MST in the context of having experienced intimate partner violence. This will entail an online discussion which should last about an hour and will be tape recorded with your permission. After the interview, you will be invited to debrief with Lucy. This will involve an informal conversation about how you found the interview and give you the opportunity to ask any questions you might have following your participation. Due to the nature of the topic, it is anticipated that you might find our discussion emotional, however if you become uncomfortable when we talk, we will of course stop our discussion and think about any possible support you may need. We also provide you with a debrief sheet which will have links to support after this interview if it is needed.

**Do I have to take part?**
No. Participating in this project is completely voluntary. If you do not want to take part, you do not have to give a reason and no pressure will be placed on you to try and change your mind. If you decide to take part, you have the right to pull out of the discussion at any time.

**If I agree to take part what happens to what I say?**

All the information you give us is confidential. The audio taped recording of our discussion will be stored securely and will only be listened to by the researchers involved in this study. Any specific thoughts or views you have about the MST project will not be disclosed to your individual MST therapist. However, if in the course of our discussions, I were to become concerned about yours or someone else's safety, then we would need to inform the MST lead at the site in which you received treatment. We will however discuss this with you first to explain why we might have to break confidentiality.

**How is this project funded?**
Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data provided during the completion of the study will be stored securely on password protected local servers.

**If I agree to take part what will happen to the information I give?**
With your consent, the interview will be audio-recorded to ensure no information is missed. A transcript of the interview will be produced by myself as the researcher. People in the research team who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the transcript. Only myself and my research supervisors will have access to the anonymised interview transcripts and interview recordings. Any extracts from what you say that are quoted in written work will be entirely anonymous. All electronic and personal data will be stored on a password protected computer. All digital recordings will be destroyed after completion of the project. Once the study is completed, transcripts will be stored securely for five years.

Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent personal data from being accidentally lost, used, or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. If after interviewing you decide you no longer wish to be involved in the study and would like to withdraw your contributions, you can let the researcher know before January 2023. After this timepoint, the researcher would have written up the research and withdrawal would be impractical.

You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/ and if you wish to exercise your rights, please contact dataprotection@royalholloway.ac.uk

Please keep this part of the sheet yourself for reference. Please feel free to ask any questions. You may wish to print a copy of the consent form or may contact the researchers for a word version of this information. This study has been approved by the Royal Holloway Research Ethics Committee.

**What will happen to the results of the study?**

A report will be written about the findings of this study. In that report the results will be presented in such a way that no one can identify anyone who participated. In other words, we can guarantee that information about you will be anonymous because we will talk about groups not individuals.

**Conclusions**

We hope that what we learn in this study may be used to help future MST therapists to deliver interventions effectively for families who are experiencing or have experienced intimate partner violence.

**Next steps**

Please contact me if you have any further questions about your participation and the study. If you decide to take part in this research after reading this information sheet, you can contact Lucy via email on lucy.kearney.2020@live.rhul.ac.uk

**Researcher**
Lucy Kearney
Psychology Department
Royal Holloway, University of London
Egham
Surrey
TW20 0EX
lucy.kearney.2020@live.rhul.ac.uk

**Internal Research Supervisor**
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emily.glorney@rhul.ac.uk

**External Research Supervisor**

Dr Simone Fox

South London and Maudsley NHS Foundation Trust
simone.fox@kcl.ac.uk

**Appendix G:** *Practitioner Information Sheet*

Department of Psychology
Royal Holloway, University of London
Egham, Surrey, TW20 0EX
www.royalholloway.ac.uk/psychology

ROYAL HOLLOWAY UNIVERSITY OF LONDON

**Information Sheet for Therapists**
**Royal Holloway University**

**Study Title:** Caregivers' and therapists' perspective on experiences of Multisystemic Therapy in the context of intimate partner violence

**Introduction**
My name is Lucy Kearney and I am a Trainee Clinical Psychologist undergoing a doctorate in clinical psychology at Royal Holloway, University of London. I am working on a study which is interested in asking MST therapists experiences of working with families who have experienced Intimate partner violence

**The Study**
This study is interested in exploring your views on how MST delivery was impacted by Intimate partner violence (IPV). Intimate partner violence or domestic violence is defined by the Domestic Abuse Act (2021) as the behaviour of a person towards another that is abusive, this includes: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; and psychological, emotional or other abuse. This research aims to understand how MST can best meet the needs of families where there are concerns of intimate partner violence.

**Who can take part in this study?**
You can take part in this study if:

- You are a standard MST therapist
- Have experienced working with families where IPV has been a concern and it was raised and worked on with the family

**What will I have to do if I take part?**
If you agree to take part in this study, we would like to talk to you about your experiences of delivering MST in the context of intimate partner violence. This will entail an online discussion which should last about an hour and will be tape recorded with your permission. After the interview, you will be invited to debrief with Lucy. This will involve an informal conversation about how you found the interview and give you the opportunity to ask any questions you might have following your participation. It is not anticipated that you will experience any psychological distress because of our discussions. If, however, you become uncomfortable when we talk, we will of course stop discussion and think about any possible support you may need.

**Do I have to take part?**
No. Participating in this project is completely voluntary. If you do not want to take part, you do not have to give a reason and no pressure will be placed on you to try and change your mind. If you decide to take part, you have the right to pull out of the discussion at any time.

**If I agree to take part what happens to what I say?**
All the information you give us is confidential. The audio taped recording of our discussion will be stored securely and will only be listened to by the researchers involved in this study. Any specific thoughts or views you have about the MST project will not be disclosed to your teams.

**How is this project funded?**

***Note**: the rest of the information sheet is the same as Appendix F.*

**Appendix H:** *Debrief form for Parents*

Department of Psychology

**Debrief Sheet for Caregivers**
Royal Holloway University of London

**Study Title:** Caregivers' and therapists' perspective on experiences of Multisystemic Therapy in the context of intimate partner violence

**Name of researcher:** Lucy Kearney (supervised by Dr Simone Fox & Dr Emily Glorney)

Thank you for your participation in the above research study. The study is interested in exploring the impact of intimate partner violence on MST delivery. The study aims to contribute to the knowledge base and to enhance the delivery of MST to support the needs of families where there are experiences of intimate partner violence.

If you have any questions or concerns about your participation in this study or if you would like to withdraw your data, please do not hesitate to contact a member of the research team using the contact details provided below.

**Researcher Contact Details:**
Lucy Kearney (Trainee Clinical Psychologist & Chief Investigator)
Email: lucy.kearney.2020@live.rhul.ac.uk

**Dr Simone Fox (Research Supervisor)**
Email: simone.fox@kcl.ac.uk

**Dr Emily Glorney (Academic Supervisor)**
Email: emily.glorney@rhul.ac.uk

We do not expect people to feel worse after participating in this study, but sometimes taking part in research studies can raise difficult thoughts and feelings. If you have experienced this, please contact your GP if you would like support with difficult emotions or if you have concerns about your mental health.

The following organisations may be able to support you:

| | |
|---|---|
| **Refuge's National Domestic Abuse Helpline:** Free, confidential support and advice is available to victims and their concerned family members or friends, 24 hours a day.<br>Call: 0808 2000 247<br>Live chat: | **Bright Sky App:** mobile app and website for anyone experiencing domestic abuse, or who is worried about someone else.<br><br>The app can be downloaded for free from the app stores. Only download the app if it is safe for you to do so and if you are sure that your phone isn't being monitored. |

| | |
|---|---|
| https://www.nationaldahelpline.org.uk/Chat-to-us-online | https://www.hestia.org/brightsky |
| **Women's Aid Local support services directory**: find local support near you<br><br>https://www.womensaid.org.uk/domestic-abuse-directory/<br><br>If you are experiencing domestic abuse or are worried about friends or family you can access the Women's aid live chat service 7 days a week, 10am to 6pm:<br>https://chat.womensaid.org.uk | **Victim Support:** run these services for victims and survivors of any abuse or crime, regardless of when it occurred or if the crime was reported to the police.<br>They run a free, independent and confidential 24/7 Supportline: 08 08 16 89 111<br>Live chat service:<br>https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/live-chat/ |
| **Ask for ANI codeword:**<br>If you are experiencing domestic abuse and need immediate help, ask for 'ANI' in a participating pharmacy. 'ANI' stands for Action Needed Immediately. If a pharmacy has the 'Ask for ANI' logo on display, it means they're ready to help. They will offer you a private space, provide a phone and ask if you need support from the police or other domestic abuse support services. | **Safe Spaces**<br>Safe Spaces are also available in Boots, Morrisons, Superdrug and Well pharmacies, TSB banks and independent pharmacies across the UK. Once you are inside, specialist domestic abuse support information will be available for you to access. Many Safe Spaces are also prepared to respond to the 'Ask for ANI' codeword, to provide victims with a discreet way to access help calling the police on 999 or specialist support services.<br>**Find your nearest:**<br>https://uksaysnomore.org/safespaces/ |
| **Get a court order to protect you or your child:** If you're a victim of domestic abuse you can apply for a court order or injunction to protect yourself or your child from:<br>your current or previous partner, a family member, someone you currently or previously lived with. This is called a non-molestation or occupation order.<br><br>You can apply online, by email or by post:<br>https://www.gov.uk/injunction-domestic-violence | **The Samaritans:** A charity which provides anonymous emotional support over the telephone, which is available 24 hours a day.<br>Tel: 116 123 (free)<br>Website: https://www.samaritans.org |

**Appendix I:** *Debrief form for Practitioners*

Department of Psychology

**Debrief Sheet for Practitioners**
Royal Holloway University of London

**Study Title:** Parent's' and therapists' perspective on experiences of Multisystemic Therapy in the context of intimate partner violence

**Name of researcher:** Lucy Kearney (supervised by Dr Simone Fox & Dr Emily Glorney)

Thank you for your participation in the above research study. The study is interested in exploring the impact of intimate partner violence on MST delivery. The study aims to contribute to the knowledge base and to enhance the delivery of MST to support the needs of families where there are experiences of intimate partner violence.

If you have any questions or concerns about your participation in this study or if you would like to withdraw your data, please do not hesitate to contact a member of the research team using the contact details provided below.

**Researcher Contact Details:**
Lucy Kearney (Trainee Clinical Psychologist & Chief Investigator)
Email: lucy.kearney.2020@live.rhul.ac.uk

**Dr Simone Fox (Research Supervisor)**
Email: simone.fox@kcl.ac.uk

**Dr Emily Glorney (Academic Supervisor)**
Email: emily.glorney@rhul.ac.uk

We do not expect people to feel worse after participating in this study, but sometimes taking part in research studies can raise difficult thoughts and feelings. If you have experienced this, please contact your GP if you would like support with difficult emotions or if you have concerns about your mental health.

The following organisations are useful for professionals working where there might be concerns of abuse:

**Practice Guidance for Professionals:**
**SafeLives:** provides guidance and support to professionals and those working in the domestic abuse sector, as well as additional advice for those at risk.
https://safelives.org.uk

**The Samaritans:** A charity which provides anonymous emotional support over the telephone, which is available 24 hours a day.
Tel: 116 123 (free)
Website: https://www.samaritans.org

**Domestic abuse: specialist sources of support**

If you want to access help specifically to cater to a background and needs or want support and help for specific types of abuse there are several organisations that can help
https://www.gov.uk/government/publications/domestic-abuse-get-help-for-specific-needs-or-situations/domestic-abuse-specialist-sources-of-support

**Local IDVA (England and Wales)**

An Idva (Independent Domestic Violence Advisor) is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. They can help a victim with everything they need to become safe and rebuild their life and represent their voice at a Multi-agency Risk Assessment Conference (Marac), as well as helping them to navigate the criminal justice process and working with the different statutory agencies to provide wraparound support.

**Domestic Abuse and Child Welfare: A Practice Guide for Social Workers Domestic abuse during COVID-19 – (2020)**
https://www.basw.co.uk/media/news/2020/apr/domestic-abuse-and-child-welfare-practice-guide-social-workers

**Appendix J:** *Interview schedules*

Parent Interview schedule

Pre-intervention:

1. What led your family to being referred to MST?
    - What difficulties/ behaviours were causing concern?
2. Were you in a relationship at the time of the referral and could you tell me a little about your relationship with your partner/ex- partner where you experienced intimate partner violence?
    - Does a specific incident come to mind?
    - What is your relationship with X (partner) like now?
    - Do you have contact with them?
    - Does X (named MST young person) have contact with them?
    - Do you co-parent with them?
    - Did your MST therapist work with your partner/ex-partner? Did they attend MST sessions/ aware of MST involvement?

Intervention:

3. Did you feel able to discuss your experiences of IPV with your MST therapist?
    - Did you discuss it in every/most/some/a few sessions?
    - How did your therapist respond?
    - What did your therapist do to make you feel safe?
    - Do you feel like there was anything that your therapist could have done differently/ responded differently?
4. How do you think your experiences of IPV might have impacted on child's referral behaviour?
    - Did X (young person) see/ hear/ or know about IPV?
    - How did X (young person) respond/ react to it?
    - Did you discuss this with your therapist/ How was this thought about/addressed with your therapist?
5. What was your overall experience of MST like?
    - What was most helpful?

- What was most difficult?
- How did you feel when trying to implement some of the MST strategies?

6. How did your relationship with your partner/ex-partner impact your ability to engage in MST and some of the strategies?
   - How did the relationship with your partner/ex-partner help or hinder some of the interventions trying to put in place?
   - Anything about the relationship that made it difficult to engage in MST?
     - Any MST strategies that you felt concerned about implementing?
     - How did you find your MST therapist working with the system?
     - How did you feel working with your partner/ex-partner/ Did this have any impact on you?
     - Was your partner/ex-partner supportive of MST involvement/ what did they think about MST involvement in the family?

<u>Post- intervention:</u>

7. Did your experience with MST impact your relationship with your ex/current partner?
   a. Were you able to apply some of the strategies learnt in MST to your relationship with your partner/ex-partner?
8. How did the COVID-19 Pandemic impact your experiences discussed in this interview?

9. Is there anything that didn't come up in this interview that they were expecting?

   - Anything I have missed that you think is important to add?

Practitioners Interview schedule

1. How common is it for you to work with families who have experienced historic/ current IPV?
    - Describe what types of IPV concerns have arisen in your work with families, both historical and current?
    - Have you noticed a change in prevalence?
2. In families where IPV was prevalent, how do you think the young persons' referral behaviours were impacted by IPV?
    - How did you discuss this with the family?
    - How did parents feel exploring this?
    - How confident did you feel exploring this with the family?
3. How Did IPV impact your delivery of MST?
    - Were there any key differences/ needs for IPV impacted families opposed to families not impacted?
    - How did it change the focus of the intervention?
    - How did it change safety planning?
    - How did it impact family engagement?
    - How did it impact working with the systems around the child?
    - How did you have to change/adapt some of the MST strategies. Why/how?
4. What types of difficulties did you experience in delivering MST to families experiencing IPV?
    - Any practical difficulties?
    - Any risk difficulties?
5. What parts (if any) of the MST intervention do you feel were particularly helpful for families impacted by IPV?
    - What are the transferable MST skills/strategies?
6. Can you think of any suggestions or changes that you would like to recommend for future MST therapists working with families impacted by IPV?
7. How confident did you feel implementing MST with families where IPV was prevalent?

- How did your MST training equip you to work with families impacted by IPV?
- How could it be improved?

8. How did the COVID-19 pandemic impact what we have discussed in this interview?
9. Is there anything that didn't come up in this interview that they were expecting?
    - Anything I have missed that you think is important to add?

**Appendix K:** *Demographic form parent*


**Parent Demographic Questionnaire**
Royal Holloway University of London

Please answer the following questions:

1. What is your age? _____
2. How would you best describe your gender? (Circle as appropriate): Male / Female / Other
   - If other, please specify: _____
3. What was your child's age at the time of MST intervention? _____
4. How would you best describe your child's gender? (Circle as appropriate): Male / Female / Other
   - If other, please specify: _____
5. Which of these best describes your ethnic group? (Please tick as appropriate):

| **Mixed/Multiple ethnic groups** | |
|---|---|
| White and Black Caribbean | |
| White and Black African | |
| White and Asian | |
| Other mixed | |
| | |
| **Asian/Asian British** | |
| Indian | |
| Pakistani | |
| Bangladeshi | |
| Chinese | |
| Other Asian | |
| | |
| **Black/African/Caribbean/Black British** | |
| African | |
| Caribbean | |
| Other Black | |
| | |
| **White** | |
| English/Welsh/Scottish/Northern Irish/British | |

| | |
|---|---|
| Irish | |
| Gipsy or Irish Traveller | |
| Other white | |
| | |
| **Other ethnic group** | |
| Arab | |
| Other ethnic group (please specify): | |
| | |

**6.** When did you receive MST?
Start month/year: .....
End month/year.....

**7.** Outcome of MST: (please circle)

Treatment completer / dropped out of treatment

**8.** Experiences of intimate partner violence: (please circle)

Prior to taking part in MST/ during MST

**9.** MST delivery (please circle all that apply)
In person at home/ in person at another location/ online

**Appendix L:** *Demographic form practitioner*


Department of Psychology

**Practitioner Demographic Questionnaire**

Royal Holloway University of London

Please answer the following questions:

**10.** What is your age? _____

**11.** How would you best describe your gender? (Circle as appropriate): Male / Female / Other
- If other, please specify: _____

**12.** Which of these bests describe your ethnic group? (Please tick as appropriate):

| | |
|---|---|
| **Mixed/Multiple ethnic groups** | |
| White and Black Caribbean | |
| White and Black African | |
| White and Asian | |
| Other mixed | |
| | |
| **Asian/Asian British** | |
| Indian | |
| Pakistani | |
| Bangladeshi | |
| Chinese | |
| Other Asian | |
| | |
| **Black/African/Caribbean/Black British** | |
| African | |
| Caribbean | |
| Other Black | |
| | |
| **White** | |
| English/Welsh/Scottish/Northern Irish/British | |
| Irish | |
| Gipsy or Irish Traveller | |
| Other white | |
| | |
| **Other ethnic group** | |
| Arab | |
| Other ethnic group (please specify): | |

**13.** How long have you worked in this role for?_____

**14.** What is the highest level of education you have completed?

- ▢ No qualifications
- ▢ GCSE's (or equivalent)
- ▢ A-Levels (or equivalent)
- ▢ Bachelor's Degree
- ▢ Master's degree
- ▢ Doctoral Degree
- ▢ Prefer not to say