The impact of destructive parental conflicts on children and their families

The role of parental availability, mother child emotion dialogues, and forgiveness

Margreet Visser

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Paranimfen
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Jack van Praag

Als de volwassenen niet aardig zijn,
waarom zouden de kinderen het dan zijn?

Ward Ruyslinck

CONTENTS

Chapter 1

General introduction

PREAMBLE

In this dissertation, I will focus on the link from parental behavior to effects on the family. While this link is the focus of my research, I am aware of research showing that there may also be child effects on the parents' behavior, as was elegantly demonstrated by Bell (1968) in his seminal work on child effects. Nevertheless addressing both effects would exceed the scope of my dissertation.

The assumption that parental actions and behavior influence children's development and wellbeing has been supported consistently in empirical studies (e.g., Afifi & MacMillan, 2011; Eisenberg et al., 2005). In view of this evidence and given the plausibility of this direction of effects, I will use causal language throughout this dissertation. Although the correlational nature of my studies prohibits firm conclusions of causality, showing that interparental violence causes children to suffer in an experimental set up, would be unethical. Demonstrating that a reduction of interparental violence may decrease symptoms of the child is not only ethical, but also supportive of the causal link I am assuming. Needless to say that given my personal interest in and commitment to therapeutic work in this area, I have described a study protocol to demonstrate such effects of an intervention for children exposed to destructive parental conflicts in Chapter 2. This protocol concerns an ongoing study, and data are not yet available. Chapters 3 and 4 concern the examination of relational processes and parental mechanisms that facilitate the reduction of symptoms among children exposed to destructive parental conflicts.

INTRODUCTION

The impact of interparental conflicts, on the whole family system, has been well-established. Being exposed to destructive conflicts is traumatic and damaging for both children and adults. Exposure to interparental conflicts may directly affect children's well-being and psychosocial adjustment (Chan & Yeung, 2009; Cummings & Davies, 2010). Destructive parental conflicts also affect parents' well-being and psychosocial adjustment (Campbell et al., 2002; Woods, 2005), their parenting behavior (Krishnakumar & Buehler, 2000), and the parent–child relationship (Appel & Holden, 1998; Levendosky & Graham-Bermann, 2001). Moreover, children may also be affected by exposure to destructive parental conflicts in an indirect way, through negative parenting and/or a parent–child relationship of low quality (Cummings & Davies, 2010).

A growing body of research stresses the importance of effective interventions to enhance children's healthy development and psychosocial adjustment after exposure

to traumatic events (Skowron & Reinemann, 2005; Wethington et al., 2008). One usually also stresses the importance of involving the parents in such interventions (Deblinger, Lippmann, & Steer, 1996; Herr, Mingebach, Becker, Christiansen, & Kamp-Becker, 2015; Lieberman, Ippen, & Van Horn, 2006). However, little is known about how the involvement of parents affects treatment outcomes for children, or how to enhance the effect of parental involvement.

Although research shows that not all parental conflicts are linked to adverse effects on children and their parents, destructive and unresolved conflicts have consistently been found linked to an increase in the likelihood of mental health problems in both children and parents (Amato, 2001; Kelly & Emery, 2003). Conflicts are more destructive if they involve hostility, contempt, coercion, abuse and withdrawal, if they are unresolved, or if they are accompanied by strong negative emotions (see page 204 Hetherington, 2006). Furthermore, they often center on the children. Destructive conflicts affect children in both intact and in separated families (Amato, 2001; Chan & Yeung, 2009; Hetherington, 2006; Kelly & Emery, 2003). Unfortunately, the specific processes and pathways of parental functioning underlying these associations are only partly understood (Cummings & Davies, 2010). The development of effective parental components in interventions for children exposed to parental conflict is hampered by limited knowledge about *how* destructive conflicts affect parenting and parental functioning. For example, little is known about how conflicts between parents affect the parent–child relationship in the way they communicate about emotions. Also, it is unclear how conflicts between parents are maintained and/or escalate post-divorce, and which relational processes underlie the maintenance of parental conflicts in high conflict divorced (HCD) families.

To address these gaps in the literature, relational processes in families that experience or have experienced extreme destructive conflicts will be studied in this dissertation. First, in a group of families exposed to interparental violence (IPV), my aim is to examine mediating relational processes and pathways relating parental conflict on the one hand, to parent functioning and parent–child relationship quality, and to children's psychosocial well-being on the other. Second, zooming in on a particular group of destructive parental conflicts, in a group of families with high conflict divorces, my aim is to examine specific relational processes in the maintenance of parental conflicts.

Children's exposure to IPV and HCD is studied by researchers from different areas. For example, interpersonal violence is often studied by researchers in the domain of child abuse, neglect, and traumatization, whereas HCD is more often studied by researchers in the domain of family processes. Despite these different origins, I propose here that IPV and HCD also share certain commonalities, the most salient being destructive parental conflicts. In this introductory chapter I will review direct and

indirect effects of exposure to destructive parental conflicts on children for families exposed to IPV, and then for HCD families. I will highlight the similarities between these two groups of families regarding the direct and indirect effects on children. However, the two groups can also be distinguished. This distinction is driven by one of the most important characteristics of HCD, namely the fact that destructive parental conflicts do not only take place in the family context, but they also take place outside the family context, in public (e.g., juridical procedures). Following an overview of their similarities, I will also focus on the differences between IPV and HCD. In the course of this chapter I will introduce the different research questions investigated in the chapters of this dissertation.

EXPOSURE TO INTERPARENTAL VIOLENCE

Definition and Prevalence of Interparental Violence

The number of children exposed to IPV is considerable. Unicef (2006) estimated that as many as 275 million children worldwide are exposed to violence in the home. Alink et al. (2011) estimated that 13% of Dutch adolescents are exposed to IPV. In the United States, 16% of all children are exposed to IPV during their childhood (2-17 years of age) (Finkelhor, Turner, Ormrod, & Hamby, 2009).

The National Child Traumatic Stress Network defined IPV as "…a behavior, or pattern of behaviors, that occurs between parents with the aim of one parent exerting control over the other" (http://www.nctsn.org/trauma-types/domestic-violence). IPV may include psychological threats, emotional abuse, sexual abuse, and/or physical violence. Children may be exposed to IPV in varying ways (Holden, 2003). For example, children may see one parent assault the other, they may witness or overhear a parent who is out of control with anger or fear, they may try to intervene in the conflict, they may see or hear parents threaten each other, they may miss a parent because of imprisonment following IPV, or they may observe the aftermath of a violent assault. Given this variety of exposure, it should not surprise us that IPV may affect children in different ways.

Direct and Indirect Effects of IPV on Children

IPV may affect children directly because they are exposed to discord between parents. The direct negative consequences of IPV for children have been widely documented. Being physically involved in IPV or being a witness to IPV may directly affect children's emotional, cognitive and behavioral responses (Kitzmann, Gaylord, Holt, & Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003), as well as their psychosocial adjustment (Chan & Yeung, 2009; Holt, Buckley, & Whelan,

2008; Kitzmann et al., 2003; Wolfe et al., 2003). Different meta-analyses of the effects of IPV on children show that children may develop internalizing, externalizing and posttraumatic stress symptoms due to exposure to IPV (Chan & Yeung, 2009; Evans, Davies, & DiLillo, 2008). Children exposed to IPV are also at risk for poly-victimization, including physical, emotional, and sexual abuse (Finkelhor et al., 2009), and they experience more life stress than children not exposed to IPV (Holt et al., 2008). Importantly, the consequences of IPV exposure may extend to children's adult lives. The Adverse Childhood Experiences Study showed that children's exposure to IPV may lead to increased health risks in adulthood for a broad range of illnesses and physical conditions (Felitti et al., 1998; Paradis et al., 2009). These findings have been replicated and clearly indicate that children may directly be affected by exposure to IPV in both the short- and the long-run.

IPV may also affect children indirectly, because of the effects IPV has on parents. Given that the majority of the research efforts to improve interventions have been directed at the direct influences of IPV, I will pay special attention to the indirect effects in this dissertation. Exposure to IPV is an adverse experience and related to both children's and adults' maladjustment and distress symptoms. Similar to children, parents experience a broad range of emotional, psychological, cognitive, and behavioral consequences after IPV. For example, being a victim of IPV as a parent put people at risk for mental health problems (Woods, 2005), such as depression (Campbell et al., 2002; Renner, 2009) and post-traumatic stress disorder (Dutton et al., 2006).

These negative consequences for parents, in turn, may adversely affect their parenting. For example, IPV is associated with problematic parenting behaviors and parenting stress (Levendosky & Graham-Bermann, 2000). Mothers exposed to IPV use more negative and less positive parenting than mothers who have not been exposed to IPV, and they are likely to use more harsh discipline towards their children (Osofsky, 2003). Consequently, IPV is associated with more aggression in the parent–child relationship (Appel & Holden, 1998), with less supportive and less effective parenting (Levendosky & Graham-Bermann, 1998), and with less child-centeredness of parents (Levendosky & Graham-Bermann, 2001). Moreover, IPV has been linked to emotional unavailability and psychological control (e.g. Fauber, Forehand, Thomas, & Wierson, 1990; Gonzales, Pitts, Hill, & Roosa, 2000). Although we know that IPV affects parents, which in turn affects their parenting and the parent–child relationship, little is known about the specific relational processes and pathways underlying this relation. To increase our understanding of how parental psychopathology among parents involved in IPV affects children's symptoms, I examine one possible pathway that may explain how parents' stress may cross over to children's stress (Chapter 3). In Chapter 4, I examine if and how exposure to IPV affects the parent–child relationship in the way they communicate about emotions.

Parental Components in Interventions

The high risk for diminished parenting quality and impaired parent–child relationships underlines the importance of including parental components in interventions for children in the aftermath of IPV. In line with recommendations from the Practice Parameter on children's posttraumatic stress (Cohen et al., 2010), trauma-focused psychotherapy is the norm for IPV- exposed children (e.g., Trauma Focused – Cognitive Behavioral Therapy (TF-CBT)). Research provides evidence in favor of these recommendations by showing that TF-CBT reduces internalizing problems, externalizing problems, and trauma symptoms among traumatized children (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Iyengar, 2011). Nevertheless, the effect sizes for such treatments are smaller for children exposed to IPV than for children who are sexually abused (Cohen, Mannarino, & Iyengar, 2011; Cohen, Mannarino, & Murray, 2011).

The above-reviewed literature on indirect effects of IPV, such as negative parenting and low-quality parent–child relationships that affect children in IPV families suggests that parenting and the parent–child relationship need to be specifically targeted in interventions for IPV-exposed children. Targeting parenting and the parent–child relationship as mechanisms of change in TF-CBT-based interventions may enhance the efficacy of treatment. To this end, Visser, Leeuwenburgh, and Lamers-Winkelman (2007) developed *HORIZON*, a trauma-focused cognitive behavioral based group therapy for children exposed IPV and their parents (Visser et al., 2007).

HORIZON group therapy includes child components that parallel TF-CBT (Cohen, Mannarino, & Deblinger, 2006). However, *HORIZON* added two parental components specifically targeting parenting and parent–child relationship problems in IPV-exposed families. In Chapter 2 of this dissertation, I will describe these components in detail. Specifically, in Chapter 2, I will describe the research protocol I developed to test the effectiveness of these parental components. The current thesis focuses on data collected in IPV-exposed families before they participated the intervention *HORIZON* (T1). Outcomes of effectiveness studies will be presented elsewhere.

Trauma-focused therapy for children to diminish internalizing, externalizing, and posttraumatic stress symptoms is only helpful for children in the long term if they are no longer exposed to destructive parental conflicts. To this end, it would be extremely helpful to gain more knowledge about relational processes that contribute to the maintenance and/or escalation of parental conflicts. In this dissertation, I will try to expand this knowledge by studying relational processes in a particular group of families, namely HCD families.

HIGH CONFLICT DIVORCE

Although, till now children's exposure to IPV and HCD has been examined as if the parental conflicts in these two groups of families are two different, mainly independent research areas, I propose that HCD is very similar to IPV, but with some different elements. First, parental conflicts in both groups are mostly unresolved, often violent, and affect both parents and children. However, in HCD families these conflicts always occur among divorced/separated couples. Sometimes, in HCD families, IPV starts after divorce. Second, parental conflicts in HCD families not only occur among parents, but these parents involve extra-familial parties into the conflicts, for example by bringing the conflicts to court. These extra-familial dynamics associated with high conflict divorces make it especially interesting to examine relational processes to fill the gap in our understanding how destructive parental conflicts may be maintained or even escalate. Following general information about high conflict divorce and its prevalence, I will review direct and indirect effects of high conflict divorce on children before elaborating on the differences between HCD and IPV families.

Description and Prevalence of Divorce and High Conflict Divorce

In the Netherlands, about 70.000 children a year are involved in a divorce (Latten, 2004; Sprangers, 2008; Spruijt & Tils, 2007). In approximately 70% of these divorces, parents can handle the aftermath of the divorce reasonably well (Whiteside, 1998; Whiteside & Becker, 2000). However, in 30% of the divorces, parents are involved in bitter conflicts. For example, they continue to have financial problems or disagree on the (design of) the so-called 'parenting plan'. In the Netherlands married and registered parents have a legal obligation after the divorce to make a parenting plan that contains agreements on the care and education of the children. Fifteen percent of these more difficult divorces are labeled 'very problematic' (Spruijt & Tils, 2007). However, international studies indicated that between 8 to 12% of parents continue to be involved in serious conflicts, even 2-3 years after divorce (Kelly & Emery, 2003). In the Netherlands such data have not yet been collected

In the families in which parents are involved in bitter conflicts, the divorce is a long, lingering, destructive, and revengeful process, riddled with suspicions, in which the parents have very negative attributions about each other, and offend each other. Furthermore, because parents (have to) bring their conflicts into court, not only the nuclear family is involved, but also extra-familial relationships, including judges, lawyers, and mediators. In many of these cases, judges ask child protection services to investigate the family (https://www.kinderbescherming.nl/over_de_raad/feiten_en_cijfers/). Consequently, schoolteachers, extended family and kin, mental health care professionals, or family doctors are involved and are potentially part of

the destructive conflicts as well. Since many parents in high-conflict divorces do not understand, are not willing to understand, or are not able to understand that their children are severely affected by their conflicts, high conflict divorce is considered to be a form of emotional abuse (Dalton, Carbon, & Olesen, 2003; Van Lawick, 2012). Similar to children in IPV families, the exposure to destructive parental conflicts in high conflict divorce affects children directly and indirectly.

Direct and Indirect Effects of High Conflict Divorce on Children

Ample research shows that destructive conflicts after parental separation and divorce also affect children directly and indirectly (Amato, 2001; Amato & Afifi, 2006; Kelly & Emery, 2003), in the short- and the long-term (Kelly & Emery, 2003; Størksen, Røysamb, Holmen, & Tambs, 2006). Children may be directly affected by divorce, because they are exposed to parental discord, before and after the divorce, but also to additional divorce-related stressors such as moving houses, changing schools, feeling that they have to choose sides between parents, and sometimes losing important relationships (Amato, 2001; Amato & Afifi, 2006). Children of divorced parents are significantly more likely to have behavioral, internalizing, social, and academic problems in comparison to children from continuously married parents (Amato & Cheadle, 2005; Kelly & Emery, 2003; Morrison & Coiro, 1999).

Children may be indirectly affected by divorce because divorced parents, compared to married parents, show more negative parenting and have lower quality parent–child relationships (Amato, 2000). The quality of parental functioning and the quality of the parent–child relationship are the best predictors of children's well-being after divorce (Amato, 2000).

The initial period after the parents have separated is quite stressful for the majority of children (Kelly & Emery, 2003). However, in the longer-run most children and young adults from divorced parents (approximately 75-80%) do not suffer serious psychological problems, achieve an average level of education, maintain close relationships with family members, and enjoy intimate relationships (Kelly & Emery, 2003). What is more, some families have been reported to be resilient to the negative consequences, because of support of the extended family, support of friends, religion and open communication amongst family members (Greeff & Van Der Merwe, 2004). The evidence is growing that it is not divorce in itself that is the primary factor explaining adverse child outcomes in the long term. Rather, the destructiveness of parental conflict that may continue or start after the divorce, increases negative outcomes for children (Hetherington, 2006; Vandewater & Lansford, 1998).

Taken together, these findings again highlight that high conflict divorce and IPV share certain features, in this case, destructive conflicts between parents, which adversely impact children's well-being. At the same time an important difference

between IPV and HCD families is, that in HCD families the destructive conflicts between parents are expanded by the involvement of others.

Extra-Familial Relationships and the Maintenance of Destructive Parental Conflicts

In the context of high-conflict divorces, an important question for researchers and clinicians is how these extra-familial relationships and involvements contribute to the maintenance and/or escalation of conflicts. Several studies have looked at risk factors for destructive parental conflicts. Bonach (2005) found that satisfaction with financial child support arrangements, smooth divorce proceedings, and forgiveness were the strongest predictors of a lower level of co-parenting conflicts. Research has also examined individual processes contributing to conflict escalation (Coleman, Kugler, Bui-Wrzosinska, Nowak, & Vallacher, 2012). Based on different models about conflict dynamics, Coleman et al. (2012) composed a basic three-dimensional model [1) the nature of the parties' goal interdependence, 2) the relative distribution of power among the parties, and 3) the degrees of total goal interdependence and relational importance] of conflicts in dyadic social relationships. According to the model, the interplay of these three dimensions explains particular conflict orientations for individuals, which may become chronic and difficult to change. Chronic, inappropriate conflict orientations may be important risk factors among HCD parents (Coleman et al., 2012). However, beyond the dyad, the role of the social network, including friends, family, and even lawyers, has received little attention (Milardo, Helms, Widmer, & Marks, 2014).

This gap in the literature is surprising, because it is generally recognized that the success and the failure of both intact relationships (Kennedy, Jackson, Green, Bradbury, & Karney, 2015) and post-divorce relationships (McDermott, Fowler, & Christakis, 2013) are not only related to the contribution of the individual partners but also to their social networks. To expand our understanding of how the extra-familial context of HCD families contributes to the maintenance of co-parenting conflicts, I examine in Chapter 5 how parents perceive their social network's opinion regarding their parenting conflicts, and how this perception is related to the level of parental conflicts.

Extra-Familial Involvement in Treatment

The maintenance of destructive conflicts in HCD families and their damaging influence on children underline the importance of involving not only the parental relationship but also extra-familial relationships in interventions for children living in HCD families. Involvement of the social network aims to reduce possible polarization between parents' social networks as well as to reduce parental conflicts.

In the Netherlands, the multi-family group intervention "*No Kids in the Middle*" was developed for HCD families (Van Lawick & Visser, 2014). The intervention targets the damaging influences of extra-familial relationships in two ways. First, parents are obliged to stop all legal procedures during the intervention and are encouraged to solve the conflicts in therapy, together with the other parents, the therapists, and with their social network members (e.g., friends, family). Second, the parent group starts with a session in which parents bring their social network, that is, any extra-familial relations involved in the conflict to inform them how they will be involved in treatment (e.g., grandparents, lawyers, sister, best friend). During treatment, parents are encouraged to share all therapy information and cooperate with their social network partners, but not in court.

The intervention takes a multi-family approach, and consists of eight parent treatment sessions and parallel child sessions (sessions of two hours). The parent sessions include psychoeducational components about co-parenting issues, stress and conflicts, communication, and consequences of the divorce for children. Children are encouraged to express their thoughts and feelings regarding the destructive parental conflicts in the child sessions. Working together with other children from HCD families, listening to their stories in the group, helping each other to cope with the situation, and expressing their feelings and thoughts about the high conflict divorce in art, poetry and theatre, is expected to empower these children (Wise, 2005). Parent-focused interventions targeting harmful interactions are needed to stop the effects of conflicts on children's well-being. In the transition and aftermath of 'normal' divorce, psycho-educational programs are widely available and sometimes court-mandated, but evaluation studies are rare (Grych, 2005). For HCD families some psychoeducational programs are available, but in an overview of these programs no published evaluations of the effectiveness of these programs were found (Goodman, Bonds, Sandler, & Braver, 2004). Again, the complex relational factors that may play a role in the maintenance of destructive conflicts between parents (e.g., social network, financial or legal problems) suggest that to increase children's well-being, a program is needed that encompasses parental intervention components in addition to psycho-education. In the appendix of this dissertation, I put a paper describing the intervention "*No Kids in the Middle*" which was developed by my colleague Justine van Lawick and myself (2014).

RESEARCH PROJECT ACADEMIC COLLABORATIVE CENTRE CHILD ABUSE

The research outlined in this dissertation was conducted within the ZonMw-funded consortium Academic Collaborative Centre Child Abuse (Academische Werkplaats

aanpak Kindermishandeling). This large-scale project had three primary goals. First, it aimed to develop and implement a hospital-based multidisciplinary center on child abuse. In this center, youth care professionals, (forensic) pediatricians, police, the justice department, and child-, adult-, and forensic psychiatry work together in severe cases of child abuse to ensure a quick and family-centered approach. Second, it aimed to develop, implement, and examine the effectiveness of treatments for children and their parents in the aftermath of sexual abuse and IPV, and in HCD families. And finally, it aimed to set up a center with the explicit purpose of exchanging and strengthening clinical knowledge and scientific knowledge in the field of child abuse. This center further aims to provide scientific knowledge and training to the large variety of professionals concerned with child abuse (for more information see hetlock.nl).

The Academic Collaborative Centre Child Abuse conducted three research projects. In this dissertation results of two research projects, one with a focus on exposure to IPV and one with a focus on HCD families are presented. In the IPV project, I examined relational processes within families of children exposed to IPV as compared to families without exposure to IPV. Also, in the IPV project, I started an intervention study on the efficacy of two parental components added to a trauma-focused group intervention for children and their parents after IPV exposure (*HORIZON* group therapy) (Visser et al., 2007). As mentioned above, the data collection for the effectiveness study is still ongoing, I will present data from the parent–child assessment that took place prior to *HORIZON*.

In the high conflict divorce project, I examine risk factors and relational processes that contribute to the maintenance of destructive parental conflicts. Also, in the high conflict divorce project, I examine the effectiveness of a multi-family approach intervention for HCD families, "*No Kids in the Middle*" (Van Lawick & Visser, 2014), by assessing changes in parent and child adaptation following this intervention. The data collection for the effectiveness study is also still ongoing.

OUTLINE OF THIS DISSERTATION

First, this dissertation presents studies on IPV-exposed families. In Chapter 2, the study protocol for a randomized controlled trial to examine the effects of parental components in a trauma-focused cognitive behavioral-based therapy for children exposed to IPV (*HORIZON*) is described. The rationale, content, and design are presented. Because this study is still ongoing and families are still being recruited to participate, I cannot yet report on the results of this study. In Chapter 3, I examine the mechanisms underlying the link between parental psychopathology and child problems in a high-risk sample of IPV-exposed families. Specifically, I tested whether parental psychopathology may spill over to parental availability, which, in turn, may show a crossover effect to children's self-reported trauma-related symptoms. Chapter 4 explores parent–child interaction in IPV families. I examine the quality of parent–child emotion dialogues among IPV-exposed mother–child dyads compared to dialogues of non-exposed mother–child dyads.

Second, this dissertation presents research carried out among HCD families. In Chapter 5, I test whether forgiveness in the co-parental relationship may mediate the association between parents' social perceived network disapproval and destructive co-parenting conflicts. To test robustness of the results, I analyzed the meditational model in a sample of divorced parents, and I replicated the study in a sample of HCD parents. I end this dissertation with a general discussion, recommendations for future research, and clinical implications in Chapter 6.

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Chapter 2

The effects of parental components in a trauma-focused cognitive behavioral based therapy for children exposed to interparental violence: Study protocol for a randomized controlled trial

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ABSTRACT

Background: Interparental violence is both common and harmful and impacts children's lives directly and indirectly. *Direct effects* refer to affective, behavioral, and cognitive responses to interparental violence and psychosocial adjustment. *Indirect effects* refer to deteriorated parental availability and parent–child interaction. Standard Trauma Focused Cognitive Behavioral Therapy may be insufficient for children traumatized by exposure to interparental violence, given the pervasive impact of interparental violence on the family system. *HORIZON* is a trauma focused cognitive behavioral therapy based group program with the added component of a preparatory parenting program aimed at improving parental availability; and the added component of parent–child sessions to improve parent–child interaction.

Methods/design: This is a multicenter, multi-informant and multi-method randomized clinical trial study with a 2 by 2 factorial experimental design. Participants (N = 100) are children (4-12 years), and their parents, who have been exposed to interparental violence. The main aim of the study is to test the effects of two parental components as an addition to a trauma focused cognitive behavioral based group therapy for reducing children's symptoms. Primary outcome measures are posttraumatic stress symptoms, and internalizing and externalizing problems in children. The secondary aim of the study is to test the effect of the two added components on adjustment problems in children and to test whether enhanced effects can be explained by changes in children's responses towards experienced violence, in parental availability, and in quality of parent–child interaction. To address this secondary aim, the main parameters are observational and questionnaire measures of parental availability, parent–child relationship variables, children's adjustment problems and children's responses to interparental violence. Data are collected three times: before and after the program and six months later. Both intention-to-treat and completer analyses will be done.

Discussion: The current study will enhance our understanding of the efficacy interparental violence-related parental components added to trauma focused cognitive behavioral group program for children who have been exposed to IPV. It will illuminate mechanisms underlying change by considering multiple dimensions of child responses, parenting variables and identify selection criteria for participation in treatment.

Netherlands Trial Register NTR4015. Registered 4th of June, 2013

INTRODUCTION

Interparental violence (IPV) is both common and harmful. At least 12% of 12-16 year old children are exposed to IPV in The Netherlands (Alink et al., 2011). In the United States, 16% of all children witness IPV at some time during their childhood (2-17 years of age) (Finkelhor, Turner, Ormrod, & Hamby, 2009). In a meta-analysis Evans (Evans, Davies, & DiLillo, 2008) found a strong association between exposure to IPV and trauma symptoms in children, in addition to small to medium associations between exposure to IPV and internalizing and externalizing problems. These findings emphasize the need for effective interventions for children exposed to IPV. Because IPV involves the whole family system, it affects children's lives directly and indirectly. Witnessing IPV or being physically involved in IPV may directly affect children's affective, behavioral and cognitive responses, their psychosocial adjustment and symptoms (Davies, Winter, & Cicchetti, 2006). IPV may also affect children indirectly (Davies et al., 2006). It may lead to deteriorated parenting and parent–child relationships (Buehler & Gerard, 2002), which may mediate the link between IPV and children's maladjustment on various dimensions. Therefore, treatment for children who have been exposed to IPV should target both direct and indirect effects of IPV.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is a well-established treatment for traumatized children. Although TF-CBT has been found to be effective in reducing post-traumatic stress disorder and depressive symptoms among traumatized children (J. A. Cohen, Mannarino, Murray, & Igelman, 2006), we know little about its effective components and the role of parental involvement (Schneider, Grilli, & Schneider, 2013). Additionally, the literature suggests that TF-CBT may be less effective for children traumatized by exposure to IPV (J. A. Cohen, Mannarino, & Murray, 2011) (J. A. Cohen, Mannarino, & Iyengar, 2011). One explanation may be that the standard components of TF-CBT have been developed for parents to learn how they can help the child to process traumatic experiences. These components may fail to address the pervasive impact of IPV on parents' psychological functioning, their parental behavior, and the parent–child relationship (J. A. Cohen, Mannarino, & Murray, 2011). The present study aims to test the relative efficacy of two components added to TF-CBT focussing on parent-related aspects of IPV, namely parenting and parent–child interactions, and thereby provides crucial insight in the mechanisms and mediating effects of treatment on children exposed to IPV. The group-based treatment developed by Visser, Leeuwenburgh and Lamers-Winkelman in the Netherlands is called *HORIZON* (Visser, Leeuwenburgh, & Lamers-Winkelman, 2006b). In addition to a regular TF-CBT-based treatment, the *HORIZON* includes two specific components focusing on parents who have let their children to become exposed

to IPV. The *HORIZON* thus consists of three parts, two specific parental components for IPV families and TF-CBT-based child and parent components.

Direct Effects of IPV on Children

Being exposed to IPV affects children on a variety of dimensions. Children's responses are often differentiated in *emotional*, *behavioral*, and *cognitive* responses (Rhoades, 2008). To explain these direct effects, Emotional Security Theory (Davies et al., 2006) and Cognitive Context theory (Grych & Fincham, 1990) have proposed several mechanisms that mediate the developmental pathways towards psychosocial maladjustment and symptoms, as well as moderating factors that may exacerbate or buffer against the effects of IPV on children.

Emotional Security Theory is based on the assumption that children derive a sense of emotional security from their trust in the integrity of the family system. IPV undermines children's trust, leading them to make efforts to restore it. Although children's affective, behavioral, and cognitive responses and adaptations toward restoring a level of emotional security may be adaptive in the IPV context, they may be maladaptive in other contexts (e.g., school, peer contacts). This may result in emotional, social, and behavioral maladjustment and problems(Katz, Hessler, & Annest, 2007). To illustrate, Davies et al.(2013) and Katz et al.(Katz et al., 2007) found that children exposed to IPV were less competent in modulating their emotions than children who were not exposed to IPV. This under-developed emotion competence may explain links between IPV and children's maladjustment (Katz et al., 2007).

Children's immediate *behavioral* responses to IPV include approach and avoidance behaviors that serve to regulate exposure to the disturbing affect displayed in marital violence and its aftermath (DeBoard-Lucas & Grych, 2011; Koss et al., 2011). Avoidance behavior is generally considered as a less adaptive coping strategy to respond to traumatic experiences than approach behavior (J. A. Cohen & Mannarino, 2008). To illustrate, Gable (Gable, 2006) found that approach motives and goals in relationships were reliably associated with less loneliness and more relationship satisfaction than avoidance motives. Although not consistently found, both approach and avoidance behaviors in the context of family conflict appear related to children's symptoms (Rhoades, 2008).

Children's *cognitive* responses to violence may shape their beliefs and expectations about aggression, about close relationships and about themselves. They might start to believe that aggressive behavior is an acceptable way of problem solving (Graham-Bermann, Lynch, Banyard, Devoe, & Halabu, 2007). Children exposed to IPV and other forms of violence may come to value aggression more positively than other children (Dodge, Bates, & Pettit, 1990; Dodge, Bates, Pettit, & Valente, 1995). Additionally, Grych's Cognitive Context theory suggests that children may

blame themselves for what happened or believe they are powerless to cope with IPV (Fosco, DeBoard, & Grych, 2007). Finally, children may become more vigilant to threat-related cues in the environment (Pollak, Cicchetti, Hornung, & Reed, 2000). These beliefs and expectations may influence their behavior in peer-relationships, in family-relationships and in romantic relationships (Fosco et al., 2007). Each of these cognitive responses of children can be assumed to exacerbate children's psychosocial maladjustment in response to IPV.

Components of TF-CBT such as emotion regulation, cognitive reprocessing, psycho-education and skill building have been shown to reduce internalizing problems, externalizing problems, and trauma symptoms (J. Cohen, Deblinger, Mannarino, & Steer, 2004; J. A. Cohen, Mannarino, & Iyengar, 2011). Nevertheless, to our knowledge research has not yet explicitly addressed whether TF-CBT or TF-CBT-based interventions ameliorates children's symptoms by improving children's emotion regulation. Furthermore, TF-CBT was found to reduce trauma-related avoidance behavior in children exposed to IPV(J. A. Cohen, Mannarino, & Iyengar, 2011). Whether children's approach behavior changes after TF-CBT or TF-CBT-based interventions is currently unknown. Also, the cognitive component of TF-CBT explores and corrects children's harmful attributions about the cause of, responsibility for, and results of traumatic experiences such as family violence (J. A. Cohen, Berliner, & Mannarino, 2010; J. A. Cohen & Mannarino, 2008). Whether cognitive responses change after TF-CBT among children who have been exposed to IPV has not yet been examined. The present study examines how these emotional, behavioral, and cognitive responses change over the course of treatment and how these changes affect treatment outcomes and children's psychosocial adjustment.

Indirect Effects of IPV on Children

Being exposed to IPV also affects children indirectly. Not only children, but parents are likely to be traumatized as well (Woods, 2005). Parents experience a broad range of emotional, cognitive and behavioral consequences of IPV. These responses can be assumed to affect their parenting and the parent–child relationship. The *Spillover hypothesis* emphasizes that distressing experiences in the interparental relationship, such as IPV, carry over to parenting behavior (Krishnakumar & Buehler, 2000) and to the parent–child interaction (e.g., (Floyd, Gilliom, & Costigan, 1998)). We propose two mechanisms that may explain how the experience of IPV may affect parenting, a cognitive-emotional mechanism and a behavioral mechanism. In the following, we will describe these theoretical underpinnings of the two specific parental components of the *HORIZON*.

Cognitive-emotional mechanism: parental availability

Mothers who have been part of IPV tend to underestimate the extent to which their child has been exposed to and is affected by the IPV (Koren-Karie, Oppenheim, & Getzler-Yosef, 2008; Pynoos, Steinberg, & Piacentini, 1999). This underestimation is assumed to be partly due to the fact that mothers may focus their attention on themselves and their own traumatic experience rather than on their children's traumatic experience (Koren-Karie et al., 2008; Pynoos et al., 1999), and to the fact that their children's behavior is a reminder of their own trauma which triggers avoidance (e.g.,Lieberman, 2004). Also, mothers who have experienced traumas, such as IPV or childhood abuse, showed difficulties in adopting an open, non-defensive style of communication when talking about emotions with their children (Koren-Karie, Oppenheim, & Getzler-Yosef, 2004). Additionally, they appeared less child-centered and less available to their children (Levendosky & Graham-Bermann, 2001). Moreover, IPV has been linked to parenting styles that are characterized by emotional unavailability and psychological control (e.g.,Fauber, Forehand, Thomas, & Wierson, 1990; Gonzales, Pitts, Hill, & Roosa, 2000). Thus, parents from violent families may be so absorbed by their own problems that they are less likely to take their children's perspective and to show insight in their children's developmental needs, behavior, and motives (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002). This deteriorated insightfulness may partly explain why children traumatized by exposure to IPV benefit less from TF-CBT than children who were traumatized by experiences that did not have a traumatic impact on their parents at the same time (J. A. Cohen, Mannarino, & Iyengar, 2011; J. A. Cohen, Mannarino, & Murray, 2011).

For children to feel secure and supported by their parents, parents need to be sensitive to their children's needs, accurately recognize their children's signals, and appropriately respond to these signals (Ainsworth, 1978; Davies, Harold, et al., 2002). Similarly, for children to benefit from a trauma-focused treatment, such as TF-CBT, parental involvement to support the child is necessary (E. B. Foa, Keane, T.M., & Friendman, M.J., 2000). Accordingly, increasing parents' cognitive and emotional availability to the child should be a primary focus of treatment for children exposed to IPV. To this end, Visser, Leeuwenburgh, and Lamers-Winkelman developed a preparatory program for parents exposed to IPV (Visser et al., 2006b). This preparatory program was aimed to increase parental availability and insightfulness in their children's needs. Parents are coached to enhance reading their children's behavioral and emotional signals and to adequately interpret these signals in light of the child's age, the development, and type of IPV the child has been exposed to. The preparatory program component precedes the TF-CBT-based treatment.

Behavioral mechanism: parent–child interaction

Parents who have experienced and have been exposed to IPV tend to engage in ineffective parenting. Compared to non-exposed parents they used more negative and less positive parenting, are likely to use more harsh discipline towards their children (Osofsky, 2003), showed more aggression in the parent–child relationship (Appel & Holden, 1998), and were less supportive and less effective (Levendosky & Graham-Bermann, 1998). Buehler and Gerard (Buehler & Gerard, 2002) found that ineffective parenting mediated the link between marital conflict and children's maladjustment. In their study, ineffective parenting comprised of harsh discipline (e.g., spanking), low involvement (e.g., talking and reading with child), and reduced parental presence (i.e., time spent together). These findings suggest that IPV reduces parents' capacity to support their child, to interact with him/her in a safe and comforting manner, and to be available to fulfill and sensitively respond to his emotional and cognitive needs (Margolin, Gordis, & Oliver, 2004).

To optimally benefit from trauma-focused treatment, parental support is important for children (E. B. Foa, Keane, T.M., & Friendman, M.J., 2000). Accordingly, we propose that trauma-focused treatment for children exposed to IPV can be enhanced by improving parents' emotional support and parent–child interaction. To this end, Visser et al.(Visser et al., 2006b) developed the second specific parental component, the parent–child interaction sessions, to complement the TF-CBT-based treatment. These weekly sessions follow the child and parent TF-CBT-based treatment sessions. They aim to help parents to gain new insights in their children's functioning and to more accurately and positively respond to their child's emotions and behaviors by interacting with their child.

Trial Objectives

In the present project, we will examine the efficacy of the two parental components of the *HORIZON*, the preparatory program for parents and the parent–child interaction sessions. *HORIZON* is a TF-CBT-based group treatment for children exposed to IPV. For a complete description of the treatment in Dutch see (Leeuwenburgh, Visser, & Lamers-Winkelman, 2006b; Visser et al., 2006b), and for a summary see paragraph 'Intervention'. In a randomized-controlled design, we will add the parental components to a TF-CBT-based core treatment to examine their independent and combined effects on parents' and children's outcomes. Overall, we expect both parental components to add to the efficacy of the TF-CBT-based core treatment. Specifically, we expect that, as compared to parents who did not participate in the preparatory program, parents who participated in the preparatory program show a greater increase in parental availability. In the same vein, we expect that the parents who participated in the parent–child interaction sessions show a greater increase

in effective and positive parenting and a greater decrease in negative parenting than parents who did not participate in these sessions. These effects of the parental components should contribute to parents' and children's outcomes and reduction of symptoms.

Primary objectives

The primary objective of the present study is to examine the efficacy of two parental components that complement a TF-CBT-based core treatment for children who have been exposed to IPV. Specifically, the study involves a randomized controlled trial with a 2 (parent preparatory program present vs. absent) × 2 (parent–child interaction sessions present vs. absent) factorial design to evaluate the effects of these two parental treatment components on child symptoms.

Secondary objectives

Our second goal is to evaluate the effects of these two parental treatment components on child adjustment. Our third goal is to investigate mechanisms underlying the efficacy of treatment for children who have been exposed to IPV by examining associations between: child symptoms, on the one hand, and, 1) child responses (i.e., child emotional, behavioral, and cognitive responses, 2) parental availability and 3) parent–child interaction, on the other.

Our fourth goal is to examine specific hypotheses of change. Specifically, we will test whether, as predicted, the preparatory program leads to increased parental availability and whether the parent–child interaction sessions lead to improved parenting behavior. Also, we will explore whether these changes lead to a reduction in symptoms.

To ensure comparability of the randomized conditions, we will control for duration and severity of the IPV (Kitzmann, Gaylord, Holt, & Kenny, 2003), parental psychopathology (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003), and new incidents of IPV.

METHODS

Study Design

This multi-center study examines the addition of two parental components to a TF-CBT-based treatment for children exposed to IPV, which results in a 2 (preparatory program present versus absent) × 2 (parent–child interaction present versus absent) factorial randomized experimental component trial. The study includes pre-treatment (T1), treatment, post-treatment (T2), and a 6-month follow-up (T3) assessment, and

HORIZON	Parent–Child Interaction	No Parent–Child Interaction
Preparatory program	Condition 1; $n = 25$	Condition 2; $n = 25$
No Preparatory Program	Condition 3; $n = 25$	Condition 4; $n = 25$

Figure 1. Study Design. Random-controlled trial examining the effectiveness of two parental components.

will include 100 children and their custodial parents (Figure 1 depicts the study design). The baseline assessment (T1, see Figure 2) will take place one week prior to the start of the 6-week preparatory program. To ensure comparability across treatment conditions, in the "No preparatory program" condition, parents and children will be assessed 7 weeks before the beginning of the TF-CBT-based treatment. Additionally, parents and children will be assessed three times during treatment, namely at the beginning of the intervention (session 1), after sharing the trauma narrative of the child with the parent (session 9), and at the end of the intervention (session 15).

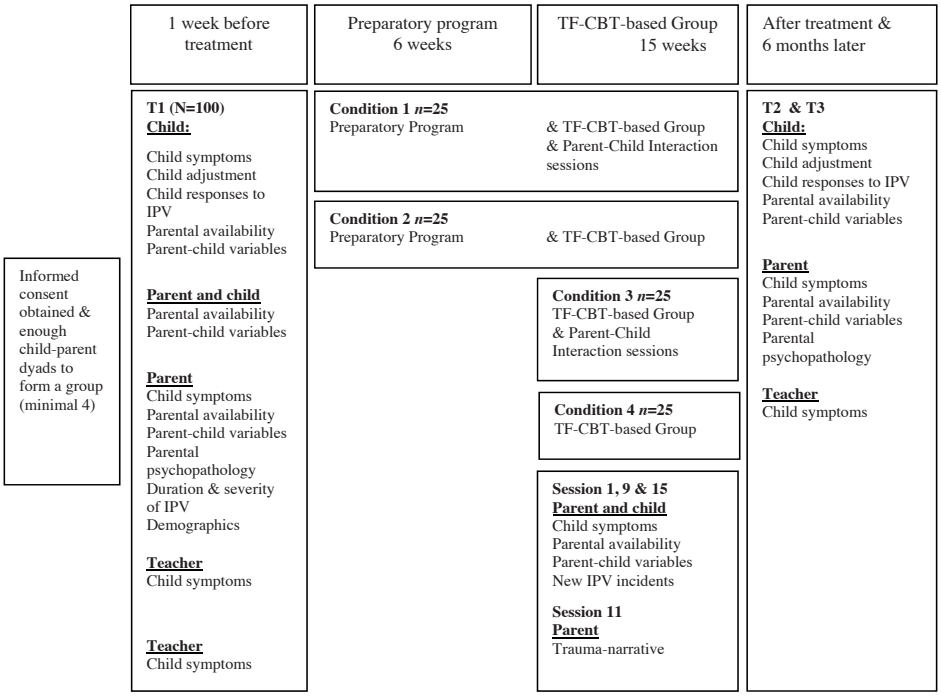

Figure 2. Research procedure. After informed consent is obtained for all parent–child dyads to form a group, they will all participate in the T1 assessments. Parents and children are asked to fill out questionnaires and to participate in two observational tasks. Additionally, the parent is interviewed with respect to the observational tasks. After T1, the group will be randomly assigned to one of the four treatment conditions by an independent researcher using a randomization procedure with lottery drawings. Condition 1 & 2 will start one week after T1, and condition 3 & 4 will start seven weeks after T1. One week (T2) and six months (T3) after the end of the program, parents and children are again invited to fill out questionnaires. At all assessments, the teacher is also sent a questionnaire.

These measurements allow us to test mediating pathways (Kazdin, 2007), and allow us to monitor, and if necessary control for, new IPV or other stressful incidents. The second assessment (T2) will take place one week after the last session of the TF-CBT-based treatment for all four conditions. The third assessment (T3) will be at a follow-up, six months after the last session of the treatment. Regardless of condition, all participants receive the standard TF-CBT-based treatment. The difference lies in the addition of the two parental components. Families who are assigned to "No preparatory program" or "No parent–child interaction" conditions will not receive an alternative component additionally to standard TF-CBT based treatment.

Randomization, Blinding, and Treatment Allocation

Recruitment will take place in three mental health centers in The Netherlands. For each center families are referred for treatment after children have been exposed to interparental violence. As soon as a group of approximately 8 families have met the inclusion criteria for participation in the *HORIZON* group treatment (see Inclusion and Exclusion Criteria), and after informed consent is obtained, the families participating in the study will participate in T1 measurements. Parents and children are asked to fill out questionnaires and to participate in two observational tasks. Additionally, the parent is interviewed about the observational tasks. After T1, the group will be randomly assigned to one of the four treatment conditions (see Figure 1) by an independent researcher using a randomization procedure with lottery drawings. Conditions 1 & 2 will start one week after T1, and conditions 3 & 4 will start seven weeks after T1. One week (T2) and six months (T3) after the end of the program, parents and children are again invited to fill out questionnaires (see Figure 2). At all assessments the teacher is also sent a questionnaire. Typically, the intervention group consists of two child groups (4-7 years and 8-12 years, respectively) and one parent group. Usually there is only one parent group, because families often have more than one child who participate in the intervention, and because parents without visitation rights do not participate. The child groups receive treatment at the same time but in different rooms. The parents of children in both groups receive group sessions on the same time. Because it is not feasible for participating trauma centers to start four interventions at the same time, we cannot randomly assign individual children or parents to one of the four conditions. Therefore, we choose randomization by group just before the start of the group therapy and after T1. Parents and children are blind to treatment condition until randomization is carried out just before the (preparatory) program starts. Clinicians will be blind for treatment condition until all families are indicated for treatment. The assessments include videotaped observational tasks. Independent research assistants will code these videos. All coders are blind for treatment condition. Sometimes it will take a few months before families can participate in one of the four

group interventions, due to waiting lists and enrollment numbers to form treatment groups. If necessary, parents and children will receive family or individual stabilization intervention during this time. Independent of their experiences with treatment preceding participation in the *HORIZON*, all participating families will be measured at T1 at the same time to ensure comparability of the families in the study.

Study Population

The population of this study will consist of 100 children exposed to IPV and their custodial parent who are referred by the Dutch Youth Care Agency (Bureau Jeugdzorg) or a physician for treatment of the child after exposure to IPV.

Inclusion and Exclusion Criteria

Typically, children are referred to the *HORIZON* treatment when they meet the following criteria established during an intake-interview with a trained therapist and standardized questionnaires: 1) the child has been exposed to IPV (or violence between a parent and a cohabitant); 2) the child is no longer exposed to IPV (or violence between a parent and a cohabitant) 3) the child is between 4 and 12 years old; 4) both custodial parents gave written informed consent consistent with the Dutch legislation; 5) the child has trauma symptoms or behavioral problems; 6) the child can control his or her (sexual) impulses; 7) the child's behavior is not dangerous to other children; 8) both child and custodial parent have sufficient cognitive and language capacities to follow a group treatment; 9) at least one custodial parent is able to participate in the parent-group.

If parents are unable to participate in the group therapy, for example, because they do not speak sufficient Dutch and have to receive individual treatment potentially with the help of a translator, parent and child will be excluded from the study. Children with severe psychopathology who represent a danger to other children receive individual treatment to stabilize their psychopathological problems. When stabilization is completed, children can participate in group therapy and will be included in the study.

Procedure

The inclusion of children and parents in this study is bound to legal requirements to obtain informed consent from both parents before children can be enrolled in a research study. This requirement is problematic when permission needs to be asked for treatment and research independently (e.g., mothers may refuse contact with father). Therefore, we ask both parents' permission for treatment and participation in the study for the child at the same time. Another challenge is that in the context of domestic violence, parents typically argue about almost everything, including con-

sent for treatment and research. Consequently, when interpreting the findings and response percentages, the requirements to obtain consent from both parents should be taken into account.

Objection by Minors or Incapacitated Subjects

The code of conduct for minors in non-therapeutic research is applicable in this research project. The risk for participating in this project is considered negligible, but when a child seems adversely affected by the questionnaires or observational tasks it may be decided to (temporarily) discontinue participation in the project.

Intervention

The *HORIZON* (Leeuwenburgh et al., 2006b; Visser et al., 2006b) is a 21-session TF-CBT-based group intervention for children who have been exposed to IPV. The aim of the intervention is to help children process the traumatic experiences of having been exposed to IPV. The aim of the parent group is to guide parents to helping their traumatized children in this process. Both children and parents receive a therapy book (Leeuwenburgh, Visser, & Lamers-Winkelman, 2006a; Visser, Leeuwenburgh, & Lamers-Winkelman, 2006a). This book is used weekly during the therapy sessions for information about the topic, assignments, and drawings and in between sessions for homework.

For the description of the intervention we distinguish three parts. First, the *Preparatory Program* is developed for parents and consists of six sessions. As mentioned above, it aims to increase parental availability and insightfulness in children's needs. Parents are coached to accurately read the behavioral and emotional signals of their children's needs, and to adequately respond to these signals.

The second part of the intervention consists the TF-CBT based core program, which comprises of parallel groups for parents and children and consists of fifteen weekly sessions. Because the *HORIZON* is trauma-focused and based on cognitive behavioral therapy principles, it includes similar components as TF-CBT that were described and studied by Cohen and Mannarino (J. A. Cohen & Mannarino, 2008). Specifically, it includes components such as psycho-education, relaxation, affective expression and modulation, cognitive coping and processing, trauma narrative, sharing the trauma narrative with their (non-violent) parent and parenting skills. Similar to TF-CBT these components are covered in the *HORIZON* by the following exercises and themes: psycho-education about therapy, violence and conflicts, and posttraumatic stress; training of emotion regulation skills; addressing incorrect attributions about conflict and violence; expressing and sharing the IPV experiences; managing anger, guilt and shame, handling nightmares; good and bad sides of mother and father; and future safety. These weekly sessions have a duration of 60 minutes.

After each session, the therapists of both the parent and child groups will evaluate the session and share information about children's as well as parents' progress.

The third part, the Parent Child Interaction Sessions (PCIS), takes place adjacent to the parallel parent and child group sessions when the parent group joins the children's group. During 30-minute sessions, parents and children are given the opportunity to interact with each other. The aim of these sessions for the parents is to learn to show more emotional supportive behavior, more involvement (e.g., talking together), more praise, less harsh discipline, and increase parental presence (e.g., time spent together). During Parent Child Interaction Sessions, parents can train and practice this parenting behavior through exercises in the presence of a therapist. Additionally, therapists observe the parent–child interaction and intervene when necessary. Therapists also give parents feedback on their parenting behavior in Parent Child Interaction Sessions during the following session in the parallel parent group. Children will receive feedback on their interaction behavior directly during the sessions together with their parents.

During the study, all children and parents in all four conditions will receive the TF-CBT based core treatment as described in part two above. There is no waiting list or control intervention.

Measures

Primary outcome measures

Child symptoms

Trauma Symptoms

Trauma Symptom Checklist for Younger Children (J. Briere, 2005). The TSCYC is a parent-reported questionnaire for children (3-12 years) measuring posttraumatic stress symptoms on a 4-point Likert scale, ranging from 'not at all' (1) to 'very often' (4). It consists of 90 items and 11 scales: two scales to assess the validity of the parent's answers (response level and atypical response), eight clinical scales (anxiety, depression, aggression, PTSS-intrusion, PTSS-avoidance, PTSS-arousal, dissociation and sexual concerns) and a total PTSS score. This total score will be used in analyses. This clinical total PTS scale showed good reliability within a sample of maltreated children in the United States (Cronbach's $\alpha = 0.81\text{-}0.91$) and in the Netherlands (Cronbach's $\alpha = 0.79\text{-}0.91$)(Lamers-Winkelman, 1998).

Trauma Symptom Checklist for Children (Briere, 1996); Dutch translation: *Trauma Symptoom Controle Lijst voor Kinderen* (Bal, 1998). This is a questionnaire to assess self-reported posttraumatic stress symptoms at children (8-12 years). It consists of 54 items clustering in 8 scales: two validity scales (underresponse, hyperresponse) and

six clinical scales (anxiety, depression, post-traumatic stress disorder, dissociation, anger and sexual concerns). The response categories are the same as in the Trauma Symptom Checklist for Younger Children and reliability was high for the clinical total PTS score, with a Cronbach alpha's ranging from 0.78 to 0.86 in a sample of sexually abused children (Briere, 2005). In a sample of maltreated children in the United States the Trauma Symptom Checklist for Children showed discriminant and convergent validity with the Trauma Symptom Checklist for Younger Children (Lanktree et al., 2008), and in the Netherlands the Trauma Symptom Checklist for Children showed convergent and criterion validity with other behavioral questionnaires (CBCL, TRF, YSR, CDI) (Curiel, 2005).

Internalizing and Externalizing Symptoms

Child Behavior Checklist (Aachenbach, 1983) measures competencies and problem behaviors of children aged 1½ to 18 years. The CBCL has a parent-report and a teacher-report (TRF) questionnaire for 1½-5 years and 6-18 years. The questionnaire measures internalizing (i.e., anxious, depressive, and over-controlled) and externalizing behavior problems (i.e., aggressive, hyperactive, noncompliant, and under-controlled) over the past 6 months. The behavior problems are measured with 120 items on a 3-point Likert scale, consisting of 'not true' (0), 'sometimes true' (1) and 'very/often true' (2). Cronbach alpha's for the broadband scales in a Dutch sample ranged from 0.78 to 0.93 for the CBCL (F. C. Verhulst, van der Ende, & Koot, 1996) and from 0.86 to 0.96 for the TRF (F.C. Verhulst, van der Ende, & Koot, 1997).

Secondary outcome measures

Child symptoms

Children's Depression Inventory (Kovacs, 1982). The CDI is a 27-item self-rated questionnaire that measures symptoms of depression in children (7-18 years): mood disturbances; capacity for enjoyment; depressed self-evaluation; disturbances in behavior toward other people; and vegetative symptoms, which include fatigue, oversleeping, having difficulty with activities requiring effort, and other symptoms of passivity or inactivity. Per item the child is asked to choose one of three sentences that best fits his/her feelings and thoughts in the past two weeks. The answers are calculated in a total score (ranging from 0 to 54). The internal consistency in a Dutch sample was high ($\alpha = 0.79$), just as the test-retest reliability ($r = 0.79$)(Timbremont, Braet, & Roelofs, 2008). The CDI has high criterion validity and scores on the CDI correlate high with scores on other measures for depression(Timbremont et al., 2008).

Screen for Child Anxiety Related Emotional Disorders (Muris, Bodden, Hale, Birmaher, & Mayer, 2007). This questionnaire is a self-report measure that assesses

anxiety symptoms in children and adolescents from age 7 on a 3-point Likert scale, ranging from 'never, almost never' (1) to 'often' (3). The scale consists of 69 items measuring symptoms of separation anxiety disorder, panic disorder, specific phobia, social phobia, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder and acute stress disorder. The internal consistency in a Dutch clinical sample was high ($\alpha = 0.92$), just as the test-retest reliability ($r = 0.81$) (Muris et al., 2007). The Screen for Child Anxiety Related Emotional Disorders showed convergent validity with other anxiety questionnaires(Muris et al., 2007).

Child Dissociation Checklist (Putnam, Helmers, & Trickett, 1993) is a 20-item parent-rated questionnaire with a 3-point Likert scale answering format ranging from 'not true'(0), 'somewhat or somehow true'(1) and 'very true'(2). The child dissociation checklist is a screening device and gives an indication for dissociative problems in children (5-18 years). It shows good test-retest reliability ($r = 0.69$) and internal consistency (Cronbach's $\alpha = 0.86$) (Hartveld & Janssen, 1992). Good convergent and discriminant validity have been indicated(Hartveld & Janssen, 1992).

Child adjustment

Coping: The cognitive emotion regulation questionnaire (Nadia Garnefski, Rieffe, Jellesma, Terwogt, & Kraaij, 2007). The cognitive emotion regulation questionnaire measures coping of younger children after stressful/negative events. In this study, we only use the subscales Rumination and Catastrophizing for children and parents. Each subscale has 4 items, and the subscales showed $\alpha = 0.79$ for Rumination and 0.67 for Catastrophizing in a sample of 9-11 year old children. Children and parents rate how often they use a certain coping style on a 5-point scale ranging from '(almost) never' (1) to '(almost) always' (5).

Emotional Awareness Questionnaire: The (Rieffe et al., 2007) aims to identify how children and adolescents feel or think about their emotions. The questionnaire measures six aspects of emotional awareness: 1) differentiating emotions; 2) verbal sharing of emotions; 3) bodily awareness; 4) acting out emotions; 5) analyses of emotions; and 6) others' emotions. The Emotional Awareness Questionnaire consists of 30 items on which children are asked to rate the degree to which each item is true on a 3-point scale 'not true'(1), 'sometimes true'(2), and 'often true'(3). The reliability of the Emotional Awareness Questionnaire subscales ranged from 0.64 to 0.77 (Rieffe et al., 2007). In a revised version 'Acting out Emotions' was changed to 'Not Hiding emotions' (Rieffe, Oosterveld, Miers, Terwogt, & Ly, 2008). For the current study, we adapted the items of the Other's Emotion subscale (5 items) such that these items enquire about parents' emotion, not about friends' emotions. We added items for mother and father separately (10 items). We omitted the subscale 'Analyses of emo-

tions' (5 items), because this dimension was not directly associated with the aims of the treatment. This led to the inclusion of 30 items.

Self-control: Self-Control Scale (Finkenauer, Engels, & Baumeister, 2005; Tangney, Baumeister, & Boone, 2004). The 11-item self-control scale aims to assess parents' and children's ability to control their impulses, alter their emotions and thoughts, and to interrupt undesired behavioral tendencies and refrain from acting on them. For adults, the original scale shows adequate internal consistency (alphas between 0.83 and 0.85), test-retest reliability over a period of three weeks (alpha = 0.87), and validity (Tangney et al., 2004). Paralleling the findings for the English versions of the scale, the short Dutch version of the scale showed adequate reliability in earlier studies with adolescents (Frijns, Finkenauer, Vermulst, & Engels, 2005). Response categories ranged from 'not at all' (1) to 'very much' (5). In this study, we will also administer the Self-Control Scale to young children (age 7 and above) (Buyukcan-Tetik, Finkenauer, Siersema, Vander Heyden, & Krabbendam, 2014). To assess perceived self-control, we will use an adapted version of the scale where each items was adjusted so as to refer to the child. Previous research shows that the scale shows good reliability (Righetti & Finkenauer, 2011).

Behavior Rating Inventory of Executive Function (Gioia, Isquith, Guy, Kenworthy, & Baron, 2000). The BRIEF measures specific behaviors relating to executive functioning on a 3-point Likert scale, consisting of 'never'(1), 'sometimes'(2) and 'often'(3). The BRIEF has a parent-report and a teacher questionnaire for 5-18 years, and a self-report questionnaire for 11-18 years. The BRIEF comprises eight clinical scales (inhibit, shift, emotional control, initiate, working memory, plan/organize, organization of materials and monitor), two composite scores (behavior regulation and metacognition) and a general executive function summary score (Global Executive Composite). The internal consistency of the Dutch BRIEF is very high (Cronbach's alpha of the eight clinical scales ranged from 0.78 to 0.90) and the mean test-retest stability on the clinical scales was 0.81 (Huizinga & Smidts, 2011).

Fundamental needs: To assess the four fundamental needs proposed by Williams (Williams, 1997), we use a measure, derived and translated into Dutch from Williams' (Williams, 1997) measures. The scale measures individuals need fulfillment in general, including their *sense of belonging*, their *self-esteem*, their *sense of a meaningful existence*, and their sense of *control and agency*. For each scale, the items will be averaged and aggregated into a single score. The scale has extensively been used in research examining ostracism and has shown good psychometric properties (Eisenberger, Lieberman, & Williams, 2003). A pilot study confirmed the usefulness and content validity of the scale with children.

Self-esteem: Global self-worth subscale (Harter, 1985). Self-esteem will be measured using the 6-item global self-worth subscale of the Self-Perception Profile for

Children (Harter, 1985). This reliable scale (α = 0.72) measures the degree to which children are satisfied with themselves. Following Thomaes, Bushman, Stegge, and Olthof (Thomaes, Bushman, Stegge, & Olthof, 2008), a 4-point scale response format will be used, which ranges from 'I am not like these kids at all' (0) to 'I am exactly like these kids' (3). Higher scores indicate higher self-esteem.

Children's responses to IPV

Emotional responses to IPV: To assess children's emotional responses to IPV, *the Security in the Interparental Subsystem* (Davies, Forman, Rasi, & Stevens, 2002) will be used. The Security in the Interparental Subsystem emotional reactivity subscale has 12 items and is subdivided in four questions about emotional arousal, α = 0.74, and five questions about emotional dysregulation, α = 0.84, and three questions about behavioral dysregulation, α = 0.65. In addition to the four questions about emotional arousal (sad, scared, angry, unsafe), we will add 5 items from the Positive and Negative Affect Scale for Children (Laurent et al., 1999). These are 'ashamed', 'guilty', 'upset', 'alert', and 'nervous'. The Security in the Interparental Subsystem uses a four-item answer format 'not at all true of me' (1) to 'very true of me' (4). Children will be asked to answer the same questions with respect to past fights and arguments between their parents and current fights and arguments between their mother and partner at T1, T2, and T3.

Cognitive responses to IPV; self-blame, perceived threat and coping efficacy: To assess two specific cognitions related to IPV, self-blame, and perceived threat, as well as coping efficacy with IPV, we will use the *Children's Perception of Interparental Conflict Scale* (CPIC), developed by Grych, Seid, and Fincham (Grych, Seid, & Fincham, 1992). Three subscales will be used: Coping efficacy, Self-blame, and Perceived Threat. The Perceived Threat subscale (6 items) assesses cognitions of perceived threat and fear. The Self-blame subscale (5 items) assesses children's perceptions that they were responsible for causing the conflict. The Coping Efficacy subscale consists of 6 items and the respondent is asked to answer on a 3-point scale consisting of 'true' (1), 'sort of true' (2) and 'false' (3). At T1, T2, and T3, children will be asked only how they respond with respect to current fights and arguments. One additional question will be asked at T1, T2 and T3 about past IPV: 'It is my fault that there were arguments and fighting between my mother and <*father/partner*>'. This questionnaire has a total of 18 items.

Child Cognitive responses; trauma-related cognition: To assess negative cognitive responses that are trauma-related, we will *use the Post Traumatic Cognitions Inventory – child version* which was developed by Meiser-Stedman et al. (Meiser-Stedman et al., 2009). The 25 items were based on the original adult version of the PTCI (E. B. Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). The CPTCI is a reliable (α = 0.86-0.91

across three samples) measure that was originally developed for children with single-event trauma (Meiser-Stedman et al., 2009). The scale assesses appraisals concerning the more abstract consequences of traumatic experiences, as well as physical threat and vulnerability. There are two subscales, 'Permanent and disturbing change' and 'Fragile person in a scary world'. For this study, the word 'event' will be changed to 'event(s)' in all items to acknowledge the multiple traumatic experiences of the children exposed to IPV. The answer format consists of a 4-item Likert scale: 'Don't agree at all (1), 'Don't agree a bit' (2), 'Agree a bit (3), or 'Agree a lot' (4).

Children's general beliefs about aggression and family violence: Normative beliefs about aggression (NOBAG). The 20-item NOBAG scale (Huesmann & Guerra, 1997) was developed to asses children's beliefs about the acceptability of specific aggressive behaviors in specific social contexts. The scale is divided in two parts. The 12-item subscale 'Retaliation beliefs' consists of short scenarios in which one child (A) is aggressive towards another child (B). The respondent is asked if it is wrong or okay for B to react with verbal aggression toward A and, second, if it is wrong or okay for B to respond with physical aggression. The second subscale 'General beliefs' consist of 8 items that assess general beliefs about aggression. Children can choose between four answer options: 'Don't agree at all'(1), 'Don't agree a bit'(2), 'Agree a bit (3), or 'Agree a lot' (4).

Attitudes about family violence (AAFV) scale assesses children's attitudes and beliefs about the acceptability of family violence (Graham-Bermann, 1994). The child is asked to indicate the extent to which ten statements are true on a 5-point Likert scale ranging from 'Do not agree'(1) to 'Strongly agree'(5). The total score indicates more negative attitudes and beliefs. The internal consistency is good (Graham-Bermann, Howell, Lilly, & DeVoe, 2011). For this study, the scale was translated into Dutch. The AAFV has been used in treatment studies on domestic violence (Graham-Bermann, Kulkarni, & Kanukollu, 2011; Graham-Bermann et al., 2007).

Behavioral response to IPV, avoidance and approach: The behavioral subscales of the *Security in the Interparental Subsystem* (Davies, Forman, et al., 2002) will be used to assess children's approach and avoidant behavioral responses to IPV. The subscale Involvement ($\alpha = 0.74$) has 7 items and the subscale Avoidance has 7 items ($\alpha = 0.79$). Involvement refers to approach behavior that the child uses to get involved in an argument between his/her parents. Avoidance refers to behavior that the child uses to escape from an argument between his/her parents. The scale uses a four-item answer format 'Not at all true of me' (1), 'A little true of me' (2), 'Somewhat true of me' (3) and 'Very true of me' (4). Children will be asked to answer the same questions with respect to past fights and arguments between their parents and *current* fights and arguments between their mother and partner at T1. At T2 and T3, children will be asked only how they respond with respect to current fights and arguments.

Measures of mediating variables

To test whether the two specific parental components of *HORIZON* mediate the effects of treatment on changes in child symptoms and adjustment, measures including parental availability and parent–child interaction are administered. Those measures will also be used to test whether the two specific parental components leads to increased parental availability and to improved parenting behavior.

Parental availability

Security in the Family System: The Security in the Family System scale (Forman & Davies, 2005) will be used to assess how much children perceive their families as a reliable source of protection, stability, and support. The subscale 'Secure' will be used, which assesses a secure pattern of emotional security. Children indicate the extent to which they agree with 7 statements using a four-point scale ranging from 'Complete disagree'(1) to 'Complete agree'(4). Psychometric properties of this security subscale are good, Cronbach's $\alpha = 0.85$ and test-retest reliability = 0.82. (Forman & Davies, 2005).

The cognitive emotion regulation questionnaire (N. Garnefski & Kraaij, 2007) is a self-report measure developed in the Netherlands that assesses cognitive coping-styles of adults and adolescents aged 12 years and older. Two subscales of the cognitive emotion regulation questionnaire are included in this study: rumination and catastrophizing. Each subscale has 4 items, and has good internal consistency ($\alpha = 0.83$ for rumination and $\alpha = 0.79$ for catastrophizing (N. Garnefski & Kraaij, 2007). The parent rates how often he or she uses a certain coping style on a 5-point scale ranging from '(almost) never'(1) to '(almost) always'(5). We use two versions of the questionnaire, one with the original questions and one version adapted for this study. The adapted version asks parents to report on how they cope with the traumatic events that happened to their children.

Emotional Awareness: The Emotional Awareness Questionnaire (Rieffe et al., 2007) is described in more detail above. For parents, we will include two subscales: "Not Hiding Emotions" and "Other's Emotions". We changed the items belonging to the Other's Emotions subscale to enquire about children, not friends.

Daily Psychological Availability Scale (Danner-Vlaardingerbroek, Kluwer, van Steenbergen, & van der Lippe, 2013). To assess parental availability for the child we will use eight adapted items of the Daily Psychological Availability Scale. Items were measured using 7-point scales from 1 (totally disagree) to 7 (totally agree). Cronbach's α was 0.78 for both fathers and mothers (Danner-Vlaardingerbroek et al., 2013). A higher score on this scale represents more psychological availability for the child.

The Children's Responses to Trauma Inventory Revised version (E. Alisic, Eland, & Kleber, 2006) is a self-report measure for children aged 8-18 years and consists of

34 items. Children answer, on a 5-point Likert scale, to which extent a reaction to a traumatic event was present during the past week. The instrument has 4 subscales: intrusion, avoidance, arousal, and other child-specific responses (e.g., feelings of guilt, regressive behavior, reckless behavior, fear of the dark, fear of going to the toilet at night, separation anxiety, sadness, crying, feeling tired, and psychosomatic complaints). A recent study found good psychometric properties for the scale, with Cronbach's α of 0.92 for the total scale, and α ranging from 0.72-0.81 for the four subscales (Eva Alisic, van der Schoot, van Ginkel, & Kleber, 2008). The parent-reported questionnaire is intended for parents of children age 4 to 18 years. The scale consists of the same 34 items measuring intrusion, avoidance, arousal, and nonspecific symptoms during the last week. Previous research shows sufficient reliability (α total scale = 0.92) and good convergent and discriminant validity (E. Alisic & Kleber, 2010). To assess concordance between parent- and child-reported trauma symptoms and parental insight in the child's trauma symptoms, we will instruct parents to fill out the questionnaire how they think the child will answer and will compare child and parent forms. This information is obtained at session 1, 9 and 15.

During the therapy, in session 6, children will be asked to draw and talk about the most adverse incident they can remember about the IPV. This is part of the regular treatment protocol of the *HORIZON* for children. In addition, in session 6, we will ask the parents in the parallel group to write down what they think their child will talk about with respect to the most aversive IPV incident. The answers to this question from both parent and child will be compared. One of the aims of the preparatory program is to coach parents to differentiate between their own trauma-history and the one of the child. If this aim is achieved, we hypothesize that parents in treatment condition 1 & 2 (see Figure 1) will more often provide an answer that is similar to their child's to the above question than the parents in treatment condition 3 & 4 (see Figure 1).

Parent–child variables

Attachment Security: The Security Scale (Kerns, Klepac, & Cole, 1996) is a 15-item self-report questionnaire for children between the ages of 8 and 18 and measures attachment security with their parents. Children report on their attachment security with both parents separately. The scale consists of three dimensions: perceptions of responsiveness and availability of the parent, tendency to seek parental support in times of stress and the quality of communication with the parent. Children rate the items on a 5-point Likert-Scale ranging from 'strongly agree' (1) to 'strongly disagree' (5) with a higher score indicating greater perceived attachment security. Several studies indicate adequate reliability and validity (Dwyer, 2005). Kerns, Tomich, Aspelmeir and Contreras (Kerns, Tomich, Aspelmeier, & Contreras, 2000) reported

high internal consistencies for 10 and 12 year olds (α = 0.82, α = 0.79). Test-retest reliability over a two-week period was high ($r = 0.75$) (Kerns et al., 1996). The Security Scale is related to other attachment measures (Kerns et al., 2000). In a Dutch sample, internal consistency was α = 0.77 for the mother version and α = 0.85 for the father version (Willemen, 2008).

Generalized Trust Beliefs: Children's Generalized Trust Beliefs (Rotenberg et al., 2005). The original questionnaire assesses children's generalized trust beliefs across three bases of trust (reliability, emotionality and honesty) in four target groups (mother, father, teacher and peers). Reliability measures the belief that parents will keep their promises. Emotionality measures the belief that parents keep their secrets confidential. Honesty measures the belief that parents are truthful. For the purpose of this study, we only use the mother and father as targets, which results in a total of 12 items. Names and situations were adjusted to fit the Dutch population. Children are presented with specific situations of fictional children and instructed to imagine that they were the children in the stories. Items are rated on a 5-point Likert scale ranging from 'very unlikely' (1) to 'very likely' (5). Reliability and validity were acceptable in earlier research (total scale 0.76, reliability subscale: 0.67, emotionality subscale: 0.62, honesty subscale: 0.65) (Rotenberg et al., 2005). A pilot study confirmed the usefulness and content validity of the scale with children.

To assess parenting behavior, both from the child's and the parent's perspective, we will use *the Ghent Parental Behavior Questionnaire* (Van Leeuwen & Vermulst, 2004). The brief child version of the GBPS has 25 items for each parent (Van Leeuwen & Vermulst, 2010). The parent version of the GBPS has 60 items and includes nine subscales: Positive parenting, monitoring, rules, discipline, inconsistent discipline, harsh punishment, ignoring, material rewarding, and autonomy. Cronbach's α for the subscales is moderate to good (Van Leeuwen & Vermulst, 2004).

Capitalization Scale (Gable, Reis, Impett, & Asher, 2004). To assess parents' capitalization attempts to their child's sharing of positive events, we adopted Gable et al.'s (Gable et al., 2004) capitalization scale. Parents indicate, using 5-point scales, whether they "reacted enthusiastically to their child's sharing of a good event" (Active–Constructive), "pointed out the potential problems or down sides of the good event" (Active–Destructive), "said little, but my child knew I was happy for him/her" (Passive–Constructive), and "seemed disinterested" (Passive–Destructive). The original scale was found to be reliable and valid (Gable et al., 2004).

Self-Control: For a description see child adjustment measures above.

Protective Factors Survey (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010). The Protective Factors Survey assesses multiple protective factors against child maltreatment. The survey consists of 20 items and five subscales, namely Family Functioning/Resiliency, Child Development/Knowledge of Parenting, Concrete Sup-

port, Social Support and Nurturing and Attachment. Items are rated on a (7-point) frequency or agreement scale.

The Confusion Hubbub and Order Scale (Matheny, Wachs, Ludwig, & Phillips, 1995) measures environmental confusion in the home. This refers to the levels of environmental noise, crowding and disorganization in a household, in short: chaos. The questionnaire was translated into Dutch for this study, and includes 15 statements that are rated by the parents as 'not true', 'quite true' or 'very true'. The Confusion Hubbub and Order Scale has good internal consistency ($\alpha = 0.79$) and test-retest reliability ($\alpha = 0.74$) (Matheny et al., 1995).

The Inclusion of the Other in the Self Scale (Aron, Aron, & Smollan, 1992). This Inclusion of the Other in the Self Scale is a single-item pictorial measure for closeness to others. Parents and children describe their relationship by selecting a set of two circles. The degree of overlap between the circles stands for the degree of closeness to the other person. Parents rate on the relationship with their child and children rate on their relationship with the mother and father separately. Respondents are presented with 7 different sets of circles, ranging from a set with no overlap and a long distance between the circles and a set with almost complete overlap between the circles. The circles are held constant and only the overlap increases. Validity and reliability were adequate (Aron et al., 1992). The Inclusion of the Other in the Self Scale has not been used before to measure the parent–child relationship. Our pilot study confirmed the usefulness and content validity of the scale with children.

Time spent together: Parents and children are asked 9 questions about the time they spent together during the past week. For example: "How often did you have breakfast together with your mother/child last week". Items are rated on an 8-point scale ranging from 'not at all', 'one time', to 'every day'.

Treatment Fidelity

All treatment sessions are audio or video-recorded to ensure that the treatment protocol of the *HORIZON* (Leeuwenburgh et al., 2006b; Visser et al., 2006b) was followed. Tapes are randomly selected to be coded for treatment adherence.

Control measures

Parental psychopathology symptoms. To assess parental psychopathology, we will use the *Impact of Events Scale – Revised (Weiss & Marmar, 1997)*. The Dutch version '*Schokverwerkingslijst* (SVL-22)' was developed by Kleber and De Jong (Kleber & De Jong, 1998). This questionnaire consists of 22 items measuring symptoms of post-traumatic stress disorder during the last week. The Schokverwerkingslijst-22 measures three dimensions: intrusion, avoidance and hyper-arousal. Parents rate the items on a 5-point Likert-scale ranging from 'not at all' to 'extremely'. The measure

has high internal consistency (α = 0.88) (Olde, Kleber, van der Hart, & Pop, 2006). Further, we will use the *Young Adult Self-Report* (Aachenbach, 1997). The Young Adult Self-Report will be used to assess psychopathology symptoms in parents. This questionnaire has the same format as the CBCL described above. The short version of 29 items will be used in this study to limit the amount of time needed to fill in the questionnaire. Previous research has shown that these items discriminated well between referred and non-referred subjects (Wiznitzer, 1993). Items are rated on a 3-point scale ranging from 'not true'(0), 'somewhat or sometimes true'(1) and 'very true or often true'(2). Reliability and validity of the Dutch version are good (Wiznitzer et al., 1992).

Insightfulness Assessment (D. Oppenheim & Koren-Karie, 2002) (only at T1). The Insightfulness Assessment is based on a semi-structured interview that evaluates the parents' ability to seek explanations regarding the motives underlying their children's behaviors and to talk about them in an open, complex, insightful, and accepting manner. The interview is based on the parent viewing child–parent or child–examiner interaction segments which are video-taped beforehand and answering questions about the segments. The interview transcripts will be coded on 10 rating scales and classified into one of the following four categories: Positively insightful, One-sided, Disengaged and Mixed. This represents a constellation of parental thoughts, feelings, and perceptions regarding the child's inner experience. Each transcript is independently coded by two coders blind to any information about the study. In a previous study, inter-rater reliability ranged from 0.77 to 0.93; inter-rater reliability on the four-way Insightfulness Assessment classification system was 0.84 (Koren-Karie et al., 2002).

Autobiographical Emotional Events Dialogues (Koren-Karie, Oppenheim, Carasso, & Haimovich, 2003) (only at T1). In the AEED parents and children participate in an emotion discussion task, in which they recall and describe an event when the child felt happy, sad, mad, and scared, respectively. They are asked to jointly describe the event and to talk about what the child felt, thought, and did during the event. Construction of the stories is scored on 7 parent scales (Shift of focus, Boundary dissolution, Acceptance and tolerance, Hostility, Involvement and reciprocity, Closure of negative feelings and Structuring of the interaction) and 7 child scales (Shift of focus, Boundary dissolution, Acceptance and tolerance, Cooperation and reciprocity, Resolution of negative feelings and Elaboration of the stories). Also, the stories are scored on adequacy of the stories and coherence. Rating scales range from 1 to 9, a higher score indicates a greater presence of that particular construct. Ratings are based on the complete session. Scores result in a classification in one of four categories: emotionally matched, emotionally unmatched: excessive, emotionally unmatched: flat or emotionally unmatched: inconsistent. Each videotaped session is independently coded by two coders (research assistants). Coders are blind for

experimental condition. In a previous study, inter-rater reliability ranged from 0.87 to 0.95 (David Oppenheim, Koren-Karie, & Sagi-Schwartz, 2007).

Positive filler task: To ensure all dyads end the AEED with a positive task before they continue with the Family interaction task, we will ask the child to briefly talk about his/her favorite food or hobby with his/her parent.

Family interaction task (Weinfield et al., 1999) (only at T1). This observational instrument measures parent–child interaction and consists of four tasks in which parent and child are instructed to complete a series of interactive tasks together. The first task is a word guessing game, in which parent and child take turns in guessing what word/picture appears on the card of the other. The second task involves getting marbles into designated holes in a labyrinth. In the third task, parent and child have to plan a pretend birthday party. The final task is constructing different patterns of pieces that match given designs. Nine rating scales are used for this study: 3 parent scales (positive responsiveness, anger and hostility, quality of assistance), 3 child scales (persistence and diligence; anger, defiance and frustration; expression of positive affect) and 3 dyadic scales (collaboration and teamwork; positive affect; negative affect / conflict). Rating scales range from 1 to 5 and a higher score indicates a greater presence of that particular construct. Ratings are based on the complete session. Each videotaped session is independently coded by two coders (research assistants). In a previous study, inter-rater reliability ranged from 0.63 to 0.73 (Weinfield et al., 1999).

Severity and intensity of IPV. To assess the severity and intensity of the violence that children have been exposed to, we will use a combined measure including items from the Conflict Tactics Scale (Straus, 2001), the Conflict Tactics Scale parent child (Straus, 2001), the Parents Report of Traumatic Impact (Friedrich, 1997); and the Adverse Childhood Experience Questionnaire (Felitti et al., 1998). This combined questionnaire has been used in a previous study on the effectiveness of a psychoeducational prevention program for children exposed to IPV (Overbeek, 2011). The questionnaire covers the topics of duration of the violence, the nature of the arguments in the relationship with the (ex-partner), followed by items from the Conflict Tactics Scale parent child and Parents Report of Traumatic Impact about problems between parent and child, and traumatic events the child has experienced. The questionnaire also includes items about traumatic experiences in parents' own childhood.

New IPV incidents: Parents and children are asked 8 questions if any new IPV incidents or other stressful events occurred.

Statistical Analyses and Sample Size Calculation

All variables are measured on at least an ordinal scale. All scale scores will be examined for normality. Should we observe deviations, steps will be taken to ensure optimal estimation of parameters in our analyses. The proposed study includes

a nested structure, because individuals are treated within groups. Following the recommendations by Peugh (Peugh, 2010), we will calculate design effects to assess group-level dependency and examine whether multi-level modeling is required. To ensure comparability of the randomized conditions, we will control for duration and severity of the IPV (Kitzmann et al., 2003), parental psychopathology (Levendosky et al., 2003), and new incidents of IPV. Power calculations were performed using the program G*power 3 (Faul, Erdfelder, Lang, & Buchner, 2007), assuming that individual-level effects can be treated as independent data. We determine required sample size to be 100 parent–child dyads, achieving statistical power of at least .80 for the primary and secondary objectives, as described in more detail in the following paragraphs. We will test for the randomness of missing data. If this is the case we will use multiple imputation.

Primary objective.

The first goal of the present study is to examine the efficacy of two parental components that complement a TF-CBT-based core treatment for children who have been exposed to IPV. Therefore, a multiple regression analysis will be executed with two dummy variables as independent variables, representing both parental components (dummy 1 = parent preparatory program present vs. absent; dummy 2 = parent–child interaction sessions present vs. absent) and their interaction. Dependent variables are child symptoms (primary outcomes) at the three time points (T1, T2, and T3) clustered into 1) Trauma symptoms, 2) Internalizing symptoms, 3) Externalizing symptoms. Analyses will be independently executed for the three dependent variables. Because children in each group receive intervention, a medium effect size is expected ($f^2 = .15$). With a maximum of five predictors and an alpha of .05, we achieve a power of .84 with 100 children included in the study.

Secondary objectives.

To investigate associated changes between: child symptoms, on the one hand, and 1) child responses (i.e., child emotional, behavioral, and cognitive responses), 2) parental availability and 3) parent–child interaction on the other, we will use the stepwise procedure in multivariate regression analyses with a maximum of 4 tested predictors. With a sample size of 100, alpha of .05 and medium effect size ($f^2 = .15$), we will achieve a power of .87 in analyses with 4 individual predictors. We will use latent variables for child responses, parental availability and parent–child interaction.

We will also use multivariate regression analyses to study the fourth goal, namely which mechanisms explain how the two components added to the TF-CBT-based *Horizon* treatment contribute to the effectiveness of TF-CBT-based *Horizon* treatment. We will follow Holmbeck's recommendations (Holmbeck, 1997) for these

mediational analyses and will test the robustness of our results by using the bootstrapping method. These analyses will allow us to determine whether the parent–child interaction variables and parental availability partly or fully mediate the effects of each parental component on child symptoms. Specifically, we will test whether, as predicted, the preparatory program leads to increased parental availability and whether the parent–child interaction sessions lead to improved parenting behavior. Also, we will explore whether these changes lead to a reduction in symptoms. Because at least partial mediation is assumed, a small to medium effect size is chosen ($f^2 = .10$). Two models are tested. A first model with component 1 (preparatory parent program) and parent availability as independent variables. And a second model with component 2 (parent–child interaction sessions) and parent–child interaction as independent variables. With a sample size of 100, alpha of .05 and medium effect size ($f^2 = .10$), we will achieve a power of .80 if 2 predictors are tested in the regression.

Exploratory analyses: Cross-lagged panel model

Based on the recommendations of Kazdin (Kazdin, 2007) to investigate mediators and mechanisms of change in intervention RCT´s, to test the causal direction of the longitudinal relation between the different types of mediators and child outcomes, we will conduct cross-lagged panel analyses (Kline, 2005). The model will include three waves of child symptoms and parent–child variables, parental availability, and child responses, respectively. We will estimate T1 associations (interpreted as correlations at T1), T2 and T3 stability (interpreted as relative stability over time), correlated change (interpreted as overlapping relative change in two variables), and cross-lagged paths between child symptoms and parent–child variables, parental availability, and child responses, respectively (interpreted as a linkage of the level of one variable at a given time point with a relative change in another variable one assessment later). Correlated change and cross-lagged paths reflect longitudinal relationships, and will be interpreted as such. These cross-lagged analyses will also be carried out with the repeated measures at session 1, 9 and 15 for child trauma symptoms, closeness and time spent together with possibilities to explore more than three waves of measurements.

Handling and Storage of Data and Documents

Privacy of participants will be protected by allocating identification numbers to the personal information, which will be traceable with a separate list. This list with personal information (names, addresses, phone numbers) that connects the participants with the research data, is accessible to one of the researchers and will eventually be destroyed. Data will be analyzed in a way that no conclusions can be drawn about individual participants.

The research data will be stored and managed by the research team. All employees who work with confidential data will sign a confidentiality agreement, on which they state not to share the information with third parties. Only if the safety of a parent or child is in danger, these concerns will be shared with the participating organization where the program is carried out.

The research material and the confidentiality agreements will be stored, according to the publication manual of the American Psychological Association, in a locked file cabinet at the VU University for five years after the last publication based on this data.

Public Disclosure and Publication Policy

The research data will be published in international and national journals, and all affiliated organizations will be mentioned. The results will also be presented on international conferences. The clinical trial is registered at the Dutch trial register (www.trialregister.nl). To make the results also available for Dutch policy makers and service providers, we plan to publish the results in (national and international) journals within the field of youth mental health care.

Ethical Considerations

The study protocol has been approved by the Medical Ethics Committee of the VU University Medical Center in Amsterdam, the Netherlands (METC VUmc 2011/101/NL39277.029.12). All substantial amendments will be presented to the METC and to the competent authority. Non-substantial amendments will not be notified to the accredited METC and the competent authority, but will be recorded and filed by the sponsor, ZonMw, the Dutch organization for healthcare research and innovative care. All changes will be described and discussed in the publications of the study results.

The *HORIZON* has been used to treat children who have experienced IPV for more than 10 years in several children and youth treatment centers in the Netherlands and does not seem to involve risks for participants. Nevertheless, should a child or a parent seem adversely affected by therapy, questionnaires or observational tasks as observed by the researchers or therapists, it may be decided to (temporarily) discontinue participation in this study. Participants can leave the study at any time for any reason if they wish to do so without any consequences. Withdrawal of participants from the study will have no impact on their treatment. Participants who withdraw from the study will not be replaced, because there is no place for them in the therapy groups, and it is not possible for parents and children to start at a later time during treatment. Should participants withdraw from the treatment, these parents and children will be followed according to the intention to treat principle. They will be asked fill in the questionnaires and the observational tasks.

DISCUSSION

This study aims to bridge the gap between clinical practice and scientific research (Kazdin, 2008). It examines mechanisms underlying change in psychotherapy for children exposed to IPV, explains how components of therapy work, and identifies moderators of treatment effects. The results, which are obtained in a RCT-study in collaboration with different trauma centers, will provide unique insights to improve clinical decision-making.

First, the RCT-design provides the best possible controls for evaluating the efficacy of psychiatric treatment. Rather than using a waiting list control group, the study zooms in on two parental components and mechanisms of change not yet investigated. All children receive TF-CBT, an established treatment for traumatized children (J. A. Cohen & Mannarino, 2008), including psycho-education, parenting skills, relaxation, affective expression and modulation, trauma narrative, and cognitive coping and processing.

Second, the study focuses on the efficacy of two IPV-related parental components added to TF-CBT. To date, research on effective components of treatment for post-traumatic stress disorder focused on trauma-oriented components (Wampold et al., 2010). Research on effective components of TF-CBT focused on the trauma-narrative (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011), on treatment lengths (Deblinger et al., 2011), and on inclusion of parents (King et al., 2000). Nevertheless TF-CBT is less effective for children exposed to IPV than for children otherwise traumatized (J. A. Cohen, Mannarino, & Iyengar, 2011). Children exposed to IPV are not only traumatized, but IPV also directly and indirectly affects their emotional, cognitive and behavioral responses. By considering this complexity this study provides important insights into the efficacy of specific IPV-related parental components. These insights are crucial to improve the treatment and maximize its effects for this specific target group (Deblinger et al., 2011).

The use of multiple informants (parent, child and teacher) and independent observations and interviews are likely to diminish reporting-bias. To pinpoint underlying mechanisms and assess the longer-term consequences of the intervention multiple data collections takes place, including a follow-up at 6 months after the end of treatment. This converging evidence will allow us to establish the reliability and validity of the collected information considerably.

A specific limitation of research on child abuse in The Netherlands is that by Dutch law, both custodial parents have to give informed and written consent to participation of their child in the study. Conflict between parents may extend to conflict about the participation of the child in treatment and scientific research, which may bias the sample of participants.

In short, the current RCT-study will enhance our understanding of the efficacy IPV-related parental components added to TF-CBT for children who have been exposed to IPV. It will illuminate mechanisms underlying change by considering multiple dimensions of child responses.

Trial status

The study protocol has been approved by the Medical Ethics Committee of the VU University Medical Center in Amsterdam, the Netherlands (METC VUmc 2011/101/NL39277.029.12). We just started to include children and parents and will be doing so for the coming four years. We expect the main results to be published in 2017.

Abbreviations

AEED: Autobiographical Emotional Events Dialogue; BRIEF: Behavior Rating Inventory of Executive Function; CBCL: Child Behavior Checklist; CDI: Children's Depression Inventory; IPV: Interparental violence; METC: Medical Ethics Committee; RCT: randomized clinical trial; TF-CBT: Trauma Focused-Cognitive Behavioral Therapy; YSR: Youth Self Report.

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Chapter 3

Interparental violence and the mediating role of parental availability in children's trauma-related symptoms

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ABSTRACT

This cross-sectional study examined the hypothesis that parental psychopathology in Interparental Violence (IPV) families crosses over to children, because parental psychopathology spills over to parental functioning. In a high-risk sample of IPV exposed families, we tested whether parental psychopathology spills over to parental availability, which, in turn, shows a crossover effect to children's trauma-related symptoms. The study population consisted of 78 IPV exposed children (4-12 years), and their 65 custodial parents referred to outpatient Children's Trauma Centers in the Netherlands for intervention. Consistent with our hypotheses, parental psychopathology was negatively related to parental availability, suggesting a spillover effect. Although parental psychopathology was not associated with children's trauma-related symptoms directly, we found evidence for the predicted indirect, crossover effects. We found an indirect crossover effect from parental psychopathology to children's trauma-related anxiety, depression, and anger, through the spillover effect of parental availability. Clinical implications for treatment and study limitations are discussed.

INTRODUCTION

Interparental violence (IPV) is both common and harmful. In the Netherlands, 12 children of every 1000, have witnessed IPV (Euser, Alink, Van IJzendoorn, & Bakermans-Kranenburg, 2013). Witnessing IPV or being physically involved in IPV may directly affect children's affective, behavioral, and cognitive responses, and their psychosocial adjustment and symptoms (Davies, Winter, & Cicchetti, 2006). In a meta-analysis, Evans, Davies, and DiLillo (2008) found a strong association between exposure to IPV and trauma-related symptoms in children. Because IPV involves the whole family system, it affects children's lives not only directly, but also indirectly, through the effects IPV has on their parents. Parents involved in IPV experience a broad range of emotional, psychological, cognitive, and behavioral consequences (Woods, 2005). IPV and parental psychopathology are associated with parenting stress and problematic parenting behavior (Levendosky & Graham-Bermann, 2000), which may amplify children's traumatic responses to IPV. This cross-sectional study among parents and children exposed to IPV sought to investigate this suggestion. Specifically, we examined whether parental availability mediates the link between parental psychopathology and children's trauma-related symptoms.

In the present article, we propose two ways by which IPV may impact parents and, thereby indirectly, children. Westman (2001), defines *crossover effects* as the interpersonal mechanism by which the psychological strain and stress of one person affect the level of psychological strain and stress of another person in the same social context. *Spillover effects* are defined as the intrapersonal mechanism by which stress experienced in one life-domain results in stress in another life-domain for the same individual. Extending this model to our research questions, we propose that IPV has crossover effects because parents' strain and stress may increase children's risk of posttraumatic stress. Further, we propose that IPV has spillover effects because parents' IPV-related stress and psychosocial adjustment spills over to their functioning as parents. Importantly, and third, we propose that the proposed spillover effect on parental functioning mediates the link between parental psychopathology and children's trauma-related responses, thereby explaining the predicted crossover effect. Specifically, we propose that, in IPV families, parental psychopathology crosses over to children because parental psychopathology spills over to their parental functioning by reducing their parental availability. Parental availability refers to parents' ability and motivation to direct psychological resources at the children (Danner-Vlaardingerbroek, Kluwer, van Steenbergen, & van der Lippe, 2013).

Crossover Effect: Parental Psychopathology and Children's Trauma-Related Symptoms

Ample research suggests that parental psychopathology crosses over to children's psychosocial adjustment. For example, different studies found that maternal depression is linked to negative child outcomes (Chronis et al., 2007; Cummings, Keller, & Davies, 2005; Luoma et al., 2001). Remission of maternal depression has been found to have a positive effect on both mothers and their children, whereas perpetuation of maternal depression has been found to have a negative effect on the rates of children's disorders (Weissman et al., 2006). Furthermore, Trickey, Siddaway, Meiser-Stedman, Serpell, and Field (2012) found in a meta-analysis that parental psychopathology is an important risk factor for children to develop posttraumatic stress symptoms. In a meta-analysis, Lambert, Holzer, and Hasbun (2014) found a moderate overall effect size ($r = .35$) for the association between parents' posttraumatic stress disorder severity and children's psychological distress. Also, higher levels of posttraumatic stress symptoms in refugee mothers were found to be associated with higher levels of psycho-social problems of their infants (Van Ee, Kleber, & Mooren, 2012) and children (Daud & Rydelius, 2009).

While direct links between parental psychopathology and child trauma are well-established, research suggests that parents' mental health may be more important to children's responses than the traumatic event itself. To illustrate, Lambert et al. (2014) found the effect of parental psychopathology on child trauma was larger when parent and child were both exposed to interpersonal trauma ($r = .46$) than when they both experienced another type of trauma (e.g., war; $r = .25$), or when only the parent experienced a traumatic event (e.g., combat veterans $r = .27$). Self-Brown et al. (2006) found that parental psychopathology was a moderator in the relation between community violence exposure and adolescent-rated PTSD, but not in the association between adolescent community violence exposure and depression. Additionally, parental psychological distress was strongly associated with both PTSD and depression in adolescents. These findings suggest that parents may play an important role in adolescents' risk for psychological problems above and beyond the mere experience of family and community violence (Self-Brown et al., 2006).

Extending existing research to IPV, parental psychopathology in IPV families is likely to cross over to their child(ren) by increasing children's trauma-related symptoms. In most studies on the proposed crossover described above, mothers reported on both their own psychopathology and the children's symptoms. In the present study, we obtained children's self-reports on their trauma-related symptoms because different symptom informants may have different perspectives on the child's symptomatology (Lanktree et al., 2008). In more formal terms, we advanced the following hypothesis:

H1: *More parental psychopathology in IPV families is associated with more trauma-related symptoms reported by the child(ren)*

Spillover Effects: Parental Psychopathology and Parental Availability

In IPV families, parental psychopathology may be especially harmful for children's trauma-related symptoms, in that it can be assumed to spill over to parenting behavior. Research consistently found that IPV and parental psychopathology are associated with problematic parenting behaviors and parenting stress (Levendosky & Graham-Bermann, 2000). Mothers who are exposed to IPV engage in more negative and less positive parenting than mothers who have not been exposed to IPV, and they are likely to use more harsh discipline towards their children (Osofsky, 2003). Also, experiencing IPV is associated with more aggression in the parent–child relationship (Appel & Holden, 1998), less supportive and less effective parenting, and less child-centeredness in parenting (Levendosky & Graham-Bermann, 2001). Moreover, marital conflict among parents, in both intact and divorced families, has been linked to diverse maladaptive parenting behaviors, such as lax control, psychological control, lower acceptance, less parental warmth, and increased parental rejection and withdrawal (e.g. Cummings et al., 2005; Fauber, Forehand, Thomas, & Wierson, 1990; Gonzales, Pitts, Hill, & Roosa, 2000). In line with these findings, Cohen, Hien, and Batchelder (2008) found that cumulative trauma among parents is a significant predictor of a range of adverse parenting outcomes, including parental abuse potential, punitiveness, and psychological and physical aggression.

Research suggests that mothers who have been exposed to IPV tend to underestimate the extent to which their child had been exposed to and was affected by the IPV (Cohen et al., 2008; Koren-Karie, Oppenheim, & Getzler-Yosef, 2008; Van Rooij, van der Schuur, Steketee, Mak, & Pels, 2015). One explanation for this effect, advanced in the literature, is that mothers exposed to IPV focus their attention on themselves and their own experiences rather than on their children (Koren-Karie et al., 2008; Pynoos, Steinberg, & Piacentini, 1999). Another explanation is that the children's behavior may serve as a reminder of mothers' own trauma, which may trigger avoidance among mothers (e.g., Lieberman, 2004). Consistent with these suggestions, mothers with traumatic experiences, show difficulties in adopting an open, non-defensive style when talking about emotions with their children (Koren-Karie, Oppenheim, & Getzler-Yosef, 2004).

Thus, theory and research provide indirect support for our suggestion that parental psychopathology spills over to parental functioning in IPV families, specifically parental availability. Following IPV, parents are likely to be preoccupied and overwhelmed by their own experiences, symptoms, and psychopathology. These psychological consequences of IPV are likely to spill over to the parenting domain by

reducing parental availability, parents' ability and motivation to direct psychological resources at the child. Thus, we expected:

H2: *More parental psychopathology in IPV families will be associated with less parental availability.*

The Mediational Role of Spillover Effects

Based on the above-described literature, we predict that in the aftermath of IPV, parental psychopathology spills over to their parenting by reducing their psychological availability, which, in turn, crosses over to children by increasing their stress. Theory and research in other areas provide indirect support for our suggestion. In the aftermath of exposure to trauma, the availability of parents is important for children to process and cope with their traumatic experiences. Some studies have examined the relationship between parental availability and child outcome in the aftermath of single trauma event. For example, Gil-Rivas, Silver, Holman, McIntosh, and Poulin (2007) found that adolescents' report of parental distress and parental unavailability were positively associated with their posttraumatic stress symptomatology 7 months after 9/11-related exposure to media. Similarly, Bokszczanin (2008) found that a lack of parental support predicted more posttraumatic stress symptoms among children after a single natural disaster. Kliewer, Lepore, Oskin, and Johnson (1998) found that violence exposure had the strongest effect on children's wellbeing when children had low parental support. Levendosky, Leahy, Bogat, Davidson, and von Eye (2006) argued that maternal mental health may be indirectly, negatively related to children's externalizing behavior problems via less parental availability. Trickey et al. (2012) found in their meta-analysis a large effect size for low social support as a risk factor for children to develop posttraumatic stress symptoms in the aftermath of trauma. This may be especially important for relatively young children (4-12 years), for whom parents represent their main source of social support.

Extending these findings to IPV, IPV may reduce parents' capacity to respond adequately to their children's needs and their motivation to support their children in processing traumatic experiences. In most IPV families, children are not only exposed to multiple traumatic events (e.g., witnessing verbal and physical violence among parents), they also have to cope with difficult family situations (e.g., physical child abuse, high conflict, lack of family cohesion) (Holt, Buckley, & Whelan, 2008). Given these multiple risks and challenges, parental availability seems especially important among children exposed to IPV.

Specifically, we expected:

H3: *More parental psychopathology in IPV families will be associated with more posttraumatic stress symptoms reported by their children, via reduced parental availability.*

The Present Study

The present study sought to test the advanced hypotheses in a sample of parents and young children exposed to IPV. To our knowledge, this is the first study to examine both the spillover and crossover effects of IPV, by investigating the indirect pathway from parental psychopathology to children's trauma-related symptoms through parental availability in a multi-informant study among parents and children who have been exposed to IPV. The proposed study contributes to existing research in multiple ways. Although studies provide support for the assumption that parental psychopathology is associated with child post-traumatic stress in different trauma contexts (e.g., among refugee families Daud & Rydelius, 2009), to our knowledge it has not yet been empirically tested in a multi-informant study among IPV families. Additionally, research has not yet examined the possibility that children's posttraumatic stress symptoms after exposure to IPV are, at least partly, explained by the lack of parental availability. This gap in our understanding of the aftermath of exposure to IPV is surprising in light of abundant evidence linking IPV to direct effects on children, and indirect effects on children via parents and parenting behavior.

METHOD

Participants

Participants were 78 children exposed to IPV (33 girls; mean age 8 years, 6 months, $SD = 29$ months, range 4.00-12.11 years) and their 65 custodial parents (age $M = 35.63$; $SD = 5.33$, range 26-49 years). The vast majority of children (94%) participated with their biological mother (79% Dutch and 76% single-parent). If siblings participated in the study ($n = 13$), both children were included with the same parent. A considerable number of families (47%) received an annual income below the poverty threshold (< 15,000€) for a single-parent family with two children in the Netherlands, although more than half of participating parents had a moderate level of education (55.7%).

Procedure

Parent–child dyads were recruited from three outpatient Children's Trauma Centers in different urban and rural regions of the Netherlands. Children were referred by the Dutch Youth Care Agency (Bureau Jeugdzorg) or a physician for therapy of the child after exposure to IPV. Families were approached to participate in the study when the child had been exposed to IPV, and the child was between 4 and 12 years of age. Based on clinical intake information participants in the IPV group were excluded when a) there was ongoing violence in the family; b) parent or child had an intellectual disability (IQ score approximately below 70, clinically assessed); and c) parent

or child were unable to complete the measures due to the inability to read or speak Dutch.

When parents received the written invitation for their clinical appointment, they also received a form to obtain permission to be contacted by a researcher to inform them about the study. If the parent agreed, the clinician sent the contact details to the researchers, who then contacted the parents. Parents provided informed and written consent for participating in the study as well as consent for access to their child(ren)'s treatment files. After obtaining informed and written consent by caregiver(s)/guardian(s) and by adolescents aged 12 years, participating parents and children filled out questionnaires in separate rooms before the start of the treatment, guided by two trained research assistants. The study was part of a larger ongoing study, of which only questionnaires relevant for our research questions are presented. To cover their travel expenses and as a reward for their participation, mothers received €25 for their participation. Children received a small gift (e.g., pen, game). The VU University Medical Ethical Committee approved the study protocol (NL39277.029.12).

In this study, 130 children and their parents were approached, and for 92 children the parents agreed to participate. In The Netherlands, both custodial parents or caregivers have to give consent for a child to participate in research and some parents, mostly mothers, did not want the other parent to be approached (no exact figures). The resulting sample consisted of 65 parents and 78 children, who filled in the questionnaires, a response rate of 60%. Due to missing values, the number of participants varies across the result section.

Measures

Family violence measures

In order to get an impression of the severity, chronicity and duration of the family violence in the sample we used different measures. To assess severity of the IPV exposure, parents are asked to fill out two scales 'Psychological assault' (8 items) and 'Physical assault' (12 items) of the *Revised Conflict Tactic Scales (CTS2)* (Straus, 2001). Parents were asked for those 20 incidents how often they and their (ex)partner engaged in this specific act, ranging from 1 *(never happened)* to 8 *(more than 20 times in the past year)*. For the total number of incidents by both the parent and their (ex) partner that had ever occurred in the relationship, we created an index of severity of IPV for psychological assault ($\alpha = .75$) and for physical assault ($\alpha = .85$). Chronicity of IPV exposure was calculated using the difference score between first time IPV as start-date and last time IPV as end-date, and when this time span was longer than the child's age, then the time from birth till last time IPV was calculated. To assess whether children have been exposed to other forms of child abuse, besides to IPV,

the parents were asked to fill out three scales ('Physical assault towards the child' [α = .55], 'Psychological aggression towards the child' [α = .60], and 'Nonviolent discipline' [α = .70] of the *Conflict Tactics Scales Parent–Child (CTSPC) (Straus, 2001)*. For each topic, parents were asked to rate on a 8-point scale how often they and how often their (ex)partner engaged in this specific act, ranging from 1 (*never happened*) to 8 (*more than 20 times in the past year*). Parents also filled out the *Parent Report of Traumatic Impact* (Friedrich, 1997) to assess other potentially traumatic events in the child's live. We calculated a total score of a range of 21 reported life events, such as suicide attempts of a parent, moving houses, divorce, hospitalization of the parent. To assess the background of the parents they filled out the *Adverse Childhood Experience Questionnaire* (Felitti et al., 1998).

Parental availability

We used the eight items of the *Daily Psychological Availability Scale* (Danner-Vlaardingerbroek, Kluwer, van Steenbergen, & van der Lippe, 2013) adapted for the parent–child relationship to assess parental availability for the child. An example item is: "When I was with my child last week, I really wanted to know how my child was feeling" (1 = *totally disagree* to 7 = *totally agree*). According to Danner-Vlaardingerbroek et al. (2013), the psychological availability has good internal consistency, with a Cronbach alpha coefficient reported of .78 for both fathers and mothers. In the current study, the Cronbach alpha coefficient was also .78. Sum scores were constructed, a higher score on this scale represents more psychological availability for the child, as reported by parents.

Parental psychopathology

The *Young Adult Self-Report* (YASR; Aachenbach, 1997) was used to assess psychopathology symptoms in parents. We used the short version of 29 items in our study to limit the amount of time needed to fill out the questionnaire. Previous research has shown that the YASR discriminated well between referred and non-referred subjects (Wiznitzer, 1993). Items are rated on a 3-point scale (0 = *not true*, 1 = *somewhat or sometimes true* and 2 = *very true or often true*). Reliability and validity of the Dutch version are good (Wiznitzer et al., 1992). In the current study, the Cronbach alpha coefficient was .92. Sum scores were constructed, a higher score on this scale represents more parental psychopathology.

Posttraumatic stress symptoms among children

To assess posttraumatic stress symptoms among children, we used the *Trauma Symptom Checklist for Children* (TSCC; Briere, 1996); Dutch translation: *Trauma Symptoom Controle Lijst voor Kinderen* (Bal, 1998)). The TSCC is a questionnaire

to assess self-reported posttraumatic stress symptoms among children (8-17 years). It consists of 54 items, clustering in eight scales: two validity scales (underresponse, hyperresponse) and six clinical scales (anxiety, depression, PTSD, dissociation, anger, and sexual concerns). Items are rated on a 4- point scale (1 = *not at all* to 4 = *very often*). Reliability has been found to be high, with Cronbach alpha's ranging from .78 to .86 in a sample of sexually abused children (Briere, 1996). In a sample of maltreated children in the United States, the TSCC showed discriminant and convergent validity with the Trauma Symptom Checklist for Young Children (TSCYC; Lanktree et al., 2008). In the current study, we used the four clinical scales that are most commonly used to assess symptoms following traumatic experiences among children (Cronbach's alpha in this study: anxiety $\alpha = .87$, depression $\alpha = .87$, anger $\alpha = .89$, and posttraumatic stress $\alpha = .87$). A higher score on the scales represents more anxiety, more depression, more anger, and more posttraumatic stress for the child.

Statistical Analyses

Descriptive analyzes explored the sample on IPV characteristics, on forms of child abuse and neglect, and on other potentially traumatic experiences. A zero-order correlation matrix described the associations between parental psychopathology, parental availability and child-reported posttraumatic stress symptoms. We used ordinary least squares path analysis to conduct a simple mediation analysis. All analyzes were conducted in IBM SPSS Statistics version 21 (IBM, 2012), in which we used macro PROCESS for mediation analyzes, model 4 (Hayes, 2013).

RESULTS

Descriptives

IPV characteristics

IPV duration was available for a subset of children ($n = 28$). On average, children were exposed to IPV for more than five years ($M = 5.37$; $SD = 2.89$; range 0.59-12.00). Parental reports on the CTS2, CTSPC, and PRTI were available for 61 children. The three most common forms of psychological aggression between parents (CTS2: Straus, 2001) were 'My partner insulted or swore at me' (97.2%), 'My partner shouted at me' (94.5%), and 'I shouted at partner' (84.9%). The three most common forms of physical assault between parents were 'My partner pushed or shoved me' (83.1%), 'My partner grabbed me' (83.1%), and 'My partner kicked me' (77.5%). The highest self-reported physical assault was 'I pushed or shoved my partner' (42.3%). As regards other forms of child abuse (CTSPC: Straus, 2001), approximately half of

the children experienced minor forms of physical assault by both parents (52.9% ex-partner, 42.3% participating parent), and nearly half of the children experienced severe forms of psychological aggression by one of the parents (47.1%) and minor forms of psychological aggression by the participating parent (57.7%). Nearly all children experienced a divorce of the parents (93.2%), more than a third had a parent who was imprisoned (35.4%), and more than two third had experienced several moves (68.9%) (PRTI: Friedrich, 1997). Thirty percent of participating parents had experienced four or more adverse childhood experiences themselves, which is known as the cutoff point for several health risk behaviors and psychological and physical diseases in adulthood (Felitti et al., 1998).

Zero-order correlations

Means, standard deviations, and bivariate correlations are presented in Table 1. For 71 children, parents filled out the YASR, 66 parents filled out the PA, and 40 children reported on the TSCC. Compared to previous research, both parents and children, scored relatively low on psychopathology (Cascardi, O'Leary, & Schlee, 1999) and trauma-related symptoms, respectively, and parents scored relatively high on parental availability. Low scores for the trauma-related symptoms may partly be explained by underreporting of the children; 44.6% of the children had an underscore on the TSCC, suggesting that those children probably had more symptoms than they reported (Briere, 1996). No child had a hyper-score on the TSCC.

Table 1. Descriptives and Zero-order Correlates of all Study Variables

	M (SD)	Min - Max	1.	2.	3.1	3.2	3.3
1. Parental Psychopathology	13.14 (10.40)	0 - 40					
2. Parental Availability	6.07 (0.75)	4.13 – 7.00	– .34**				
3. Symptomatology children							
3.1 Anxiety	47.89 (13.63)	32 - 92	.26	–.53**			
3.2 Depressive	46.73 (12.09)	32 - 80	.35*	–.53**	.87**		
3.3 Anger	47.28 (11.63)	33 - 78	– .08	–.23	.58**	.58**	
3.4 Posttraumatic stress	48.53 (10.87)	34 - 72	.05	–.23	.75**	.75**	.62**

Note. Confidence intervals: *$p < .05$; **$p < .01$

As expected, higher self-reported parental psychopathology was significantly related to more depressive symptoms reported by the child ($r(35) = .35$, $p = .033$). Contrary to our expectations, results of bivariate correlations among study-related variables showed that the level of parental psychopathology was not significantly related to children's self-reported post-traumatic stress symptoms, anxiety symptoms, and symptoms of anger. Importantly, parents with higher self-reported psychopathology

were significantly less available as a parent ($r(63) = -.34$, $p = .005$), and less parental availability was significantly related to more child-reported anxiety ($r(31) = -.53$, $p = .001$) and depressive symptoms ($r(31) = -.53$, $p = .002$). There was no significant relation between parental availability and posttraumatic stress and anger symptoms in children. Low sample size in these above correlations between parental reports and children's reports are due to children's age filling out the TSCC, only children eight years and older did fill out this questionnaire.

Parental Availability as a Mediator

Simple mediation analyzes using ordinary least squares path analysis yielded that parental psychopathology indirectly influenced children's report of anxiety, depression, and anger symptoms through its effect on parental availability. As presented in Table 2, parents with higher scores on psychopathology scored lower on parental availability ($a = -.031$, $p = .024$), and when parents scored lower parental availability, children scored higher on child-reported anxiety symptoms ($b = -10.34$, $p = .003$), depressive symptoms ($b = -8.179$, $p = .006$) and anger symptoms ($b = -5.694$, $p = .057$). Parental availability was not significantly related to child-reported posttraumatic stress symptoms ($b = -4.575$, $p = .101$). We calculated bias-corrected bootstrap confidence intervals estimated based on 50,000 bootstrapped samples and a 95% confidence interval. The indirect effects (ab) of parental psychopathology through parental availability on children's self-reported depression, anger and anxiety symptoms, respectively, did not include zero (for more details see Table 2), which indicates that effects are significant. In contrast, we did not find an indirect effect for children's posttraumatic stress symptoms (Table 2).

Table 2. Parental availability (PA) as a Mediator Between Parental Psychopathology (PP) and Child Reported Symptoms (n = 30 dyads)

		95% CI				
Model	*ab*	*LL*	*UP*	k^2	*c*	*c'*
PP → PA → Anxiety symptoms	0.32	0.01	0.69	.22	.27	−.05
PP → PA → Depressive symptoms	0.25	0.26	0.66	.20	.34	.09
PP → PA → Anger symptoms	0.17	0.01	0.56	.15	.22	.39
PP → PA → Posttraumatic Stress Symptoms	0.14	−0.02	0.50	--	−.07	−.21

Note. Unstandardized regression weights are presented. k^2 represents kappa, an effect size measure for indirect effects. *c* represents the direct effect of parental psychopathology on children's symptoms. *c'* represents the direct effect of parental psychopathology on children's symptoms, controlling for parental availability.

To examine the robustness of our findings, we repeated the reported analyses for multiple sub-samples: 1) inclusion of only the eldest children of the families to examine effects of statistical interdependence; 2) mothers as participating parents; 3)

dyads which filled out all three questionnaires; and 4) without children who had an underscore on the TSCC. Given that these selections reduced statistical power, some of the reported findings in the subsample became non-significant. Nevertheless, all results maintained the same direction.

DISCUSSION

This study examined one underlying mechanism to explain an expected crossover effect in IPV families from parental psychopathology to children's trauma-related symptoms. We hypothesized that this effect could be explained by the spillover hypothesis that parents with more psychopathology would be less available as a parent. Our hypotheses were partly supported by the results. Consistent with our expectations, we did find that reduced parental availability explained the crossover effects from parental psychopathology to children's depressive, anxiety and anger symptoms, but not to children's posttraumatic stress symptoms. Given the relatively small sample size, it is important to interpret the results regarding the crossover and mediational effects with caution. In light of the different calculations that we conducted on the various compositions of the sample, we feel confident that the results are robust, however. Nevertheless, research including larger samples would be promising not only to replicate our findings, but also to investigate moderators such as child age and gender. To illustrate, girls, compared to boys, have been found to be more dependent on the relationship with their parents and more in need of emotional support from their caregivers (e.g., Geuzaine, Debry, & Liesens, 2000).

Crossover Effects

Consistent with previous literature and our crossover hypothesis, we found that parental psychopathology and children's depressive symptoms were positively related (Chronis et al., 2007; Connell & Goodman, 2002; Luoma et al., 2001). In contrast to other research, in this study we found no direct association between parental psychopathology and children's anxiety (Connell & Goodman, 2002), anger (Connell & Goodman, 2002), and posttraumatic stress symptoms (Trickey et al., 2012). The lack of a direct link between parental psychopathology and children's trauma-related anger is consistent with the suggestion that maternal mental health may be indirectly, negatively related to children's externalizing behavior problems (i.e. agression, negative emotional reactivity, and activity) via less parenting effectiveness (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). Nevertheless, the lack of findings also differs from existing studies. One possible explanation may be that we used two informants, both parents and children, to report their own symptoms. In former studies (Dehon

& Weems, 2010), parents did not only report their own symptoms, but they also reported child symptoms. As Kassam-Adams, Garcia-Espana, Miller, and Winston (2006) showed, parents' own responses to a potentially traumatic event appear to influence their assessment of child symptoms. In their study, as compared to children's self-report, parents with an Acute Stress Disorder (ASD) overestimated child ASD, and parents without ASD underestimated child ASD (Kassam-Adams et al., 2006).

Another explanation may be that the level of parental psychopathology was relatively low compared to a sample of physically abused women (Cascardi et al., 1999). The relative low levels of parental psychopathology in this sample may be due to sample bias; In The Netherlands both parents have to give informed consent for their child to participate in research. It is possible that families who were better adjusted more often participated in our study. Families, particularly mothers, with more problems (e.g., financial hardship, lack of social support, parental psychopathology) may not have had the energy, courage, or feelings of safety to contact the other parent to ask for permission for research participation of the child.

Lastly, a methodological issue may be at play. To measure parental psychopathology, we used the Young Adult Self Report (shortened version), in which most items tap depressive symptoms, and fewer items tap anxiety, anger, and posttraumatic stress symptoms. Crossover effects for psychopathology may be more likely for symptom-specific assessments. To illustrate, parental depression is typically related to children's depressive symptoms and parental anxiety to children's anxiety symptoms, and both parental depression and anxiety are not directly related to children's anger (Weissman, Leckman, Merikangas, Gammon, & Prusoff, 1984). Future research should include measures that parallel parent and child symptoms to examine these possibilities.

Spillover Effects

In line with our spillover hypothesis, parental psychopathology was negatively related to parental availability, suggesting that strain and stress in the mental health domain of parents spill over to the domain of parenting. Extending the current literature demonstrating relations between IPV, parenting behavior, and a deteriorated parent–child relationships (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002), this study showed that parental psychopathology in IPV families is negatively related to parental availability. It may be that parents exposed to IPV are so absorbed by their symptoms that they do not have the physical, mental, and/or emotional resources (e.g., energy, time, or empathy) to be available for their children (c.f. Lieberman, Van Horn, & Ozer, 2005). To be able to show an open and non-defensive attitude when talking about emotions with their children, it is helpful to parents if they have an open and non-defensive attitude towards their own feelings (Koren-Karie et al., 2004). This openness may be difficult for parents with depressive or anxiety symptoms. For

future research, it might be interesting to use an observational measure, and examine behavioral cues of openness and parental availability in the parent–child relationship. Studies investigating whether and how children discern behavioral cues of parental availability would be particularly promising.

Mediational Effect of Parental Availability

Our third hypothesis that the crossover effect of parental psychopathology on children's trauma-related symptoms can be explained by the spillover effect of parental psychopathology to parental availability was only partly confirmed. We did find an indirect effect for children's trauma-related anxiety, and depressive and anger symptoms. It is possible that children's anger and anxiety following IPV are, at least partly, directed at the parent 'as a parent' rather than at the parent 'as a victim of interparental violence with psychopathology'. Our results suggest that children's emotional reactions may not necessarily be attributable to the parent's psychological functioning and mental health, but at the parent not being available, not being responsive, and recognizing children's needs. In future research, it would be important to further specify whether and how different domains of adult functioning (e.g., psychological, physical, parental, relational) determine children's reactions to IPV, and thus are responsible for possible crossover effects between parents and children trauma symptoms in IPV families.

In contrast to what we expected based on the existing literature (Bokszczanin, 2008; Gil-Rivas et al., 2007; Kliewer et al., 1998), our results partly failed to provide support for our third hypothesis, namely that parental psychopathology has an indirect effect on children's PTSD via parental availability. There are three possible explanations for this difference in findings. First, there are a multitude of additional processes (e.g., direct effects of IPV on children; effects of severity and duration of earlier traumatic experiences on children) which put children at risk for posttraumatic stress symptoms that were not measured in this study (Trickey et al., 2012). Medium to large effect sizes for risk factors for children to develop posttraumatic stress symptoms were shown for factors relating to subjective experience of the IPV experience (e.g., perceived threat) and post-trauma variables (e.g., children's post-trauma cognitions of the traumatic experiences) (Trickey et al., 2012). Second, earlier studies used children's self-reports of parental availability (Bokszczanin, 2008; Gil-Rivas et al., 2007; Kliewer et al., 1998) instead of parental reports. Children may perceive parental availability differently and more negatively than their parents (Bokszczanin, 2008; Gil-Rivas, 2007). And last but not least, availability, as measured in this study, is about the parent's capacity to be psychologically present to the child and to be able to spend time with the child. Other types of parental availability may be necessary to help children cope with post-traumatic stress. To illustrate, Meiser-Stedman

(2002) suggested that for children to cope with traumatic stress, they need to form a coherent memory of the traumatic event represented in a verbal format. Parents can support this type of coping by communicating about the traumatic events with their child. Nevertheless, this specific type of parental availability requires the capacity of parent and child to compose a coherent emotional story. To compose such a story, parents need to be able to verbalize emotional experiences in a developmentally adequate way, which was not assessed by our measure of parental availability. Future research on the characteristics of emotional dialogues between parents and children in IPV families compared to non-violent families may be important to further our understanding of the role of different dimensions of parental availability for children's PTSD symptoms, particularly in response to IPV.

Research Strengths and Limitations

Several limitations of this study should be taken into account. First, the cross-sectional nature of the study prevents us from drawing conclusions about the directionality of the effects. Longitudinal research provides initial evidence for a link from parental depression to psychopathology in children (Gunlicks & Weissman, 2008), but also yields bidirectional parent–child effects between parental depression and child adjustment (Elgar, McGrath, Waschbusch, Stewart, & Curtis, 2004). Although we provided theoretical arguments for the proposed pathways, and our results suggest that these are plausible, future research investigating the direction of effects between parental psychopathology and child psychopathology in high-risk IPV families are important. Prospective, longitudinal designs would be particularly promising.

The findings of this study are limited to this sample of families – those families who were willing to seek help, families in which both parents gave informed consent to participate, and families with a low socioeconomic status (SES). Other factors may contribute to spillover effects on parental availability (e.g., living in poverty, household chaos, single parenthood), which may also contribute to trauma-related symptoms among children. Longitudinal research and a more complete assessment of the full range of potential crossover and spillover effects is necessary to enhance our understanding of the multiple factors and their interplay in children's trauma-related symptoms. This is necessary to identify the optimal starting point for intervening in IPV families.

Clinical Implications

Our findings highlight the role of parental availability for children's recovery from IPV experiences. Because parental availability was found to be debilitated by parental psychopathology, our results suggest that treatments for children, such as cognitive behavioral therapy or Eye Movement Desensitization and Reprocessing (EMDR),

may be enhanced by including treatment and/or treatment components for parents. Reducing parental psychopathology, and increasing parental availability among IPV parents may enhance the efficacy of trauma-focused treatment for children in IPV families. To this end, Visser, Leeuwenburgh, and Lamers-Winkelman (2006) developed a *preparatory psycho-educational program* for parents which precedes children's treatment. The preparatory program is aimed to increase parental availability and insightfulness in their children's needs. Parents are coached to read their children's behavioral and emotional signals accurately and to adequately respond to these signals. The effectiveness of this treatment component is currently investigated (Visser et al., 2015).

Our results further suggest that services that support parents exposed to interpersonal violence (women shelter, psychiatric clinics) may contribute to the recovery of parents and their children by not only addressing parents' psychopathology but also raising awareness of parents' psychological resources to support their children in the aftermath of domestic violence (Diderich et al., 2013). Treatments of parents exposed to IPV focusing not only on the reduction of IPV-related psychopathology but also taking parenting skills and parental availability into account may directly and indirectly contribute to the recovery of children exposed to IPV. Derived from our questionnaire, a clinician could for example ask a parent: "Were you in the mood to undertake anything with your child last week?" or "Were you fully open to what your child wanted to tell you last week?" (Danner-Vlaardingerbroek et al., 2013). Again, we would like to emphasize these suggestions should be used with caution, given the relative small sample size and the cross-sectional design of the study.

Concluding Remarks

The crossover of stress of parental psychopathology to children's trauma-related symptoms may result from different processes. In the current study, we focused on parental availability as one mechanism to explain the crossover effect of parental psychopathology to child symptoms in high-risk families with multiple informants. Parental availability seems to be important to reduce children's IPV-related depressive, anxiety, and anger symptoms, and highlight that to recover from IPV exposure, children may need their parents' help. Greater knowledge as to the parental mechanisms that facilitate the reduction of posttraumatic symptoms among children is essential to providing effective treatment for children exposed to IPV and will be of great benefit to professionals.

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Chapter 4

Mother–child emotion dialogues in families exposed to interparental violence

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ABSTRACT

This cross-sectional study examined the hypothesis that parent–child emotion dialogues among Interparental Violence (IPV) exposed dyads ($n = 30$; children's age 4–12 years) show less quality than dialogues among non-exposed dyads ($n = 30$; 4–12 years). Second, we examined whether parental posttraumatic stress symptoms and parental adverse childhood experiences (ACE) were associated with the quality of the dialogues. As expected, in the IPV-exposed group, mother–child emotion dialogues were of lesser quality, they more often showed a lack of elaboration compared to dialogues in the non-exposed group. Additionally, exposed mothers showed less sensitive guidance, and children showed less cooperation and exploration then mothers and children in the non-exposed group. Although maternal posttraumatic stress symptoms and maternal history of ACEs were significantly higher in the IPV-exposed families than in the non-exposed families, these variables were not associated with the quality of emotion dialogues. Clinical implications and study limitations are discussed.

INTRODUCTION

Exposure to Interparental Violence (IPV) has considerable direct effects on children. Children exposed to IPV are at risk to develop posttraumatic stress symptoms and internalizing and externalizing behavior problems (Evans, Davies, & DiLillo, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003). An important protective factor for children in the aftermath of IPV exposure is the parent–child relationship (Afifi & MacMillan, 2011). For children to process difficult and even traumatic life events, it is important to form a coherent narrative of the events (Cohen, Mannarino, & Murray, 2011). Parent–child relations in which children feel safe to give meaning to the traumatic events may enhance their recovery (Fivush, 2007). In IPV-exposed families, talking about the traumatic events may be a problem because IPV affects the family system as a whole. Therefore, parents as well are at risk for posttraumatic stress symptoms and other forms of psychopathology (Campbell, Kub, Belknap, & Templin, 1997; Cascardi, O'Leary, & Schlee, 1999). This vulnerability, in turn, may negatively affect parenting and the parent–child relationship (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003), and thus, the impaired parent–child relation may impede children's narrative formation.

Although there has been a concerted research effort to determine the direct and indirect effects of IPV on children's functioning (Buehler & Gerard, 2002; Davies, Winter, & Cicchetti, 2006; Hungerford, Wait, Fritz, & Clements, 2012), little is known about the capacity of IPV-exposed parent–child dyads to talk about emotions and to compose coherent narratives about emotional events in children's lives. In the present study, we compare emotion dialogues in parent–child dyads between IPV-exposed and non-exposed families. Additionally, we examine the role of parental posttraumatic stress and parents' own history of adverse childhood experiences in parent–child emotion dialogues.

Parent–Child Emotion Dialogues

In recent years, several studies have underlined the importance of parents' capacity to engage with their child in a sensitive and emotionally expressive way in the reminiscence of emotional events for children's cognitive and socio-emotional development (e.g., Fivush, Haden, & Reese, 2006). For example, high quality of parent–child emotion dialogues is related to children's secure attachment (Fivush & Vasudeva, 2002; Laible, 2011), effective emotion regulation skills (Laible, 2011), positive self-image (Goodvin & Romdall, 2013), a realistic view of how to relate to others and to the world (Fivush, 2007; Laible, 2011), and effective coping mechanisms (Goodvin & Romdall, 2013; Laible, 2011).

Quality of parent–child emotion dialogues is not only related to a healthy socio-emotional development, but also to children's mental health (Fivush, Marin, McWilliams, & Bohanek, 2009; Fivush & Sales, 2006). For example, Fivush et al. (2009) found that a more engaged contribution of mothers to mother–child emotion dialogues about conflict-events resulted in lower child internalizing and externalizing behavior problems. More generally, parent–child relationship quality has been related to internalizing (Brumariu & Kerns, 2010; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012), and externalizing behavior problems (Buist, Deković, Meeus, & van Aken, 2004; Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010; Groh et al., 2012).

The impact of experiences on children's feelings of security, development, and mental health depends on the meaning children ascribe to these experiences (Oppenheim, 2006). Children need their parents to co-construct and give emotional meaning to experiences (Tronick & Beeghly, 2011). By reminiscing past events, parents help their children to understand themselves emotionally and the world surrounding them (Fivush, 2007).

Reminiscing about past events between parents and children in emotion dialogues may serve different goals, depending on the positive or negative emotional meaning of the event. In reminiscing about positive events, parents may stimulate social and emotional bonding by sharing history (Fivush, 2007). In reminiscing about stressful events, parents may help their child understand what happened, why it happened, and what the child can do to avoid such negative experiences and events in the future (Fivush, 2007). Especially reminiscing about negative and stressful events seems to be important for children's coping skills, their emotion regulation skills, and to diminish the development of internalizing and externalizing behavior problems (Fivush & Sales, 2006).

Given the inherently dyadic nature of emotion dialogue, not only is parental contribution important, but also the children's contribution to the dialogue is important when studying parent–child emotion dialogues. Both parents (Fivush, 2007; Fivush & Sales, 2006), children (Gentzler, Contreras-Grau, Kerns, & Weimer, 2005), and even families (Bohanek, Marin, Fivush, & Duke, 2006), may differ in reminiscing styles. For example, elaboration, that is, the parents' ability to engage in rich, detailed and coherent emotion dialogues, is studied extensively and is one of the critical dimensions in reminiscing styles along which parents vary (Fivush, 2007; Fivush et al., 2006). Other critical dimensions of parents' contributions are the level of engagement (Fivush & Sales, 2006), emotional expressiveness (Fivush & Sales, 2006), emotional coaching (Ellis, Alisic, Reiss, Dishion, & Fisher, 2014), and explaining (Fivush & Sales, 2006). Children may differ in emotional openness and involvement (Gentzler et al., 2005), as well as coping abilities (Amato & Afifi, 2006). Also, parents

and children mutually influence and accommodate to each other during emotional dialogues (Fivush et al., 2006; Fivush & Sales, 2006), and dialogues are shaped by the quality of the parent–child relationship. Parents who support and guide their children sensitively when talking about emotions help them to organize and understand experiences, which promotes a secure psychological base for children (Koren-Karie, Oppenheim, Haimovich, & Etzion-Carasso, 2003). To illustrate, secure attachment in infancy is related to high-quality emotion dialogues among children aged 4.5 and 7.5 years (Oppenheim, Koren-Karie, & Sagi-Schwartz, 2007). The more secure children feel, the higher levels of child cooperation and exploration they show (Hsiao, Koren-Karie, Bailey, & Moran, 2015). So, to examine the impact of IPV on parent–child emotion dialogues, it is crucial to observe the parent, the child, and the parent–child interaction.

Parent–Child Emotion Dialogues and Exposure to Interparental Violence

For children to process traumatic events, like exposure to IPV, they need their parents to make meaning of their experiences (McDonald, Jouriles, Rosenfield, & Leahy, 2012). Empirical evidence consistently shows that children's understanding of the meaning of IPV experiences is important for their psychosocial adjustment (e.g., Grych, Harold, & Miles, 2003; Sturge-Apple, Davies, Winter, Cummings, & Schermerhorn, 2008). Also, diverse indicators of effective parenting behavior and better quality of the parent–child relationship have been linked to more positive child adjustment in the aftermath of exposure to IPV (Afifi & MacMillan, 2011; Holt, Buckley, & Whelan, 2008; Hungerford et al., 2012; Levendosky et al., 2003). Furthermore, parental support is a strong predictor of positive trauma-focused treatment outcomes in traumatized children (Cohen & Mannarino, 2000), and sensitive parental guiding in parent–child emotion dialogues stimulates children's ability to process stressful experiences (Fivush, 2007). This may especially be important in families exposed to IPV.

Although the benefits of parent–child emotion dialogues for children to process stressful experiences have been well-established, these dialogues may be challenging in IPV families because of the differential effects IPV has on all family members. For example, both parents and children have an advanced risk for posttraumatic stress symptoms (Cascardi et al., 1999; Evans et al., 2008). Due to posttraumatic stress symptoms, like hyperarousal, intrusions, avoidance, and numbing (Taylor, Kuch, Koch, Crockett, & Passey, 1998), it may be very difficult for parents to sensitively guide the child, and for the child to cooperate in parent–child emotion dialogues and to explore the emotional meaning of stressful events freely.

In particular, the impact of maternal posttraumatic stress symptoms may have significant implications for parent–child emotion dialogues. Koren-Karie, Oppen-

heim, and Getzler-Yosef (2004) showed that lower levels of maternal resolution of trauma is associated with over- or under-structuring, rigid and inflexible interaction, lack of attunement and empathy, and emotional dysregulation in the joint narrative between mother and child. Also, traumatized mothers may be less engaged in the dialogues because they need to focus their attention on themselves rather than on their children. Children's emotions may be a reminder of their own trauma which may trigger avoidance (Lieberman, 2004). A study of mother–child dyads in which mothers were traumatized by war, but children were not exposed to war, showed that maternal posttraumatic stress symptoms were negatively associated with parent–child relation quality, and children showed lower levels of responsiveness and involvement in mother–child interactions (Van Ee, Kleber, & Mooren, 2012).

In addition to the high risk of maternal posttraumatic stress in IPV-exposed families, research also shows that parents in these families often have been exposed to adverse childhood experiences (ACE themselves (Bensley, Van Eenwyk, & Simmons, 2003). Parents exposed to ACEs are at increased risk to develop psychopathology (Anda et al., 2006), and parental psychopathology has been shown to be a risk factor for negative parenting and lower parent–child relation quality (Levendosky & Graham-Bermann, 2000). Lieberman, Van Horn, and Ozer (2005) showed a negative association between maternal life stress and quality of the parent–child relationship. Unresolved maternal child abuse experiences are related to difficulties in talking about emotions with their children (Koren-Karie et al., 2004). So, both parental posttraumatic stress and parental exposure to ACEs may contribute to the quality of the parent–child emotion dialogue in IPV families.

Despite the recognized importance of parental support in children's processing of traumatic experiences in IPV-exposed families through emotional narratives and dialogues, empirical research on parent–child emotion dialogues in these families is scarce. Knowledge about the specific dynamics between parents and children in their emotion dialogues may point to important clinical insights for trauma-focused treatment.

Current Study

To enhance our understanding of the impact IPV has on parent–child emotion communication, in the present study, we compare the quality of emotion dialogues in parent–child dyads between IPV-exposed and non-exposed families. Given the effects of IPV on parents, children, and the parent–child relationship, we hypothesize, first, that the quality of emotional dialogues among IPV-exposed mother–child dyads will be lower than the quality of emotional dialogues among dyads who have not been exposed to IPV. Second, we will examine the role of parental posttraumatic stress and parents' own history of adverse childhood experiences on the quality of

parent–child emotion dialogues. Based on the existing literature, we hypothesize that IPV-exposed parents show more post-traumatic stress and have more ACEs than non-exposed parents. Furthermore, we expect that parental posttraumatic stress and parental ACEs will further undermine emotional dialogues among IPV-exposed dyads.

METHOD

Participants

Participants were 30 children exposed to IPV (13 girls; mean age 8 years, 11 months, *SD* = 24 months, range 4.2-12.11 years) and their mothers (29 biological and one adoptive mother) and a control group of 30 non-exposed children (13 girls; mean age 9 years, 1 months, *SD* = 24 months, range 4.5-12.6 years) and their mothers. No siblings participated in the study. Since only mothers participated in our study, from now on the manuscript is about mothers instead of parents.

To be able to compare the IPV-exposed group with a control group, one child between 4 and 13 years old was selected in the IPV-exposed group, which we could best match with a child in our control group on gender and age. All mothers signed fully informed consent and children gave assent, as approved by the VU University Medical Ethical Committee (NL39277.029.12). As a reward for their participation and to cover travel expenses, mothers received €25. Children received a small gift (e.g., ball, pen, game).

Procedure

This study is part of a larger longitudinal study examining the efficacy of two parental components of an intervention for IPV-exposed children. Only measures relevant for our current research questions are presented.

Mother–child dyads in the IPV-exposed group were recruited from three outpatient Children's Trauma Centers in different urban and rural regions of the Netherlands. Between 2012 and 2015, children were referred to the centers by a physician or by the Dutch Youth Care Agency for the treatment of the child after exposure to IPV. Mothers were asked to participate in the study when the child had been exposed to IPV, and the child was between 4 and 12 years of age. Certificated clinicians gathered information and participants were excluded when 1) violence was still going on in the family; 2) child or mother had an intellectual disability (IQ score clinically assessed and approximately below 70); and 3) child or mother were unable to fill out questionnaires or participate in the observational measure due to the inability to read or to speak Dutch.

The non-exposed group was recruited through the social network of students and research assistants. Exclusion criteria were 1) child or mother had an intellectual disability (self-reported); 2) child or mother was unable to fill out questionnaires or participate in the observational measure due to the inability to read or to speak Dutch.

Trained research assistants visited each family of the IPV-exposed group in the Trauma Center or at home, and each family of the non-exposed group in their home. Mother–child dyads completed the Autobiographical Emotional Events Dialogues (AEED, see below). After the dyad had completed the AEED, mothers were asked to complete a set of questionnaires.

Measures

Family violence measures

The degree and type of IPV was assessed by use of the Dutch translation (translated by Lamers-Winkelman, 2005) of the Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). For each item, mothers were asked to rate whether and how often this specific tactic was used, either by themselves or by their partner, in a conflict situation in the last year of the (violent) relationship, ranging from 1 (*never happened*) to 8 (*more than 20 times in the last year*). Frequency scores (range 0 – 25) were calculated for the amount of psychological aggression (8 items) and physical aggression (12 items). Internal consistency for psychological violence was .76 for self-used and .89 for partner-used psychological violence. Internal consistency for physical violence was .62 for self-used and .96 for partner-used physical violence.

Autobiographical Emotional Events Dialogues (AEED)

In this method, mothers and children recall and describe autobiographical events during which the child felt happy, sad, angry, scared, and proud. In our study, dyads received five cards, depicting an emoticon and the accompanying feeling. They were asked to remember an event in which the child experienced each feeling and to construct a story about each event together. The conversations lasted between 5 and 15 minutes and were transcribed verbatim. To ensure that dialogues were coded unaffected by non-verbal cues and behavior, dialogues were coded using the transcripts (Koren-Karie, Oppenheim, Carasso, & Haimovich, 2003, p. 350). Koren-Karie, Oppenheim, Carasso, et al. (2003) developed a coding system for these dialogues. The coding includes seven scales for the mother (*Shift of focus*, *Boundary dissolution*, *Acceptance and tolerance*, *Hostility*, *Involvement and reciprocity*, *Closure of negative feelings*, and *Structuring of the interaction*), seven parallel scales for the child (*Shift*

of focus, *Boundary dissolution*, *Acceptance and tolerance*, *Hostility*, *Cooperation and reciprocity*, *Resolution of negative feelings*, *Elaboration of the stories*), and two scales assessing the overall quality of the dialogue (*Adequacy of the stories* and *Coherence*). Every scale ranges from 1 to 9, with higher scores indicating more enactment of the specific behavior. To increase statistical power, two composite scores (mean of all relevant subscales) were calculated to reflect mothers' and children's contribution to the dialogues (Koren-Karie, Oppenheim, & Getzler-Yosef, 2008). Internal consistency of the maternal scales (*Maternal Sensitive Guidance*) was .74, and of the child scales (*Child Cooperation and Exploration*) .71.

Based on all rating scales, the dyads were classified into one of four groups of dialogues, 1) emotionally matched and; emotionally unmatched, namely: 2) exaggerating; 3) flat and; 4) inconsistent. *Emotionally matched* dyads are capable of creating coherent stories with a clear and believable link between the emotion and the story. Stories can either be rich and full of details or brief, but the most important features are that both mother and child are involved, and mothers leave space for the child while guiding the dialogue toward a positive closure of negative emotions. *Exaggerating dialogues* are charged with negative, extreme, or dysregulated emotional themes. The story does not match the emotion on the card. Mothers often talk about their children's emotions as if they were identical to their own. Themes are often raised but immediately blocked. There is a lack of coherence in the stories, expressed by repetitiveness. Additional features are the tendency toward extremes and overdramatization, boundary dissolution, and the strong need of the child to please the mother. *Flat dialogues* are characterized by their lack of involvement, low elaboration, and poor development of the stories. Both partners display a lack of interest in the task. *Inconsistent dialogues* are characterized by contradictory features such as discussing two emotions in an emotionally matched way and the others in an emotionally unmatched manner. Or cases in which one of the two partners is cooperative and providing emotionally matched stories, whereas the other blocks the opportunity for dialogues, derails the conversation to irrelevant directions, or expresses high levels of hostility and anger.

The second author, who was blind to whether the dyads were exposed to IPV, coded all transcripts and had only information about children's age and gender. She was trained by N. Koren-Karie in the AEED coding system and established adequate reliability. To improve coding in a sample of traumatized children, a subgroup of researchers coded transcripts of dialogues between parents and their children in a different IPV-exposed sample, consulted by the developer. Inter-rater reliabilities for the four classifications (Cohen's Kappa = .80) and the two-way classification (Emotionally Matched vs. Emotionally Unmatched; Cohen's Kappa = 1.0) were good. Inter-rater reliability of the composite scores was .95 for *Maternal Sensitive Guidance* and .95 for *Child Cooperation and Exploration*.

Maternal Posttraumatic Stress Symptoms

To assess maternal post-traumatic stress symptoms, we used the *Impact of Events Scale – Revised* (Weiss, 2004), translated into Dutch by Brom & Kleber (Schokverwerkingslijst (SVL-22), 1985). This questionnaire consists of 22 items measuring symptoms of post-traumatic stress disorder during the last week, and it measures the three dimensions of post-traumatic stress disorder: intrusion, avoidance and hyperarousal. Mothers rate the items on a 5-point Likert-scale ranging from '*not at all*' to '*extremely*'. The IES-R has shown good discriminant validity and diagnostic utility in other research (Olde, Kleber, van der Hart, & Pop, 2006). In the current study, the Cronbach's alpha coefficient for the total score of post-traumatic stress symptoms was .94.

Maternal Childhood Experiences

The Adverse Childhood Experiences questionnaire (Felitti et al., 1998) was used to assess mothers' traumatic childhood experiences. The Adverse Childhood Experience study showed a strong relation between exposure to abuse during childhood and emotional well-being in adulthood (Felitti et al., 1998). Mothers were asked to report whether they had experienced emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, parental divorce, witnessing domestic violence, parental addiction, parental mental illnesses or parental incarceration in the first 18 years of their life.

Statistical analyses

First, all continuous variables were checked for outliers ($-3.29 < z < 3.29$), and outliers were winsorized to the nearest non-outliers (7 values of 4 dyads) (Tabachnick & Fidell, 2007). Second, descriptives and Pearson correlations were calculated for background variables (marital status, parental education, and family income), characteristics of IPV, AEED child and maternal scales, maternal PTSD, and maternal ACEs. With a Chi-square test and t-tests, we tested group differences between the IPV-exposed group and non-exposed group in maternal post-traumatic stress symptoms, maternal adverse childhood experiences, and AEED maternal and child contributions. Third, Fisher's Exact Test was used to examine further associations between group (IPV-exposed vs. non-exposed) and AEED classifications. Fourth, two multivariate analyses of variance (MANCOVA) were conducted to compare the combined quality of child and maternal contributions to emotion dialogues between IPV-exposed dyads and non-exposed dyads. In the first MANCOVA, the effect of IPV-exposure on emotion dialogues was examined by use of a dummy variable (0 = *non-exposed*, 1 = *IPV-exposed*). In the second MANCOVA, maternal posttraumatic stress symptoms (continuous) and maternal adverse childhood experiences (continuous) were added to the model.

RESULTS

Descriptive analyses

IPV characteristics

In the IPV-exposed group, mothers reported at intake 19.26 psychological aggression incidents in the last year of the violent relationship committed by themselves ($SD = 28.73$, range 0-105), and 62.15 psychological aggression incidents committed by their partner ($SD = 57.62$, range 0-177). The frequency of events involving physical aggression by the mother in the last year of the relationship was 5.22 ($SD = 10.58$, range 0-39), and by their partner 42.85 ($SD = 72.79$, range 0-275). In the non-exposed group, some incidents of psychological and physical aggression were reported (psychological aggression mother: 7.75 incidents, $SD = 14.95$, range 0-75; psychological aggression partner: 5.86 incidents, $SD = 14.59$, range 0-75; physical aggression mother: 0.57 incidents, $SD = 2.27$, range 0-12; physical aggression partner: 0.25 incidents, $SD = 0.84$, range 0-4, respectively). Significantly more incidents occurred in the IPV-exposed group than in the non-exposed group ($t(32.86) = -4.21$, $p < .001$ for psychological aggression (mother and partner combined); $t(26.08) = -3.25$, $p = .003$ for physical aggression (mother and partner combined)).

Background characteristics

Mothers in the IPV-exposed group were significantly more likely to be single-parent ($\chi^2(1) = 29.76$, $p < .001$), and less likely to be Dutch ($\chi^2(1) = 7.22$, $p = .01$; 6 mothers, 22.2% non-specified other ethnical background). Also, they were significantly more likely to receive an annual income below the poverty threshold (< 15,000€) ($\chi^2(1) = 18.72$, $p < .001$), and were significantly more likely to have a lower education ($\chi^2(2) = 22.07$, $p < .001$) (see Table 1).

Mothers in the IPV-exposed group reported at intake on average 2.19 incidents of psychological maltreatment of their child in the last year by themselves ($SD = 3.46$, range 0-12), and 11.96 incidents by their partner ($SD = 26.31$, range 0-98). The frequency of events involving physical maltreatment of the child in the past year by the mothers was 0.19 ($SD = 0.62$, range 0-3), and by their partner 1.00 ($SD = 3.17$, range 0-16). Mothers reported 1.81 incidents of neglect in the past year ($SD = 4.91$, range 0-23) and 0.07 incidents of sexual abuse of the child ever ($SD = 0.38$, range 0-2). No data on neglect by the partner were available. In the non-exposed group some incidents of psychological and physical maltreatment of the child in the last year were reported (psychological maltreatment child by mother: 3.76 incidents, $SD = 5.57$, range 0-25; psychological maltreatment child by partner: 3.67 incidents, $SD = 5.87$, range 0-25; physical maltreatment child by mother: 0.07 incidents, $SD = 0.26$, range 0-1; physi-

cal maltreatment child by partner: 0.00 incidents, $SD = 0.00$, range 0, respectively). Mothers reported 0.72 incidents of neglect in the past year in the non-exposed group ($SD = 1.77$, range 0-8) and 0 incidents of sexual abuse of the child ever. There was no significant difference in the number of incidents of psychological and physical maltreatment (mother and partner combined), neglect or sexual abuse of children between the IPV-exposed group and non-exposed group ($t(34.37) = -1.20$, $p = .238$ for psychological maltreatment; $t(26.32) = -1.81$, $p = .082$ for physical maltreatment; $t(32.23) = -1.09$, $p = .284$ for neglect; $t(26.00) = -1.00$, $p = .327$ for sexual abuse).

We explored the distribution of these demographic variables (i.e., marital status, parental education, and family income) across groups. As can be seen in Table 1, the demographic characteristics were highly skewed and unevenly distributed across groups. To illustrate, the non-IPV-exposed group included only one single-parent (see Table 1). Given these distributions in combination with the small sample size, we refrained from controlling for these variables in our statistical analyses to prevent undue influence. We will come back to this issue in the discussion.

Table 1. Background Variables by Group

	IPV-exposure		Non-exposure	
	n	%	*n*	%
Dutch (Yes)	21	77.8	29	100
Single parent household (Yes)	21	77.8	1	3.4
Poverty level (Yes)	13	52	0	0
Parental educational level				
Low	4	14.8	0	0
Middle	17	55.6	5	14.3
High	5	25.9	23	85.7

Correlations between study variables

Table 2 shows the descriptives, and Table 3 shows the Pearson correlations for the study variables. Violence characteristics were highly correlated with each other ($r = .31$-$.76$) and weakly or moderately correlated with mother–child communication ($r \leq -.32$), maternal post-traumatic stress symptoms ($r \leq .32$), and maternal adverse childhood experiences ($r \leq .50$). Characteristics of mother–child communication were highly correlated ($r = .69$), and child contribution of emotion dialogues was negatively associated with maternal post-traumatic stress symptoms ($r = -.32$). Maternal post-traumatic stress symptoms and adverse childhood experiences were moderately associated ($r = .46$). These results indicate that IPV was, as expected, negatively associated with positive indicators of mother–child communication and maternal functioning, and was positively associated with maternal ACEs.

Table 2. Descriptives

Variable		N	Range	M	SD
1.	Marital status	56	0-1	.38	.49
2.	Parental education	54	1-3	2.44	.63
3.	Low family income	52	0-1	.25	.44
4.	Psychological aggression self	55	0-105	13.4	23.3
5.	Psychological aggression partner	55	0-177	33.5	50.1
6.	Physical assault self	55	0-39	2.85	7.87
7.	Physical assault partner	55	0-275	21.16	54.89
8.	AEED child scales	60	33-56.5	44.9	5.83
9.	AEED mother scales	60	28-56.5	45.1	5.95
10.	Maternal PTSD	55	1-4.28	1.56	0.78
11.	Maternal ACEs	56	0-9	1.96	2.40

Note. Reported variables are winsorized variables. AEED = Autobiographical Emotional Events Dialogue. PTSD = Post-Traumatic Stress Disorder. ACEs = Adverse Childhood Experiences.
Marital status is operationalized as single parent (1) vs. with a partner (0). Parental education was operationalized in three levels (low (1), middle (2), high (3). Family income was coded as below (0) or above (1) €35.000 annually.

Table 3. Pearson correlations between variables

Variable		2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1.	Marital status	−.50***	.76***	.16	.40**	.19	.33*	−.24	−.12	.60***	.35**
2.	Parental education	-	−.48***	−.08	−.24	−.24	−.16	.25	.25	−.35**	−.24
3.	Low family income		-	.17	.37**	−.10	.35*	−.25	−.03	.68***	.19
4.	Psychological aggression self			-	.66***	.76***	.31*	−.25	−.16	.12	.43**
5.	Psychological aggression partner				-	.64***	.74***	−.31*	−.21	.32*	.47***
6.	Physical assault self					-	.37**	−.32*	−.24	.30*	.50***
7.	Physical assault partner						-	−.25	−.18	.31*	.34*
8.	AEED child scales							-	.69***	−.32*	−.22
9.	AEED mother scales								-	−.16	−.14
10.	Maternal PTSD									-	.46***
11.	Maternal ACEs										-

Note. Reported variables are winsorized variables. AEED = Autobiographical Emotional Events Dialogue. PTSD = Post-Traumatic Stress Disorder. ACEs = Adverse Childhood Experiences.
Marital status is operationalized as single parent (1) vs. with a partner (0). Parental education was operationalized in three levels (low (0), middle (1), high (2). Family income was coded as below (0) or above (1) €35.000 annually.
*** $p < .001$, ** $p < .01$, * $p < .05$

Group differences in maternal posttraumatic stress and adverse childhood experiences

Maternal posttraumatic stress

Mothers in the IPV-exposed group reported significantly more symptoms of posttraumatic stress ($M = 1.98$, $SD = 0.88$) than mothers in the non-exposed group ($M = 1.17$, $SD = 0.26$; $t(29.05) = -4.52$, $p < .001$).

Maternal Adverse Childhood Experiences

Mothers in the IPV-exposed group reported overall more adverse childhood experiences in their own childhood than mothers in the non-exposed group (see Table 4).

Table 4. Comparison of number of mothers in non-IPV exposed group and IPV-exposed group who experienced Adverse Childhood Experiences (ACE)

Adverse Childhood Experiences	Non-IPV (*M* (*SD*)	IPV (*M* (*SD*)	χ^2	*p*
Childhood Abuse				
Emotional abuse	2	6	2.31	.129
Physical abuse	2	10	6.67	.010
Sexual abuse	4	10	3.35	.067
Emotional neglect	5	13	5.08	.024
Physical neglect	0	5	5.46	.020
Household Dysfunction				
Divorce/separation	6	7	0.10	.754
Domestic violence	2	9	5.46	.020
Substance abuse	2	9	5.46	.020
Mental illness	6	9	0.80	.371
Incarceration	0	3	3.16	.076
Total ACEs *(M* (*SD*))	1.00 (1.46)	3.00(2.77)	$t(38.81) = -3.34$	.002

Group differences in AEED classifications and composite scores

AEED classifications

The association between group and two-way classifications showed that mother–child dyads in the IPV-exposed group were significantly more likely to be classified as Emotionally Unmatched (24 dyads) than mother–child dyads in the non-exposed group (14 dyads; $\chi^2(1) = 7.18$, $p = .007$). Fisher's Exact Test was used to examine associations between group and four-way classifications, because more than 20% of cells had an expected cell frequency lower than five. IPV-exposed children were less likely to engage in Emotionally Matched dialogues and more likely to engage in Flat

dialogues (Fisher's Exact = 9.37, $p = .020$). The distribution of classifications across both groups can be seen in Table 5.

Table 5. Distribution of AEED classifications in non-IPV exposed group and IPV-exposed group

	Emotionally Matched		Emotionally Unmatched	
	Matched	Excessive	Flat	Inconsistent
Non-IPV exposed group	16	4	6	4
IPV-exposed group	6	3	16	5

AEED composite scores

An independent t-test revealed significant group differences in Maternal Sensitive Guidance ($t(58) = 2.08$, $p = .042$, effect size $r = .26$) and Child Cooperation and Exploration ($t(58) = 3.25$, $p = .002$, effect size $r = .39$). Mothers in the IPV-exposed group ($M = 43.53$, $SD = 4.94$) showed less sensitive guidance than mothers in the non-exposed group ($M = 46.63$, $SD = 6.52$). Similarly, children in the IPV-exposed group ($M = 42.63$, $SD = 5.57$) showed lower levels of cooperation and exploration than children in the non-exposed group ($M = 47.17$, $SD = 5.24$).

Group differences in predictors of mother–child interaction

We conducted two MANCOVA's to examine the effect of IPV-exposure, maternal posttraumatic stress, and maternal adverse childhood experiences on children's and mother's contributions to emotion dialogues (combined as AEED composite scores). IPV-exposure was significantly associated with dyadic interaction ($F(2,57) = 5.20$, $p = .008$, partial $\eta^2 = .15$, Wilks' Lambda = .85). Second, we examined associations between IPV-exposure, maternal posttraumatic stress symptoms, maternal adverse childhood experiences, and AEED composite scores. Neither maternal posttraumatic stress ($F(2,50) = .71$, $p = .50$, partial $\eta^2 = .03$, Wilks' Lambda = .97), nor maternal adverse childhood experiences ($F(2,50) = .08$, $p = .93$, partial $\eta^2 < .01$, Wilks' Lambda = .99) contributed to explaining the total composite score of dyadic interaction. In addition, IPV-exposure was no longer a predictor of AEED composite scores ($F(2,50) = 1.08$, $p = .35$, partial $\eta^2 = .04$, Wilks' Lambda = .96).

DISCUSSION

Our goals for this study were to examine whether mother–child emotion dialogues among IPV-exposed dyads showed less quality than dialogues among non-exposed dyads, and to test associations with maternal posttraumatic stress symptoms and maternal history of adverse childhood experiences. We found support for our hy-

pothesis that mother–child emotion dialogues are of lesser quality in IPV-exposed families than in non-exposed families. Specifically, we found that in IPV-exposed families, as compared to non-exposed families, significantly more dyads had emotionally unmatched emotion dialogues, most of which were classified as 'flat'. Flat dialogues are characterized by a lack of involvement of both parent and child, low elaboration, and poor development of the stories. Both partners display a lack of interest in the task. Furthermore, mothers of the IPV-exposed dyads showed less sensitive guidance and children of the IPV-exposed dyads showed less cooperation and exploration than mothers and children in non-exposed dyads.

Consistent with previous studies (Bensley et al., 2003; Lieberman, 2004), maternal posttraumatic stress symptoms and maternal history of ACEs were significantly higher in the IPV-exposed families than in the non-exposed group. However, contrary to our expectations, maternal posttraumatic stress symptoms and maternal ACEs were not associated with the quality of mother–child dialogues. Furthermore, when associations between IPV-exposure, maternal posttraumatic stress symptoms, and maternal ACEs, were examined at the same time, none of the three contributed to explaining maternal and child contribution on parent–child emotion dialogues.

Based on the existing literature, we predicted that the lower quality of mother–child interaction in IPV-exposed families may be explained by several mechanisms. One mechanism we examined was maternal posttraumatic stress, which was not significant. The AEED focuses on dialogues about daily child experiences, rather than IPV experiences. Although maternal posttraumatic stress may impair maternal contribution to emotion dialogues with their child about IPV experiences, maternal contribution to dialogues about daily events may be impaired by other factors. For example, other risk factors associated with IPV, such as poor economic circumstances or single parenthood, may impede mothers' availability in emotion dialogues about everyday life emotional experiences with their children (Visser, Schoemaker, de Schipper, Lamers-Winkelman, & Finkenauer, 2015). Also, it is possible that mothers avoid talking about negative emotions such as anger and anxiety because these emotions may function as a reminder of their own traumatic IPV experiences (Lieberman, 2004). Consequently, for flat dyads, we would expect a negative association between maternal posttraumatic stress avoidant symptoms and maternal sensitive guiding behavior. Larger samples would be needed to examine this hypothesis. Our sample of IPV-exposed mothers showed relatively low posttraumatic stress levels, which may be due to the fact that our sample is based on a sample of children referred to the outpatient clinic, and included only participants in which both custodial parents gave permission to participate in the research. Future studies may involve IPV victims in shelters, for example, to increase the variance of posttraumatic stress among mothers and examine its association with parent–child emotion dialogues. Furthermore,

given the observed differences between the IPV-exposed and non-exposed group on demographic variables (e.g., single motherhood, socio-economic status), it is possible that confounding variables affected our results. Larger studies allowing a better match between the two groups on these variables or providing the statistical power to examine their effects on the observed differences in quality of mother–child emotion dialogues between the two groups would be particularly relevant.

Another mechanism, which we examined, centered on maternal ACEs. Again, we found no support for our prediction that lower quality mother–child interaction would be partly explained by maternal ACEs. Possibly, qualitative differences in maternal trauma may be more important to the quality of emotion dialogues than the mere frequency of ACEs we measured in our study. Future research should, for example, examine whether maternal childhood trauma resolution in IPV mothers is related to AEED unmatched classifications (Koren-Karie et al., 2004).

It is also possible that mechanisms not assessed in our study are at play. For example, IPV-exposed children may be less cooperative and exploring than non-exposed children, because role reversal and parentification may be more prevalent in IPV families (Carroll, Olson, & Buckmiller, 2007). IPV-exposed children may want to prevent their mother from becoming upset (Holt et al., 2008). Consequently, rather than reacting to mother's actual emotions during the dialogue, children may anticipate their mother's vulnerabilities or stress and try to protect her.

Finally, it is possible that IPV-exposed and non-exposed families differ in other dyadic processes in the interaction between mothers and children. For example, IPV-exposed children are likely to exhibit more challenging behavior than non-exposed children (e.g., aggressive, deviant, Kitzmann et al., 2003). Although parents are generally capable of adapting their parental behavior and sensitive caregiving in accordance with the particular needs of different children (Van IJzendoorn, Goldberg, Kroonenberg, & Frenkel, 1992), IPV may impair parents' sensitivity especially when children's behavior is challenging. Future research including larger samples of IPV-exposed dyads, would be particularly promising in the examination of these different mechanisms, and would ideally allow researchers to pit different mechanisms against each other.

Clinical implications

The results of this study have significant implications for clinical practice. The results show that in clinical practice when working with IPV-exposed families there is a higher risk that parent–child emotion dialogues will be flat. Specifically, our findings suggest that interventions that increase maternal sensitivity and children's cooperation and exploration may help to improve the quality of parent–child emotion dialogues, and, thus ameliorate the parent–child relationship. Higher quality

parent–child relationships may facilitate children's adjustment to IPV-exposure and promote children's healthy development (Afifi & MacMillan, 2011).

A promising direction for future research is to examine whether the quality of parent–child emotion dialogues generalizes to parent–child emotion dialogues about IPV experiences. Additionally, it may be clinically relevant to know if the capacity to create a trauma narrative for children requires the same skills and abilities as those needed in parent–child emotion dialogues about stressful events.

Our findings also underline that parents and children both contribute to these dialogues together. Several trauma treatments already recognize the importance of children's meaning-making (Chaffin et al., 2004; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Lieberman, Van Horn, & Ippen, 2005; Valentino, Comas, Nuttall, & Thomas, 2013; Visser, Leeuwenburgh, & Lamers-Winkelman, 2007). For example, Child Parent Psychotherapy highlights the importance of a relationship focus in the treatment of mother–child dyads after IPV-exposure and helps the child and the mother in creating a joint trauma narrative (Lieberman, Van Horn, & Ippen, 2005). Child Parent Psychotherapy is specifically developed for IPV-exposed children aged 0-5, and the mother–child dyad is the unit of treatment. Furthermore, Valentino et al. (2013) studied the efficacy of a short training for maltreating parents in elaborative and emotion-rich reminiscing with their children to benefit child cognitive and emotional development. Future research examining the efficacy of this training to benefit cognitive and emotional processing of IPV experiences in children may be promising.

Strengths and Limitations

Before closing, it is important to note several strengths and constraints of the present study. One strength of the present study is the use of an observational measure to capture both mothers' and children's contribution to emotion dialogues. By comparing an IPV-exposed group with a non-exposed group, our study has laid the foundations for more in-depth research into the links between mother–child emotion dialogues and child adjustment in IPV-exposed families. Both research investigating the mechanisms underlying the observed group differences, as well as research examining the clinical applications of our findings would be especially promising.

Several limitations of this study should be acknowledged. First, only mothers participated in the study. The lack of information about father–child emotion dialogues hampers the generalizability of the findings to parent–child relationships. Fathers seem to contribute in unique ways to children's emotional development (Katz, Maliken, & Stettler, 2012) and mothers appear to talk more about emotional aspects of experiences and use more emotion words than fathers in parent–child emotion dialogues about daily events (Fivush, Brotman, Buckner, & Goodman, 2000). These

gender differences suggest that paternal and maternal dialogues may differentially affect children and their development. Second, the sample sizes of both the exposed and the non-exposed groups in our study were relatively small. This not only detracted from the statistical power of our analyses, but also prevented us from examining the confounding influence of third variables associated with IPV and present in our IPV-exposed group (e.g., single parenthood, lower education and income).

We are not claiming that IPV always impairs emotional dialogues. Our goal here was to demonstrate, for the first time, that they *can*. Given the limitations, it is unclear at this point whether there are boundary conditions to this effect. Several interesting questions remain to be addressed. Is the effect limited to certain types of emotional dialogues? Is the effect dependent on individual differences or situational characteristics? Does the effect change with age and child development? Is this effect limited to IPV, or do other types of child abuse have similar consequences? And how exactly can we help parents, children, and their relationship to enable them to reclaim some degree of wellbeing and emotional security after IPV?

In sum, awaiting future research, we conclude that, to our knowledge, this is the first study in which an in-depth comparison is made between mother–child emotion dialogues in IPV-exposed dyads and non-exposed dyads. In IPV-exposed dyads, as compared to non-exposed dyads, mother–child dialogues were more poorly developed, and dyads were less interested and involved in the interaction. Also, in the IPV-exposed dyads, mothers showed less sensitive guidance and children showed less cooperative and exploring behavior during dialogues. These differences were not associated with maternal posttraumatic stress symptoms or maternal ACEs. These results suggest the importance to focus on parent–child emotion dialogues in the treatment of children in the aftermath of IPV exposure. Crucially, they underline that the parent–child relationship needs to be considered to enhance our understanding of the effects of IPV on families.

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Chapter 5

I'll never forgive you: High conflict divorce, social network, and co-parenting conflicts

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Under review

ABSTRACT

The relation between divorce, co-parenting conflicts, and children's adjustment problems has been well established. An unresolved question for research and clinical interventions, however, is how conflicts between parents are maintained and/or escalate. This cross-sectional study tested the hypothesis that co-parenting conflicts in divorced couples are associated with perceived social network disapproval and that this relation is mediated by parents' tendency to forgive each other. In Study 1, a convenience sample of 136 divorced parents recruited via online forums, we showed that perceived social network disapproval was indeed positively related to co-parenting conflicts and that parents' tendency to forgive the other parent—albeit partly—explained this relationship. Strength of our research is that in Study 2, 110 parents referred to children's mental health care because the wellbeing of the children was severely compromised by the severity of the conflicts between parents, we replicated these results. In both studies perceived social network disapproval and co-parenting conflicts were positively related and this link was mediated by forgiveness: perceived social network disapproval was negatively related to forgiveness, which in turn was negatively related to more parental conflicts. Clinical implications and study limitations are discussed.

INTRODUCTION

Living in divorced families is common and may be harmful. In the Netherlands, approximately 70.000 children experience parental divorce every year (Spruijt & Kormos, 2010). The most devastating effect of divorce for children's adjustment and well-being is to be exposed to parental conflict (Amato, 2001; Kelly & Emery, 2003). Consequently, one of the most challenging tasks for parents' adjustment after divorce is to establish a high quality co-parenting relationship. This is crucial, not only for parental adjustment and wellbeing (Katz & Woodin, 2002), but also because co-parenting quality is essential to ensure children's healthy and smooth adaptation to divorce (Amato, 2005; Bronstein, Clauson, Stoll, & Abrams, 1993; Nunes-Costa, Lamela, & Figueiredo, 2009; Whiteside, 1998) and prevent developmental decrements in the long-run (Cabrera, Scott, Fagan, Steward-Streng, & Chien, 2012; Levine & Painter, 1998; Prevoo & Ter Weel, 2014).

An important question for research is then to explain how conflict between divorced parents is maintained and/or how it escalates. Although research has examined risk factors for co-parenting conflicts (see for an overview, Bonach, 2005), and increased our knowledge about conflict escalation (Coleman, Kugler, Bui-Wrzosinska, Nowak, & Vallacher, 2012), one aspect that has received little attention in empirical research is the role of the social network, including friends, family, and even lawyers (Milardo, Helms, Widmer, & Marks, 2014). This oversight is surprising, given that it is generally recognized that the success and failure of relationships does not only depend on the individual partners but also on their social networks, both in intact relationships (Kennedy, Jackson, Green, Bradbury, & Karney, 2015) and post-divorce relationships (McDermott, Fowler, & Christakis, 2013). As an example, it has been found that social network approval is an important protective factor for the quality of romantic relationships (Le, Dove, Agnew, Korn, & Mutso, 2010). Also, social network support was found to be an important protective factor for parents' individual adjustment after divorce (Albeck & Kaydar, 2002; Kramrei, Coit, Martin, Fogo, & Mahoney, 2007). In the present research, to our knowledge for the first time, we examine how social network approval or disapproval influences the quality of the co-parenting relationship in divorced couples.

To explain how social network approval or disapproval may influence the level of co-parenting conflicts, we extend findings on the so-called third-party forgiveness effect (Green, Burnette, & Davis, 2008) to divorced families. In these families, social network members, like family and friends, can be regarded as third parties in transgressions made between parents. Research has shown that third parties are generally less forgiving than first parties (Green et al., 2008). Applying these findings to divorced parents, we suggest that perceptions of network disapproval are positively

related to co-parenting conflicts, because they prevent parents from forgiving each other. We conducted two studies to examine the proposed mediational role of forgiveness in the link between perceived social network disapproval and co-parenting conflicts.

Co-parenting can be conceptualized as the parental relationship in the planning and execution of a joint parental plan for the children. Nunes-Costa et al. (2009) define co-parenting as "the joint and reciprocal involvement of both parents in the education, background and decision-making about their children's lives. Cooperative parents prioritize their children's well-being, while creating and maintaining a constructive relationship, with new, more flexible boundaries between one another". Furthermore, it is important that parents support each other's educational decisions (Maccoby, Depner, & Mnookin, 1990) and parental efforts (McHale, Kuersten-Hogan, & Rao, 2004; Whiteside & Becker, 2000). In addition, Whiteside and Becker (2000) found that high levels of positive supportive co-parenting are negatively associated with conflicted co-parenting. Because of the detrimental effects of co-parenting conflicts on children's well-being (Amato & Afifi, 2006; Morrison & Coiro, 1999), in the present research, we will focus on this aspect of co-parenting in particular.

A majority of divorced parents succeeds in remaining supportive of one another and develop a cooperative co-parenting style (Whiteside, 1998; Whiteside & Becker, 2000). They communicate frequently, although they often have different opinions when parental and educational decisions concerning the children need to be taken (e.g., Maccoby et al., 1990). However, approximately one third of divorced parents have high levels of ongoing hostility and tension (Whiteside, 1998). The combination of differing opinions and high levels of ongoing hostility and tension between parents may result in unresolved conflict and contribute to the escalation of co-parenting conflicts (Bonach, 2005; Coleman et al., 2012). We propose that social network disapproval further amplifies this escalation.

Ample evidence shows that social network support is important for individuals' well-being (Pinquart & Sörensen, 2000). Furthermore, research has shown that network relationships (being part of a group), more than specific relationships (one-on-one contact), promote positive post-divorce adjustment, including adaptive coping, mental wellbeing, and life satisfaction (Kramrei et al., 2007). This highlights that being part of a supportive social network is particularly important for healthy adjustment after divorce. Social networks provide divorced individuals with a feeling of belongingness and offer emotional support, for example, by approving of the relationship breakup and making negative statements about the ex-partner (Sprecher & Felmlee, 2000). Thereby, social networks may help the individual ex-partners to feel better by increasing their sense of belonging as well as by decreasing feelings of uncertainty about ending the romantic relationship (Eaton & Sanders, 2012).

Despite its beneficial effect for individual post-divorce adjustment, however, such social network support might at the same time have an escalating effect on conflict with the ex-partner. When network members express themselves negatively about the ex-partner as an act of support, they also fuel their divorced friend or family member's negative thoughts, feelings, and behaviors regarding the ex-partner (Lickel, Miller, Stenstrom, Denson, & Schmader, 2006). We therefore propose that perceptions of social network approval of the divorce may be perceived as social network *dis*approval of the ongoing co-parenting relationship and should thus be positively related to co-parenting conflict.

Thus, in the present research, we hypothesize that perceived social network disapproval is positively associated with the level of co-parenting conflicts among divorced parents. How and why might social network disapproval contribute to co-parenting conflicts among divorced partners? The literature suggests that forgiveness may play a key role in the answer to this question.

Forgiveness is an interpersonal process (for a review see Karremans & Van Lange, 2008), which serves to maintain the relationship after a transgression has been committed, and to rebuild the quality the relationship had before the transgression. In relationships, including post-divorce relationships, partners intentionally or unintentionally hurt or offend each other. They may lie about extramarital affairs, are emotionally absent, disclose secrets, break promises, or gossip about each other with their friends. To effectively deal with these inevitable transgressions and prevent conflict, relationship partners need to forgive each other. Not surprisingly, empirical research consistently finds that forgiveness has profound consequences for the forgiving individual, such as beneficial effects for psychological and physical health, greater life satisfaction, and lower levels of psychological distress (Karremans, Van Lange, Ouwerkerk, & Kluwer, 2003; Lawler et al., 2005; Michael E. McCullough, Bellah, Kilpatrick, & Johnson, 2001). Forgiveness also plays a crucial role in relationships. For example, it is associated with less conflict and greater relationship quality in romantic relationships (Paleari, Regalia, & Fincham, 2005) and more cohesion in families (Maio, Thomas, Fincham, & Carnelley, 2008). Last but not least, forgiveness not only affects individuals and relationships, but also their social network (Green, Davis, & Reid, 2014). People close to the victim of a transgression, so-called third parties (Green et al., 2008), who are not directly involved in the transgression, may feel that they are in a position to grant or withhold forgiveness themselves, and/or influence the forgiveness process of the victim.

Research shows that third parties are generally less forgiving than victims themselves and offers several explanations for this third party forgiveness effect (for a review see Green et al., 2014). For example, family, friends, or other important network members may be afraid to jeopardize their close relationship with the victim by being

forgiving toward the perpetrator. Furthermore, given that they have less information about the perpetrator than the victim does, social network members may blame the perpetrator more for what happened, and make more negative, internal, and stable attributions about the perpetrator. Finally, research indicates that third parties are less likely to believe apologies and see less profit in reconciliation than do victims themselves (Cheung & Olson, 2013; Eaton & Sanders, 2012; Green et al., 2008; Green et al., 2014). Extending these findings to divorced parents, we propose that perceived network disapproval of the co-parenting relationship fuels unforgiving motivations in the divorced parent.

Interpersonal transgressions are important stressors before, during, and after divorce, which may contribute to the maintenance and escalation of co-parenting conflict (Bonach, 2005). Research on clinical interventions for divorcing couples suggests that, in these couples, forgiving the other parent is crucial, not only because forgiveness is negatively related to conflicts, but also because it is positively related to the quality of the co-parenting relationship (Reilly, 2014; Rye et al., 2012). Furthermore, forgiveness is one of the strongest predictors of the quality of co-parenting over time (Bonach, 2005; Bonach & Sales, 2002). Following from our previous reasoning, perceived social network disapproval of the co-parenting relationships should negatively affect the level of co-parenting conflicts by decreasing forgiveness among divorcing parents. Specifically, we hypothesize that the positive relation between perceived social network disapproval and co-parenting conflicts is mediated by forgiveness among parents in divorced families.

To our knowledge, the current research is the first to examine the indirect relation between perceived social network disapproval and co-parenting conflicts via forgiveness in the divorce context. Our first hypothesis is that among divorced parents the level of perceived social network disapproval would be positively related to co-parenting conflicts. Our second hypothesis is that parental forgiveness would be negatively related to more co-parenting conflicts. Our third hypothesis is that the association between perceived network disapproval and co-parenting conflicts would be mediated by parental forgiveness of the other parent/ex-partner. To examine these hypotheses, we conducted two studies. In the first study, we tested our predictions using a convenience sample of divorced parents recruited via online forums. To examine the robustness and generalizability of our findings, we conducted a second study among a clinical sample of parents involved in high-conflict divorces who were referred to treatment because of the imminent threat their conflicts posed to the psychosocial wellbeing of their children.

It is possible that parental education, the length of the relationship, and time since separation are linked to the key variables in our research (Yárnoz Yaben, 2009). Also, although both men and women tend to increase mobilization of social network sup-

port in times of greater distress (Fincham, Beach, & Davila, 2007), gender differences may affect the hypothesized processes. Especially, because for forgiveness conflicting results are found on gender differences (Johnson, 2014). To rule out the confounding influence of these variables, we will examine their influence in both studies.

STUDY 1

In Study 1, we sought to provide evidence for our theoretical model that perceiving network disapproval of the co-parenting relationship is associated with greater conflict between divorced parents. We also expected that divorced parents' forgiveness toward the ex-partner would mediate the association between network disapproval and co-parenting conflict.

METHOD

Participants

Participants were 136 divorced parents (mean age 44.5 years, $SD = 5.8$, range 27-58 years). None of the participants were each other's ex-partner as far as we know. Ninety-six percent was Dutch. On average, they had two children with their ex-partner ($SD = 0.7$, range = 1-4). The oldest child had a mean age of 13.8 years ($SD = 5.0$, range 4-25 years). Forty-nine percent of the parents had a new relationship ($n = 66$), and only 3% had children in their new relationship ($n = 4$). Fifty-two percent sought professional help (e.g., therapy) to adjust to the divorce ($n = 70$).

Procedure

We recruited divorced parents through websites, forums, and the social networks of university students. Parents filled in an online questionnaire about themselves, their children, their ex-partner, and their current relationship with the other parent. Only demographic characteristics and the measures central to our research questions will be described below. To avoid the confounding influence of complex, high-conflict divorce cases, we excluded parents with ongoing legal procedures with the other parent ($n = 26$). All participants gave informed consent before completing the questionnaires. As a reward for participating, they received a gift-voucher of 7.50 Euro for an online web-shop.

Measures

Demographic information, family and divorce measures

To collect socio-demographic information about the participants, they answered questions about their age, and ethnicity. Additionally, several questions assessed information about family and divorce characteristics including number of children, time since divorce, seeking of help to adjust to divorce, and new relationship.

Confounding variables

To assess information about gender, level of education, time since separation, and duration of marriage/legal cohabitation, we added several questions.

Co-parenting conflicts

To assess co-parenting conflicts, we used the 7-item co-parenting subscale of The Psychological Adjustment to Separation Test (PAST; Sweeper & Halford, 2006). The scale was translated into Dutch and showed good psychometric properties (De Smet, 2013). Example items are: "When I speak to my former partner we usually fight over the child/children" "My former partner and I avoid speaking to one another". Items were rated on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). Mean scores were calculated such that a higher score indicated more co-parenting conflicts (Cronbach's alpha = .89).

Perceived network disapproval

To assess parents' perception of the extent to which their social network disapproved of the co-parenting relationship, we first asked each parent to make a list of people who are involved in and concerned by the divorce (e.g., lawyers, parents(-in-law), friends, new partners). Subsequently, participants completed four questions assessing their perception of network partners' overall reactions to the divorce, including questions concerning their (dis)approval (e.g., "in general, my network partners approve of my relationship with my ex-partner (reversed)" (cf Lehmiller & Agnew, 2007). Items were rated on a 5-point scale (1 = *not at all*; 5 = *very much*). Mean scales were calculated with a higher score indicating higher levels of perceived social network disapproval (Cronbach's alpha = .65).

Forgiveness

To assess feelings of forgiveness, we used a twelve-item Dutch translation of the Transgression Related Interpersonal Motivations Inventory (Michael E. McCullough, 2013), rated on a 5-point scale (1 = *strongly disagree* to 5 = *strongly agree*). Parents rated their feelings of forgiveness toward the ex-partner (e.g., "I keep as much dis-

tance as possible from my ex-partner." (reversed); "I want to see my ex-partner hurt and miserable." (reversed); "Although my ex-partner hurt me, I am putting the hurts aside so we can resume our contact."). Mean scale was calculated such that a higher score indicated a higher level of forgiveness (Cronbach's alpha = .91).

Statistical Procedure

Descriptive analyses were conducted to examine family and divorce, and social network characteristics, possible gender differences, and zero-order correlations among all study related variables. Second, we used ordinary least squares path analyses to conduct simple mediation analyses, to test whether forgiveness explained—albeit partly—the relation between perceived social network disapproval and co-parenting conflicts. All analyses were conducted in IBM SPSS Statistics version 21 (Spss, 2012), in which we used macro PROCESS for mediation analyses, model 4 (Hayes, 2013). We controlled for parental relationship length, gender, and educational level to rule out alternative hypotheses and the influence of confounding variables.

RESULTS

Descriptives

Confounding variables and social network characteristics

Seventy-two percent was female. The educational level was moderate (41%, secondary vocational education) to high (57%, higher vocational education and university). Participants had had a relationship with their ex-partner before divorce for 16.1 years ($SD = 7.2$; range 2-35 years), and had been separated for 4.7 years ($SD = 4.0$; range 0-16 years). Participants reported a mean of five persons ($SD = 3.0$) in their social network (range 0-10), 34% own family, 1% family of the other parent, 44% own friends, 0% friends of the other parent, 6% psychological counselors, 3% legal workers, 6% new partner, 5% other not specified, and 4% reported to have nobody.

Gender differences

Independent-samples t-tests were conducted to compare the study variables for fathers and mothers. Preliminary results indicated that perceived social network disapproval, forgiveness, and co-parenting conflicts did not differ significantly across gender, $t(134) \leq 1.361$, $p \geq .179$, $d \leq .02334$.

Zero-order correlations

Means, standard deviations, for men and women, and bivariate correlations among study related variables, are presented in Table 1. Consistent with the first hypothesis, higher levels of perceived network disapproval were significantly related to more co-parenting conflicts, $r(134) = .611$, $p = .000$, and to lower levels of forgiveness, $r(136) = -.521$, $p = .000$. Also, consistent with our second hypothesis, lower levels of forgiveness were significantly related to more co-parenting conflicts ($r(134) = -.536$, $p = .000$).

Table 1. Descriptives and Zero-order Correlates of all Study Variables Study 1

	Study 1 $n = 136$					
	Mean		*SD*			
Variable	male	female	male	female	1.	2.
1. Network Disapproval	2.95		.91			
	3.07	2.91	.88	.92		
2. Co-parenting conflicts	2.36		1.04		.611**	
	2.58	2.28	1.17	.98		
3. Forgiveness	3.56		.89		−.521**	−.536**
	3.49	3.58	.90	.90		

*$p < .05$, **$p < .01$.

Forgiveness as a Mediator

Consistent with our mediation hypothesis, simple mediation analyses using ordinary least squares path analysis yielded that perceived social network disapproval indirectly influenced the amount of co-parenting conflicts through its effect on forgiveness. As presented in Table 2, parents who perceived more disapproval in their social network were less likely to forgive the other parent ($b = -.512$, $p = .000$), and when parents were less likely to forgive the other parent, they reported more co-parenting conflicts ($b = -.347$, $p = .000$). We calculated bias-corrected bootstrap confidence intervals estimated based on 5,000 bootstrapped samples and a 95% confidence interval. The indirect effect (ab) of perceived network disapproval through forgiveness on co-parenting conflicts, did not include zero (for more details see Table 2), which indicates that the effect is significant.

Also, the indirect effect (ab), controlling for the effect of parental educational level ($b = .011$, $se = .043$, $p = .803$), length of parental relationship ($b = -.000$, $se = .001$, $p = .782$), time since separation ($b = -.037$, $se = .018$, $p = .047$), and gender ($b = -.002$, $se = .151$, $p = .989$), of perceived network disapproval through forgiveness on co-parenting conflicts, did not include zero (for more details see Table 2), which indicates that the effect remained significant when controlling for possible confounders. As

can be seen in Table 2, perceived social network disapproval remained a significant direct predictor of co-parenting conflict after controlling for the level of forgiveness, which indicates that other factors, at least partially, mediate the relation between perceived network disapproval and co-parenting conflict.

Table 2. Forgiveness (F) as a Mediator Between Perceived Social Network Disapproval (ND) and Co-parenting Conflicts (CC) in divorced families (n = 131)

		95% CI				
Model	*ab*	*LL*	*UP*	k^2	*c (p)*	*c'(p)*
ND → F → CC	.179	0.0671	0.3063	.1684	.700(.000)	.523(.000)
ND → F → CC (with covariates)	.161	0.0530	0.2909	---	.676(.000)	.515(.000)

Note. Unstandardized regression weights are presented. k2 represents kappa, an effect size measure for indirect effects. c represents the direct effect of perceived social network disapproval on co-parenting conflicts. c' represents the direct effect of perceived social network disapproval on co-parenting conflicts, controlling for forgiveness. Covariates are educational level, relation length, and gender.

BRIEF DISCUSSION

Extending previous research on social network disapproval and forgiveness to co-parenting conflicts between divorced parents, we predicted that forgiveness mediates the link between perceptions of network disapproval and conflict. The findings from Study 1 support our hypotheses. They provide the first empirical evidence for the relation between perceptions of network disapproval and co-parenting conflict and document that forgiveness is a critical mechanism of this effect. Specifically, we predicted and found an indirect relation between perceived social network disapproval and co-parenting conflicts through parents' tendency to forgive the other parent, but the direct effect also remained.

Although these findings are encouraging, Study 1 included a convenience sample of divorced parents recruited via online forums, thereby reducing the generalizability of our findings. This is especially important, given that self-selection may have biased our sample. For example, it is possible that only well-adjusted divorced parents participated. Therefore, it remains unclear whether our findings can be replicated among divorced couples with high conflict levels. Given the devastating effects of co-parenting conflicts on children's post-divorce adjustment and well-being (Amato, 2001; Johnston, 1994; Kelly & Emery, 2003), and the fact that high conflict parents often underestimate the effects of their conflicts on children (Anderson, Anderson, Palmer, Mutchler, & Baker, 2010), a replication of our findings in a high conflict sample of parents was deemed necessary.

STUDY 2

Our second study was guided by two central goals. First, recognizing the importance of applying the proposed hypotheses to a wider variety of relationships, it aimed to include divorced parents with high conflict levels. Second, we also sought to include more men to examine the robustness of our findings on gender differences in Study 1 (28% fathers). This is especially important because fathers' features and behavior are related with children's normal and abnormal development (Cassano, Adrian, Veits, & Zeman, 2006), but they are underrepresented in pediatric research and in therapeutic treatment of children's mental health (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005).

METHOD

Participants

Participants were 110 parents (mean age 42.6, *SD* = 5.6, range 26-60 years) who were referred for intervention at several family treatment centers in the Netherlands, because the wellbeing of their children was threatened by parents' long-lasting conflicts, aggression, and anger surrounding parental decisions. Men had a mean age of 43.3 (*SD* = 6.2, range 27-60), and women had a mean age of 42.0 (*SD* = 5.0, range 26-56). Ninety-six percent of the sample was native Dutch or Belgian. From 32 families only one parent participated, and from 39 families both parents participated. The 110 parents had 127 children, with a mean of 1.79 children (*SD* = 0.7) and the mean age of the oldest child was 10.9 years (SD = 3.6). Seventy-four percent of the parents had a new relationship (*n* = 72), and 27% had children in their new relationship (*n* = 19). One hundred percent had sought professional help to adjust to the divorce.

Procedure

Parents were recruited from ten outpatient health care institutions in different urban and rural regions of the Netherlands and Belgium. All parents were referred by judges, Youth Care Agencies (in Dutch: Bureau Jeugdzorg), or a physician, because the wellbeing of the children was severely compromised by the severity of the conflicts between the parents. After the referral, parents enrolled voluntarily in the intervention *No Kids in the Middle* (Van Lawick & Visser, 2015).

Parents were invited for clinical intake as soon as they had both signed up for the intervention separately. Together with the written invitation, parents received information about the research project entitled 'Parenting in the Aftermath of Divorce and *No Kids in the Middle*: an ongoing study among divorced families'. During the

first clinical intake, all questions parents had about the research were answered and the consent form was signed. Subsequently, the clinician informed the researcher and the researcher sent an email to parents with their personal code and a link to the online questionnaire. All questionnaires were programmed in Qualtrics, an online survey software program. Parents were asked to complete the online questionnaire before the second clinical intake or at least before the start of the intervention.

Measures

In Study 2, we used the same measures as in Study 1 to assess demographic information and family and divorce measures, confounding variables, co-parenting conflicts (Sweeper & Halford, 2006) ($\alpha = .75$), perceived network disapproval (Lehmiller & Agnew, 2007) ($\alpha = .62$), and forgiveness (Michael E. McCullough, 2013) ($\alpha = .91$).

Statistical Procedure

Like in Study 1, descriptive analyses were conducted to examine family, social network, and divorce characteristics, and possible gender differences. Second, to examine whether we successfully included a high-conflict divorce sample, we conducted an independent t-test to examine whether high conflict divorced parents in Study 2 showed more co-parenting conflicts than the divorced parents in Study 1. Third, we replicated the statistical procedures of Study 1.

RESULTS

Descriptives

Confounding variables and social network characteristics

Forty-six percent was male, so we succeeded to include more men in Study 2 than in Study 1. The educational level was moderate (46%, secondary vocational education) to high (53%, higher vocational education and university), and only 1% had a low level of education (lower vocational education). Parents had had a relationship with their ex-partner for 12.0 years ($SD = 6.3$; range 0-26), and had been separated for 4.6 years ($SD = 2.9$; range 0-12). Participants reported a mean of six persons ($SD = 2.8$) in their social network (range 0-10), 31% own family, 1% family of the other parent, 34% own friends, 0% friends of the other parent, 8% psychological counselors, 7% legal workers, 6% new partner, 12% other not specified, and 3% reported to have nobody.

Gender differences

To explore possible gender differences, we conducted independent-samples t-tests to compare the study variables for fathers and mothers. The results indicated that perceived social network disapproval, forgiveness, and co-parenting conflicts did not differ significantly across gender in the high conflict divorced group, $t(108) \leq 1.691$, $p \geq .094$, $d \leq 0.3252$ (for more information see Table 3).

High conflict divorce sample

Also, an independent-samples t-test examined hypothesized group differences for co-parenting conflicts. As expected, the sample of divorced parents in Study 2 scored significantly higher on co-parenting conflicts ($M = 3.34$, $SD = .72$) than the sample in Study 1 ($M = 2.36$, $SD = 1.04$), $t(235) = 8.666$, $p = .000$, $d = 1.1297$. So, our recruitment strategy successfully resulted in the inclusion of parents involved in high-conflict divorces.

Zero Order Correlations

The pattern of zero-order correlations in Study 2 (see Table 3 for more details) closely replicated the one observed in Study 1. Again, higher levels of perceived social network disapproval were significantly related to more co-parenting conflicts ($r(110) = .262$, $p = .006$), and to lower levels of forgiveness ($r(110) = -.301$, $p = .001$). Also, lower levels of forgiveness were significantly related to more co-parenting conflicts ($r(110) = -.408$, $p = .000$).

Table 3. Descriptives and Zero-order Correlates of all Study Variables Study 2

	Mean		Study 2 $n = 110$ SD			
Variable	male	female	male	female	1.	2.
1. Network Disapproval	3.31		.75			
	3.19	3.40	.78	.73		
2. Co-parenting conflicts	3.34		.72		.262**	
	3.46	3.23	.75	.68		
3. Forgiveness	3.23		.79		−.301**	−.408**
	3.28	3.18	.73	.84		

*$p < .05$, **$p < .01$.

Forgiveness as a Mediator

Importantly, replicating the mediational findings in Study 1, simple mediation analyses using ordinary least squares path analysis yielded that perceived social network disapproval indirectly influenced the amount of co-parenting conflicts through its

effect on forgiveness in Study 2. As presented in Table 4, parents who perceived more disapproval in their social network were less likely to forgive the other parent ($b = -.317$, $p = .001$), and when parents were less likely to forgive the other parent, they reported more co-parenting conflicts ($b = -.327$, $p = .000$). We calculated bias-corrected bootstrap confidence intervals estimated based on 5,000 bootstrapped samples and a 95% confidence interval. The indirect effect (ab) of perceived network disapproval through forgiveness on co-parenting conflicts, did not include zero (for more details see Table 4), which indicates that the effect is significant.

Again, the indirect effect (ab), controlling for the effect of parental educational level ($b = .008$, $se = .026$, $p = .773$), length of parental relationship ($b = -.001$, $se = .001$, $p = .257$), time since separation ($b = -.057$, $se = .024$, $p = .019$), and gender ($b = -.247$, $se = .132$, $p = .064$), of perceived social network disapproval through forgiveness on co-parenting conflicts, did not include zero (for more details see Table 4), which indicates that the effect remained significant. In contrast to Study 1, Table 4 shows that perceived social network disapproval was no longer a significant predictor after controlling for the level of forgiveness, indicating full mediation.

Because 78 participants were ex-partners (39 couples), their answers may not have been statistically independent. To examine the robustness of our findings and to rule out possible effects of statistical interdependence, we conducted mixed analyses with a random intercept model. All results remained unchanged.

Table 4. Forgiveness (F) as a Mediator Between Perceived Social Network Disapproval (ND) and Co-parenting Conflicts (CC) in high conflict divorced families (n = 108)

		95% CI				
Model	*ab*	*LL*	*UP*	k^2	*c (p)*	*c'(p)*
ND → F → CC	.104	0.0325	0.2172	.1089	.249(.006)	.146(.097)
ND → F → CC (with covariates)	.109	0.0369	0.2239		.258(.004)	.148(.082)

Note. Unstandardized regression weights are presented. k^2 represents kappa, an effect size measure for indirect effects. *c* represents the direct effect of perceived social network disapproval on co-parenting conflicts. *c'* represents the direct effect of perceived social network disapproval on co-parenting conflicts, controlling for forgiveness. Covariates are educational level, relation length, and gender.

BRIEF DISCUSSION

Results of Study 1 were consistently replicated in Study 2. Among parents with high levels of co-parenting conflicts, we found a positive relation between perceived social network disapproval and the number of co-parenting conflicts. Furthermore, results confirmed our hypothesis that forgiveness between ex-partners plays a crucial role in explaining this association. So, the results provide empirical support for the indirect

relation between perceived social network disapproval and co-parenting conflicts through parents' tendency to forgive the other parent in a group of high-conflict parents. In contrast to Study 1, Study 2 revealed full mediation of forgiveness. By adopting a different recruitment procedure, we succeeded not only in including a high-conflict divorce sample, but also in including more fathers than in Study 1. Additionally, all effects remained significant when we ruled out possible statistical interdependence among ex-partners. All three aspects contributed to the robustness of our results.

GENERAL DISCUSSION

The findings of the two studies presented here shed light on one underlying mechanism that can account for why in many divorced couples co-parenting conflicts are maintained or even escalate. Results showed that parents who perceive more disapproval in their social network after a divorce have more co-parenting conflicts. In addition, the willingness of parents to forgive the other parent's transgressions explained, at least in part, the link between perceived network disapproval and co-parenting conflicts. Speaking of the robustness of these results, we found the hypothesized mediation across two studies, involving a convenience sample of divorced parents and a sample of high conflict divorced parents whose children were clinically referred for intervention because their wellbeing was severely compromised by the severity of parental conflicts. These findings are in line with a growing body of research demonstrating the importance of the broader social network on relationship processes between (ex)partners (Agnew, 2014; Crowley & Faw, 2014; Hogerbrugge, Komter, & Scheepers, 2013).

Consistent with our first hypothesis in both studies, we found that divorced parents who perceived more disapproval in their social network had more co-parenting conflicts. Extending existing previous work on the importance of social network influences on relationship quality in ongoing relationships (Lehmiller & Ioerger, 2014), the current research demonstrated that the perception of a negative attitude toward an ex-partner is linked to more parental conflict. Our findings are compatible with our suggestion that ex-partners mobilize social and emotional support to justify the divorce (Sprecher & Felmlee, 2000), which may help the individual ex-partners to increase their sense of belonging and decrease feelings of uncertainty (Eaton & Sanders, 2012). Despite its beneficial effect for individuals' post-divorce adjustment (Kramrei et al., 2007), our findings suggest that such perceptions of social network approval of the divorce may be perceived as social network *dis*approval of the continuing co-parenting relationship and are positively related to co-parenting conflict.

Our studies did not allow us to test these processes, because they were correlational and did not include items tapping ex-partners strategies to mobilize support (Crowley & Faw, 2014). In light of the important implications such insights may have for interventions, longitudinal research on these strategies and the interplay of approval of the divorce and disapproval of the co-parenting relationship would be particularly promising. Another future direction for research may be the actual involvement of social network members to answer the question whether parents' *perceived* social network disapproval is the same as parents' *received* disapproval, and second, whether received disapproval is also related to the co-parenting relationship. In a review, Haber, Cohen, Lucas, and Baltes (2007) showed that perceived social support is related to relationship quality, but received social support is not.

In line with previous research, we found support for our second hypothesis, that the level of forgiveness is positively related to the quality of the co-parenting relationship among divorced parents (Bonach, 2005; Bonach & Sales, 2002; Reilly, 2014; Rye et al., 2012). These results suggest that parents who are more likely to forgive each other's transgressions made in the far or recent past, may be more capable to prioritize their children's well-being and share parenting responsibilities in a mutual supportive and cooperative way (Maccoby et al., 1990; Nunes-Costa et al., 2009). Underlining the important implications these findings have for interventions, a preliminary study by Reilly (2014) in a small sample of high-conflict divorce cases ($n = 32$) provided initial evidence that a psycho-educational intervention focusing on forgiveness (Worthington & Scherer, 2004) can promote forgiveness and co-operative co-parenting. More research is needed to examine the role of forgiveness in intervention programs for high-conflict divorces.

Although we confirmed the hypothesized mediation model in both studies, Study 1 yielded a partial mediation, while Study 2 yielded a full mediation model. These findings require replication and explanation. One explanation may be that, although there is a decline in overlap between parents' social networks after divorce (Albeck & Kaydar, 2002; McDermott et al., 2013), an overlap between the social networks remains in less conflictive divorces (e.g., children keep seeing grandparents). In high-conflict divorced families, two villages seem to be at war, and often there is no contact and/or overlap between the social networks (Van Lawick & Visser, 2015). Given the greater overlap in social network, social network partners in less conflictive divorces may have more information about transgressions between both parents, or they blame 'the other' parent less (Green et al., 2014). More research, ideally including network partners, is needed to examine these suggestions.

While our studies shed light on one potential mechanism underlying the link between perceived social network disapproval and co-parenting conflicts, other mechanisms seem possible. For example, parents who perceive more network disap-

proval may interpret this disapproval as emotional support for their feelings regarding old marital conflicts (Cabrera, Shannon, & La Taillade, 2009), or as support for child custody disputes (Sbarra & Emery, 2008).

Research Strengths, Limitations, and Future Research Directions

Before closing, it is important to note several strengths and a limitation of the present work. Limitation of the present research is the cross-sectional nature of both studies. Nevertheless, the direction of the proposed associations is consistent with longitudinal studies showing that forgiveness predicts conflict resolution (e.g., Fincham et al. (2007). Although plausible, other directional effects can be proposed. To illustrate, DiDonato, McIlwee, and Carlucci (2015) manipulated relationship partners' forgiveness and found that it predicted how social network partners perceived the relationship of the forgiving individual with the perpetrator. Specifically, more forgiveness was associated with great perceived commitment, satisfaction, and warmth. These results not only emphasize the need for more experimental and prospective studies investigating the proposed links, but also point to the possibility that parental forgiveness, co-parenting conflicts, and perceived social network (dis-)approval may reinforce each other in a cyclic model.

One important strength is the robustness of the results, which replicated across a convenience sample of divorced parents recruited via online forums and a clinical sample of high-conflict divorced parents. A second strength is the broader relational perspective we took in this research. Till now, research mostly focused on the effects of social support and approval of family and friends on individual parental adjustment after divorce (Kramrei et al., 2007), and on social network influence on partners' decision to divorce (Hogerbrugge et al., 2013). Our study showed that social network (dis)approval also affects the post-divorce relationship between ex-partners. This is important as more and more divorced parents maintain a co-parenting relationships and (un)forgiveness is especially impactful when divorced parents have frequent contact (Kluwer, 2015). Second, in the clinical sample, we were able to include 46% fathers, allowing us to examine gender differences and to exclude their confounding influence in the proposed links. Although fathers' characteristics and behavior are associated with children's normal and abnormal development, fathers are underrepresented in child psychopathology research (Cassano et al., 2006), as well as in pediatric research and in therapeutic treatment of children's mental health (Phares et al., 2005).

Clinical Implications

The findings of this research highlight the role of forgiveness for the quality of the co-parenting relationship. Information and psycho-education about the found re-

lation between forgiveness and co-parenting conflicts, and the impact of conflicts on children's well-being and adjustment (Amato, 2001; Kelly & Emery, 2003), may promote forgiveness among divorced parents and decrease parental conflicts (Reilly, 2014). In addition, our findings suggest that it may be helpful to include the social network in interventions and stimulate the networks of both ex-partners to exchange information about parents' perceived stable and internal characteristics, about negative attributions they have of the other parent, about apologies made by one or both parents (Cheung & Olson, 2013; Eaton & Sanders, 2012; Green et al., 2008), and their own role in parental conflicts between ex-partners. Derived from our questionnaire, a clinician could for example ask a social network member: "Do you approve of the relationship your family/friend still has with the other parent?". Or, also derived from our questionnaire, a clinician could for example ask a parent: "Although your ex-partner has hurt you, is it possible to put the pain aside, and to move on in your co-parenting relationship?". The intervention *No Kids in the Middle* (Van Lawick & Visser, 2014) is aimed to decrease co-parenting conflicts by inviting both social networks in the intervention and by promoting mutual parental forgiveness. The effectiveness of this intervention is currently being investigated.

Elaborating on the clinical importance of forgiveness in high conflict divorce, Worthington and Scherer (2004) offer an interesting perspective on forgiveness. There is substantial evidence that divorced adults, relative to married adults, report more psychological distress (Sweeper & Halford, 2006). Worthington and Scherer (2004) conceptualize forgiveness as an emotion-focused coping strategy to reduce stress as a reaction to transgression. In this light, forgiveness may be stimulated between high conflict divorced parents by clinical work focused on stress reduction like mindfulness (Webb, Phillips, Bumgarner, & Conway-Williams, 2013). To this end, Van Lawick and Visser (2015) also use mindfulness as a component in their intervention.

Concluding Remarks

Divorce is particularly difficult for parents because they have to continue to be parents together. Especially in light of findings showing that conflictive relationships among divorced parents are associated with important decrements in the psychosocial well-being of children, enhancing our understanding of how and why conflicts among divorced parents escalate is crucial. The current set of studies identified forgiveness as an important mechanism to explain parenting conflicts among divorced parents. Both studies showed that perceived network disapproval of the co-parenting relationship was related to less forgiveness among ex-parents, which, in turn, was associated with more co-parenting conflicts. The present work thereby offers an important contribution to the current knowledge on the role of social networks in relationship

breakup. We have demonstrated the proposed relations across both a convenience sample and a clinical high-conflict sample. Our findings thereby provide important inroads for interventions.

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Chapter 6

Summary and general discussion

INTRODUCTION

The impact of destructive parental conflicts on the whole family system, not only requires child-focused but also parent-focused interventions to decrease children's symptoms and to improve their well-being. Interventions aimed at decreasing negative direct effects of exposure to destructive parental conflicts (Cohen et al., 2010) need to be improved by adding parent-focused components aimed to decrease the negative indirect effects of destructive parental conflicts on children, such as negative parenting behavior and impaired parent–child relationships. Because parents can be adversely affected in a variety of ways (e.g., depressed, frightened, stressed) by the parental conflicts, examining how the mental health state of parents can cross over to children's self-reported stress symptoms, provides a relevant contribution to our knowledge on how parental conflict affects children. Such reasoning also applies to examining the negative relation between exposure to destructive parental conflicts and the parent–child relationship. When parents are stressed by the parental relationship, or by a divorce, they may be occupied by daily life stress, they may be frustrated and tired. As a result, they may find it difficult to direct their attention to the children, to be psychologically available, or to talk about emotions with their children. The first goal of this dissertation was to contribute to a better understanding of the impact of destructive parental conflicts on children and their environment by examining relational mediating processes and pathways relating parental conflict on the one hand to parent functioning and parent–child relationship quality, and to children's psychosocial well-being on the other. I examined these questions in families exposed to interparental violence (Chapters 3 and 4).

A specific group of families with parental conflicts are divorced parents. They face the challenge of establishing a high quality co-parenting relationship despite of their relationship difficulties. This is crucial, not only for parental adjustment (Katz & Woodin, 2002), but also because co-parenting quality with a low level of destructive conflicts is essential to ensure children's healthy development (Amato, 2005; Bronstein, Clauson, Stoll, & Abrams, 1993; Nunes-Costa, Lamela, & Figueiredo, 2009; Whiteside, 1998). An important question for research is then how conflicts between parents are maintained and/or how they escalate. In high conflict divorced (HCD) families not just parents and children are involved in the destructive parental conflicts, but also the extra-familial network. As a result, family, friends, lawyers, teachers and other social network members are likely to have a role in the maintenance and escalation of destructive parental conflicts. The second goal of this dissertation was to get a better understanding of the specific relational processes that maintain parental conflicts after divorce. Examining how the social network of parents may contribute to the maintenance of parental conflicts also provides important knowledge.

First, I examined a high-risk sample of parents and children (4 – 12 years) exposed to interparental violence (IPV). In this sample, I tested how the effects of IPV on both parents and children influence each other in relational processes. Specifically, and based on parents' and children's self-reports, I examined how parental stress may cross over to children's stress-related symptoms. Furthermore, I compared parent–child communication in IPV exposed and non-IPV exposed families, based on behavioral observations.

Second, I examined relational processes that maintain parental conflicts in a specific sample of families with destructive parental conflicts, namely HCD families. Before testing my hypothesis in a clinical sample, I first tested how parents' tendency to forgive each other mediated the positive link between perceived social network disapproval and parental conflicts in a convenience sample of divorced families. Following this initial test, I replicated these findings in a sample of HCD families referred for treatment because the mental health of the children was severely compromised by the severity and duration of the conflicts between parents. The current chapter provides a summary and discussion of the main findings, strengths and limitations, and will set out future directions for research and clinical practice.

MAIN FINDINGS

Relational Processes in the Aftermath of Exposure to IPV

Although research shows that children are not only directly affected by IPV but also indirectly, through parenting and the parent–child relationship (Appel & Holden, 1998; Krishnakumar & Buehler, 2000; Levendosky & Graham-Bermann, 2001), the possible interpersonal cross-over effect of parental psychopathology to children's self-reported trauma-related symptoms has not been examined, yet. This was the main aim of Chapter 3. In this chapter the main result was that parents' ability and motivation to direct psychological resources at the children mediates the link between parental psychopathology and children's self-reported IPV-related anxiety, depression, and anger. In the study reported in Chapter 3, this parental availability (Danner-Vlaardingerbroek, Kluwer, van Steenbergen, & van der Lippe, 2013) was found to be one underlying mechanism to explain a crossover effect, in a high risk sample of IPV families, from parental psychopathology to children's trauma-related symptoms. Specifically, the results indicated that parents' psychopathology spills over to parents' ability to direct psychological resources at the children, which in turn affected children's trauma-related symptoms. Spillover effects were defined as the intrapersonal mechanism by which stress experienced in one life-domain results in stress in another life-domain for the same individual (Westman, 2001), in this study

parents exposed to IPV. Crossover effects were defined as the interpersonal mechanism by which the psychological strain and stress of one person affects the level of psychological strain and stress of another person in the same social context (Westman, 2001); in this study parents were assumed to affect children. More specifically, more parental psychopathology was related to more IPV-related anxiety, depression, and anger in children through a decrease in parental availability.

Although abundant research shows that parents are affected by IPV, too (Campbell et al., 2002; Woods, 2005), the results reported in Chapter 3 indicate a new pathway through which parental mental health may indirectly affect children's mental health. These results suggest that parental psychopathology may limit the capability of a parent to be fully available for the child. For example, when the child comes home after trauma treatment and wants to talk about a bad memory involving a fight between the parents, and finds a depressed mother in bed without any energy or interest to listen to the child, children's reactions may be characterized by children's withdrawal or anger. The lack of direct relations between parental psychopathology and children's anger and anxiety suggest that children's emotional reactions need not necessarily be attributed to the parent's psychological functioning, but to the parent not being available to comfort the child. Another important mechanism may be that parental psychopathology is linked to a diminished capability to listen to and share positive events with the child. Research shows that both the act of telling others about good events and the response of the person with whom the event was shared have positive consequences (Gable & Reis, 2010). Personal benefits may be subjective well-being and self-esteem, and decreased loneliness. Relational benefits are linked with commitment, trust, liking, closeness and stability. So, when a child comes home and wants to tell about a happy adventure with a friend, while mother reacts with anxiety, again, children's reactions may be characterized by anger or withdrawal.

In contrast to what I expected based on the existing literature (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012), parental psychopathology did not have a crossover effect on children's posttraumatic stress symptoms, neither directly nor indirectly. This lack of a link between parental mental health and children's posttraumatic stress symptoms may be because of a multitude of additional processes and factors which may put children at risk for developing posttraumatic stress symptoms not measured in this study (e.g., direct effects of IPV on children; effects of severity and duration of earlier traumatic experiences on children) (Trickey et al., 2012).

Also, in contrast to what I expected based on the literature on single trauma and exposure to community violence (Bokszczanin, 2008; Gil-Rivas, Silver, Holman, McIntosh, & Poulin, 2007; Kliewer, Lepore, Oskin, & Johnson, 1998), parental availability was not related to children's trauma symptoms. It is possible that in IPV families, children need their parents' availability to process traumatic events in

another way than I envisaged. To process difficult and even traumatic life events, it is important for children to give meaning to the IPV they have been exposed to (McDonald, Jouriles, Rosenfield, & Leahy, 2012), and to form a coherent narrative of the events (Cohen, Mannarino, & Murray, 2011). In this research, I assessed parents' capacity to be psychologically available to the child and to be able to spend time with the child (Danner-Vlaardingerbroek et al., 2013). Nevertheless, it may be that more specific capacities of parents are needed, such as being able to verbalize emotional experiences in a developmentally adequate way. Thus, parents may not only have to be available, but also capable of talking about emotions in a meaningful and sensitive way that helps children to process traumatic events like IPV.

Research showed that parent–child relationships in which children feel safe to give meaning to traumatic events, may enhance their recovery (e.g., Fivush, 2007; Oppenheim, 2006). At the same time, it is known that parent–child relationships in families exposed to IPV may be of low quality (Appel & Holden, 1998; Levendosky & Graham-Bermann, 1998; Levendosky & Graham-Bermann, 2000; Levendosky & Graham-Bermann, 2001; Osofsky, 2003). However, observations of parent and child contributions to emotion dialogues in IPV exposed families and non-exposed families were neither studied nor compared, yet. My dissertation was the first to fill this theoretical gap. The second main result of the current study is that mother–child emotion dialogues are of lesser quality in IPV-exposed dyads than in dyads not exposed to IPV. Specifically, in the research reported in Chapter 4, I found that in IPV families, mother–child dialogues were often classified as flat (Koren-Karie, Oppenheim, Haimovich, & Etzion-Carasso, 2003). Flat mother–child dialogues are characterized by a lack of involvement of both parent and child, low elaboration, and poor development of the stories compared to healthy mother–child dialogues. Furthermore, mothers showed less sensitive guidance and children showed less co-operation and exploration when exposed to IPV, compared to mothers and children not exposed to IPV. These results may have important implications for children's development. Lower quality of mother–child emotion dialogues may impede children's healthy adjustment to possibly overwhelming experiences such as exposure to IPV (Fivush, Marin, McWilliams, & Bohanek, 2009)

Taken together, the results in Chapter 3 and 4 of this dissertation highlight the importance of focusing on parental availability and parent–child emotion dialogues in the treatment of children in the aftermath of IPV exposure. Crucially, they underline that parenting and the parent–child relationship need to be taken into account to improve our understanding of the indirect effects of IPV on children.

Relational Processes in the Maintenance of Parental Conflicts

Although the link between social network approval or disapproval and the quality of romantic relationships (e.g. Le, Dove, Agnew, Korn, & Mutso, 2010), and parents' individual adjustment after divorce (Sprecher & Felmlee, 2000) is well-established, the relation between perceived social network disapproval and the level of destructive parenting conflicts has not been examined, yet. Furthermore, research shows that the level of forgiveness is also an important predictor of the quality of the co-parenting relationship (Reilly, 2014; Rye et al., 2012). However, to my knowledge, forgiveness has never been studied as a possible underlying mechanism in the link between perceived network disapproval and conflicts. This was studied in Chapter 5. In this chapter, the main result was that the level of parenting conflicts in divorced couples is associated with perceived social network disapproval and that this link is mediated by parents' tendency to forgive each other. I found this result first in a convenience sample of divorced parents. Then I replicated the result in a clinical sample of HCD families who were referred to treatment because of the imminent threat parental conflicts posed to the psychosocial wellbeing of their children. The replication of the proposed mediation results in two different samples underlines the robustness of the findings.

The results confirm the established positive relation between social network support and the quality of the co-parenting relationship. Specifically, a high quality co-parenting relationship is often characterized by high levels of positive support among parents and low levels of destructive conflicts (e.g., Whiteside & Becker, 2000). The results reported in Chapter 5 extend our knowledge by indicating a new underlying mechanism which may explain why in many divorced couples co-parenting conflicts are maintained or even escalate, namely through parents' unwillingness to forgive each other. Forgiveness is an important interpersonal process, which serves to maintain the relationship after conflicts (for a review see Karremans & Van Lange, 2008). Family, friends and other important social network members can be regarded as third parties in conflicts between parents. For several reasons, third parties are generally less forgiving than first parties (for a review, see Green, Davis, & Reid, 2014). So, parents may perceive that close others are not willing to forgive their ex-partner, which may fuel a less forgiving attitude in the parent. This less forgiving attitude, in turn, may explain the continuation and escalation of destructive parental conflicts after a divorce. These results suggest the importance of focusing on parental forgiveness in interventions for HCD families. In addition, they underline the importance of involving the social network of both divorced or separated parents.

LIMITATIONS AND STRENGTHS

Limitations of the Current Research

Causality of the results: cross sectional study

A limitation of the research in Chapter 3, 4 and 5 is the cross-sectional nature of the studies. Nevertheless, the direction of the proposed associations is consistent with longitudinal studies showing that positive parenting behavior and high quality parent–child relationships predict children's healthy development and wellbeing (e.g., Afifi & MacMillan, 2011; Eisenberg et al., 2005). Also, forgiveness predicts conflict resolution in longitudinal studies (e.g., Fincham, Beach, & Davila, 2007). Although these results are certainly plausible, other directional effects can be proposed. To illustrate, Stice and Barrera (1995) found that negative parenting was not prospectively related to externalizing symptoms in adolescents, although adolescent externalizing symptoms prospectively predicted negative parenting. Also, as mentioned in Chapter 5, DiDonato, McIlwee, and Carlucci (2015) manipulated relationship partners' forgiveness and found that it predicted how social network partners perceived the relationship of the forgiving individual with the perpetrator. Specifically, more forgiveness was associated with greater perceived commitment, satisfaction, and warmth. These results emphasize that relational processes in families exposed to destructive parental conflicts may reinforce each other in a cyclical model. To investigate relational processes in these families the ideal study is with prospective data collection over multiple time points, with both a normative and a clinical sample.

Generalizability: informed consent, sample size, child age and development.

Generalizability of the results may be limited for several reasons. First, the generalizability may be limited, because selection bias cannot be ruled out. In the Netherlands, the Central Committee on Research Involving Human Subjects requires, based on Dutch law, that both parents give informed consent to participate in research for children till 16 years. As required by law, and the Medical Ethical Committee of the VU University, *both* parents had to consent to children's treatment and to their participation in the research project.

In the Netherlands, as in many other countries, (mental health) clinicians need to obtain the consent of both parents for the assessment and treatment of a child, also in the aftermath of child abuse and neglect. Before reporting to Child Protection Services, Dutch professionals are obliged to refer a family on a voluntary basis to counselling, treatment or (psycho)therapy. Clinicians then need to obtain permission for assessment and treatment from *both* parents. In IPV families, however, it cannot be assumed that *both* parents protect the child's best interest. Often one, or

both parents minimize(s) the effects of their conflicts, in the belief that their children were not aware of the fights. For example, parents often assume that children did not witness their conflicts, because they only fought when the children were sleeping (Koren-Karie, Oppenheim, & Getzler-Yosef, 2008; Pynoos, Steinberg, & Piacentini, 1999). Also, parents might not wish to give consent, because they fear this might be used as an acknowledgement of child abuse, or IPV. Finally, parents may refuse consent for treatment to annoy the other parent, or to prevent disclosure of (personal) problems not yet known to the professional. In the Netherlands, clinicians are obliged to acquire both parents' consent for treatment, even if this takes months. If a parent refuses to give consent for treatment, the clinician can report the family to Child Protection Services, which can force parents to start assessment and therapy.

A first limitation of the 'double consent' requirement and the long procedure may have excluded children, often the most traumatized and marginalized, from treatment and therefore also from the research reported in this dissertation. As a result of these strict demands, it is likely that the representativeness of the sample that was recruited and therefore the validity of the findings are at risk (Cashmore, 2006). To study a representative sample of exposed children, a clinical assessment of all children and their families reported at Child Protection Services is necessary.

A second limitation of the double consent requirement is the small sample size. Despite our efforts to obtain a larger sample size, I did not get sufficient numbers of participants to enable us to present results of the study protocol described in Chapter 2. Also, the sample size in Chapter 3 was quite small, 78 children and their 65 parents participated. However, I tested the robustness of the findings and repeated the reported analyses for multiple sub-samples (inclusion of only the eldest children; inclusion of only the mothers; dyads which filled out all three questionnaires; exclusion of children who had an underscore on the trauma symptom checklist). The results across the different subsamples remained essentially the same in direction and strength, which underlines the robustness of the findings.

Another aspect that limits the generalizability of our findings is the focus on families exposed to destructive parental conflicts with children aged 4 to 12 years. Young children learn to talk about emotional events, primarily, in the parent–child relationship (Kopp, 1989). However, adolescents face different developmental challenges (Scharf, Mayseless, & Kivenson-Baron, 2004) and were not included in this sample. How the results can be translated to families exposed to destructive parental conflicts with adolescents, or how family relationships will develop over time and affect emotional well-being and children's healthy development, is not known.

Adolescents have to learn how to engage in intimate relationships with friends, how to engage in romantic relationships, and at the same time how to establish an autonomous role in the parent–child relationship by the time they leave home (Scharf

et al., 2004). Furthermore, research shows a link between exposure to destructive parental conflicts and dating violence in adolescence (Dardis, Dixon, Edwards, & Turchik, 2014). The developmental age of children will in all probability influence the direct and indirect effects of IPV on family relationships, and will also affect post traumatic reactions. Falling in love, having a conflict with your romantic partner may be new life events for the adolescent, which may give new meaning to the exposure to IPV in the past and/or the present. In other words, children who may have experienced traumatic experiences at a younger age may later on have posttraumatic reactions because of new life events. To study long-term and developmental aspects of relational processes in families exposed to destructive parental conflicts, longitudinal research, with experimental data collection, from early childhood into adulthood may be especially promising, if we wish to find out about long-term effects of IPV and HCD children.

The role of fathers in IPV families in research

Unfortunately, and in line with other research (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005), in both IPV studies the majority of participants were mothers (Chapter 3, 94%, and in Chapter 4, 100%). Fathers as participants are underrepresented in child psychopathology research (Cassano, Adrian, Veits, & Zeman, 2006), in pediatric research, and in therapeutic treatment of children's mental health (Phares et al., 2005). Specifically, in child maltreatment research fathers are underrepresented (Dubowitz et al., 2001). We need more fathers as participants to understand their roles and relationships in IPV-exposed families.

By (almost) only having mothers participating in the studies, we run the risk of getting a one-sided picture of the family violence children have been exposed to. The mothers participating in this research reported on the father's violence (peer report), and they reported about the violence they used themselves (self-report). Self-reports may be limited by considerably disparity in recall for violence between mothers and fathers (Browning & Dutton, 1986), by lack of awareness, and by social desirability (Morsbach & Prinz, 2006). We need fathers' reports about family violence to gain a more complete overview of the violence children have been exposed to. Such knowledge may have important implications for the relational processes in parenting as well as for the parent–child relationships of both parents. For example, Guterman, Lee, Lee, Waldfogel, and Rathouz (2009) showed that a healthy father–child relationship was associated with a reduced risk of maternal child abuse. Also, perpetrators of IPV may undermine their ex-partners' parenting in different ways (Bancroft & Silverman, 2002). So, perpetrators' parental behavior (mothers and/or fathers) may be especially important to address to promote healthy and supportive parental relationships, and to repair and enhance healthy parent–child relationships. In Chapter 5, I succeeded

at including 46% fathers to participate in this study, because they were already committed by treatment. To increase fathers' participation in research, increasing their commitment to treatment seems essential.

Strengths of the Current Research

Apart from the abovementioned limitations, the studies in this dissertation also have several noteworthy strengths. First, I commenced the integration of two different research areas, by combining not only a focus on IPV families, but also on HCD families. Children living in IPV and HCD families are exposed to destructive parental conflicts. These conflicts affect the whole family system, both parents and children. In Chapter 1, I highlighted the similarities between these two groups of families regarding the direct and indirect effects on children. However, I also distinguished between the two groups of families, based on the extra-familial context of the destructive conflicts between parents in HCD families. So, future research in both areas could benefit by using the same or comparable measures, and by including both kinds of families, IPV exposed and HCD families.

Second, the studies reported in the Chapters 3 and 4 not only included parental reports but were also based on children's self-report and observational measures. Using self-report questionnaires for children is important because different informants may have different perspectives on children's symptomatology (Lanktree et al., 2008). Furthermore, Hennigan, O'Keefe, Noether, Rinehart, and Russell (2006) found that current maternal psychological distress was associated with more pessimistic assessments on children's symptoms. In their review about the relation between interparental conflicts and children's adjustment, Buehler et al. (1997) found that only 23% of interparental conflicts were measured by way of observations, and that observational data produced stronger effect sizes between IPV and children's symptoms than questionnaires. For this reason they recommended the use of behavioral observations when studying parental and parent–child relationships and IPV. In Chapter 4 I used an observational measure of the parent–child relationship.

Third, in Chapter 5, I identified parents' tendency to forgive each other as one underlying mechanism between perceived social network disapproval and parental conflicts, which may account for the maintenance and escalation in divorced families. One strength of this study is the replication of this result in HCD families: Families in which the children were referred for intervention because their mental health was seriously compromised by the severity of the parental conflicts. This is especially important because clinical implications based on scientific research for this group of children are scarce.

DIRECTIONS FOR FUTURE RESEARCH

The results of this dissertation provide several recommendations for future research. Below, I will discuss three issues that may guide future research to improve our understanding of the impact of destructive parental conflicts on the whole family system. First, I suggest how the two separated research fields of IPV and HCD families may be more integrated by addressing issues (relational processes in the nuclear family and extra-familial influences) present in both areas. Second, I illustrate how the results may be important for understanding abuse-specific parent–child interactions. Third, I suggest, in addition to the role of the social network in maintaining, and potentially enlarging divorce-related conflicts, to study the possible influence of other characteristics of HCD families on maintaining parental conflicts.

Comparing HCD and IPV Exposed Families

Future research would gain from parallel research in both IPV-exposed and HCD families to delineate similar as well as different pathways of mediators and moderators between parental relationship characteristics, the maintenance of destructive conflict, social network risk and protective factors for different subsystems, parenting behavior and child and parent mental health outcomes. As mentioned in Chapter 1, one of the most salient similarities between families exposed to IPV and to HCD is how destructive parental conflicts affect children not only directly, but also indirectly because of the negative influence of the conflicts on parenting behavior and the parent–child relationship. A characteristic distinguishing the two groups of families, based on clinical experience and descriptions of HCD (Anderson, Anderson, Palmer, Mutchler, & Baker, 2010; Van Lawick & Visser, 2014), seems to be the extra-familial context of the unresolved, ongoing conflicts by parents in high-conflict divorced families. However, the underlying mechanisms of the indirect and direct effects need to be studied in HCD families, and the influence of the social network on the maintenance of parental conflicts in IPV exposed families, which to my knowledge has not yet been investigated.

Another important research question in HCD and IPV exposed families concerns the dynamics and development of violence (e.g., when, if, and how often family violence occurs, severity, and chronicity). The rates of family violence in HCD families are estimated to range from 25 to 50 percent (Morrill, Dai, Dunn, Sung, & Smith, 2005). Yet, these studies mainly include intimate partner violence of male perpetrators and female victims. This gender paradigm frames intimate partner violence as primarily male perpetrated, and presents female intimate partner violence as self-defensive. Dutton, Corvo, and Hamel (2009) have argued that a predominant gender paradigm in domestic violence is politically driven and not supported by the data. At

the same time, apart from this gender paradigm, the differentiation between types of intimate partner violence (Kelly & Johnson, 2008), the development of family violence over time, and the risk of poly-victimization for children (Finkelhor, Turner, Ormrod, & Hamby, 2009) have over the last decade been recognized as especially important as they may point to future directions for interventions. Especially longitudinal, multi-informant, experimental research may deepen our understanding of how to intervene in these families on all abovementioned aspects. One example, a study to examine if different types of IPV serve as a moderator in the link between the intervention "*No Kids in the Middle*" and child outcome.

Abuse-specific parent–child communication and parental availability

The results of Chapter 4 led to another important research question, namely how mother–child communication about daily events may transfer to mother–child communication about IPV-experiences. Preliminary results of a comparison between mother–child dialogues about a devastating tornado and about two affectively more neutral events suggest that mother–child conversations about traumatic and non-traumatic events are more similar rather than different (Bauer, Burch, Van Abbema, & Ackil, 2007). However, conversations about multiple, interpersonal traumas like destructive parental conflicts may have some additional challenges compared to conversations about a single trauma like a natural disaster. With multiple or chronic, interpersonal traumas such as family violence, both parents and children may experience feelings of isolation, shame, and guilt (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Street, Gibson, & Holohan, 2005). In addition, role reversal may influence children's contribution to difficult and possibly negatively affected family issues (Carroll, Olson, & Buckmiller, 2007). Future studies are needed to compare mother–child emotion dialogues about IPV events with mother–child emotion dialogues about daily negative events.

Research suggests that parents exposed to IPV more often focus their attention on their own needs rather than on their children's needs (Koren-Karie et al., 2008; Pynoos et al., 1999). Also, they tend to underestimate the influence of IPV on their child (Cohen, Hien, & Batchelder, 2008; Koren-Karie et al., 2008; Van Rooij, van der Schuur, Steketee, Mak, & Pels, 2015) and may experience their children's behavior as a reminder of their own trauma (Lieberman, 2004). My results suggest that in future research more attention should be paid to the mechanisms explaining how dimensions of IPV-related parental psychopathology are associated with perceived (by parents and children) and observed (by researchers) parental unavailability in daily exchanges between IPV exposed parents and their children. Longitudinal research and a more complete assessment, with different informants and observational measures of the full range of parental mechanisms that facilitate the reduction of

children's symptoms in the aftermath of IPV exposure is essential to providing effective treatment.

Relational processes in maintaining, and potentially deteriorating, divorce-related conflicts

Several attempts have been made to characterize HCD families (Anderson et al., 2010; Retz, 2014). However, often the characteristics mentioned have not yet found empirical support (Anderson et al., 2010). Similarly, the possible influence of the social network on destructive parental conflicts has largely been ignored. As we still have only scant knowledge of how conflict works within the broader family system context, I examined whether the perceived views of the social network members in HCD families affected the continuation of destructive conflict in HCD families.

When developing "*No Kids in the Middle*" (Van Lawick & Visser, 2014) (see also Appendix I), we assumed that five relational factors contribute to destructive conflicts among HCD parents and thus to the deterioration of children's psychosocial wellbeing and healthy development. These five factors, among which social network influences figure prominently, are anchored in the existing literature (Finkenauer et al., 2014; Van Lawick & Visser, 2014): 1) polarized opinions of social network members (see Chapter 5), 2) hostile attributions and feelings (Bradbury & Fincham, 1992), 3) incongruence of goals (Fincham & Beach, 1999), 4) superindividual conflicts (Johnston, 1994), and 5) perceived inequity between parents (Davidson, Balswick, & Halverson, 1983). In this thesis, I only studied one factor that contributes to parents' divorce-related conflicts, namely perceived social network disapproval of the co-parenting relationship. Future research examining the extent to which the other (relational) factors are linked to parental post-divorce adjustment may further expand our knowledge on the maintenance and potential escalation of conflict among HCD parents. We need to know more about the link between parental post-divorce adjustment with children's post-divorce adjustment and psychosocial wellbeing, so as to be better able to contribute to effective interventions for HCD families.

IMPLICATIONS FOR CLINICAL PRACTICE

The results of this dissertation offer several important clinical implications. First, interventions aimed at improving parenting and parent–child relationships may well help children's recovery in the aftermath of their exposure to destructive parental conflicts. This is in line with research showing a positive relation between improving parenting behavior and parent–child relationships on the one hand, and children's reduction in symptoms and an increase in healthy development on the other hand.

For example, Child Parent Psychotherapy (Lieberman & Van Horn, 2005), Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006), Parent Child Interaction Therapy (McNeil & Hembree-Kigin, 2010), and Video-feedback Interaction to Promote Positive Parenting (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2012) demonstrated the importance of joint parent–child sessions, and the focus on positive parenting for children's outcome in treatment interventions (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Lieberman, Van Horn, & Ippen, 2005; Moss et al., 2011; Timmer, Ware, Urquiza, & Zebell, 2010). The results complement these findings by specifying relational mediating pathways relating parental conflicts on the one hand to parent functioning and parent–child relationships, and to children's psychosocial well-being on the other hand. Adding a parental component aimed at teaching parents how to improve and direct their psychological resources toward their children might be especially favorable in trauma-focused interventions for children. Furthermore, adding parent–child joint sessions in which parents are trained to be more sensitive and ask the child more questions, children may feel safer in the mother–child relationship to cooperate and explore the inner world of emotions (for suggestions see Chapter 2 of this dissertation). Again, improving the parent–child relationship may enhance trauma-focused interventions for children in the aftermath of exposure to destructive parental conflicts.

The results further suggest that services focusing not only on a reduction of parental psychopathology, but also on parenting skills and the parent–child relationship may contribute to the recovery of IPV parents and their children (Diderich et al., 2013). The children themselves may not (yet) have been referred to a mental health office, either because they show resilience and strength, or because problematic emotional development is not recognized by parents as they are absorbed by their own problems. For example, Diderich et al. (2013) showed that in a group of parents who attended the emergency department, and who had also serious psychiatric problems or who had been exposed to intimate partner violence, child abuse was confirmed in 91% of the cases. So, services that support parents may contribute to children's recovery and healthy development by unearthing acts of intimate partner violence and/ or psychopathology and teaching parents how they can be more available for the children.

In the treatment program *HORIZON* (Visser, Leeuwenburgh, & Lamers-Winkelman, 2007), described in Chapter 2, the preparatory psycho-educational program focuses on this aspect of parental availability. The preparatory program precedes children's trauma-focused treatment. Parents are coached to read their children's behavioral and emotional signals accurately and to adequately respond to these signals. Also, parent–child joint sessions are added to a trauma-focused cognitive behavioral intervention. It is plausible that strengthening the ability of parents and children

to talk about daily emotions may also translate to a better ability to give meaning to traumatic experiences like exposure to IPV, and to create a coherent trauma-narrative. In the *HORIZON* treatment program, the joint parent–child interaction sessions focus on this aspect of the parent–child relationship. Parents and children spend 30 minutes together each week, at the end of the separate, parallel parent and child sessions, in which they are trained to communicate about daily emotional events and children share their trauma narrative with the parent. The effectiveness of these treatment components are currently investigated (see Chapter 2 for more information on the study design).

Third, interventions for HCD families aimed at improving parents' preparedness to forgive each other may decrease destructive parental conflicts. This is in line with the positive relation between a high quality co-parenting relationship and forgiveness (Bonach, 2005; Bonach & Sales, 2002). The results from Chapter 5 are consistent with the findings that psycho education about forgiveness may decrease parental conflicts (Reilly, 2014), and reveal that promoting forgiveness to both parents and their involved family members, new partners and friends, may help reduce destructive parental conflicts. To this end, data collection to examine the effectiveness of "*No Kids in the Middle*" is still ongoing (Finkenauer et al., 2014).

SUMMARY AND CONCLUSION

This dissertation provides insights into how mediating relational processes and pathways are related to parental conflict, on the one hand, to parent functioning and parent–child relationship quality, and to children's psychosocial well-being, on the other. Specifically, parents who report more psychopathology in IPV-exposed families tend to be less psychologically available, which in turn, is related to more self-reported symptoms by children. Also, in IPV families, mother–child dyads show lower quality in emotion dialogues then dyads not exposed to IPV.

This dissertation also provides insight into how parents' perception of social network disapproval of the co-parenting relationship is related to a lower tendency to forgive each other, which, in turn, is related to more parental conflicts in divorced and in HCD families. While being exposed to destructive conflicts is challenging enough for children as it is, being exposed to destructive parental conflicts may even be more difficult for children, because of the negative impact the conflicts have on parenting behavior and on parent–child relationship quality. Furthermore, for children's wellbeing and healthy development it is important to create a safe environment without destructive parental conflicts. The results in this dissertation underline the importance to focus on the direct and the indirect effects of exposure to destructive

parental conflicts in interventions for children. The focus on similarities and differences between the two different research areas of IPV-exposed and HCD families offer promising future directions for empirical, clinical research.

The interplay of parental conflicts and interactions among all family members shape parenting abilities, parent–child relationships, and may be important in the maintenance of parental conflicts. At the same time, this means that we may be able to improve children's lives by supporting parents to be available for their children, by promoting healthy ways of communicating about emotions between parents and children, and by stimulating parents to forgive each other.

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Appendix

No kids in the middle: Dialogical and creative work with parents and children in the context of high conflict divorces[1,2]

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[1] Some parts of this article are taken from a Dutch article that is published in 'Systeemtherapie': Van Lawick, M.J. (2012) Vechtscheidende ouders en hun kinderen. *Systeemtherapie.* 24/3, 129-150.

[2] All case material is de-identified. Quotes are translated in English.

ABSTRACT

This article contains a description of the context, development and delivery of *No kids in the middle*, a group approach for divorced fighting parents and their children. After addressing the social and legal context of high conflict divorces, we describe the main characteristics of this destructive dynamic.

We describe some aspects of the approach and give examples. Key principles for the project include: keeping the child in mind; working in groups; stopping legal processes; making free space for interactions; creative presentation ceremonies; and reaching out to the network. The outcomes are promising. Research on the project has started.

Keypoints:

1. Working with families in high conflict divorce is one of the most complex areas of clinical practice
2. The provision of a unique 8 sessions group programme in the Netherlands holds promise for dealing with the impasse experienced by parents and children (and also professionals)
3. Key principles of this programme are keeping the child in mind, working in groups, stopping legal processes, making free space for interactions, creative presentation ceremonies, inclusion of the family's networks
4. The programme seeks to provide three safe therapeutic dialogical spaces – one for parents, one for their children and one for the network of involved persons around them.
5. Within this space therapists' support curiosity, open dialogue, openness to the unexpected, responsiveness, spontaneity and creativity
6. The group provides an opportunity for children to witness their parents taking responsibility for them, while providing parents the opportunity to witness how their children are experiencing their current situation

1. INTRODUCTION

Working with families who continue in bitter dispute after divorce is, for many experienced couple, child and family therapists, one of the most complicated areas of their practice. What is effective in therapy with families and children often seems not to work in these cases. Distrust, paranoia and the taking of a defensive stance, by one or both parents, frustrates the formation of a safe therapeutic relationship in which therapy might help. Ongoing legal fights or the threat of new legal proceedings, with the stress and financial consequences this imposes, complicate the dynamic.

Two specialised centres in Haarlem, the Netherlands - the Lorentzhuis, and the Children's Trauma Center (KJTC) - struggled to find a useful way to work with these families. The Lorentzhuis is a centre for systemic therapy, training and consultation; and the KJTC is a centre for treatment, training and consultation focussed on traumatized children and their families. Both centres receive referrals from diverse professional contexts: child protection, child and youth health, psychiatry, other health agencies, psychotherapy and family therapy services, as well as the legal system and mediation services. In recent times a growing number of referrals has involved complicated high conflict divorce situations. Often the professionals who referred to us had arrived at an impasse with these clients. It was as if not only the children, but also the professionals, could end up in the middle.

Experienced couple and family therapists at the Lorentzhuis tried hard to promote a therapeutic dialogical space in which to create more safety for both family members and professionals. Sometimes they succeeded; however, there still remained a group of parents so caught up in their destructive fighting that they were unable to find the space to work together.

The Lorentzhuis therapists were increasingly concerned about the children of these parents and referrals were sought to the KJTC. However, the KJTC therapists had stopped working with the children of these fighting parents, because they found that the help they were able to offer was of no benefit and, in some cases, the children developed more serious symptoms. KJTC therapists found that through therapy, the children became more aware of their emotions, and especially their loneliness and their pain. Whilst they learned to express this in the context of therapy, they also became more aware of the powerlessness of their position. They could not express their pain at home because all utterances could be used as ammunition in the war between the parents. The child therapists therefore concluded that they should stop attempting to intervene with therapy as long as the context of the child's problems remained the parental war. In fact, these therapists had actually decided to refer these cases to the Lorentzhuis! Ultimately both services needed each other.

The two authors - Justine van Lawick from the Lorentzhuis, and Margreet Visser from the KJTC – therefore decided to engage in a dialogue exploring new ideas and practices that could potentially benefit these children and their parents. That is where the project '*No kids in the middle*' was born. This article draws on both research findings and our clinical experiences and reflections. Because the theme and area is rather new we cannot draw on much evidence at the moment. Apart from these articles, we have published a Dutch book about the project (van Lawick & Visser, 2014).

We could draw on many sources of inspiration in the development of this approach. Important are authors from the open dialogical practices network (www.opendialogicalpractices.eu: Rober, 2012; Seikkula & Arnkil, 2014; Shotter, 2005, 2008; Wilson, 2007). We also like to name Haim Omer (2010) who helped us to find anti demonizing and non violent ways of working as well as including the network around families. Cecchin (1987) inspired us to stay curious and open minded. Bateson (1979) always invites us not to believe too much in our own ideas and theories. And White's (2007) narratives on identity, ceremonies and outsider witness helped us to create useful ceremonies for this project. To understand the trauma reactions of parents and children we drew among others on Siegel (2003) and Szalavitz & Perry (2011).

This article contains a description of the context, development and delivery of the approach. At this moment we do not have a scientific evaluation of the outcomes of the first 6 groups. The VU (Vrije Universiteit van Amsterdam) has started outcome and qualitative research on the project.

2. SOCIAL AND LEGAL CONTEXT

In the Netherlands, due to various reasons, the number of children caught up in the acrimonious divorce of their parents has grown (Spruijt & Kormos, 2014). Since 1998, legal authority for children following divorce has been assigned to both parents rather than one parent. The emancipation of women has produced changes in patterns of childcare within families. Fathers have become more active in caring tasks and as a consequence, have legitimised their legal right to see their children. Mothers have also become legally obliged to cooperate with access arrangements. A successful political lobby by *Fathers4Justice* resulted in equal legal power for both parents after divorce in the Netherlands in 1998 and in most other Western countries around that time.

Most parents are able to keep their children in mind whilst negotiating the complicated process of divorce. They separate as partners but stay active and connected as parents and give their children the feeling that they matter. Children are not solely

victims in the divorce of their parents. They are also active in giving meaning to the divorce; they take a position and develop a personal narrative that helps them to go on. The IPOS (Interdisciplinary Project to Optimize Divorces) research (Buysse et al., 2011) shows that children have a lot of resilience - as long as they have the experience that they do matter to their parents.

A smaller group of parents are so caught up in their conflict that they are no longer really aware of the wellbeing of their children. They become convinced they have to fight against the other parent for the sake of the children. Because they love their children they feel driven to rescue them from the other parent's damaging behaviour. To these parents, a stop to the fighting feels as though they are abandoning their children. And so they continue to argue and fight about everything concerning the children: structure, family life, school, sports, contact arrangements, finances, birthdays, holidays, celebrations, and so on.

Such long, fierce battles became a growing concern to many of the professionals confronted with the pain of children caught up in these situations and requests were made for the introduction of legislation to better protect children from their fighting parents (Spruijt & Kormos, 2014). In 2009, the Netherlands introduced a new law that obliged parents to make a parental plan before being legally granted divorce. The unintended consequence of this legislation was that the relational war became situated even closer to the children. Research by Spruijt (Spruijt & Kormos, 2014) shows that this law aggravates the battles in high conflict divorces, the numbers went up: a clear example of a solution that creates a problem (Watzlawick et al., 1974).

3. THE DYNAMIC OF FIGHTING DIVORCES

3.1. Partners and parents

Many love relationships start with romantic expectations: the other will always love me, understand me, listen to me, share with me, accept me as I am, and give me the feeling that I matter. Most people can handle the normal frustrations that arise when relational experiences diverge from the romantic dream. Many couples repair the rifts in their relationship and adapt to frustrations, but in some cases these adaptations do not occur.

When frustrations such as one partner not listening, not understanding, or becoming angry, are experienced as personal attack, the other partner can become defensive. This defensiveness can take many forms, but can also be experienced by the other partner as reproach or attack that in turn calls for a defensive response. This repetition of attack and defence can escalate (van Lawick, 2008) so that a destructive

dynamic colours the whole relationship. Both partners feel misunderstood, unloved and alone.

Psychological injuries dating back to childhood often resonate in these processes; the hope was that the partner would understand and heal the pain, not add to it. When both partners are hurt and frustrated, each tries to convince the other of their 'wrong' behaviour. Each becomes caught up in monologues about the other, able to identify the truth behind the façade of the other person, and therefore what is wrong with the other person. Pathologising the other can be part of this process. The other partner is said to have a narcissistic or psychopathic or borderline personality disorder, or to be delusional, or autistic, and so on. With the internet, they can 'prove' the psychopathology of the other partner with many examples, everything fits. The other partner becomes defined as a pathological human being who fails relationally, and the one who needs treatment and has to change! He or she can been seen as a 'monster', a 'demon', and the perpetrator of wrongs of which the other partner is a victim.

Alon & Omer (2006) link the process of demonization with an inability to accept 'the tragedy of life' (p.28). They contrast this with the dominant illusion that we can create a happy life with a loving relationship that gives us everything we need: enough money, attractive children who develop well, satisfying work, holidays and good friends. When this does not happen, explanations for the difficulties are sought in order that they can be eliminated or alleviated. For example, when children do not develop as expected an explanation is sought that involves a pathological label that determines good treatment and a solution to the problem. Similarly, with relational difficulties a cause is sought that will allow the partner to eliminate or alleviate the problem.

Alon & Omer (2006) propose that the opposite of demonization is acceptance of the tragedy of life. We agree with this shift to a multi-voiced landscape where life is not always cheerful, satisfying, prosperous and changeable; it is also sad, unsatisfying, frustrating and unchangeable. When a person wishes to create the ideal life, but fails in spite of great perseverance and efforts to control life and control others, there emerges the potential for destructive processes to escalate. This destructiveness makes no space for accepting the tragedy of life, or for a multi-voiced dialogue to emerge. This process may lead to solitude and desolation, perhaps a new relationship that diminishes the sense of abandonment, and often, divorce.

It is not surprising that the same destructive process continues after divorce. When lawyers, child advocates, mediators and judges ask for a good, child friendly parental plan, the negotiations required for this plan draw out the same intense fighting that preceded the separation. Parents act with the conviction that they have to protect their children from the harmfulness of the other parent. Parents feel compelled to

protect their children against the 'demon' parent, and sacrifice more and more to continue the fight: money, family relationships, health, sleep, time, holidays, housing, and friends. The more that is invested, the more intense the fighting. The idea that the fighting could all be for nothing is unbearable.

Other family members and friends can also become embroiled in the relational war. New partners can exert considerable influence, often as an ally to the parent in demonizing the other parent. Over many years, two communities fight, two 'villages' combat each other.

3.2 Children

The conflicts of the parents influence children's images of family life, love, parenthood and partnership. These images and experiences can make children feel sad, angry and anxious. In these emotional states they need their parents for comfort and protection, but the parents are at the same time the source of disquiet. This makes the children confused and lonely. The child that does not want to make a choice between parents is torn apart, but struggles to express this painful experience (see figure 1). If the child does express their pain it can easily become ammunition in the parents' battles, adding to the child's distress and the parents' mutually destructive behaviour.

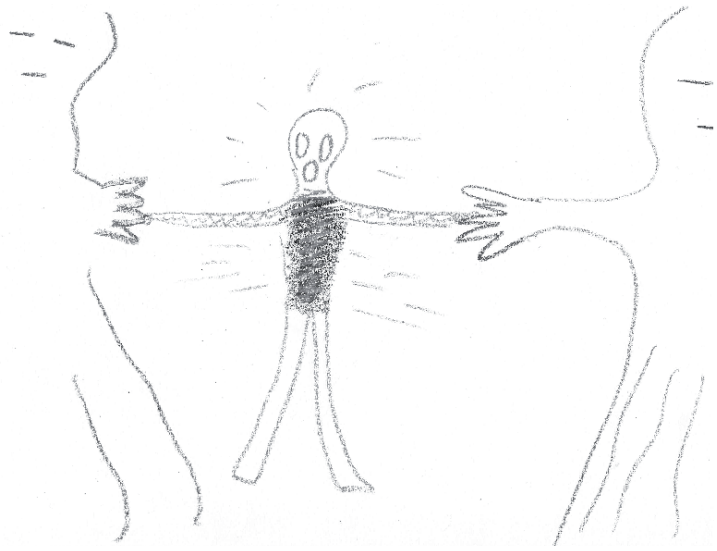

Figure 1. Drawing of a 7-year-old boy

The child is hanging between the parents, with no ground to stand on. All his senses are wide open and his drawing resembles 'The Scream' by Edvard Munch. The parents both pull at their child and he is being torn apart, yet they do not perceive what they are doing and seem to be blind and deaf. They are locked in on themselves and do not sense their child. This is one of the most emotionally charged and shocking images we have ever received from a child.

Permission has been granted to use this drawing.

As a consequence many children develop behaviour that others can see as problematic. They can be angry and oppositional, or silent and sad. Their inner balance is disrupted, resulting in sleep, concentration and eating problems, or psychiatric symptoms such as conversion. These children are often referred to child and adolescent mental health services, but these professionals are limited in what they can do when the context of the child's distress does not change.

Children can also become involved in the parents' fight by becoming an ally for one or the other parent. We understand that children make this choice because it can be unbearable to live for a long time caught between two different truths. It can be a relief to make a choice. The whole network may feel forced to make a choice as well, so that grandparents, family, friends, and often the professionals also make a choice between the fighting parents. We are therefore opposed to the idea that the children are diagnosed with the so-called Parental Alienation Syndrome (Gardner, 1998) when they make a choice. Of course they are influenced, as is the whole network. So why are the children burdened with a diagnosis? If we want to speak of parental alienation, we suggest that it is the parents who alienate themselves from each other, from the other parent with whom they had a child.

Some children try to ignore the parental war and concentrate on other things in life. They can do well in school and social life. Most of the time they turn to other safe resources like brothers, sisters, friends, parents of friends, or other involved persons. Nevertheless, although they do not show it, they too often suffer from their parents' endless disputes (Spruijt & Kormos, 2014).

4. THE PROJECT

In the *No kids in the middle* project we try to find new roads that create a context for movement out of deadlock for these families. We try to create a dialogical space where rigid, destructive processes can be made more flexible and dialogical for parents, children and the professionals who work with them. We work with six families at a time. Twelve parents work with two therapists and, at the same time, all their children work with two therapists in a different room in the same building. Participants in both groups attend eight two-hour sessions, with a scheduled mid-session break.

Key principles for the project include: keeping the child in mind; working in groups; stopping legal processes; making free space for interactions; creative presentation ceremonies; and reaching out to the network. We discuss these six points below.

4.1 Keeping the child in mind

The parents with whom we work are involved in relational wars that have already lasted many years – some as long as12 years - that are full of destructiveness revenge, paranoia and demonization. Some children can only remember fighting parents.

The need to create a context where parents are able to sense their children again and make a safer place for them is not optional. These situations demand a therapeutic presence. We, as human beings, as professionals, as a community, cannot accept that children are maltreated for years. We want to connect to the parents and accept them, but we reject their destructive behaviour. We try to facilitate parents' rediscovery of their qualities as parents who see, hear, empathise and connect with their children. We try to create space where the fighting can be much less or even stops. We have learned not to be too romantic, not to expect all parents to be a better team. Sometimes parents are able to team up more and communicate better when they have their child in mind; but sometimes the differences or the hurts are so huge that the fighting can only stop if they take more distance and let the other parent do things his or her way, without interfering. Cottyn (2009) calls this 'parallel solo parenthood'.

In most cases, the two parents are capable of negotiating shared parenting roles in their children's lives. There are exceptions when one or both of the parents are so caught up in personal problems, (eg addiction) that they cannot create a safe place in which their children can develop well. In such circumstances, a temporarily safer place for the children to live and develop may need to be created. This may be either in the context of one of the parents becoming the primary parent with legal authority or by placing the children in an alternative care setting, ideally with family members who love the children and are less caught up in the parental fighting. Such arrangements, however, must be regarded as exceptions when all other possibilities fail.

4.2 Working in groups.

For this project we chose to work in two groups: a parents' group and a children's group. Group work with fighting parents creates more space for both the therapists and the parents. Ex-partners can observe other ex-partners fighting, whilst observing their own conflicts at the same time. This invites and encourages reflection, which is often missing in demonising fights. Therapists are also able to adopt a different position. Instead of a possible ally for two fighting parents, the therapist can become the involved and observing outsider who tries to create a safe therapeutic context where change becomes possible.

In a group context parents are able to help each other. They understand the entanglements of the other parents. When common conflicts emerge, around holidays for example, they can see possibilities where others get stuck. While helping the other members of the group, they help themselves to navigate similar problems and

often become more flexible in their own efforts to negotiate conflict. This frees the therapists from the expectation that it is solely their role to help find solutions for the 'insoluble' problems presented by members of the group.

Another advantage is that group members inspire each other to move from previously entrenched positions. For example, when two parents start to change and talk about new solutions and possibilities, and about the effect this is having on their children - how they are more relaxed and sleeping better - others feel inspired to do the same. Faced with examples of what may be possible these other parents may also want to move forward. This frees the therapist from having to motivate parents to move from their rigid positions.

Finally, a group approach makes it less likely that the therapist will adopt a 'colonising position' (Rober & Selzer, 2010) wherein the therapist attempts to change the clients according to personal or professional theories and ideas.

The main goal for the group is, however, a constant: parents are invited to see, empathise and connect with their children and act with their child in mind. The road to this end, and the steps that can be taken towards it, are open. As therapists we adopt a position of curiosity and openness to the unexpected. We choose to focus on possibilities (Wilson, 2007).

Simultaneous parent and child sessions minimise the risk of 'drop out' or 'no show' due to baby-sitting problems. Simultaneous sessions also create space where parents and children come together and meet before the session, during the break, and at the end. For many families this is the first time in years that they are together. Group work creates the opportunity for parents to see the other parent interacting constructively with other group members and with the children.

4.3 Stopping legal processes

We learned to create space for dialogue and change by setting a few rules and boundaries. Within these boundaries we give parents the responsibility to change the context for their children and we express trust that they can. Often there is a pressure on the parents from child protection agencies or judges to cooperate and join the project, but we do not put a pressure on them. We explain that the project is hard work and it is possible to create a better situation for all involved, but that it will take great efforts from the parents and the therapists. There are a few important exclusion criteria: serious addictions, ongoing and actual violence, and ongoing legal procedures.

A condition of participation is that the parents stop all legal processes, or at least put them on hold during the project. We became aware of how many legal processes and trials these parents undergo and how much these processes add to the destructive and demonizing dynamics of the parental fight. The legal arena focuses on winning

or losing, defending one's territory. This creates distrust and makes it impossible to show vulnerability. In contrast, the therapeutic space is about building trust, about expressing hesitations and feeling vulnerable, about connection and about trying to understand the other. These two domains are incompatible (Groen & van Lawick, 2013).

4.4 Making free space for interactions

A room where the families could come together without the presence of therapists turned out to be very important. A lot happens in the free unstructured time before the group sessions start, during the break and after the sessions. Sometimes change starts to happen in this room, and other areas away from the therapists, rather than in the therapy sessions. Children who have not seen one of the parents for some time (perhaps years) can mix with all the parents and children in the group, and are able to be in the same room as the alienated parent. For most children, this setting is the first time in years that they have seen both of their parents in the same room.

Two divorced parents with four children were in the family room. The two youngest children visited their father regularly however, on this occasion, the eldest son saw his father for the first time in years. When he saw how happy and loving the father was toward his younger brother, he started to move towards his father as well.

4.5. Creative presentation ceremonies

The children's group aims to give the children a voice and to stimulate their resilience without being caught in the fights of their parents and their personal pain. The children are encouraged to make a theatre production or movie around the topic of their fighting parents, or choose some other form of artistic expression. They are invited to enter the metaphorical world of their imagination. Parents are given the assignment to prepare a presentation at home about what they have learned in the group and what they wish for their children in the future.

If children or parents do not want to present we do not press them. Most children find a way to be involved, sometimes by making a choice of music to be played rather than being on stage themselves. Sometimes parents say they do not have time to prepare. We tell them not to worry, and assure them that if they want to say something we will make space for this. When the parents who have prepared their assignment present it to their children, the other parents do not want to leave their children with nothing and offer a short spontaneous speech. In this setting, everybody is vulnerable and feels a bit exposed. This creates space for new movements, possibilities and connections. These ceremonies are very powerful in bringing about positive change.

4.6 Reaching out to the network

Involved network members may include: grandparents, brothers and sisters, other family members, new partners, the family and children of the new partner, friends, neighbours, school/workmates, and professionals. These network members are very actively involved in the relational war. They tend to take side with one of the parents who they define to be the victim of the other one. They try to be a good ally but fail to improve the situation.

We encountered difficulties after noticing that positive changes in the group had disappeared by the next session. We understood that the social network around each parent did not expect or understand the changes and reacted in a usual way that drew the situation back in the well-known old interactions. So we decided that it was also important to connect to the involved people around the families We organised a network evening to be held before the first group session.

In this session parents can bring as many persons from their network as they want, including personal contacts and professional people. On one occasion 70 persons attended. We make it clear that the evening is important as part of the preparation for the project and that it increases the likelihood of success. Attendance at the evening is anonymous, and its focus is to be informative. Only the therapists introduce themselves. At the network evening we present the project. We provide information about our basic principles and assumptions, how we work, and why we do what we do. We are as open as possible. People can ask questions; we are responsive.

A grandfather asked, 'What do you do when one parent refuses to cooperate?' A therapist answered, 'I can imagine that you have lost hope over the years that positive change is possible. I think that many of you have. But we believe that it is possible. We have to, because we cannot give up on the children.'

At the end of the evening all therapists line up before the public group and ask, 'Please support us. Without your support we cannot make it work. Please help us in this work.' Every time we organise this evening, many attendee thank us at the end; they wish us good luck and tell us they hope we will do well. '*It has already taken much too long*'.

After the network evening, we continue to reach out to them during the project. We ask parents to share what we cover in the group with their network. We ask them to see movies together that address a relevant topic, and to reflect together on the movie. We send text messages for them to share with their networks. Sometimes we have in-between sessions with new partners or other network members. We try to be as responsive as we can because our experience is that this makes positive movement so much more possible. It also means that we need to create time in our agendas to be responsive.

5. WORKING WITH THE PARENTS

We developed a framework in which parents can feel safe enough to become calm in each other's presence, thus creating a space to listen and reflect. In the context of this article we focus on the dialogical aspects of practice. The open dialogue allows us to be open to the unexpected and to understand the parents from within our interactions and involvements with them. This understanding from 'within' instead of 'thinking about' is clearly described by Shotter (2005):

While we can study already completed, dead forms at a distance, seeking to understand the pattern of past events that caused them to come into existence, we can enter into a relationship with a living form and, in making ourselves open to its movements, find ourselves spontaneously responding to it. In other words, instead of seeking to explain a present activity in terms of its past, we can understand it in terms of its meaning for us, now, in the present moment, in terms of our spontaneous responses to it. It is only from within our involvements with other living things that this kind of meaningful, responsive understanding becomes available to us. (Shotter, 2005, p.140).

So we position ourselves in the present moment, with space for spontaneous responses to the direct experiences in the group. Being *with* the parents we find that trying to control the parents is unhelpful. These parents are experts in making agreements: mediators have helped them to make agreements about everything in life, but afterwards the parents accuse each other of not keeping to the agreements.

The parents start to expect the same from us. They tell us that we are the last straw of hope, that they cannot believe that we can help but they are curious what we are going to do. This attitude of sitting back and waiting to see what the other is going to do, and of reacting to what is done, leads only to repetition of previous patterns. To arrive in a landscape of new possibilities, of new movements, we have to invite the parents to try a new dance.

We do this by not knowing what steps to take next, by asking for their help again and again: 'Please help us! What would be a good next step to take out of this painful situation? Is there anybody with an idea?' We acknowledge their pain and their efforts, always keeping in mind the wellbeing of their children and believing that we can work toward a better situation for all.

We as therapists can be 'within' the process, but the parents often stick to 'aboutness thinking' in their analysis of what is wrong, what has to change and what the therapists have to do. In order to avoid arguments with the parents we developed experiential exercises that can bring about movement. We describe three such exercises:

5.1 Pictures and stories

For the first session, we ask the parents to bring pictures of their children. In the group, we ask them to introduce themselves as parents, to show the pictures of their children to the group and tell the group about a special and concrete memory of an experience together with that child. When there are 12 children of these 12 parents we listen together to 24 very short stories, full of relational experiencing and emotion. They can be very recent events or experiences of togetherness that come to mind in the here and now. Stories can be about baking cookies together, a talk at the bedside, laughing together, playing with a ball, helping each other. Anything meaningful will do. This exercise can be very painful for parents who have not seen their children, sometimes for years.

Tom: I cannot tell you about a memory because I have not seen my daughter for four years now, because she [the other parent] has made me a monster in the eyes of Iris.

Therapist: I hear you telling us that you have not seen your daughter for four years, and how painful that experience is for you. But maybe you can share with us a wonderful experience with Iris that occurred before that time?

Tom: [silent for some time]: … I think of the day she was born, the best day of my life.

[He bursts into tears. The whole group is touched by his sorrow. Even the mother of Iris seems to be confused.]

In one group, the fathers started to tell the group about very expensive and fancy experiences, like deep sea diving or paragliding. This created an atmosphere of competition and unease in the group, which the therapists also felt.

Therapist: What exciting experiences! We can all imagine that the children would have liked them. Experiences can also be about small occasions of being in contact, about the special relationship you have with your special child, like having an intimate talk at the bedside, or baking cookies together.

Emma: OK. Yesterday, I was with Dave at the center - Food for Free. Dave told me that he wanted to do that kind of work when he was a grown up, that he wanted to help other people. I was so touched by what he said, I gave him a big hug. He hugged me as well, and we felt very much together.

This story raised the sense of warmth in the group and made space for a great diversity of stories and experiences. After all the stories were spoken the whole atmosphere in the room changed. We have the sense of being with twelve loving parents and their lovely children together. The therapist can express a sense of hope that comes from this and also the sadness that so much love and connection has been overshadowed by all the conflicts and fighting.

5.2 Children in the middle

In the next session we conduct an exercise aimed at getting the parents to place themselves in the position of their children. We start the exercise by gathering accusations often used by parents in conflict on a flip chart, like: 'You are only thinking of yourself!', 'You just want all the money!', 'After spending time with you, the children are impossible!', 'You never keep your promises! Do you even know what that means for the little one?!', 'You're always lying!', and so on. After a while the parents come up with a big list, and can even laugh about all the recognisable examples.

We then put four parents on little chairs in the centre of the room. We ask them to imagine themselves as children, though not their own child, and to focus on their bodily sensations. The rest of the group is divided into two opposing lines of four parents. They are asked to shout accusations at each other across the room, while the 'children' sit silently in the middle. After about two minutes of fighting we stop and ask the 'children' on the small chairs what they have felt. What these parents as children experience always leaves a deep impression. Some become white as a ghost, others start to cry as if they suddenly realise what it must be like for their children. They know, more than we might expect, how to describe what they experience as the child. The sentences they utter are written down on a flip chart.

'Stop it!', 'I can't choose.', 'I want to get out of here!', 'I don't want to be here!', 'I close my ears.', 'I'm scared.', 'I feel like crying.', 'Why don't you see me?', 'You're not at all concerned about me!', 'I want to help but I cannot understand what's going on.', 'I want it to stop!', 'I want to go somewhere else!', 'I'm getting angry!', 'Everything hurts!' …

This exercise often proves to be transforming. Inner reflection has started. Afterwards, we reflect together on what they have experienced and what it tells them about their children. In the post-group evaluation, parents describe this experience as transformative.

5.3 Movement out of dead lock

Usually around session four, when confidence in the group has grown, we start to work together on the problematic issues that occur again and again and are experienced and described as unresolvable.

We have developed a dialogical way of working with these issues where the whole group is active and on the move. We developed this way of working together with the second group who participated in the project and continued with it because it proved to be so useful to and valued by all parents. This way of working, which includes elements of ritual and ceremony, is also not fixed and can change flexibly.

All group members are actively involved. One parent pair presents an issue that they, as parents, have become stuck in. Each parent then chooses a 'buddy', a supportive group member who can also help that parent to move. Four parents are 'children'

sitting in small children's chairs (see 5.2). The 'children' are asked to move closer to or further from the 'parents' in response to the physical and emotional sensations they experience while the 'parents' interact. In this way they can give direct emotional feedback on the parents' conversation. The other four parents are asked to use their own experience to be 'coaches', to think about possible solutions, give advice or helpful reflections, coming from their own experiences. And the therapists are present within the moment. Everybody is actively involved. The therapists step back and say, 'OK, go ahead, find a solution. The children need it.' The parents start with their arguments.

Barry explains that it is impossible to return from the holiday in Turkey on Friday. It is an all-inclusive week, and they have a flight back at Saturday. Sheila reacts that this is not her business, that the agreement is that her holiday week with the children starts on the Friday, that she is due to leave with the children on Friday to go camping in France together with her children and her friend. They are sharing a car and she cannot let her friend wait until Sunday. The argument goes back and forth. Neither parent listens to the other. They only try to convince the other. As Barry and Sheila continue, the 'children' move backwards, away from the arguing couple. The conflictual communication of the parents does not change. The therapists stop the argument and ask the 'children' about what made them move backwards, about what they feel. The 'children' express their discomfort with the parental argument and they feel nausea, stomach-aches, headaches. They all feel stressed and want to leave the room, close their ears, scream. They feel as though they do not matter, that it is just about the parents, even when the parents say they are doing this for the sake of the children. The 'children' do not want to go on holidays anymore, neither to Turkey nor to France. They say that they feel hopeless … .

It strikes us again and again how well the parents can express what the children feel when they are in the small chairs as children of fighting parents.

The 'buddies' are asked to reflect with the parents. They can support the parents but also help them to improve the situation for the 'children'. Meanwhile the 'coaches' are invited to exchange reflections and ideas.

After a short time the therapists ask the parents to go on. Barry starts by saying that he understands that he put Sheila in a difficult situation by returning late on Saturday when she expected to leave on Friday. The 'children' move forward a little. Sheila starts to listen and is surprised: 'You never say you understand me! Of course, I understand your problem as well, that you cannot change an all-inclusive holiday package, but you should have thought about it when you booked the holiday'. Barry replies, 'I didn't expect you to make such a fuss about one day. I suppose I thought you would imagine the children having fun in that hotel in Turkey, with a swimming pool and everything.' The children move back again. The parents start to become aware of the movement in

front of them. Sheila says, 'Of course I can imagine that they would enjoy the hotel and swimming pool …' (The children move a little forward.) '… You should have communicated your plans better. You never do!' (The children move back again.) Both parents give a deep sigh.

We ask the 'coaches' for help. It is wonderful how parents can give each other advice in a way that we as therapists never allow ourselves to. One father said to Barry, 'Why don't you drive the children to France on Sunday, so that Sheila can leave with her friend on Friday?' A mother suggested that Sheila could leave on Sunday but also stay a couple more days at the end. Another parent asked about travel insurance in case the week in Turkey could be cancelled or changed.

After all these reflections and suggestions we ask the parents again to come to a solution. When the parents continue to be stuck in arguments, we ask the buddies to play the solution 'as if' they were the parents. We explain that it is often much easier to see where you can go if you are not part of the dynamic. If the 'buddies' act out a potential solution, where the children move their chairs forward, the parents can finish the ritual by trying to repeat the solution acted out by the buddies by doing it themselves.

In the end, Barry offered to drive the children to the camping ground in France so that Sheila could leave on the Friday and prepare the camping ground.

Sometimes parents do not reach good outcomes from the dead-lock in the session. We put no pressure on them, but simply stop the ritual and express curiosity about what the next steps might be. We like to hear about this at the next session. Groups are enthusiastic about this way of working and sometimes four parent couples ask to work on their issues in one session. We have learned very simply to divide the time so that all parents who so wish can initiate some movement that often continues in the time between sessions.

6. WORKING WITH THE CHILDREN

The children meet with two therapists at the same time and in the same building whilst the parents attend their group. By having two parallel groups children witness their parents taking responsibility and working together. This can be a relief. Although the parents often fight about them, it is important to remember that the children are not responsible for the fights of their parents. Because of the different ages of the children (4-18 years), it is useful when two therapists and a trainee are present. The children regularly work in smaller (age-related) groups. They support and stimulate each other, learn from each other, and function like a small village.

The children's group is not organised as a therapy group with a program to process painful experiences. We do not want to problematize or pathologize the children, although many of them have serious symptoms. We want to relate to them in their power and resilience. Of course the effect of the group can be very therapeutic. The main activity in the group is artistic expression connected to the situation in which they live. We offer a range of possibilities: film, photography, drawing, painting, graffiti, collage, dance, theatre, music, or other ideas that the children themselves bring to us. All children have something that they like to do; we do not put pressure on them. We invite them to work with us on a presentation of their art for the parents, but of course let them select what they want to show.

In structuring the children's group, we create a rhythm that is repeated during the sessions with the children:

Warming up. Each session begins with a warm up activity aimed at helping the children to let go of their daily worries and be in the present moment. Children can throw a soft ball to each other, calling the name of that child, or they can copy each other's movements one after another, and so on.

Artistic Expression. The children work in their own way on their project. Many children like to work together. Some work on their own.

Break. The break can be stressful and exciting for the children who have not seen their parents together for a long time or who have not seen one of the parents for a long time. The children are invited to share what they feel and think about their experience and to consider what they might be able to do if they do not feel at ease. Sometimes children relax and are happy to see their parents together.

Reactions. After the break, the children are invited to talk about what they experienced during the break. Children also share observations: 'I saw that your father offered you a drink and you accepted it!' They can interview each other like television reporters for a youth program. Children can also talk about their experiences while making art. Children who had acted out a scene of a school class with quarrelling teachers expressed how they felt. They did not feel safe and they did not know what to do when the teachers disagreed. The children also started to feel angry: 'What's the point?', 'I couldn't concentrate at all!' and, 'I wanted to leave the room!' This last response came from a 9 year old girl who repeatedly ran away from home.

Reflections. The children are invited, but never pressed, to reflect and talk about the connections between their artistic expressions and their home situations. They talk about feeling powerless, about trying to help their parents to stop fighting or trying to help their parents to like each other again. They also talk about blaming one of their parents, perhaps seeing one parent as the bad one and the other one as the good parent. When children share these thoughts, other children in the group always question this reality. The therapists do not have to do so. When talking about their

home situations, children sometimes think, 'Stop this! Think about me!' They cannot understand why their parents, both of whom they love, are unable to reconcile. In one presentation all the children entered the room demonstrating their message to all the parents by making huge banners with the words, STOP FIGHTING!

Children also help each other and give ideas about how to suffer less from the parental fights. For instance, when the parents are screaming at each other or through the phone, one child suggested putting in earplugs and listening to good music. This support from other children is important because although we wish for all parents to stop fighting, we are not always successful and we let the children know this. With this reality in mind, the support of the children's group and the ideas that come from it can help them to be more resilient in the future, and to suffer less.

Sometimes children just want to hang around and do nothing for some time. Or they need time to do some homework. We make sure that this, too, is possible!

7. CHILDREN AND PARENTS IN THE PRESENTATION CEREMONIES

Session seven starts with preparations in both groups. In the parents' group, we particularly concentrate on issues for the parents to anticipate as they see and listen to their children's presentations. We ask the parents to support the children as much as possible because they are in a vulnerable position when they present. We also ask them to concentrate on themselves while watching the presentations, to notice what is happening inside. When invited, the parents enter the space where the children have worked. It is touching to see how the children care for their parents: 'Here's a chair for you mum; dad you can sit here.' Children may sit on the lap of one parent then change to sit on the lap of the other parent after some time. We have had many different presentations from the children.

Two groups had a joint venture in which they made a small movie. One movie was about two teachers who demonised each other. The children acted out situations where the two teachers met before the class and started to fight and scream at each other. Some children went away, others withdrew, some expressed how confused they were, or tried to stop the teachers from fighting. The children were energised by screaming, all together, "STOP IT! STOP IT! STOP IT!" The other movie was about a ten year old girl who had to change home and school because of the divorce of her parents. In the movie script all the children and the teacher of the new class had divorced parents. This expressed a wish by the children not to be thought of as an exception. The teacher (played by Dido, a boy of eleven) talked with the class about the experience of having parents who fight. Dido spoke about how sad he was, saying, 'It is as if you do not have parents. They fight like children and you as a child have to be the wise one.' Making the movies together was

also fun. The children laughed a lot. Two fourteen year-old girls who did not want to perform theatrically searched for the right music for the movie. They found a touching song by Mindy Smith and Matthew Perryman Jones, 'Anymore of This' (Smith, Jones & Jones, 2013), which included the lines:

Everything's familiar,
But I don't know who I am
Do you know where you're going?
Don't even know where I've been
Watching moments pass
I wanna run away from it
But I still don't take that step
Locked inside the glass
An empty box of memories
And a heart full of regret
Do you know where you're going?
Don't even know where I am

Other groups presented different forms of artistic expression: drawings, graffiti, sequences of photographic stills, dance. Two boys made the graffiti text: Change home! *(meaning something has to change at home),* Behave normal man, relax! *Beneath the text were two animals: a trembling small animal on four legs with blood dripping from the belly; and a huge angry werewolf with a full moon with black holes in it behind the werewolf. The boys explained that when parents fight they start to feel like a scared animal, trembling all over their body, but when it goes on they become very angry, like a werewolf. When presenting to the parents and therapists, the boys explained their art, like museum guides. The first boy, who spoke about the scared animal, had been diagnosed with conversion disorder and hospitalised several times. The other boy, explaining the werewolf, had been diagnosed with oppositional defiant disorder. When asked about the black holes in the moon, he said with a serious and deep voice, 'They are the unknown holes.' Three girls, aged 4, 8 and 10, worked on three dances connected to their experience of being children of fighting parents: a dance of sadness, a dance of anger, and a solo dance of confusion. They chose sad, angry, and confusing music. A fifteen year-old boy with chronic severe headaches for which he had many different medical investigations without any clear outcome, made a shield: 'When you fight I get stressed. From the stress, I get headaches. Because of the headaches, I cannot concentrate. That's why I fail in school!' After this, he played a moving guitar solo because he also wanted to console and comfort his parents.*

During the children's presentation, the parents are deeply affected by the effort the children have to put in the presentations, they are impressed and moved. They often feel ashamed about their children's clear messages. Stress is obvious on the

children's faces, they watch the reactions of their parents more than they watch the presentations. At the end, the therapists and the parents applaud. Before the break, the children and the parents sit together briefly in their respective groups to share their initial reactions and emotions.

After the break, the parents sit together briefly to prepare for the presentations that they worked on at home. They have been invited to work with their networks in their preparations. Most parents have prepared something to present, but some have not. We tell these parents that there is also space for them to present if they wish.

One mother brought her ten year-old son's school backpack filled with heavy stones that were wrapped in paper with text on it. She explained that her son had carried these burdens for much too long, and that she had now understood that it was the burden of his parents, not his burden. She took the stones one by one from his backpack, reading the words about sadness, anger and fighting. She also brought some beautiful small and light gemstones, and told him he could choose one. She also drew coloured cards and wrote her wishes for him on them and gave them to him to put in his backpack. The boy reacted by laughing and crying at the same time. His father wrote him a poem about their life together and his wishes for their future.

Another mother sang a song, dancing under an umbrella. She sang, 'I'm singing in the rain ….' She explained that there still was rain but that she and her children also could sing and dance together again and that this was her wish for the future.

Two parents made a film clip together with clear messages about what they learned and what they wished for their children. To this point in time, they have been the only parents who have presented together.

Sometimes the presentations are spontaneous speeches and sometimes speeches can also create some discomfort. One father used the space to tell his son that he understood that his parents should not use him again as a referee, and that he now expected his son to improve at school in order to have a successful and happy future and so on. These words were familiar to the son.

We have found that the children love the efforts that their parents make for them. After six groups we have a rich collection of possible presentations. The whole ritual is a powerful experience that creates space for a new dance.

CONCLUSIONS

After the seven groups that we have completed we can tell that this way of working is enriching for children, parents and therapists. The elements of an open dialogue - not knowing, believing, being present, ceremonies and creative expression, seem to open up new possibilities and spaces for families and professionals who get stuck in repetition, destruction and dead lock. Still, we do not reach all families in our groups and we are continually looking for new and better ways.

Our clinical impression, also supported by evaluation sessions with the parents and children, is that in each group: two families were able to reach a turning point, to stop the destructive fighting so that the children were in a much better place; in two cases the children and parents were in a better place but they needed some follow up sessions to keep it going; and two families were still stuck and frustrated, but most of these families wanted to continue work with us. Because of our dialogical way of working we are feedback oriented and will keep moving and changing, together with the parents and children with whom we work. We will continue to be responsive to their voices.

Jimmy: 'Things are so much better now. My parents do not fight anymore, they have stopped talking. But they said hello last time when daddy fetched me'.

Marieke (a mother): 'When I saw that other mother saying only bad things about the father I felt ashamed because I realized: I do the same, I use the same words'

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Dit proefschrift gaat over ouderschap. Van niemand heb ik zoveel geleerd over ouderschap, houden van, voorwaardelijk, onvoorwaardelijk, over kinderen, stief zijn, over stief hebben, aanpassen, strijd, compromissen, lol maken, mahjongen, en heel

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Curriculum vitae

Margreet Visser (1964) was born in Rotterdam, The Netherlands. She obtained the athenaeum certificate at *Scholengemeenschap Van Oldenbarnevelt* in Rotterdam. In 1991, she graduated in Educational Sciences at the Rijks Universiteit Leiden. Since that time she got involved in treating people (adults, children and parents) in the aftermath of child abuse, and she developed several interventions for traumatized people. She initially worked as a psychotherapist in a specialized mental health care center for traumatized women "Henny Verhagen". Together with her colleagues she set up a mental health day care for chronically traumatized women. Since 1999, Margreet is employed as a clinical psychologist at the Jeugdriagg Noord Holland Zuid, a youth mental health care institution. In collaboration with the Jeugdriagg, prof. Francien Lamers Winkelman founded the Children's and Youth Trauma Center (KJTC) in Haarlem. Since Francien's retirement in 2008, Margreet is the center's coordinator. Together with Francien, Ingrid Leeuwenburgh and the KJTC's treatment team Margreet developed HORIZON, a trauma-focused group intervention for children exposed to interparental violence. With Justine van Lawick and their colleagues, Margreet developed "No Kids in the Middle", a multi-family group intervention for high conflict divorced families. She regularly teaches about the topic of 'child abuse and neglect' in and outside The Netherlands.

In 1998, Margreet completed a 4-years post-graduate training at the RINO Noord-Holland Amsterdam to qualify as a licensed psychotherapist. In 2006 she was registered as a licensed healthcare psychologist ('gz-psycholoog) and post-graduate clinical psychologist. Also in 2010, the KJTC and the VU University Amsterdam received a funding from ZonMw for an Academic Collaborative Centre Child Abuse. In 2011 this funding enabled the onset of the research described in this dissertation. As the coordinator of the KJTC, Margreet combines coordinating activities, scientific research and clinical work until today. Margreet is involved in the Taskforce 'Effectieve Traumabehandeling Kind en Gezin'. From 2016, she is a board member of the 'Meldpunt Kinderporno op Internet'. Her next research project will focus on the effectiveness of 'No Kids in the Middle' for high-conflict divorced families.

Margreet enjoys hanging around with friends, playing tennis, playing mahjong with Niels, Sophie, Ian, Jeroen and Amber, and she enjoys working. In the holidays she loves sunny weather, hiking or skiing, and long evenings on a terrace with nice food and wine. She lives happily in Leiden with Niels.

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