

**ANNA NORLÉN**



**TRAUMA TREATMENT FOR YOUNG CHILDREN  
OUTCOME AND EXPERIENCES OF  
CHILD-PARENT PSYCHOTHERAPY IN SWEDEN**



# Trauma Treatment for Young Children

Outcome and Experiences of Child-Parent  
Psychotherapy in Sweden

Anna Norlén

Faculty of Arts and Social Sciences

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Psychology

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DOCTORAL THESIS | Karlstad University Studies | 2025:17

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## **Abstract**

A considerable proportion of children exposed to adversities and trauma are under six years old, yet most trauma-focused treatment methods target older children and adolescents. Child–Parent Psychotherapy (CPP) is one of few interventions designed for traumatized children under six, focusing on the child–caregiver relationship as the foundation for recovery. This doctoral thesis aimed to evaluate CPP outcomes and experiences in a Swedish naturalistic clinical context. Study I examined caregiver experiences and how CPP meets the demands for dissemination in Sweden. Study II evaluated the impact of CPP on general psychological symptoms and post-traumatic stress in children, caregivers, and caregivers’ perceptions of their relationship with their child. Study III explored the long-term effects of CPP and potential predictors of outcomes. The overall findings were positive. The caregivers reported high satisfaction with CPP, and the intervention was practical to implement. Reductions in general psychological symptoms and post-traumatic stress were observed in both children and caregivers. Caregivers also reported improved abilities to manage their child’s behavior and a noticeable reduction in signs of disorganized caregiving. The results were sustained at follow-up. One potential predictor identified was that higher levels of child trauma symptoms were associated with a smaller reduction in caregiver trauma symptoms. The results align with international studies, demonstrating CPP’s effectiveness in reducing symptoms and improving child-caregiver relationships. Additionally, the findings highlight CPP’s sustainability in a naturalistic clinical setting in a new culture, indicating its promise for wider dissemination in Sweden. Considering a relatively small sample size and lack of control group, a Swedish RCT is needed to further investigate the effectiveness of CPP.



## Svensk sammanfattning

En betydande andel av de barn som drabbas av påfrestningar och trauma är under sex år, men de flesta traumafokuserade behandlingsmetoderna riktar sig till äldre barn och ungdomar. Child-Parent Psychotherapy (CPP) är en metod som är utformad för barn under sex år och som utgår från relationen mellan barn och omvårdnadsperson som grund för återhämtning. Denna avhandling syftade till att utvärdera effektiviteten hos och erfarenheterna av CPP i en svensk naturalistisk klinisk kontext. Studie I undersökte omvårdnadspersoners erfarenheter av CPP och hur metoden möter kraven för vidare spridning. Studie II utvärderade CPP:s inverkan på generella psykologiska symptom och posttraumatisk stress hos barn och omvårdnadspersoner, samt omvårdnadspersoners uppfattning om relationen till sitt barn. Studie III utforskade de långsiktiga effekterna av CPP och potentiella prediktorer för utfall. Resultaten var över lag positiva. Omvårdnadspersonerna rapporterade hög tillfredsställelse med metoden, som visade sig vara praktiskt genomförbar. Minskningar av generella psykologiska symptom och posttraumatisk stress observerades hos barn och omvårdnadspersoner. Omvårdnadspersonerna rapporterade även förbättrade förmågor att hantera sitt barns beteende och en minskning av tecken på desorganiserad omvårdnad. Resultaten var stabila vid uppföljningen. En potentiell prediktor för utfall som identifierades var att högre traumasymptom hos barn var associerade med en lägre minskning av omvårdnadspersoners traumasymptom. Resultaten överensstämmer med internationella studier och visar CPP:s effektivitet för att minska symptom och förbättra relationen mellan barn och omvårdnadspersoner. Fynden belyser CPP:s hållbarhet i en naturalistisk klinisk miljö i en ny kulturell kontext, vilket indikerar att metoden har potential för bredare spridning i Sverige. Utifrån begränsningar som litet urval och avsaknad av kontrollgrupp behövs resultat från en svensk RCT för att ytterligare undersöka effektiviteten hos CPP.





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## List of studies

The doctoral thesis is based on the three following studies. Hereafter, the studies will be referred to in the text by their Roman numerals:

- I. Norlén, A., Thorén, A., & Almqvist, K. (2021). Implementing Child–Parent Psychotherapy (CPP) in Sweden: A qualitative study exploring experiences by caregivers taking part of the intervention with their child. *Journal of Infant, Child, and Adolescent Psychotherapy*, 20(2), 152-168. <https://doi.org/10.1080/15289168.2021.1925001>
- II. Norlén, A., Bäckman, C., Thorén, A., & Almqvist, K. (2024). The effectiveness of Child–Parent Psychotherapy on traumatized preschoolers and their caregivers: A Swedish multi-site study. *Evidence-Based Practice in Child and Adolescent Mental Health*. <https://doi.org/10.1080/23794925.2024.2358486>
- III. Norlén, A., Bäckman, C., Lindqvist, K., Mechler, J., Thorén, A., & Almqvist, K. (Submitted). Long-term effects and predictors of outcome of Child–Parent Psychotherapy for traumatized young children and their caregivers: A 6-month follow-up of a Swedish clinical sample.



## **Author Contributions**

### **Study I**

*Anna Norlén:* Funding acquisition, Conceptualization, Data curation, Methodology, Writing–Original draft, Writing–Review & Editing

*Agneta Thorén:* Data curation, Conceptualization, Methodology, Supervision, Writing–Review & Editing

*Kjerstin Almquist:* Funding acquisition, Investigation, Data curation, Conceptualization, Methodology, Supervision, Writing–Review & Editing

### **Study II**

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*Charlotte Bäckman:* Data curation, Methodology, Formal analysis, Supervision, Writing–Review & Editing

*Agneta Thorén:* Conceptualization, Supervision, Writing–Review & Editing

*Kjerstin Almquist:* Investigation, Data curation, Methodology, Conceptualization, Formal analysis, Supervision, Writing–Review & Editing

### **Study III**

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*Charlotte Bäckman:* Data curation, Methodology, Formal analysis, Supervision, Writing–Review & Editing

*Karin Lindqvist:* Methodology, Formal analysis, Visualization, Writing–Original draft, Writing–Review & Editing

*Jakob Mechler:* Methodology, Formal analysis, Visualization, Writing–Original draft, Writing–Review & Editing

*Agneta Thorén:* Conceptualization, Supervision, Writing–Review & Editing

*Kjerstin Almqvist*: Investigation, Data curation, Methodology, Conceptualization, Formal analysis, Supervision, Writing–Review & Editing

All authors have read and agreed to the published version of the manuscripts and have contributed substantially to the work reported.

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## Introduction

Childhood experiences of adverse events are more frequent than commonly presumed. Adverse events can be associated with societal situations including migration, war, terror, accidents, and catastrophes. Stressful events can also arise within the caregiving system, such as various forms of violence and abuse, neglect, mental or physical illness, and the loss of significant others. Affected children sometimes recover with support from their environment, at other times, the consequences are such that qualified interventions and treatment are needed to mitigate negative sequelae. Adverse and potentially traumatic events often affect both children and their caregivers and can undermine caregiving capability and negatively affect the well-being of the child (Fong et al., 2019).

A considerable proportion of childhood victims of adversities and trauma are under the age of 6 (U.S. Department of Health & Human Services, 2022). However, most available support and treatment interventions are designed to meet the needs of school-aged children and adolescents and are sometimes adapted for use with young children. Providers of mental healthcare interventions are rarely trained in evidence-based trauma-focused treatments for children aged 0–6 years (Smith et al., 2020). Hence, there is an evident need for further studies on interventions for young children and explorations of such interventions' effectiveness (Sleed et al., 2023).

In Sweden, a discussion on prevalence, impact, and support in the context of childhood trauma is ongoing, and services are developing. Previous evaluations of existing treatment methods for abused children within Swedish social services and Child and Adolescent Mental Health Services (CAMHS) showed that the applied methods did not provide satisfactory recovery and that young children rarely have access to appropriate treatment (Almqvist et al., 2018; Broberg et al., 2011, 2015; Furmark & Neander, 2018). Consequently, there is a clear need to increase access to evidence-based trauma-focused treatment for young

children and to investigate whether adaptations of these methods are needed when they are disseminated in Sweden.

Child-Parent Psychotherapy (CPP) is one of the few treatment methods specifically developed and evaluated for traumatized children under the age of 6 (Lieberman et al., 2015). This method focuses on the child–caregiver relationship as the foundation for recovery and healthy development following trauma exposure. CPP is primarily adapted to a North American context and is not widely disseminated. Consequently, the implementation and evaluation of CPP in a Swedish clinical context is of significant interest.

## **Child exposure to potentially traumatic events**

### ***Definitions***

There are several definitions of trauma; however, most align with that used by the American organization Substance Abuse and Mental Health Services Administration (SAMHSA), which describes trauma as an event or circumstance that results in physical, emotional and/or life-threatening harm with lasting adverse effects on the individual's mental, physical, and emotional health, and social and/or spiritual well-being (SAMHSA, 2022). Due to the sometimes-delayed onset and varied pattern of consequences and symptoms after trauma exposure, the term *potentially traumatic event* is generally used. The concept of *adverse childhood experiences* (ACEs) is commonly used as a less-specified comprehensive concept that refers to a variety of childhood experiences of forms of abuse, neglect, and family dysfunctions that may negatively influence development. ACEs were initially described and studied by Felitti and colleagues (1998), who demonstrated that such events are common, interrelated, have a cumulative dose-response impact, and contribute significantly to a range of later health and societal problems. Screening for ACEs is promoted by some researchers and

clinicians to identify individuals at risk of trauma associated with family relationships (Hays-Grudo & Sheffield Morris, 2020).

To cover the symptomatology following trauma, four different diagnoses are commonly used within mental health services for children today. The first two are *acute stress disorder* and *post-traumatic stress disorder* (PTSD), specified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association [APA], 2013), along with the subtype *post-traumatic stress disorder for children 6 years and younger* (DSM-5 PTSD<6Y). These diagnoses are completed by the third diagnosis, specified in the International Classification of Diseases (ICD-11) (World Health Organization, 2022): *complex post-traumatic stress disorder*. The different diagnosis systems, DSM-5 and ICD-11, are similar but not identical and address three core symptoms of post-traumatic stress: intrusions or re-experiencing of the event (e.g., intrusive memories, repetitive play, distress triggered by reminders of the event); avoidance (e.g., of thoughts, feelings, or memories of the event, or of people and places associated with the event); and arousal and reactivity or a sense of current threat (e.g., irritability, being easily startled, concentration problems, sleep disturbances). The fourth diagnoses, *reactive attachment disorder* manifest in children under the age of 5 and are attributed to experiences of abuse, neglect, or maltreatment. Both DSM-5 and ICD-11 describe two subtypes: *reactive attachment disorder with social inhibition*, and *disinhibited social engagement disorder*.

However, in young children, manifestations of clinical symptoms may be less differentiated and more shifting, such that the applied diagnosis does not cover the full range of trauma-related reactions (Scheeringa & Zeanah, 2001). It has also been found that a significant number of children exhibit impairment after trauma, even in the absence of a full PTSD diagnosis, such as behavioral problems and, restrictions in participating in activities with family and peers (Mongillo et al., 2009; Scheeringa et al., 2005). To provide a developmental, more detailed, and valid approach for classifying the mental health of children up to 5 years of age, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-5)

(Zero to Three, 2016) was designed. This system includes PTSD as a diagnosis (Zeanah & Lieberman, 2016; Zero to Three, 2016). There is an ongoing discussion in the literature concerning the potential need for a specific diagnosis, such as developmental trauma, to describe the symptomatology associated with chronic traumatization during childhood (Cook et al., 2005; Ford, 2009).

Thus, in clinical practice with young children it is important to be aware of developmental considerations, in addition to variations in trauma symptoms. An assessment of cognitive, emotional, social and behavioral capacities, along with neurobiological vulnerability and the significant salience of the parent–child relationship, provides meaningful information (Zeanah et al., 1997). Furthermore, clinicians must recognize that disturbances in children following trauma can manifest in various forms—including both internalized and externalized problems—beyond PTSD symptoms.

### ***Prevalence in Sweden***

Systematic studies of the prevalence of trauma exposure and subsequent responses in young children are relatively recent (Salmon & Bryant, 2002; Woolgar et al., 2021). Potentially traumatic events in early childhood were previously often overlooked and considered to have a limited impact on young children, under the assumption that their cognitive immaturity would prevent them from retaining or being negatively affected by traumatic experiences. This is one reason for the previous gap in knowledge regarding the impact of early childhood trauma (Lippard & Nemeroff, 2020). However, during the last decades several studies have shown that experiences of adverse events during childhood are more prevalent than previously presumed and that these can affect children in both the short term and long term (Annerbäck et al., 2012; Felitti et al., 1998; Finkelhor et al., 2013).

A recent national survey in Sweden (Jernbro et al., 2023) revealed that 19.7% of Swedish children report having been physically abused and

15.0% report having been psychologically abused by a parent or another adult. Additionally, 10.0% have been exposed to intimate partner violence (IPV), 13.3% report having been sexually abused by an adult (with 0.8% reporting a parent as the abuser), and 11.9% report having been neglected by their parents. The results from the survey also revealed that the children at increased risk for exposure to abuse are those living with single parents, in low-income households, with parents who have substance abuse issues, are involved in custody disputes, experience mental illness, or are engaged in criminal activities. Children with disabilities and those in foster care are also at elevated risk.

International studies emphasize that nearly half of child maltreatment victims are under the age of 6 (Smith et al., 2020). One study found that 23% of young children had experienced at least one potentially traumatic event, such as a car accident, medical trauma, or witnessing intimate partner violence (IPV), between the ages of 6 months and 36 months (Mongillo et al., 2009). However, there is a lack of studies specifically examining the prevalence of abuse and violence toward young children in Sweden. The available data show that, in 2023, a total number of 3,847 cases of violence against children aged 0–6 years were reported to the police (Swedish National Council for Crime Prevention [Brottsförebyggande rådet, Brå], 2025). An analysis of more than 400 cases of child abuse against children aged 0–6 years reported to the police, showed that 57% were boys and 43% were girls and that the majority were aged 4 years and above (Brå, 2000). The reported abuse had often occurred regularly, mainly within the family, and most of the offenders were men. In about half of the cases, the abuse caused minor physical injuries to the children.

According to a national overview of cases reported to child protection services, one-third of the children involved were under the age of 6 (The National Board of Health and Welfare [Socialstyrelsen], 2021). However, a recent national report revealed that children younger than 9 rarely gained access to interventions following reports, in contrast to older children (Persdotter, 2024). The number of cases of child abuse is assumed to be higher due to unreported cases and a lack of representation of young children in crime victim surveys (Brå, 2000; 2023). A

study on introducing routine questions concerning exposure to traumatic events, e.g. abuse and violence, revealed that as many as half of the patients in CAMHS had been exposed to various forms of violence (Hultmann, 2015).

Young children have been identified as being at increased risk for accidental trauma, including burns, falls, and driveway runovers (De Young et al., 2011). In Sweden, the occurrence of such incidents has significantly declined over the past 50 years. However, falls continue to be the most frequent cause of accidents that necessitate medical care for young children (Socialstyrelsen, 2015). There is a large variety of non-interpersonal adverse and potentially traumatic events that can affect children, such as medical trauma and serious illness, loss of significant others, accidents, disasters, terror, or war. A survey among Swedish youth (mean age 16.7 years,  $SD = 1.1$ ) revealed that 99.6% had experienced one or more of such events, with the average number of events being 7.5 for boys and 6.7 for girls (Nilsson et al., 2012). Growing up in an environment marked by adverse family circumstances, including parental mental or physical illness, separation/divorce, or substance abuse, can also cause long-lasting effects on children. In a report by Nilsson and colleagues (2012) adolescents reported experiencing a mean of one adverse circumstance during their upbringing. Every year, about 3,500 Swedish children under the age of 18 years lose a parent, often unexpectedly due to accidents, suicide, or illness, and just under 20% of these are under the age of six. Losing a parent during childhood has been shown to increase the risk of later health problems (Socialstyrelsen, 2013).

In summary, the prevalence of potentially traumatic events among young children in Sweden requires further exploration, as this group appears to be more exposed than previously assumed and seem to rarely access interventions. This situation underscores the potential need for a revised approach to treatment for this vulnerable population.



## **Consequences of trauma on child development and psychopathology**

Young children have limited capacity to independently regulate strong emotions and reactions such as stress, helplessness, worry, and fear, and are dependent on their caregivers to not become overwhelmed (Bowlby, 1982). A robust body of research demonstrates the importance of caregiving quality in child socioemotional development (Cooke et al., 2022). Under optimal conditions, where the caregiving environment predominantly provides positive experiences and sensitive support, children are likely to develop a stable sense of trust in the social environment. This forms the foundation for children to establish a future capacity to calm, reassure, and regulate themselves—a process known as self-regulation (Fonagy, 2004). These abilities promote overall development, including curiosity, exploration, play, and learning, which rely on experiences of safety and consistent regulatory support. Children raised in unsafe, frightening, and non-regulatory caregiving circumstances will be exposed to high levels of relational stress, as well as a lack of protection and comfort, which endanger the development of fundamental abilities (Cook et al., 2005).

While most children demonstrate resilience and return to normal functioning following traumatic events (Alisic et al., 2014), the association between childhood adversities and subsequent mental and somatic ill-health, as well as social problems throughout the lifespan, is stronger than commonly assumed (Asmussen et al., 2020; Felitti et al., 1998). An extensive body of research shows that childhood exposure to abuse and other traumatic events can contribute to significant immediate and long-term disruptions in development, as well as social, psychological, and somatic problems (Ford & Delker, 2018; McCrory et al., 2012; National Scientific Council on the Developing Child, 2010; Scheeringa & Zeanah, 2001; Teicher & Samson, 2016). A meta-analysis has shown a significant relationship between short- and long-term reactions to traumatic events. The greater a child's acute post-traumatic reaction is, including stress symptoms, depression, and anxiety, as well as exposure to parental post-traumatic stress, the more severe the child's long-term symptoms are (Alisic et al., 2014). It is commonly suggested that

up to 30% of trauma-exposed children under the age of 6 meet the criteria for PTSD, although a higher incidence has also been reported (De Young & Landolt, 2018; Salmon & Bryant, 2002; Woolgar et al., 2021). Furthermore, it has been estimated that about half of children with PTSD symptoms will show lasting symptoms over time (Scheeringa et al., 2011).

Particularly burdensome is the so-called *polyvictimization*, which is characterized by exposure to several ( $\geq 4$ ) different types of adversities (Finkelhor et al., 2007). The term “multiple victimization” is also used to describe this situation. Polyvictimization is highly predictive of trauma symptoms, and polyvictimized children show more symptoms than children exposed to repeated episodes of the same kind of victimization (i.e., revictimization) (Ford & Delker, 2018). It has been assumed that victimization often begins in early childhood and then continues, and that polyvictimization is more prevalent among older children. However, a study indicated that early polyvictimization occurred during early childhood in a cohort of children subsequently placed in foster care (Horan et al., 2015). Findings of a high prevalence of mental and physical health concerns have been reported for children in foster care (Dalgaard et al., 2022; Szilagyi et al., 2015). These findings suggest that this group might be at particularly high risk for developmental disturbances, including affect regulation and executive functioning. The findings are consistent with the body of research suggesting that negative developmental outcomes are more strongly predicted by cumulative risk factors than by the presence of a single harmful condition (Chu & Lieberman, 2010).

### ***Post-traumatic stress symptoms in young children***

Exposure to early childhood trauma has been shown to be linked to various negative psychological outcomes, including PTSD and other trauma-related severe symptoms such as learning and behavior problems, anxiety, depression, attention-deficit/hyperactivity disorder, and oppositional defiant disorder (Alisic et al., 2014; De Young et al., 2011;

Hunt et al., 2017). While exposure to a potentially traumatic event is necessary for the development of post-traumatic symptoms, such exposure is not sufficient on its own. Hence, the role of factors other than the event in explaining children's development of symptoms following trauma has been studied, including age as a significant variable. It has been suggested that young children are more vulnerable to traumatic exposure because of their limited coping skills and their dependence on caregivers for protection and emotional regulation (De Young et al., 2011, Trickey et al., 2012). Research reviews have found stronger associations between early exposure and the later development of psychopathology, such as depression, post-traumatic stress, and suicidal ideation, in comparison with exposure at an older age. Cognitive impairment—including poor working memory, attention problems, and inhibitory control—has also been suggested to be associated with early exposure (Hunt et al., 2017; Lippard & Nemeroff, 2020).

However, studies examining the relationship between trauma exposure and subsequent effects on young children have yielded inconsistent findings. It remains unclear whether developmental and age-related factors act as risk or protection. How a young child's limited ability to regulate emotions affects the capacity to cope with events can both increase and decrease vulnerability, depending on the context (Fong et al., 2019; Salmon & Bryant, 2002). For example, younger children's immaturity and level of knowledge might limit their capacity to understand, encode, and appraise complex events. This may lead to a failure to recognize danger, as well as strong reactions of fear to less dangerous situations. These limitations, together with the young child's immature language, influence the representation of experienced events in memory, which can serve as either protection or vulnerability, depending on the circumstances (Salmon & Bryant, 2002). Similarly, unclear results have emerged when investigating the child's gender as a risk factor (De Young et al., 2011). For instance, research reviews have identified both boys and girls as being at increased risk for developing externalizing behavior problems following IPV exposure. The significance of considering the gender of both the child and the perpetrator has also been emphasized (Fong et al., 2019).

Being subjected to interpersonal trauma seems to considerably increase the risk of negative sequelae, affecting one in four children compared with one in 10 children for non-interpersonal events (Alisic et al., 2014). A review by Woolgar and colleagues (2021) estimated the risk for preschool-aged children to develop PTSD as being three times higher after interpersonal trauma compared with non-interpersonal or single events. Nevertheless, severe non-interpersonal adversities, such as accidents, catastrophes, loss, and medical trauma, can also lead to considerable negative psychiatric and behavioral outcomes in children (Copeland et al., 2007). High levels of internalizing, externalizing, and self-regulation problems have been shown in young children who were exposed to a variety of non-interpersonal traumatic events (Mongillo et al., 2009).

Poor family functioning and a lack of social support have consistently been shown to be risk factors for the development of trauma symptoms in children (Foy et al., 1996; Trickey et al., 2012). However, the associations between parenting behavior and child post-traumatic stress are reciprocal and remain unclear. Child symptoms can evoke dysfunctional parenting and vice versa (Fong et al., 2019; Williamson et al., 2017). Nevertheless, studies indicate a link between parental trauma-related distress and child psychological distress. Trauma can lead to disturbances in a child's relationship with the primary caregiver and interfere with the child's ability to develop secure attachment, autonomy, and social skills, which can intrude on the child's interactions with caregivers and other significant people (De Young et al., 2011). Difficulties may be associated with the child's experiences of lacking protection and safety from caregivers and with challenging child behaviors, such as outbursts, aggression, avoidance, clinginess, and emotional dysregulation (De Young et al., 2011).

### ***Traumatic stress and the immature brain***

To further understand the connection between the stress caused by early childhood adversities and abuse and its relation to pathology,

various aspects of early brain development have been investigated (Ford, 2009). Neurobiological research has contributed to an increased understanding of brain development, demonstrating that it occurs mainly through stimulation, rather than maturation, and is closely related to and influenced by the child's experiences with caregiving. This insight has gained traction, particularly in the realm of interpersonal and repeated trauma (Cook et al., 2005; Perry et al., 1995). Reviews of current research on the consequences of child abuse and maltreatment indicate a complex interaction among experiences, environment, and individual differences that underpins psychological and pathological development following childhood trauma (Lippard & Nemeroff, 2020; McCrory et al., 2012).

There seems to be an association between massive early stress exposure and dysregulation in the neural core stress response systems, which can predispose psychiatric vulnerability (Heim & Nemeroff, 2001). The impact of early elevated stress hormones on developing brain structures, such as the hippocampus, amygdala, and prefrontal cortex, has been argued to alter a child's fear response, memory, attention, and control of impulses. However, these findings are still inconsistent, and additional longitudinal research is needed to investigate the mechanisms by which early adversities affect the development of different brain regions at different ages. In addition, the role of genetic influences needs to be further explored (Lippard & Nemeroff, 2020; McCrory et al., 2012). Different psychiatric outcomes in children as a result of similar adversities can partly be explained by genetic differences and the interaction between genes and environment. Childhood abuse can increase the risk of later psychopathology for some children more than others, indicating that a child's genes can partly determine their risk for developing psychopathology. From that perspective, McCrory and colleagues (2012) have suggested that clinical interventions might serve to moderate environmental and genetic risks.

## ***Attachment and trauma***

The early years are a critical period, not only for the maturation of a child's neurobiological stress response system but also for the development of affect regulation capacities and the establishment of styles for attachment relationships (Lieberman et al., 2011; Watamura et al., 2004). The affect-regulating function of attachment relationships constitutes the environment for the development of a child's brain. Hence, if caregiver protection and care are deficient, in addition to potential trauma, the situation becomes even more serious for the young child (Cook et al., 2005; Toth & Manly, 2018). *Attachment* refers to the emotional bond with a caregiver through which a child seeks and maintains proximity and comfort (Bowlby, 1982). The attachment behavioral system motivates the child to increase proximity—and often physical contact—when alarmed by, for example, separation, fear, or pain. The attachment system is deactivated when the caregiver is perceived to be accessible and responsive and provides protection (Forslund et al., 2021). *Attachment quality* refers to the variations that develop in a child's expectations about the availability of the caregiver. The main attachment styles described are secure, insecure avoidant, insecure anxious, and disorganized (Ainsworth et al., 1978). There is a significant association between caregiver sensitivity and child attachment style, and most children form multiple attachment relationships with various qualities (Forslund et al., 2021).

Securely attached children use their primary caregiver as a safe base from which they explore their environments—and to which they can retreat, when distressed, for protection, comfort, and regulation of stress and fear. Secure attachment is generally considered a protective factor in child development (Scott et al., 2011) and is associated with greater social competence, enhanced cognitive performance, and reduced externalizing and internalizing problems (Groh et al., 2017). Attachment quality also interacts with other factors conveying risk and protection, such as exposure to adversities and the degree of family social support (Alexander, 2013; Forslund et al., 2021). Meta-analyses show that insecurely attached children and particularly those showing signs of disorganization are at increased risk for psychopathology,

behavior and regulation problems, and poor developmental outcomes in several areas, such as emotion regulation, cognitive functioning, peer relationships, and language development (Cyr et al., 2010).

Studies show that maltreatment has a destructive impact on the development of secure attachment and increases the risk of disorganized attachment. Disorganized attachment may also be more prevalent following major separations, such as during divorce and custody processes (Solomon & George, 2011). Furthermore, disorganized attachment can emerge from the absence of regulation of fear, as in cases of exceedingly insensitive caregivers. Accumulation of socioeconomic risks ( $\geq 5$ ), such as low parental education, low income, or substance abuse, may have the same impact as maltreatment on child attachment, probably because these circumstances negatively influence caregiving and increase insecurity in children (Cyr et al., 2010).

Disorganized attachment is predicted by frightening, frightened, and dissociative caregiver behavior. A disorganized or fearful/avoidant attachment style, in relation to one or both parents, is more frequent in children exposed to potentially traumatic events, such as IPV, abuse, and neglect (Alexander, 2013; Forslund et al., 2021). Moreover, disorganized attachment seems to increase the risk for post-traumatic symptoms in exposed children (McDonald et al., 2008) and is associated with less positive outcomes in general child development (Fearon et al., 2010). Research shows that children's disorganized attachment symptoms decrease if caregivers develop more sensitive parenting strategies (Bakermans-Kranenburg et al., 2005; Facompré et al., 2018).

Children in foster care are at increased risk for psychopathology and attachment disorders. The increased risk is associated with the child's exposure to multiple potential traumatic events, as well as disruptions in relationships and instability in caregivers due to recurring replacements. However, secure child attachment and well-being can develop with early placement, secure foster caregivers, and appropriate support and interventions (Bakermans-Kranenburg et al., 2011; Dalgaard et al. 2022; Szilagyi et al., 2015). Regardless of whether a child is in foster

care or not, the quality of attachment remains a crucial factor in the child's capacity to resolve traumatic experiences (Chu & Lieberman, 2010).

### **Consequences of trauma on caregiver mental health and caregiving**

Adverse and traumatic events often affect both children and caregivers and can cause considerable stress and emotional reactions within the caregiving system. Caregiving capability can be undermined if the caregiver is suffering from long-lasting traumatic stress and depression (Fong et al., 2019; Greene et al., 2018). The emotional well-being of the caregiver plays a central role in structuring the young child's emotion regulatory processes. Caregiver sensitivity and attunement—a relational approach that emphasizes mutual influences between caregiver and child—is pivotal in fostering optimal regulatory capacities as the child develops. Research from an infant and attachment perspective has demonstrated that experiences of emotional regulation are co-created by caregivers and children, meaning that one relies on the other to acknowledge, return, and adjust her or his actions as the dyad develops a mutually regulated state (Calkins & Hill, 2007). Negative caregiver cognitions, behaviors, and emotions may impair the caregiver's ability to be responsive and attuned to the child's needs.

It has been shown that depressed mothers adjust more slowly and to a lesser degree in interactions with their infants compared with non-depressed mothers, which has been identified as a risk factor for later psychopathology in offspring. Caregiver depression has been found to be associated with a less supportive and more controlling parenting style, and maternal depression increases the risk of the mother showing more punitive and less affectionate behavior toward the child (Cullum et al., 2022). Maternal anxiety, which frequently co-occurs with depression, has also been identified as a risk factor, as anxious mothers often exhibit heightened arousal and controlling behaviors during interactions with their child, potentially limiting the child's ability to



explore and develop. However, research on this field remains limited and somewhat contradictory, with some studies showing associations between maternal anxiety and responsive, sensitive parenting (Feldman et al., 2009; Ostlund et al., 2015).

Caregiving factors can significantly influence the longitudinal course of child psychopathology following traumatic events. Caregiver and child PTSD symptoms are associated, and child PTSD-related impairment and externalizing symptoms are linked to caregiver stress, regardless of the type of traumatic event (Cervin et al., 2021). In addition, when the children of parents with PTSD are exposed to trauma, they are at a higher risk of developing trauma-related stress reactions (Bosquet Enlow et al., 2011; Greene et al., 2018; Leen-Feldner et al., 2013). Meta-analyses show associations between parental PTSD and depression symptoms and child PTSD symptoms after child exposure to trauma (Lambert et al., 2014; Morris et al., 2012). Analyses of moderators reveal that maternal PTSD—but not depression—seems to increase child PTSD (Morris et al., 2012). The associations for symptoms are stronger in dyads where both have been exposed to interpersonal trauma (Lambert et al., 2014).

### ***Caregiving, trauma, and attachment***

A solid body of research has shown the negative impact of neglect and abuse on a child's development of attachment security—findings that have contributed to the understanding of how childhood trauma involving caregivers can negatively affect young children (Cyr et al., 2010; Sroufe et al., 2005). Caregiving has been described as a complex process reflecting earlier relationship experiences as well as past and current experiences with a child. Thus, caregiving and child attachment are linked and transferred across generations (Solomon & George, 1996; 2011).

Caregiving that includes frightening and/or frightened, intrusive, withdrawn, or role-confusing behaviors has been associated with

attachment disorganization (Forslund et al., 2021; Sleet et al., 2021). Maltreating parents simultaneously activate their child's fear and attachment systems, resulting in a characteristic experience of "fright without solution." This process is probably the key mechanism through which maltreated children develop attachment disorganization (Cyr et al., 2010). Research also shows that caregivers often underestimate the level of trauma exposure their child has experienced, as well as the degree of their PTSD symptoms (Woolgar et al., 2021).

The caregiver's ability to provide safety, stimulate development, and provide authoritative guidance when needed may be reduced by a stressful event, even after the event has ended. Caregivers who are struggling with their own trauma-related reactions and symptoms may be less able to acknowledge the needs of their child and to regulate their own maladaptive responses to their child (Scheeringa & Zeanah, 2001). Furthermore, several meta-analyses have provided robust evidence of how a parent's own exposure to childhood trauma increases later caregiving risks, such as child maltreatment, and how trauma can be transmitted across generations (Madigan et al., 2019; van IJzendoorn et al., 2020). However, it is important to recognize the complexity of disorganized attachment and its etiology, underscoring that disorganized attachment is not *per se* an indicator of maltreatment, and there are many pathways to it (Wilkins, 2020).

It has been proposed that, within the context of early attachment relationships, children learn to identify and psychologically represent their affects through the caregiver's interest in the child's mind and feelings. This is considered to enhance the development of the child's self-regulation and self-control through attention-shifting and communication concerning affects (Fonagy, 2004). Studies have shown that the caregiver's capacity for emotional understanding, *mentalizing*, is associated with secure attachment and facilitates emotion regulation in children (Camoirano, 2017). The capacity to mentalize has been revealed to be poorer in both children and caregivers in the context of child abuse and maltreatment. If this capacity fails, it might diminish the caregiver's ability to acknowledge and prioritize the needs of the child (Ensink et al., 2016). It has been suggested that the caregiver's ability

to understand and mentalize the child's experiences and attachment needs following trauma is crucial for the child's ability to regain security and recover. Hence, it has been proposed that interventions aiming at enhancing mentalization may be of importance in trauma treatment for children and caregivers. Play has been hypothesized to serve as a precursor to mentalization and is thus suggested to be a useful tool in supporting these abilities (Tessier et al., 2016).

In summary, the findings linking the caregiver's and child's mental health and trauma symptoms support an approach to treatment for young children and their families that considers the needs of the entire family. Consequently, mental health providers working with children are advised to routinely inquire about both child and caregiver history of physical and psychological violence and subsequently screen for post-traumatic stress (Greene et al., 2018; Socialstyrelsen, 2014). Regardless of whether caregivers are traumatized or not, it has been highlighted that the critical issue after exposure to trauma is the caregiver's ability to accurately pay attention to, read, and interpret the child's symptomatology (Scheeringa & Zeanah, 2001). In cases involving traumatized young children, it is important to address the caregiver's symptoms as well as the child's symptoms, based on the assumption that the most powerful potential change catalyst in young children's development and symptoms is their relationship with their primary caregivers. There is a clear pattern showing a relational link between caregiver and family functioning and child functioning following trauma.

### ***Transmission of trauma-related symptoms between caregivers and children***

Although a substantial body of studies indicates that trauma-related problems within the caregiver–child system are linked to mental health and behavioral problems in children, little is known about how the mechanisms of transmission work. There is growing evidence of effects associated with complex interactions of genetic, epigenetic, and

parental behavior factors (Leen-Feldner et al., 2013; Pereira et al., 2012; Scheeringa & Zeanah, 2001). In a meta-analytic review, negative parental responses were linked to the development and maintenance of child psychopathology, impairments in child ability to regulate emotions, the formation of negative trauma-related appraisals, and poorer treatment outcomes for the child (Williamson et al., 2017). Another potential pathway is that parental PTSD interferes with positive parenting behaviors, caregiving sensitivity, and the modeling of emotions, which can negatively affect the child's development (Morris et al., 2012). In addition, increased reactivity to stress following trauma may lead to the use of less positive, more restrictive, and harsher, maladaptive, or aggressive parenting strategies (Greene et al., 2018). Harsh parenting is one of the strongest predictors of a child experiencing externalizing and internalizing problems (Rivera et al. 2022; Zubizarreta et al., 2018). Exposure to IPV often coincides with child physical abuse, and children who have both witnessed IPV and experienced harsh parenting—particularly corporal punishment—have demonstrated more severe behavioral problems (Fong et al., 2019). Furthermore, overprotective strategies have been identified as a common and potentially problematic caregiver response following trauma, possibly related to increased child PTSD. Overprotection can maintain attachment insecurity, hindering a child's development of exploration, self-efficacy, and opportunities to engage with therapeutic trauma-related materials or activities that facilitate recovery (Williamson et al., 2017).

The relational aspects of post-trauma adjustment may be most salient in young children because of their relatively greater dependence on caregivers (Scheeringa & Zeanah, 2001). Few studies concern the parents of young children, but findings are consistent, with studies linking PTSD symptoms with harsh or reactive parenting (Ammerman et al., 2012; Chemtob & Carlson, 2004) and insensitivity to child cues (Greene et al., 2018). Furthermore, greater parental emotional sensitivity has been found to be associated with higher child PTSD symptoms (Scheeringa et al., 2015). However, the findings regarding the correlation between parents' and children's symptoms following trauma are somewhat inconsistent, as some studies suggest parents can facilitate the child's coping by providing safety and support (Fong et al.,

2019; Williamson, et al. 2017). In one study, IPV-abused mothers unexpectedly rated themselves as more effective parents to their exposed children, being able to compensate for the violence (Levendosky et al., 2003).

## **Interventions for traumatized young children**

### ***Overview***

Effective psychological treatment following childhood trauma is fundamental in alleviating personal and social costs and preventing the chronic development of negative consequences (Alisic et al., 2014; Gutermaun et al., 2016; Sled et al., 2023). The literature emphasizes the importance of early interventions for trauma-related problems as they promote changes in the relational, physical, and mental health trajectories of exposed children. Research indicates that approximately 50% of young children with trauma symptoms do not recover and will have lasting impairments (Scheeringa et al., 2011). If symptoms of post-traumatic stress remain 3–6 months after a traumatic event, it is likely the child will not recover without interventions addressing the symptoms (Margolin & Vickerman, 2007; Nilsson & Svedin, 2017). Moreover, it has been emphasized that young children may be significantly functionally impaired even without a full PTSD diagnosis and may still require treatment (Scheeringa et al., 2015). However, most trauma-focused therapeutic methods are designed for school-aged children and youth, and effectiveness studies on trauma-focused methods lack ample data for children under the age of 5 years (Dorsey et al., 2017; Mavranouzouli et al., 2020).

Several researchers have noted that the quality of available research on trauma treatment for children and youth has several weaknesses, primarily due to small sample sizes and a lack of follow-up data. Additionally, child–parent interaction quality has been assessed using a wide range of different measures (Sled et al., 2023). The overall findings on

the effectiveness of such interventions show a diverse picture, with effect sizes ranging from small to large. Moreover, most studies are in the context of single-event trauma and PTSD diagnoses, leaving complex events and other trauma-related symptoms less explored (Dorsey et al., 2017; Mavranezouli et al., 2020).

Treatment strategies focusing directly on children's PTSD symptoms seem to be more effective than strategies that assume improving the parent's parenting skills—through such as supportive counselling, family therapy, and parent training—will subsequently improve the child's PTSD symptoms (Mavranezouli et al., 2020; Scheeringa et al., 2015). In contrast, other researchers argue that the findings indicate that addressing parental psychopathology and deficits may foster caregiver warmth and affection, thereby enhancing a sense of child security. This, in turn, could positively impact the child's adaptive coping and reduce externalizing problems, likely mediated by improvements in the quality of parenting (Fong et al., 2019; Williamson, et al. 2017). Thus, further research is needed to better understand the impact of parental support and mental health on children's outcomes following trauma.

Evidence from meta-analytic research (Dorsey et al., 2017; Gutermann et al., 2016; Mavranezouli et al., 2020) shows individually delivered cognitive behavior therapy (CBT) treatments in various forms, such as trauma-focused CBT (TF-CBT) (Cohen et al., 2017) and narrative exposure therapy (NET) (Neuner et al., 2008), to be the most promising methods for treating PTSD in children and youth. Play therapy, eye movement desensitization reprocessing therapy (EMDR) (Shapiro 2018), and group TF-CBT have also been found to be effective, albeit to a lesser extent. However, very few children under 6 years of age are included in the covered studies. Furthermore, it has been revealed that effect sizes are larger in studies with older participants, indicating that young children tend to benefit less from CBT interventions (Gutermann et al., 2016). This is likely attributable to the cognitive components of the methods being too complex for young children to comprehend and execute. In addition, the less distinct pattern of PTSD symptoms in young children may not have been adequately assessed and evaluated. Caretaker involvement in treatment seems to be associated

with larger effects (Gutermann et al., 2016). It has been concluded that both assessment and treatments should be better adapted to the specific needs of young children and that further research and development are urgently needed.

An overview of clinical experiences and research findings by Landolt and colleagues (2017) presented evidence supporting psychotherapy as the first choice of treatment for trauma symptoms in young children. Yet, it was emphasized that the available clinical recommendations are inconsistent due to the use of diverse treatment approaches and techniques, while several commonalities can be noticed. They concluded that, in order for therapeutic interventions targeting young children to be successful, appropriate treatment modalities should be used that differ from those designed for older children. It was suggested that the methods applied for young children should be more flexible, nonverbal, and sensitive to developmental issues. The role of caregivers in treatment was emphasized and should be customized according to the individual child–parent relationship. Above all, clinicians must tailor interventions to meet the specific needs of the young patient (Landolt et al., 2017).

### ***Caregiver participation in trauma treatment***

Given a young child's dependency on caregivers for protection and regulation of emotional responses, such as fear and stress, and the importance of the relational context following potential traumatic events, the participation of non-offending caregivers in the trauma treatment of young children is considered essential. It has been suggested that the negative impact of interpersonal trauma such as violence and abuse primarily originate in the realm of relationships rather than merely affecting mental health (Levendosky et al., 2003). Consequently, successful interventions for traumatized children should target not only child behavioral and emotional symptoms but also caregiving capacities and the relational safety context, as these aspects will have been distorted by the traumatic experiences in various ways (Landolt et al.,

2012). Meta-analytic research has found parental participation in child PTSD treatment to result in improved child outcomes compared with child-only or parent-only interventions (Williamson et al., 2017). The inclusion of caregivers is associated with a greater reduction of symptoms in children and improvements in caregiving capacities, relational aspects, and caregiver understanding of the child's symptoms (Gutermann et al., 2016; Landolt et al., 2017).

Several child trauma treatments include caregiver components. Caregivers may participate in parallel, conjoint, or observational sessions. Based on the efficacy demonstrated by treatments including caregivers, this approach is empirically supported, particularly when the child is young (Dorsey et al., 2017). However, it is not clear whether this conclusion is based on the caregivers' actual effect on treatment process or outcome (Clark & Nadeem, 2022). Limitations in the current literature are evident, as there is a lack of consistent operationalization of caregiver factors and various forms of participation. Additionally, the role of cultural context and diversity in caregivers' engagement in children's trauma treatment is understudied. Thus, caregiver involvement and its different forms continue to be a discussed issue. Nevertheless, based on these findings, it has been suggested that there may be some benefit in simultaneously addressing particularly negative parenting practices during child PTSD treatment. However, the direction of effects—that is, whether child symptoms evoke negative parenting or vice versa—remains unclear. It is also possible that effective treatment of child PTSD alone may result in changes in parenting practices (Williamson et al., 2017).

Different models to provide parental involvement in trauma-focused treatment have been developed from distinct theoretical platforms. Studies have reported the effectiveness of CBT treatments, in which parents are typically offered psychoeducation and communication- and stress-management skills to modulate adaptive behavior. However, joint child–parent sessions to process traumatic experiences are less frequent (McGuire et al., 2021). Attachment-based interventions presume that insecure or disorganized attachment, which are characterized by shifts in child attachment behaviors and harsh and inconsistent



parenting strategies, may develop in the context of trauma. This suggests that interventions should target multiple parental and child factors, as well as their mental representations and the dynamics of their relationship (Fong et al., 2019). Joint sessions to process traumatic experiences are suggested to enhance the restoration of the child's experiences of safety and the parent's ability to function as a *safe haven* (Chu & Lieberman, 2010).

In the context of foster care, it is particularly important to involve caregivers in interventions and to explain how the child's complex history of trauma and caregiving may predispose the child to certain problems and behaviors. It is central to provide support for caregivers in managing feelings of rejection when the child does not seek support or during moments of frustration caused by child outbursts. It is equally important to encourage caregivers to remain emotionally available to the child during challenging times (Stovall & Dozier, 2000). Despite the demands imposed, there is an unfortunate lack of research on psychotherapeutic interventions for children in foster care and their foster caregivers, probably due to complex research challenges concerning this group (Dalgaard et al., 2022; Midgley et al., 2019). It is well known that children in foster care often have a history of exposure to multiple traumatic events, instable caregiving and relationship disruptions. Hence, they are at increased risk for psychopathology and attachment disorders. It has been shown that early placement, secure foster caregivers, and appropriate support and interventions can restore child attachment and develop well-being (Bakermans-Kranenburg et al, 2011; Szilagyi et al., 2015).

Nevertheless, few treatments have been developed and evaluated regarding the needs of children in foster care, and knowledge of effective treatments for this target group is currently very limited (Midgley et al., 2021). Meta-analytic research (Dalgaard et al., 2022) has shown that attachment-based caregiving interventions to improve attachment security and reduce disorganized attachment in foster children are inconclusive, partly due to the limited number of studies and short duration of intervention periods. However, findings suggest that attachment-

based interventions show promising short-term effects and increase positive child and parent behaviors in foster families.

### ***Trauma-focused treatment methods for young children***

National Swedish reports show that a variety of interventions for abused and neglected children are offered in Sweden, primarily by social services and CAMHS. However, most of the interventions offered are not empirically evaluated for the target group, whether in Sweden or internationally, and the availability seems uneven. Agencies offering specialized treatments for young children are few and have limited capacity regarding the number of patients and appropriate therapeutic competence. Hence, there is an evident need to further evaluate and develop this area in Sweden (Furmark & Neander, 2018; Swedish Agency for Health and Technology Assessment and Assessment of Social Services [SBU], 2018).

The sparse amount of research on trauma treatment for young children suggests that several of the commonly used treatments lack evidence or that methods designed for older children are being applied. Another potential problem is that the methods offered do not directly focus on traumatic experiences, which has been suggested to be a more effective technique (Landolt et al., 2017; Mavranezouli et al., 2020; Scheeringa et al., 2015). Of the commonly recommended interventions for young children presented below, all of which have conceptualized the inclusion of caregivers in the treatment of young children, only TF-CBT (Cohen et al., 2017) and CPP (Lieberman et al., 2015) explicitly address trauma.

Attachment and Biobehavioral Catch-Up (ABC) (Dozier et al., 2006) is a home-visiting intervention aimed at reducing the risk of the development of insecure attachment in children who have experienced early adversity. Initially, it was developed for young children in foster care. The intervention comprises ten one-hour weekly sessions for caregivers and children aged 6 months to 4 years. The goal of the intervention

is to promote secure relationship formation, strengthen child regulatory capacities, and decrease problem behaviors in children. The treatment uses video feedback and intense in-session instructions on how to interpret and respond to the child's signals of insecurity in order to improve child regulation and support exploration and development. Adverse and potentially traumatic events are not specifically focused on in this method. Research has shown that ABC enhances the development of secure attachment, decreases disorganized attachment in children, and increases positive self and emotional regulation capacities (Attachment and Biobehavioral Catch-up, 2024). The intervention has not been evaluated in a Swedish context, and the extent to which the program is used in Sweden is unclear (Furmark & Neander, 2018; SBU, 2018).

Parent child interaction therapy (PCIT) (Brinkmeyer & Eyberg, 2003) is a behavioral intervention aimed at the treatment of children aged 2–12 years with disruptive behavior, including those with PTSD symptoms; it is conducted in 12–16 one-hour sessions. The model assumes that dysfunctional child–caregiver interactions can lead to conduct problems, and that authoritative parenting leads to positive child outcomes. PCIT focuses on the child–caregiver relationship, and the dyad is jointly treated. The goal is to teach caregiver skills, such as consistent discipline and positive attention to appropriate child behavior. The therapist coaches the caregiver to apply the skills calmly and consistently by communicating with the caregiver using a “bug in the ear” system. Adverse and potentially traumatic events are not specifically focused on in this model. Meta-analytic research has summarized that PCIT is well supported as an effective treatment for externalizing and internalizing symptoms in young children, caregiver distress, and caregiver behavior issues (Phillips & Mychailyszyn, 2022). Support for the model is weaker for abused children, although PCIT has been shown to lead to symptom improvement and increased healthy functioning for trauma-exposed young children (Eslinger et al., 2014). Parents completing PCIT have been the subject of fewer abuse referrals to child welfare services. The intervention is rarely used in Sweden, which explains why it is difficult to properly assess its effectiveness in a Swedish context (SBU, 2018).

Project Support (Jouriles et al., 2009) is a parenting home-based intervention for parents with children aged 3–9 years. It was originally developed to support mothers and children subjected to IPV in handling children with conduct problems. It has been evaluated for IPV-exposed and physically abused children. The intervention is performed one or two times per week for 1–1.5 hours over 8 months and teaches the parent skills to reduce harsh parenting through the therapist demonstrating and instructing the parent. Adverse and potentially traumatic events are not specifically focused on in this method. Studies of this method have shown it to decrease externalizing, internalizing, conduct problems in children, and maternal distress, as well as decreasing harsh and negative parenting. Similar results were found when the program was transferred to a Swedish context (Draxler et al., 2018; SBU, 2018).

TF-CBT (Cohen et al., 2017) is a brief, manualized, phase-based CBT model recommended for children from age 3, built on nine components delivered across 8–25 sessions. The first phase, *stabilization skills*, involves psychoeducation about the impact of trauma, parenting skills aimed at addressing children’s behavioral responses to trauma, and enhancing communication and support. It also includes relaxation skills to alleviate physical trauma responses, affective skills to manage emotional dysregulation, and cognitive processing to understand how thoughts, feelings, and behaviors are connected and can be transformed into more helpful patterns. Phase two is *trauma narration and processing*, which aims at describing and cognitively processing the child’s trauma experience. Finally, phase three, *consolidation*, involves practicing skills in real-life situations to tackle overgeneralized fear and avoidance of trauma reminders, along with conjoint child–caregiver sessions to enhance communication about the child’s experience and improve future safety. Each session is split equally between time spent with the child and time spent with the caregiver, with both being individually guided through the components. A session is often 20–30 minutes for young children, and therapists typically use toys, books, and activities as tools in the treatment (Pollio & Deblinger, 2017). During conjoint sessions, most of the time is spent with the child and caregiver together.

TF-CBT is one of the most studied treatment models for children and youth and has been recommended as well-established for treating PTSD, emotional and cognitive regulation, and comorbid conditions such as depression (Cohen et al., 2017; McGuire et al., 2021; Pollio & Deblinger, 2017). Still, only four randomized controlled trials (RCTs) have studied the application of TF-CBT on preschool children, and two of these studies were limited to sexually abused children. The results show that the treatment mainly decreases PTSD and, to some extent, internalizing and externalizing problems (Cohen & Mannarino, 1996; Deblinger et al., 2001; Salloum et al., 2016; Scheeringa et al., 2011). Given the few published studies and the limited types of traumatic events they investigate, a recent review suggested that the intervention appears to meet the criteria to be “probably efficacious” for preschool-aged children (McGuire et al., 2021).

CPP (Lieberman et al., 2015), the studied intervention in this thesis, is one of the few treatment methods developed and evaluated for traumatized children below 6 years of age (Rizo et al., 2010). This method is theoretically based on attachment and psychodynamic theory and will be presented in more detail below.

### ***Long-term effects of trauma-focused treatments for young children***

Follow-up data of trauma-focused treatments for young children is very limited, often includes short follow-up windows (e.g., 3–6 months) and lacks relational or attachment perspectives (Dorsey et al., 2017; Mavranouzouli et al., 2020; Sled et al., 2023). Available data from follow-ups of sexually abused children aged 4–11 years who had received TF-CBT show that the treatment outcomes of decreased child anxiety and parental stress were sustained at a 6-month follow-up. Additional improvements in child anxiety and parental distress were reported at a 12-month follow-up. However, for children with higher levels of internalizing and depressive symptoms at pretreatment, PTSD symptoms were found to persist at the 12-month follow up (Mannarino

et al., 2012; Salloum et al., 2022). Improvements in child externalizing and internalizing symptoms, parenting skills, and maternal mental health were maintained at a 12-month follow-up of children aged 4–9 years who had received Project Support (Jouriles et al., 2009; McDonald et al., 2006). A small case series study evaluating the effects of EMDR treatment for children aged 5–10 years who had been exposed to a single traumatic event showed a stable decrease in child PTSD symptoms at 3-month follow-up (Lempertz et al., 2023).

A follow-up study of group interventions for IPV-exposed children aged 4–13 years by Pernebo and colleagues (2019) showed that decreases in the children’s internalizing and externalizing symptoms and PTSD symptoms were sustained at 6- and 12-month follow-ups. Children with more severe trauma symptoms benefited the most. Somewhat contradictory outcomes were reported from a follow-up of a community-based group program for IPV-exposed children from 5 years of age. The positive changes in behavioral problems post-intervention were not sustained at the 12-month follow-up (Grip, 2012).

Thus, the results are unclear regarding which children benefit the most from the studied interventions in the long term. Children with higher levels of internalizing and depressive symptoms at pretreatment seemed to have benefited less from TF-CBT when followed-up (Manarino et al., 2012), while children with more severe trauma symptoms benefited the most in a follow-up to group treatment (Pernebo et al., 2019). The results from follow-up studies of CPP treatment will be presented below.

### ***Predictors of treatment outcome***

To better understand how different circumstances may be related to treatment outcomes, analyses of mediating and moderating factors have been carried out. However, knowledge is limited about the factors influencing psychotherapy treatment effects in general. *Moderators*—that is, individual conditions for which a treatment works—and

*mediators*—that is, the mechanisms through which treatment is effective—are rarely explored in studies of trauma treatment for children. Small sample sizes restrict possible analyses, the number of studies is limited, and reviews report mixed results (Woolgar et al., 2021). Moreover, it has been argued that the relationship between moderators and mediators is complex, making the interpretation of whether a condition moderates or mediates outcomes unclear, even in large sample studies and RCTs. To develop treatment methods, it is essential to further identify and understand these factors and differences, which is why it has been proposed that identified baseline measures affecting outcomes might be considered *nonspecific predictors* of outcome (Kraemer et al., 2002).

A review found that demographic characteristics such as the child’s age and gender do not seem to moderate outcomes, whereas parental functioning, treatment dose, the use of explicit exposure in treatment, and sudden treatment gains moderate the effects of traumatic stress symptoms (Dorsey et al., 2017). A meta-analysis of treatment for sexually abused children found that none of the examined moderators—that is, child age, sex, ethnicity, and caregiver involvement—or treatment modalities were significant for the outcome (Trask et al., 2010). However, an evaluation of mediating factors of TF-CBT outcome in sexually abused children found parental support to predict child outcome at both 6- and 12-month follow-ups (Cohen & Mannarino, 1998). Two studies of group treatment for IPV-exposed children showed greater exposure to trauma pretreatment to be associated with a decrease in child PTSD symptoms and higher levels of parental mental health to be a mechanism of change in parent–child interaction and decrease in child symptoms (Overbeek et al., 2017; Pernebo et al., 2019). Hence, conclusions about outcome moderating and mediating factors are tentative and should be interpreted with caution (Woolgar et al., 2021).

An exploration of the moderators of symptom change in CPP treatment revealed that improvements in parental PTSD symptoms were associated with reduced symptoms of avoidance and arousal in the child. Both parent and child improvements were greater for dyads with fewer parental lifetime stressors and fewer treatment sessions. Unexpectedly,

girls seemed to benefit more than boys (Hagan et al., 2017). In another CPP study, a high degree of pretreatment trauma exposure was shown to positively moderate outcomes—that is, greater reductions in PTSD and depression symptoms—in both children and mothers receiving the treatment (Ghosh Ippen et al., 2011). Guild and colleagues (2017) found that attachment security mediated the relationship between child peer relations, maternal warmth, and child behavior problems, as children who had received CPP as toddlers were more likely to demonstrate secure attachment post-treatment, which was associated with more positive peer relations, maternal and child affective expression, and dyadic cohesion at age 9.

## **Child–Parent Psychotherapy**

### ***Background and outline of the method***

Child–Parent Psychotherapy (CPP) is a treatment method designed and evaluated for traumatized children under 6 years of age experiencing mental health, attachment, and/or behavioral problems (Lieberman et al., 2015). This method was developed from parent–child psychotherapy based on attachment and psychodynamic theory to a trauma-focused treatment method with the integration of elements from developmental, trauma, social learning, and cognitive behavioral theories. A central goal of CPP is to strengthen the caregiver–child relationship, as this is hypothesized to be the most powerful change mechanism for restoring and protecting the child’s mental health, development, and emotional, cognitive, and social functioning following adversity and trauma. By primarily focusing on the child–caregiver relationship, the treatment aims to improve child attachment and increase the child’s overall well-being and recovery. Furthermore, the relational therapeutic approach is assumed to help children and caregivers share painful experiences while also discovering safe, protective strategies for mutual emotional regulation, thus enhancing their ability to cope.



CPP is component-based in accordance with a treatment manual but is still adaptive to the needs of the caregiver–child relationship and the sociocultural context. The intervention addresses various complex clinical areas and has a flexible design built on therapeutic skills. Therapeutic sessions are dyadic and include the child and primary caregiver; individual sessions with the caregiver also occur, if needed. CPP was originally developed for children exposed to IPV and comprised 50 weekly 1-hour sessions. The method has been further developed and is currently recommended for use after various adverse and potentially traumatic experiences. The method has been further modified into a flexible phase-oriented design in which the treatment process and length are tailored to the needs of the child and caregiver. Weekly sessions of 60 minutes over a period of 20 weeks or more are suggested; however, treatment can also be briefer. Sessions typically take place in a clinic playroom, while home visits may also occur to enable the family to partake in the treatment.

The overall goal of CPP is to decrease trauma-related mental health symptoms and behavior problems in the child and attachment problems in the child–caregiver relationship. The intervention addresses traumatic stress reactions in both caregivers and children, promotes affect regulation in the child and caregiver, changes maladaptive mental representations and behaviors in the child and caregiver and their relationship, and encourages developmentally appropriate interactions and activities. Contextual and cultural factors affecting the relationship are also approached. CPP aims to decrease caregiver stress, restore and support the development of caregiving capacities, facilitate attention to the needs of the child, and improve parental protection and care for the child. The treatment manual provides a framework of components that the therapist relates to and uses as needed, rather than following a strictly manualized program. Moreover, the manual provides treatment strategies and clinical examples. It is common to plan the intervention in sub-steps, where progress and continued treatment needs are gradually evaluated in dialogue with the child and caregiver.

CPP consists of three phases:

- **Foundational phase:** The treatment is preceded by a foundational phase with the caregiver, which consists of several interview sessions (typically 2–4) conducted by the therapist. These sessions aim to screen and assess, as well as collect information about the child’s developmental history, the trauma histories of both the caregiver and child, their present symptoms, and details about their living conditions. Establishing a therapeutic climate, a trustful alliance, and a solid comprehension of the dyadic work to come is essential. A dialogue about cultural values and child rearing and trauma-informed and developmental perspectives on the child’s problems is introduced. A treatment plan, including an agreement on how to address traumatic events and other difficult topics with the child, is formulated.
- **Core intervention phase:** This phase begins with a session in which the child is introduced to the treatment aims, while communication about traumatic events and the dyadic treatment process begins. In this phase, the joint creation of the trauma narrative is central, offering an opportunity to emotionally process experiences and address challenges in the dyad. The frequency and number of dyadic sessions are tailored based on the therapist’s continuous assessment of the needs of the dyad. The manual describes 12 domains of core interventions; examples include child aggression toward the caregiver, separation and loss reminders, relationship with the perpetrator/absent parent, and caregiver’s use of criticism of the child, which are particularly salient to focus on sessions. The therapist is encouraged to use the domains to formulate an intervention strategy and prioritize the most urgent focus.
- **Recapitulation and termination phase:** The final phase involves a gradually decreased focus on trauma and difficulties and an increased focus on the positive changes accomplished and how to promote the sustainability of gains. The termination is a process of several weeks and is planned in cooperation with the

child and caregiver. Psychoeducation includes how trauma-related symptoms may fluctuate over time and emphasizes that the process of meaning-making of traumatic experiences is continuous throughout a child's development.

The main therapeutic tools in CPP are playing and giving words to painful and overwhelming feelings and experiences. Dyadic trauma-related and regulating play activities, verbal expression, and physical contact between caregiver and child are aimed at facilitating understanding and sharing of trauma-related experiences and ways to handle them. From a developmental perspective, dyadic interaction through playful activities is encouraged, as play is viewed as the main modality for children to express emotions, explore relationships and experiences, and experiment with ways of controlling their inner and outer reality.

One of the core components of CPP is the joint creation of a trauma narrative by the child and caregiver, during which the dyad receives direct emotional support from the therapist. This process incorporates play to support the trauma story and is a vital treatment tool through which affects can be integrated and modulated and fragments can be brought together to form more coherent patterns. The therapist guides the child and caregiver through a joint construction of the trauma narrative by using toys, drawing materials, pictures, and other playful techniques, adjusted to the needs of the caregiver-child dyad, so that the trauma narrative holds meaning for both parts. The CPP therapist helps translate the emotional meaning of behaviors and interactions to both child and caregiver, allowing them to understand each other's perspectives and enabling the mutual emotional processing of traumatic experiences.

During the treatment process, the therapist focuses on enhancing the caregiver's ability to develop and attempt various regulation capacities through supportive vocabulary, behavior, and interactions, rather than by means of coercive, avoidant, or repressive interactions. Through the co-creation of experienced traumatic events in a safe therapeutic situation, conflict resolution and restoration of hope and trust can emerge.

Playful interactions are also used to enhance and support emotional and behavioral regulation strategies to strengthen joy, relaxation, and hope within the dyad.

CPP is described as cross-disciplinary, as it combines mental health intervention, psychoeducation, and case management, where the latter is defined as “assistance with problems of living.” Case management is an integral component of CPP when working with families facing socio-economic challenges; it uses elements from social work and advocacy to support the needs of families. This perspective is an extension of the model’s emphasis of the context when supporting child development. The CPP therapist uses knowledge of the family circumstances to identify areas where additional support is needed and to monitor the integration of services such as social services, child protection, or adult mental health services.

With a complex method like CPP, it is challenging to ensure method fidelity by therapists, as the intervention design is built on therapeutic skills. The CPP fidelity framework is described as multidimensional and consists of six interrelated strands of fidelity: reflective practice, emotional process, dyadic relational, trauma framework, procedural, and content fidelity. The manual provides fidelity packets built on the strands for each phase to support therapists, who are encouraged to use the packets regularly.

The CPP training program runs over 18–20 months, including 6–9 days of didactic training and competency building, with regular digital group consultations every other week at which each therapist presents the process from at least four CPP therapies and applies the fidelity packets to ensure method fidelity. The Swedish training is concluded with a written exam, and the complete training provides a university-level certificate. Moreover, regular method consultations and therapeutic supervision are recommended, even after completing training.

## ***Previous research on CPP***

Recent meta-analytic research showed positive effects from CPP and recommended further research due to the limited number of studies, small numbers of participants, and lack of long-term follow-ups (Mavranouzouli et al., 2020; Slead et al., 2023). CPP has been evaluated in RCTs and observational studies in the United States, with promising results after various forms of traumatic events. RCTs with CPP have provided empirical support for significant treatment effects for children exposed to IPV, physical and sexual abuse, and loss (Ghosh Ippen et al., 2011; Lieberman et al., 2005, 2006). Studies have also examined outcomes after child maltreatment (Cicchetti et al., 2011; Stronach et al., 2013; Toth et al., 2002) and maternal depression (Cicchetti et al., 1999; 2000; Guild et al., 2017; Peltz et al., 2015; Toth et al., 2006). The number of sessions in the RCTs ranged from 21.56 to 45.24. The results indicated that children receiving CPP showed greater reductions in traumatic stress symptoms and total behavior problems (Lieberman et al., 2005), improvements in negative self-representations and maladaptive maternal attributions, and greater improvements in relationship expectations (Toth et al., 2002), compared with children receiving community services and caregiver case management.

Studies evaluating attachment changes resulting from CPP have demonstrated significant positive shifts in attachment in maltreated infants (Cicchetti et al., 2006), with the number of children with secure attachment changing from 3.1% pretreatment to 60.7% post-treatment and the rate of disorganized attachment decreasing from 87.5% to 25.9% at post-treatment. Similar outcomes were found in children with depressed mothers (Cicchetti et al., 1999), where 74.1% of the children treated with CPP showed significant improvements in attachment security, whereas the children in the no-treatment group continued to show a greater rate of attachment insecurity.

Furthermore, positive outcomes have been found in mothers participating in CPP, showing significant reductions in general psychological distress and PTSD avoidance after treatment, compared with mothers receiving community services and case management (Lieberman et al.,

2005). Furthermore, decreased child-related stress was reported in mothers participating in CPP post-treatment, although no differences were found compared with mothers receiving parental psychoeducation (Cicchetti et al., 2011).

Studies evaluating biological regulatory processes have found that maltreated infants aged 1–3 showed significant normalized patterns of stress hormone production, measured as cortisol regulation, after receiving CPP, compared with children receiving community standard services (Cicchetti et al., 2011). A study examining cellular aging in children demonstrated that children who had received CPP showed lower epigenetic age acceleration compared with a non-treatment group. These findings may indicate lower risk for later health problems (Sullivan et al., 2024). Moreover, effectiveness studies of the outcomes of CPP for children affected by foster care (Weiner et al., 2009) and children exposed to child physical abuse, traumatic loss, and severe accidents (Hagan et al., 2017) have shown significant reductions in PTSD symptoms post-treatment.

Despite these promising results, the overall body of CPP research presents a somewhat unclear picture, with sample constraints and substantial attrition rates raising questions about generalizability and limited evidence for long-term benefits (McMahon & Maxwell, 2021). Empirical evidence on how and under what circumstances secure attachment influences later child development is also limited (Thompson, 2016).

### ***The long-term effects of CPP***

It has been stressed that the long-term effects of child psychotherapy in general warrant further investigation (Midgley et al., 2021), and the same can be concluded for CPP. Nevertheless, the long-term effects of CPP have been evaluated in several RCTs (Cicchetti et al., 2011; Ghosh Ippen et al., 2011; Guild et al., 2017, 2021; Lieberman et al., 2006; Strodnach et al., 2013; Toth et al., 2015).

The long-term treatment effects for CPP were demonstrated in a 6-month follow-up that showed sustained decreased child behavior problems and maternal distress in a group of children and mothers exposed to IPV and other traumatic events (Lieberman et al., 2006). Furthermore, the results showed greater improvements in PTSD and depression symptoms, number of co-occurring diagnoses, and behavior problems in children and greater reductions of symptoms of PTSD and depression in their participating mothers for a high-exposure subgroup ( $\geq 4$  events) compared with a comparison group receiving community services and case management. Children who were less exposed ( $\leq 4$  events) showed greater improvements in PTSD symptoms than the comparison group at follow-up. It was also suggested that CPP may be more effective for children with severe symptoms (Ghosh Ippen et al., 2011). A 1-year follow-up of maltreated children and their mothers showed a maintained decrease in both child and maternal stress, measured as cortisol production, compared with a control group receiving community services (Cicchetti et al., 2011; Toth et al., 2015).

The long-term effects of CPP treatment regarding improved attachment relationships were shown at a 12-month follow-up of maltreated children. The children showed sustained improvements, with higher rates of secure attachment and lower rates of disorganized attachment compared with children receiving community standard services together with their mothers (Stronach et al., 2013). Children receiving CPP together with their depressed mothers as toddlers were also followed up at age 9 and exhibited maintained higher rates of change to secure attachment compared with the non-treatment control group (Guild et al., 2021). These findings were associated with higher levels of maternal warmth and lower levels of child anger and problem behaviors. Follow-up data from teachers' reports on the same children's classroom competence suggested that children who had received CPP treatment seemed more likely to have positive peer relationships, although the results were not significant compared with the non-intervention control group (Guild et al., 2017).

## **Implementing treatment methods in a new context**

### ***Dissemination and implementation of treatment methods***

The process of adopting a therapeutic method from one country to another is known to be associated with various barriers. A significant number of studies have described challenges associated with cultural, organizational, and structural issues when implementing new treatment programs. Implementation research indicates that the implementation design influences outcomes, and that low implementation strategy quality is common (Aarons et al., 2010; Durlak & DuPre, 2008; Fixsen et al., 2005; Meyers et al., 2012). Research also indicates that the diffusion of effective interventions typically yields diminishing results as the process unfolds. In effective implementation, factors associated with, for example, funding, provider characteristics (e.g., CAMHS), and support systems (e.g., leadership) seem to interact (Durlak & DuPre, 2008). A systematic phase-structured implementation strategy has been suggested, including (a) preparation and exploration, (b) creating implementation structure, (c) supervising implementation, and (d) improving future applications and enhancing sustainment (Aarons et al., 2010; Meyers et al., 2012).

Implementing programs designed for parenting and the child–caregiver relationship is particularly challenging, as such programs are aimed at areas closely associated with culture, legislation, and profound contextual values. Thus, it is recommended that the introduction of novel methods in this area is not done without considering adaptations for cultural reasons. Tailoring novel parenting programs to the Swedish context in terms of cultural norms or practicalities has been found to enhance the program effects (Sundell et al., 2016). A recent study of the transfer of Project Support from the United States to Sweden showed the need to amend therapeutic tools and aspects of the view of child discipline and to consider legal aspects (Draxler, 2020). It has been suggested that a feasibility research approach should be used in the intervention-research process as a determinant for



accepting or discarding a new intervention. Appropriate areas that have been emphasized include the intervention's acceptability to the target group and those involved (e.g., therapists and services), demand for the intervention, the implementation process, the practical opportunities to deliver the intervention, the adaptations needed, the intervention's integration within the overall system, efficacy testing of the intervention, and opportunities to expand (Bowen et al., 2009; Proctor et al., 2011). Very little research has focused on the determinants of the implementation of trauma-focused treatments for early childhood populations. However, attention to organizational factors has been shown to enhance the implementation of evidence-based treatments in child mental health services. Such factors include a positive working climate, a good fit between the agency's philosophies and the treatment, commitment to measuring outcomes, appropriate support for clinicians, secure funding, access to supervision, and a focus on adherence and child outcomes. Importantly, the appeal of and openness to the method may impact therapist adherence and facilitate implementation (Barnett et al., 2014).

The use of an implementation strategy through close cooperation among researchers, clinicians, and organizations has been shown to be key when implementing complex interventions in child mental health services (Beidas & Kendall, 2014). Specific conditions among therapists and organizations that may amplify barriers and limitations to the implementation of trauma-focused therapy have been shown to include a reluctance to work extensively with severely traumatized clients, experiences of a lack of support and supervision, and limited experiences in the field. However, self-care approaches have been shown to significantly increase trauma therapists' competency and fidelity (Deblinger et al., 2020). In their meta-analysis of trauma treatments, Dorsey and colleagues (2017) concluded that the biggest challenge in the field is how to implement and sustain *any* intervention with evidence of efficacy or effectiveness. Thus, the challenges in the field are extensive.

## ***The contribution of naturalistic design to psychotherapy studies***

RCTs of therapy methods for youth generally show positive outcomes, while clinical studies typically show small or modest effects (Weisz & Simpson Gray, 2008). However, the results are inconsistent. A meta-analysis of evidence-based practices versus usual clinical treatment for youth showed modest outcome differences and a need for the development of study designs (Weisz et al., 2006). Meta-analytic research has shown an overall medium effect size for psychotherapy for children and youth ( $d = 0.46$ ), with stronger effects for anxiety treatments ( $d = 0.61$ ), lower effects for depression ( $d = 0.29$ ), and non-significant results for multiproblem treatment (Weisz et al., 2017). Furthermore, Weisz and colleagues (2013) found that evidence-based methods, which are often developed in the United States, diminished in effect in studies from other countries. Weisz and colleagues (2017) concluded that this may indicate the potential value of cultural adaptation of methods, as well as the need to tailor interventions to the complex everyday settings of clinical practice, where patients often represent a heterogenous sample with multiple problems, and clinicians carry large workloads. Moreover, a naturalistic design is assumed to increase the contribution of a clinical intervention to the development of the method, as interventions with such a design are generally conducted in close cooperation between researchers and clinicians and include attempts to integrate clinical assessment and therapeutic process with outcome measures (Beidas & Kendall, 2014; Halfon et al., 2020).

The positive experiences reported from Swedish CPP feasibility studies have shown no need for a Swedish adaptation of the method, which is why further dissemination was supported. The need for continuous exploration of the effectiveness of CPP in Swedish clinical settings has been pointed out, however, and a study on this method in a clinical practice setting has been proposed (Almqvist et al., 2018; Broberg et al., 2015; Norlén et al., 2021).

## ***Feasibility and dissemination of CPP***

At present, CPP is implemented in 39 states in the United States and has proved feasible in mental health agencies in urban and rural contexts. A few studies from the United States, Australia, and Sweden following the implementation and sustainability of CPP reported both facilitators and barriers. Identified facilitating factors included the individual therapists' desire to learn the method (Smith et al., 2020), prior knowledge of and experience with interventions for young children and working with trauma (Hooker et al., 2022), the availability of appropriate premises and materials (Barnett et al., 2014), and access to collegial, leadership, and organizational support (Broberg et al., 2015; Smith et al., 2020).

The main barrier to implementing CPP seemed to be staff turnover (Almqvist et al., 2018; Smith et al., 2020). Other obstacles included therapists being overwhelmed by a complicated training process and the challenge of finding the time to apply the model (Smith et al., 2020), the logistics associated with the training process, and funding difficulties (Skale et al., 2020). Several evaluations showed that problems with recruiting clients due to referral and cooperation challenges, as well as working with complicated legal processes linked to family law, inhibited implementation of the method (Almqvist et al., 2018; Broberg et al., 2015; Hooker et al., 2022; Pernebo et al., 2024; Skale et al., 2020; Smith et al., 2020). Key factors supporting the sustainability of CPP included access to supervision (particularly reflective consultation), continued learning, the training of new therapists, support from directors and local advocates, and improved collaboration with referring agencies to effectively identify children and families in need of the treatment (Barnett et al., 2014; Hooker et al., 2022; Noroña & Acker, 2016; Smith et al., 2020).

The international dissemination of CPP is sparse thus far. Training has taken place in Australia, Hong Kong, Israel, Norway, Sweden, and the United Kingdom to varying extents. CPP has been found to be feasible for implementation in Australia and Sweden and in various

organizations including CAMHS, community-based services, and child advocacy centers in differing contexts such as urban and rural areas (Almqvist et al., 2018; Broberg et al., 2015; Hooker et al., 2022). A feasibility study in Australia found CPP feasible and acceptable for the treatment of mothers affected by IPV. Problems with recruiting clients from referring agencies were reported. While the sample in the study was too small and the attrition too high to evaluate efficacy, positive changes were noted in child behavior and parental capacities based on qualitative reports from mothers and therapists. Further research to assess intervention efficacy in the Australian context and explore the participation of children in CPP was recommended (Hooker et al., 2022). A dissemination study of CPP in Israel investigated how the implementation process and method were experienced among professionals. The results showed high motivation among the Israeli therapists to contribute to the implementation of CPP. At the time of the study, general knowledge and routines concerning therapy for early childhood trauma were described as low in Israel. The overall positive attitude among the therapists was interpreted as being partly due to the opportunity to provide a therapeutic response to an urgent need. A summary of the findings from the implementation in Israel suggested that, to be successful, a large-scale implementation of CPP should be preceded by a professional discourse and the introduction of a conceptual framework regarding early childhood trauma knowledge (David & Shiff, 2015).

### ***Implementation of CPP in Sweden***

During 2013–2015, a feasibility study of CPP was carried out in Sweden. In connection with the study, the first training course in the method was held at Karlstad University in collaboration with the University of California (PhD Alicia Lieberman and PhD Chandra Ghosh Ippen). The study was funded by the Swedish National Board of Health and Welfare with the aim of testing different mapping instruments and treatment interventions for children in Sweden exposed to violence (Broberg et al., 2015). The study showed positive experiences with CPP among therapists in the participating mental services (CAMHS and

NGO), who reported that the method filled a gap, suited the services, and was both challenging and stimulating to work with. However, certain difficulties in method fidelity within the framework of Swedish CAMHS were observed, such as the current barriers associated with joint custody and visitations with a violent parent. The importance of organizational and collegial support when working with CPP was underscored. Preliminary analyses of interviews with participating caregivers revealed overall satisfaction and appreciation of the method. Caregivers reported experiencing improvements in their own and their child's well-being and in the child–parent relationship. Despite the small sample, positive effects on children's and caregivers' general psychological symptoms and reduced PTSD symptoms were reported. It was concluded that previous positive effects in international studies seemed to persist in the Swedish context and that CPP was possible and suitable to implement without amendments or adaptation to the Swedish clinical and cultural context. Further dissemination of CPP in Sweden was supported in combination with extended training of therapists to obtain a better basis for further evaluation of the strengths and weaknesses of the method in the Swedish clinical context (Almqvist et al., 2018; Broberg et al., 2015).

Pernebo and colleagues (2024) invited all CPP therapists who had been trained in Sweden up to 2020 (66 therapists at the time of the study) to participate in a survey aimed at exploring the extent to which they were still working with CPP. The response rate was 73%, and 80% of the respondents were currently using CPP, albeit mostly in very few cases. Interviews with 12 of the therapists revealed common difficulties in gaining access to children for treatment, due to failures within their own and referring organizations to identify young children exposed to trauma and to identify and assess symptoms of trauma in the target group. This was in line with descriptions of a clear lack of trauma-informed knowledge and services for young children. Qualitative analyses of the therapists' experiences of barriers and facilitators in the implementation and sustainability of work with CPP showed an interplay between organizational and individual factors in both areas. Organizational mandates, available resources, and existing clinical frameworks (e.g., time and workloads) were described as supporting sustained

implementation. Finally, many therapists reported enjoying working with CPP, expressed trust in the effectiveness of the method, and continued to use fidelity instruments to support their work.

## **Current studies**

### **Background of the thesis**

The background of this thesis was a previous evaluation of existing treatment methods for children exposed to IPV within Swedish social services and CAMHS, commissioned by the Swedish National Board of Health and Welfare (Broberg et al., 2011). The evaluation showed that children who had been treated with services specializing in violence-related issues and had taken active part in the treatment showed significant reductions in psychiatric symptoms and improvement in general functioning, albeit with modest effects. Children whose parents had received support but who had not taken part in the treatment themselves showed no significant improvements. In sum, the evaluation showed that the available methods were appreciated by parents, children, and therapists but did not provide satisfactory symptom reduction. Additionally, most children with severe psychiatric symptoms before treatment were found to have persistent levels of clinical symptoms afterwards, even though improvements were seen in children who participated in the treatment.

Subsequently, Karlstad University was commissioned in 2012 to test the feasibility of four international evidence-based interventions for abused children, two of which were considered appropriate for social services and two suitable for CAMHS. The latter group included CPP and TF-CBT. The purpose was to investigate whether methods that had shown positive effects in international studies could be implemented in Sweden with equivalent results. A training collaboration was established with the method's originators, PhD Alicia Lieberman and PhD Chandra Ghosh Ippen, with the purpose of introducing the CPP

method to Sweden while maintaining its quality and method fidelity. Subsequently, specialized training for future Swedish trainers and supervisors was conducted in collaboration with the originators to support continued education in the method.

## **General aim**

The overarching aim of this thesis was to evaluate the outcomes of CPP treatment in children and caregivers within a Swedish naturalistic clinical context, explore the long-term effects of CPP, identify potential predictors of outcomes at follow-up, and examine whether the outcomes correspond with the findings previously reported in international studies. In addition, this thesis aimed to explore how CPP meets the demand for its dissemination in Sweden and to extend the understanding of its acceptance. A further purpose was to investigate the need for adaptations to increase the feasibility of CPP in Sweden by analyzing the experiences of caregivers undergoing the treatment with their children. Finally, an overarching aim of this thesis was to contribute to improving the therapeutic support provided by the Swedish healthcare system for young children and caregivers affected by adversities and trauma.

## ***Specific aims***

- I. Study I aimed to explore how CPP treatment is experienced by caregivers taking part in the intervention with their child.
- II. Study II aimed to explore the effectiveness of CPP on general psychological health and post-traumatic stress symptoms in children and caregivers participating in the treatment, as well as on caregivers' perceptions of their relationship with their child, when CPP is implemented in a Swedish naturalistic clinical context.

- III. Study III aimed to evaluate the long-term effects of CPP treatment and potential predictors of outcome in children and caregivers, measured as post-traumatic stress symptoms, and caregivers' perceptions of their relationship with their child at follow-up in a Swedish naturalistic clinical setting.

## **Research methods**

The three studies included in this thesis concern the treatment of young, traumatized children and their caregivers, who received the trauma- and attachment-focused method CPP through various agencies within the Swedish healthcare system. The naturalistic study design evaluates how participation in CPP is experienced and the effectiveness of the method when implemented in a new cultural clinical setting. The three studies are part of a research project using a mix of methods (one interview study, one effectiveness study, and one follow-up study). An overview of the studies is presented in Table 1. Different research methods were chosen in accordance with the specific aims and research questions. Using this approach, the aim was to gain new theoretical and clinical knowledge, as well as perspectives concerning young children and caregivers involved in trauma treatment in real-life settings, rather than controlled environments.

To gain a deeper understanding of how CPP meets the demands for dissemination in Sweden, the experiences and views of the caregivers taking part in the treatment with their child were collected through in-depth interviews, making qualitative analysis an appropriate approach for capturing their perspectives. The interviews were intended to gain insight into the caregivers' perspectives by inviting them to talk freely and explore evolving themes using an inductive approach. To evaluate the outcomes of the treatment when offered within the Swedish mental health system, a naturalistic design was applied, with assessments before treatment (T1) and at the time of 20 dyadic sessions (T2), or at the end of the treatment if it was briefer, enabling a pre-/post-



measurement design. To evaluate the sustainability of outcomes, assessments were also conducted 6 months after the conclusion of treatment (T3). At each of the three assessment points, outcome data was collected for both the children and their participating caregivers. Information about the study, consent to participate, and data including sociodemographic and anamnestic facts were collected by the involved CPP therapist. The two outcome studies employed instruments for assessment, facilitating their use in different clinical settings and allowing certain comparisons with the results from previous studies. The use of self-report instruments was considered to potentially narrow the focus. Due to funding, data were collected over two time periods. During the first period (2013–2015), data on 20 children and their caregivers were collected; in the second period (2017–2021), data on 37 children and their caregivers were collected. The number of eligible caregivers who declined participation is unknown. Two dyads dropped out from T1 to T2; at T3, a total of 12 dyads were lost.

**Table 1***Overview of the design, participants and instruments in Studies I-III.*

	Study I	Study II	Study III
Design	A qualitative pre-study with an inductive approach, individual interviews with caregivers, conducted in a naturalistic clinical setting	A one-group, pre-/post-design study, conducted in a naturalistic clinical setting	A one-group, pre-/post-design study, with a 6-month follow-up, conducted in a naturalistic clinical setting
Participants	Caregivers ( $N = 11$ ) of children aged 3–7 years ( $M = 4.9$ , $SD = 0.8$ )	Children ( $n = 57$ ), aged 2–6 years, ( $M = 4.7$ , $SD = 1.2$ ), Caregivers ( $n = 57$ )	Children ( $n = 37$ ) aged 2–6 years, ( $M = 4.6$ , $SD = 1.0$ ), Caregivers ( $n = 37$ )
Instruments	A semi-structured interview guide	Caregiver ratings of child's and own general psychological symptoms, PTSD symptoms, and the caregiver-child relationship	Caregiver ratings of child's and own PTSD symptoms and the caregiver-child relationship
Therapists Clinics	8 therapists 5 clinics	33 therapists 12 clinics	22 therapists 9 clinics

**Ethical considerations**

The studies were approved by the Regional Ethics Committee in Uppsala, Sweden (No. 2012/2018, No. 2013/115, No. 2012/259-13, and No. 2016/413).

Research involving traumatized children and their caregivers raises several delicate questions and challenges, and ethical questions arise during the collection, analysis, and reporting of data. These issues are

relevant to all types of research, but specific demands and considerations are required in studies involving children and caregivers exposed to potential trauma (Cater & Øverlien, 2014). The UN Convention on the Rights of the Child states that children are competent and have their own rights, such as to have access to information and to be heard, while also being vulnerable and having the right to protection. The researcher needs to approach such issues in a balanced manner and with sensitivity. However, children as young as those included in the current studies (i.e., 2–6 years) are undoubtedly dependent on the decisions made by caregivers and other adults. Questions of research information and informed consent are also more complex with young children. In this study, we chose to inform and collect consent from the adults involved (i.e., legal custodians, participating caregivers, and therapists) and to mainly rely on them to inform the child. When deemed possible, children were verbally informed by their therapist.

Both children and caregivers exposed to trauma may exhibit severe symptoms and high levels of stress, and both may feel vulnerable, relying on being acknowledged and receiving appropriate support and treatment. Caregivers with these experiences often report challenges in gaining access to the interventions needed. Consequently, being dependent on an agency and a therapist for necessary support can affect caregivers' perceived ability to decline participation in research and express critical viewpoints or questions and may increase their risk of overestimating improvements in self-reports. On the other hand, many caregivers and children wish to participate in research to contribute to the support of others facing similar situations. Involving particularly vulnerable groups in research can be legitimized by the possibility that the participants will contribute to improving the support for others in the same groups and by the fact that such participation can be an empowering experience (Alver & Øyen, 1998).

In the current studies, efforts were made to increase the caregivers' sense of safety and their own value as informants while clearly communicating their freedom to contribute to the research. All participants—that is, therapists and caregivers—received both oral and written information about the studies and the handling of confidentiality

and gave written consent to participate. Caregivers were also informed of their continuous right to withdraw at any time without providing any reason or facing any consequences for their treatment. Furthermore, caregivers were informed about the need to develop effective treatments for traumatized young children and were told that CPP had not been used previously in Sweden. The study required caregivers to repeatedly complete several instruments, which could be challenging. However, caregivers were free to ask for support from the therapist, and the instruments had been previously employed by researchers without ethical dilemmas being reported. In clinical work with abused children, it is common to encounter custody disputes and children living in foster care. These issues were carefully managed. In cases involving joint custody or children in foster care, information about the study and treatment was given to the legal custodians, and their written consent was obtained. All treatments offered by the agencies in the project were free of charge, being covered by the Swedish health and welfare system.

## **Brief descriptions of the studies included in this thesis**

### **Study I**

Implementing Child–Parent Psychotherapy (CPP) in Sweden: A qualitative study exploring experiences by caregivers taking part of the intervention with their child.

#### ***Aim***

The study aimed to explore how trauma-focused, dyadic treatment for young children with CPP was experienced by the participating caregivers. CPP has previously been studied in the United States, but only to a

limited extent in the Swedish context; therefore, the underlying questions focused on the feasibility of CPP and how it can meet the demands of dissemination in Sweden.

### ***Design***

The study is a qualitative interview study with an inductive approach. Five Swedish healthcare agencies (four CAMHS and one non-governmental organization, NGO) providing CPP treatment for IPV-exposed children were included in the study. Caregivers undergoing treatment together with their child were interviewed.

### ***Instruments***

Caregivers were interviewed at the agencies, in their homes, or at another preferred location. At the time of the interview, the caregivers had participated in five or more dyadic CPP sessions. A semi-structured interview guide with open-ended questions was developed (Appendix I). The following themes were covered: acceptance of the features of the method, degree of satisfaction, conditions for implementation of the method, practical realization, and adaptation needs. The interviews lasted 30–60 minutes; they were audio-recorded and later transcribed verbatim.

### ***Participants***

A total of 11 caregivers (10 mothers and one father) were included in the study. Their children were 3–7 years old ( $M = 4.7$ ). All mothers were victims of IPV. The father was not subjected to IPV, but his child had been exposed to IPV with the mother and a stepfather. The violence varied concerning type and amount; in most cases, it was reported to have occurred repeatedly and to be long-lasting. Psychological violence

was most common, physical violence was less common, and sexual violence was rare. All children had witnessed the violence and over half of them were also abused themselves by their violent fathers/stepfather. One child had been sexually abused. All children maintained some degree of continued contact with their abusive father; one lived part time with the father, and three children had monthly visitations. The reasons for referral to treatment were significant psychiatric issues, such as behavioral problems, attachment disorders, or aggression. Half of the caregivers had contacted the agency on their own initiative, while the other half were referred by social services, child healthcare centers or other services.

### ***Analyses***

Interpretative phenomenological analysis (IPA) was used in sampling, data collection, and analysis (Smith, 2004; Smith et al., 2009). This approach is considered to be appropriate when exploring how people make sense of subjective experiences. It enables topics to emerge from the data so that a deep knowledge of the perspectives can be obtained (Brocki & Wearden, 2007; Smith, 2004). IPA is preferably used for the analysis of small and homogeneous samples and is strongly connected to the interpretative or hermeneutic tradition. The analyses were conducted in stages and revised collaboratively by the authors to ensure transparency in the process and careful consideration of validity, credibility, and reflexivity (Granehem & Lundman, 2004; Malterud, 2001; Smith et al., 2009). For each interview, clusters of themes were organized into subcategories and then summarized under main categories. Representative quotations were retrieved for each category. The final step involved analyzing categories across all interviews to identify commonalities and discrepancies and then developing each category into a narrative section supported by quotations.

## **Results**

The results showed six main themes that emerged across all interviews. Four of the themes were positive: developing as a parent through gaining understanding, tools, and confidence; children's experiences of and benefits from CPP therapy—as perceived by the caregivers; an understanding of play as a reflection of trauma and a pathway to communication, processing, and recovery; and appreciation of the CPP therapist for validation, support, and cooperation. A fifth theme touched upon opinions and suggestions concerning the structure of the CPP method, including a wish for more individual parental support. This theme was partly related to the sixth theme, which covered legislation, responsibility, and violence as perceived barriers to CPP treatment.

The findings showed that Swedish caregivers with children profoundly affected by IPV were appreciative of and gained benefits from their treatment with CPP. Positive effects concerning the child's mental health and development were reported by the caregivers. The caregivers' degree of acceptance of the method was high, and the intervention could be realized practically. The caregivers were satisfied with the cooperation with the therapists and their own degree of involvement in the intervention. However, a suggestion on extended individual parental support was expressed. The caregivers described several barriers to their CPP treatment associated with the offenders. Problems related to parental collaboration, obtaining consent to the therapy from fathers, and worries linked to visitations and contact were described as demanding and probably impeding treatment effects. No need for significant amendments to the CPP method was found.

## **Conclusions**

Despite challenges linked to the context of Swedish family law, such as joint custody and extensive visitations with abusive parents, and an expressed need for extended parental guidance, the findings support the further implementation and dissemination of CPP in Sweden without

cultural adjustments being made to the method. This method seems to fill a gap in the trauma treatment offered to young children in Sweden.

## **Study II**

The effectiveness of Child-Parent Psychotherapy on traumatized preschoolers and their caregivers: A Swedish multi-site study.

### ***Aim***

The aim of this study was to evaluate the effectiveness of CPP in a Swedish cohort of young children taking part in CPP treatment together with their caregiver in a naturalistic clinical setting. Effects on the child's and caregiver's general psychological health and post-traumatic stress, as well as caregiver perceptions of the relationship with their child, were evaluated. An additional aim was to examine whether the outcomes were consistent with the findings previously reported in international studies.

### ***Design***

The study has a one-group, pre-post design, conducted in a naturalistic multi-site clinical setting. It explores the outcomes and effectiveness of CPP when provided by regular staff (33 therapists) through 12 general mental health services that offer treatment for trauma-exposed children, among other interventions. Each therapist collected data from one to three therapies, including sociodemographic and anamnestic data. The therapists were either CPP certified or undergoing CPP training. They were instructed to complete the CPP fidelity check packet, which included fidelity forms covering the core treatment objectives and intervention components after each session. Additionally, the



therapists were supervised every 2 weeks. However, this study did not analyze therapist adherence. Caregivers completed several questionnaires before the start of therapy and after 20 dyadic sessions (or fewer if the therapy was shorter). The treatment was concluded when the therapist determined that the child had been properly treated, in alignment with the child's individual needs and regular CPP routines. The number of dyadic sessions in this clinical sample ranged from 7–20.

### ***Instruments***

The study employed several instruments to assess the exposure to potential traumatic events of both the child and caregiver (one for the child and two for the caregiver), psychological symptoms in both the child and caregiver (two for each), and caregiving perceptions of the relationship (two).

To assess the child's exposure to violence, the questionnaire titled *The Violence against the Child* (VMB) was applied (Almqvist & Broberg, 2004; Broberg et al., 2015). This questionnaire screens for exposure to physical violence, psychological violence, sexual abuse, and other violence or violations.

Assessment of the caregivers' exposure to violence was conducted using *The Violence within the Family* (VIF), which screens for exposure to IPV and other types of violence between adults (Broberg et al., 2015). *The Life Incident of Traumatic Event* (LITE) was employed to screen for the caregivers' lifetime exposure to traumatic events (Greenwald & Rubin, 1999). LITE scores are divided into two subscales: non-interpersonal events and interpersonal events.

General psychological symptoms in children were assessed with the *Strength and Difficulties Questionnaire—Parent* (SDQ-P) (Goodman, 1997, 2001). The SDQ assesses prosocial behavior and psychopathology in children aged 3–16. It consists of five subscales and a supplement inquiry about the impact of problems. The subscales are

emotional symptoms, conduct problems, hyperactivity/inattention, peer problems, and prosocial behavior. The suggested Swedish cut-off scores for children aged 3–5 is  $\geq 11$  for the total difficulties score and  $\geq 1$  for the impact score (Dahlberg et al., 2019; Malmberg et al., 2003).

To assess general psychological symptoms in caregivers, the *Hopkins Symptom Check List–25* (HSCL-25) was used (Derogatis et al., 1974; Reshvanloo & Shamir, 2016). This instrument assesses current symptoms of anxiety, depression, and somatic troubles. The scores are summed up and divided by the number of items, which results in a Global Severity Index (GSI) indicating the level of general psychological problems. Swedish cut-off scores are  $\geq 0.49$  for women and  $\geq 0.32$  for men (Fridell et al., 2002; Lundin et al., 2015). In this study, the cut off score for women was applied.

To assess PTSD symptoms in children, the *Young Child PTSD Checklist* (YCPC) for children aged 1–6 years was used (Scheeringa, 2013). The YCPC produces an overall total symptom scale and three subscales: re-experiencing, avoidance, and arousal. There is also a supplement measuring the functional impairment caused by the problems. The scales have two suggested cutoffs, one for clinical attention (12) and one for probable PTSD diagnosis (26). For the subscales, the suggested cutoffs are as follows: for Re-experiencing, clinical attention = 4 and PTSD = 8; for Avoidance, clinical attention = 2 and PTSD = 4; for Arousal, clinical attention = 4 and PTSD = 10; and for the supplement, Functional impairment, clinical attention = 2 and PTSD = 4.

To assess PTSD symptoms in caregivers, the *Impact of Event Scale–Revised* (IES-R) was employed (Creamer et al., 2003; Weiss, 2004). IES-R produces three subscales: intrusion, avoidance, and hyperarousal. It is suggested that a mean of  $\geq 1.89$  on any subscale indicates problems, and a mean of  $\geq 1.80$  on the total score indicates PTSD (Weiss, 2007).

To assess caregivers' perceptions of their relationship with their child, the *Caregiving Helplessness Questionnaire* (CHQ) was applied. This questionnaire screens for signs of caregiving disorganization with

children aged 3–11 years (Solomon & George, 2011), focusing on experienced helplessness, fear, and reversed child–caregiver roles. High scores indicate disorganized caregiving. Furthermore, the *Parental Locus of Control* (PLOC) was used (Campis et al., 1986). In this study, only the PLOC sub-scale to assess parents’ experienced ability to control their child’s behavior was used. Parents experiencing problems with controlling their child produce higher ratings on the subscale.

### **Participants**

Fifty-seven children aged 2–6 years ( $M = 4.7$ ,  $SD = 1.2$ ) with trauma-related symptoms and their caregivers—that is, biological mothers ( $n = 43$ ) and fathers ( $n = 3$ ) and foster mothers ( $n = 11$ )—participated in the study. The inclusion criteria for the children were exposure to at least one potentially traumatic event, showing clinically assessed psychiatric symptoms related to these experiences, and being recommended specialized psychotherapeutic treatment. The inclusion criteria for the caregivers were being the non-offending caregiver, having responsibility for the daily care of the child, and being able to participate in the treatment without support from a professional interpreter.

### **Analyses**

Descriptive statistics were used to summarize reported exposure to potentially traumatic events as measured by the VMB, VIF, and LITE. Clinical cutoff scores on the SDQ-P, YCPC, and norm data on the HSCL-25 were used for clinical significance. The differences between pre- and post-treatment (at  $\leq 20$  dyadic sessions) assessments were analyzed by means of paired sample *t*-tests (within-group differences). To calculate effect sizes, Cohen’s *d* was applied, where 0.2 indicates a small effect, 0.5 a medium effect, and 0.8 indicates a large effect (Cohen, 1988). To explore possible differences between children living with biological versus foster caregivers, the non-parametric Mann–Whitney

U test was used, due to the small sample size. To investigate associations between reported changes in child and caregiver outcomes, standardized values ( $z$ -scores) for the differences were used to calculate Pearson's product-moment correlation coefficient ( $r$ ). Associations ( $r$ ) are considered weak at 0.10, moderate at 0.30, and strong at 0.50. To further explore the correlation analysis of differences, a hierarchical regression analysis (*Backward* model) was tested.

## **Results**

Overall, symptom improvements were found with small to medium effect sizes. Reductions in general psychological symptoms were revealed in both children (SDQ-P,  $d = 0.57$ ) and caregivers (HSCL-25,  $d = 0.29$ ). Moreover, improvements were shown in post-traumatic stress in children (YCPC,  $d = 0.60$ ) and in caregivers (IES-R,  $d = 0.52$ ). No significant differences were found in outcomes between children living with biological parents and those in foster care. The caregivers' sense of their ability to control their child increased (PLOC,  $d = 0.53$ ), and the signs of disorganized caregiving decreased (CHQ,  $d = 0.54$ ), with medium effect sizes. Correlations were found between outcomes in children and those in caregivers. The strongest associations were shown between reduced signs of disorganized caregiving and reductions in child PTSD symptoms. Strong associations were also revealed between reductions in general psychological symptoms in caregivers and those in children.

## **Conclusions**

The findings indicate that CPP may be an effective intervention for early childhood trauma and is a promising method for traumatized young children that can be implemented in regular Swedish CAMHS. The effects found are consistent with previous research. The dyadic model seems to address the association between child traumatic stress

and caregiver capacities. The study indicates that CPP reduces both the symptoms of the individual child and those of the caregiver and improves the child–caregiver relationship. Children in foster care appeared to benefit to the same extent as children participating in treatment with a biological parent. However, the findings should be interpreted with caution, given the relatively limited sample size and the potential influence of unknown concurrent circumstances. Further dissemination testing is suggested.

### **Study III**

Long-term effects and predictors of outcome of Child–Parent Psychotherapy for traumatized young children and their caregivers: A 6-month follow-up of a Swedish clinical sample.

#### ***Aim***

This study aimed to evaluate the long-term effects of CPP treatment and potential predictors of outcome in a sample of young children and their caregivers at a 6-month post-treatment follow-up in a Swedish naturalistic clinical setting. Child and caregiver post-traumatic stress symptoms and caregivers' signs of disorganized attachment in their relationship with their child were assessed. Possible effects of type of trauma exposure, trauma symptom severity, and number of treatment sessions on outcomes were explored. A further aim was to determine whether the outcomes aligned with the long-term effects previously reported in international studies.

## ***Design***

The study has a one-group, pre-post design with a 6-month follow-up conducted in a naturalistic multi-site clinical setting. Assessments were performed before therapy, after  $\leq 20$  dyadic sessions, and at a follow-up 6 months after the end of the treatment. Caregivers completed several questionnaires for assessment. Twenty-two therapists in nine clinics offering treatment for trauma-exposed children, among other interventions, collected data. Each therapist collected data from 1–3 therapies.

## ***Instruments***

The same three instruments were consistently used to assess the outcomes regarding post-traumatic stress symptoms in the child and caregiver, as well as signs of caregiving disorganization.

To assess post-traumatic stress symptoms in children, the *Trauma Symptom Checklist for Young Children* (TSCYC) was employed (Briere et al., 2001; Nilsson et al., 2012). TSCYC is a broad-spectrum caregiver report instrument that screens for trauma symptoms in children aged 3–12 years. The instrument consists of eight clinical scales. The scale for Total post-traumatic stress consists of three subscales: Intrusion, Avoidance, and Arousal; the other scales are Anxiety, Depression, Anger/aggression, Dissociation, and Sexual concerns. The suggested clinical cutoff is a T-score of 70 indicating PTSD, while T-scores of 65–69 indicate moderate traumatic stress problems. In this study, raw scores on the total post-traumatic stress subscale were used as the primary outcome.

An assessment of PTSD symptoms in caregivers was carried out using the IES-R (Creamer et al., 2003; Weiss, 2004). IES-R has three subscales: Intrusion, Avoidance, and Hyperarousal. It is suggested that a mean of  $\geq 1.89$  on any subscale indicates problems, and a mean of  $\geq 1.80$  on the total score indicates PTSD (Weiss, 2007).

To assess the caregivers' perceptions of their relationship with their child, CHQ (Solomon & George, 2011), was applied. As mentioned earlier, this questionnaire screens for signs of caregiving disorganization with children 3–11 years focusing on experienced helplessness, fear, and reversed child–caregiver roles. High scores indicate disorganized caregiving.

### ***Participants***

In this study, 37 children aged 2–6 years ( $M = 4.6$ ,  $SD = 1.0$ ) and their caregivers (24 biological mothers, two biological fathers, and 11 foster mothers) participated. Of the children, 73% were reported to have been exposed to four or more potential traumatic events, 70% had been exposed to interpersonal potential traumatic events, 62% had been exposed to non-interpersonal potential traumatic events, and 73% were reported to have lived with adverse experiences (e.g., substance abuse or/and mental health problems within the family). Of the children, 27% had been subjected to physical violence, 24% to psychological violence, and 5% to sexual abuse, while 59% were exposed to IPV and 13% had witnessed sexual violence. The caregivers had been exposed to several potential interpersonal traumatic events ( $M = 4.21$ ) and non-interpersonal traumatic events ( $M = 6.88$ ). About half of the caregivers reported being exposed to IPV as adults.

### ***Analyses***

Piecewise Linear Mixed Models were applied to explore the effects in outcomes from the pre-treatment assessment to the follow-up. Model fit was assessed (Burnham & Anderson, 2004). Due to the limited sample size, all analyses were based on total scores for the instruments. Within-group effect sizes were calculated using Model-estimated differences in mean values divided by the pretreatment standard deviation (Feingold, 2009). Possible predictors of outcome were analyzed on

all three outcome measures by adding them as centered covariates in the Linear Mixed Models and interacting them with the time variables. Predictors were Grand mean-centered, meaning that the Grand mean of all individual's scores on the predictor were subtracted from the individual's score on the predictor at baseline.

## **Results**

Changes in children's post-traumatic stress symptoms showed sustained positive effects from pre-treatment to follow-up, with a medium effect size (TSCYC,  $d = 0.62$ ). The conversion of raw scores to T-scores showed that the percentage of children with possible PTSD dropped from 78% at pre-treatment to 32% at follow-up. A sustained decrease in caregivers' post-traumatic stress symptoms (IES-R) was found from pre-treatment to follow-up, with a medium effect size ( $d = 0.57$ ). At pre-treatment, nearly half of the caregivers (47%) had a score indicating PTSD ( $\geq 1.8$ ), while this proportion decreased to 17% at follow-up. Changes in caregivers' perceived signs of caregiving disorganization (CHQ) from pre-treatment to follow-up showed sustained positive effects, with a medium effect size ( $d = 0.64$ ).

The exploratory analyses of possible predictors of outcome (i.e., type of trauma exposure, trauma symptom severity, and number of therapy sessions) showed no significant predictors in terms of child predictors. However, a significant interaction between child post-traumatic stress pre-treatment (TSCYC) and changes in caregivers' post-traumatic stress symptoms (IES-R) was revealed, meaning that higher trauma symptoms in the child predicted less change in caregiver trauma symptoms during the treatment.



## **Conclusions**

The results of this study indicate that both traumatized children and caregivers and their attachment relationship benefited from CPP treatment and that these benefits were lasting. Positive effects in terms of reduced child and caregiver post-traumatic stress symptoms and signs of disorganized caregiving were maintained when followed up 6 months after the end of treatment. The relatively high attrition rate (32%) at follow-up is consistent with what is typically seen in naturalistic intervention studies (Alto et al., 2021). Nevertheless, the factors related to attrition require further investigation to be fully understood. A reliance on caregiver reports has been argued to increase the risk of response bias (Rosenman et al., 2011) and limits possible conclusions. The naturalistic design mirrors the Swedish clinical context and supports the applicability of CPP for traumatized young children in Swedish clinics providing psychotherapeutic treatment. Since effective treatment options are often lacking for young children, the findings are encouraging regarding further dissemination of the CPP method.

## **General discussion**

The overarching aim of this thesis was to evaluate the outcomes of CPP treatment in children and caregivers within a Swedish naturalistic clinical context, explore the long-term effects of CPP, identify potential predictors of outcomes at follow-up, and examine whether the outcomes correspond with the findings previously reported in international studies. In addition, this thesis aimed to explore how CPP meet the demands for dissemination in Sweden and to extend the understanding of its acceptance. A further goal was to investigate the need for adaptations to enhance the feasibility of CPP in Sweden by analyzing the experiences of caregivers undergoing the treatment with their children. Another overarching aim was to contribute to the improvement of therapeutic support provided by the Swedish healthcare

system for young children and caregivers affected by adversities and trauma.

The overall results from our studies on effectiveness and follow-up were positive. Due to differences in study designs and measurements, direct comparisons with previous research on CPP are limited, but the results from the effectiveness study (Study II) and follow-up (Study III) included in this thesis are consistent with previous findings, showing reductions in child and caregiver general psychological symptoms and PTSD symptoms (Lieberman et al., 2005) that are sustained at follow-up (Ghosh Ippen et al., 2011; Lieberman et al., 2006).

However, evaluating the effectiveness and experiences of a treatment method in a new cultural and clinical context raises several issues that need to be addressed. This section will discuss the results of the current studies mainly in relation to previous studies of CPP.

### **The effectiveness of CPP in a Swedish clinical context**

Despite the significant symptom reductions, general psychological problems over the clinical cut-off remained for half the children. For a third of the children, PTSD symptoms remained at a level indicating a need for clinical attention after treatment (Study II). At the follow-up, it was indicated that these proportions had decreased (Study III). Analyses of remaining symptoms in relation to the clinical cut-off are rarely reported in child psychotherapy research but might be reflected in the relatively modest effect sizes presented. Clinical cut-offs have not been reported in previous CPP research, which makes it difficult to further discuss these findings. However, Swedish evaluations of other interventions for IPV-exposed children revealed similar results (Broberg et al., 2011; Grip, 2012; Pernebo et al., 2018). These findings highlight the importance of carefully evaluating and following up on the treatment of trauma-exposed children.

The relational aspects following trauma may be most evident in young children because of their greater dependence on caregivers (Scheeringa & Zeanah, 2001). The quality of attachment is recognized as an important factor in children's capacity to resolve traumatic experiences (Chu & Lieberman, 2010). In CPP, improving the quality of caregiving and attachment is regarded as a crucial strategy to improve the outlook for young children who have been exposed to adversities (Lieberman et al., 2015). Trust and security in the child-caregiver relationship are assumed to be restored by promoting affect regulation strategies, addressing maladaptive behaviors in child-caregiver interactions, and supporting developmentally appropriate activities (Lieberman et al., 2006). Previous research on CPP using validated attachment measurements has shown positive changes in attachment quality, from disorganized to secure attachment, in children having received CPP treatment (Cicchetti et al., 1999, 2006; Guild et al., 2021; Stronach et al., 2013). In our studies, the caregivers' self-rated signs of caregiving disorganization (measured with the CHQ) showed significant reductions following treatment, with these improvements remaining stable at follow-up. Hence, our findings are in line with previous research results and suggest that the dyadic approach of CPP seems to promote secure attachment and caregiving when applied in a new clinical context.

Traumatic experiences can not only damage existing attachment (Chu & Lieberman, 2010) but also increase caregiver reactivity to stress, which can lead to harsher, maladaptive, or aggressive caregiving behavior (Ammerman et al., 2012; Chemtob & Carlson, 2004; Greene et al., 2018). Negative parental responses have been found to be associated with impairment in child emotion regulation (Williamson et al., 2017), and harsh parenting is a strong predictor of child externalizing and internalizing behavior problems (Rivera et al., 2022; Zubizarreta et al., 2018). Consequently, in our effectiveness study (Study II), we aimed to explore both signs of disorganized caregiving and caregivers' perceptions of their relationship with their child regarding their experienced ability to control their child's affective behavior (measured with the PLOC). The results showed that the caregivers' sense of their ability to control their child's behavior significantly improved after treatment. Our findings suggest that CPP seems to positively address caregiver

behavior and diminish problematic caregiver responses following trauma when implemented in a new clinical and cultural context.

To summarize, the overall results from the studies included in this thesis show significant reductions in child and caregiver general psychological symptoms and PTSD symptoms. Positive outcomes were also observed in the caregivers' perceived ability to control their child's behavior, and a decrease was reported in signs of disorganized caregiving. These results were sustained at follow-up. The naturalistic design mirrors the Swedish clinical context and supports the applicability of CPP for traumatized young children in Swedish agencies providing psychotherapeutic treatment. The overall findings are encouraging regarding further dissemination of CPP. However, results from a Swedish RCT are needed to further investigate the effects of CPP in a Swedish context and build upon these findings.

### **Children in foster care**

Given the complex history of exposure to multiple traumatic events, unstable caregiving, and relationship disruptions, children in foster care are at increased risk for psychopathology, trauma-related problems, and attachment disorders. Our studies (Studies II & III) included a minor group of children in foster care ( $n=11$ ) taking part in the CPP treatment together with their foster caregiver. These children seemed to benefit to the same extent as children participating with a biological caregiver. These findings are in accordance with a previous CPP study including children in foster care whose results indicated reduced traumatic stress symptoms and behavior problems in the children (Weiner et al., 2009).

Although research shows that early placement, secure foster caregivers, and appropriate support can promote child attachment and develop well-being (Bakermans-Kranenburg et al, 2011; Szilagyi et al., 2015), there is an evident lack of treatments for the target group (Midgley et al., 2019). It has been suggested that attachment-based interventions

can increase positive child and parent behaviors in foster families (Daugaard et al., 2022). Such interventions might contribute to stabilizing caregiving, thus preventing placement breakdowns and further adverse outcomes for children. Our findings are limited but align with these results. As children in foster care are rarely offered specialized treatment in Sweden, the need to examine and develop interventions for this group is evident. Moreover, there is a need to better understand polyvictimization in children—a common background in foster children—and to develop targeted interventions to restore health and self-regulation (Ford, 2009; Ford & Courtois, 2013).

It makes clinical sense that interventions such as CPP, which support both child trauma history and associated symptoms, along with the child–caregiver relationship, fit the context of foster care. Attachment is a dynamic process, and supporting the interactions between a child and foster caregiver holds potential for positive changes. It is promising that CPP appears to be just as effective for children participating with foster caregivers as it is for those participating with their biological parents.

### **Caregiver experiences of CPP**

CPP was well-received and appreciated by the participating caregivers, who reported benefits from treatment for their child, for themselves as parents, and for their relationship with their child (Study I). The caregivers described gaining a new understanding of play as a tool for communication and connection, which helped them share experiences and gain insight into their child’s perspectives by engaging in play together in the treatment. This finding may support theoretical suggestions that play may be a valuable tool for treating children and caregivers following trauma, increasing emotional understanding and mentalizing (Tessier et al., 2016), and supporting abilities associated with secure attachment and emotion regulation in children (Camoirano, 2017). Moreover, the caregivers underscored the importance of support from family, employers, and social services in engaging in treatment. Their

cooperation with the therapist, through which they received validation and support as a caregiver, was also appreciated. Such circumstances are likely to be important to most caregivers with young children participating in regular treatment over a period of time. Suggestions from the caregivers concerning necessary adjustments of the CPP method were found to be few and minor. The caregivers expressed a wish to extend their individual time with the therapist, in order to gain more support and time to reflect. Opportunities for collateral calls and sessions with the therapist were not always well timed, according to the caregivers. Such challenges are common when organizing treatment and adjusting therapists' workloads to align with caregivers' schedules and needs.

However, certain questions arose when the participating caregivers identified Swedish family law as a barrier to treatment. The caregivers reported obstacles related to obtaining consent for treatment from (violent) fathers with custody, as well as managing child–father visitations, which were described as causing significant stress in the children. Some fathers were reported to have a negative attitude toward the treatment, which—according to the mothers—might have impacted child outcomes. These challenges reflect the Swedish Children and Parents Code, in which parents have joint responsibility to ensure that children remain in close contact with a parent with whom the child is not living. While these findings reveal complicating factors, these factors are not CPP specific and should be of importance to all trauma-focused methods involving children.

### **Caregiver and caregiving issues**

Addressing caregiver issues, as well as the child's symptoms, has been described as one of the most powerful mechanisms for facilitating change in young children's development and recovery following trauma (Scheeringa & Zeanah, 2001). The associations that have been shown between caregiver traumatic stress, depression, and undermined caregiving capability (Fong et al., 2019; Greene et al., 2018), as

well as the link between caregiver and child PTSD (Lambert et al., 2014; Morris et al., 2012), support a clinical approach that addresses caregiving after trauma that has affected young children. In line with these findings, a fundamental assumption in CPP is that caregivers' well-being is influenced by their sense of competence as a parent and their perception of their child's functioning (Lieberman et al., 2015). Our results support this assumption, as they demonstrate strong associations between decreased signs of disorganized caregiving and decreased child PTSD symptoms and between reductions in caregiver general psychological problems and reductions in those of the child (Study II).

The emotional well-being of the caregiver and the attachment relationship play central roles in the development of a young child's emotion regulation capacities, with caregiver sensitivity being a crucial component in shaping the child's ability to regulate. However, trauma can cause caregiver insensitivity toward the child (Greene et al., 2018). Children exposed to trauma may engage in problematic behaviors that exacerbate the caregiver's maladaptive responses. In this process, negative caregiver cognitions, behaviors, and emotions may inhibit caregiver ability to be sensitive, responsive, and attuned to the needs and signals of the young child. Consequently, it is important to address and reduce caregiver psychological symptoms.

The caregivers in our studies showed a decrease in symptoms of general psychological distress (measured with the HSCL); however, their mean score remained over clinical cut-off after treatment. The findings are consistent with previous RCTs using the same measure (Ghosh Ippen et al., 2011; Lieberman et al., 2005, 2006). A previous study of CPP also found remaining symptoms of depression in caregivers (Guild et al., 2021). As this method does not specifically aim to treat mental health problems in adults, such findings are not surprising. Still, the observed improvements might be attributed to the perceived support and improvements in the child's symptoms. Despite caregivers' persisting symptoms, positive changes in attachment and caregiving have been observed, indicating that—through CPP—caregivers may become more adept at managing their mental health challenges without negatively impacting the child–caregiver relationship (Chu et al., 2021).

The caregivers in our study experienced a reduction in PTSD symptoms. These reductions were general, affecting intrusion, avoidance, and hyperarousal symptoms; in comparison, previous CPP studies specifically found a decrease in avoidant symptoms (Lieberman et al., 2005, 2006). These differences may be explained by methodological factors and the use of different measures. Nevertheless, caregiver PTSD has been suggested to interfere with positive parenting behaviors, caregiving sensitivity, and the modeling of emotions (Morris et al., 2012). Despite the small sample limiting our results, reductions in caregiver PTSD are a promising outcome that may hold potential to enhance caregiving quality, strengthen the caregiver–child relationship, and improve child outcomes. The observed decrease in caregiver PTSD symptoms might be surprising, as CPP does not primarily target adult trauma symptoms. This somewhat unexpected effect has been highlighted in previous research as well, where it was discussed as likely to be associated with the joint construction of a trauma narrative and the improvement in child symptoms—both mechanisms that can function as protective factors in caregiver mental health.

The dyadic design of CPP aims to address the adult deficits related to trauma that can negatively impact the child–caregiver relationship. Research from the infant and attachment perspective has demonstrated that experiences of emotional regulation are co-created by caregivers and children (Calkins & Hill, 2007). In CPP, a dyadic clinical approach that emphasizes reciprocity between caregiver and child is essential in fostering and restoring the dyad’s regulatory capacities. The CPP therapist supports the search for resolution of failures in reciprocity and helps both the child and caregiver to recognize and understand one another’s perspectives and emotions and develop toward a mutually regulated state (Lieberman et al., 2015). The underlying theoretical model suggests that enhancing the caregiver’s capacity to provide sensitive, positive, and protective interactions—particularly during times of child stress—fosters secure attachment. However, some researchers have argued that the evidence supporting this model needs further investigation, particularly in explaining how shifts in attachment behavior are sustained and how these shifts influence child behavior and emotional regulation (Thompson, 2016).



The outcomes of our quantitative studies (Studies II & III) are consistent with the qualitative findings from the interviews with caregivers (Study I), who reported that they before treatment were insecure regarding their communication about the traumatic experiences (i.e., IPV) with their child. The caregivers reported avoiding speaking about the topic to protect their child and focusing on remaining neutral regarding the other (violent) parent. Nevertheless, as the children communicated, primarily through play, about their experiences, thoughts, and questions related to stressful events during treatment, the caregivers realized that the child did, in fact, remember and was affected by the violence. They concluded that the child would benefit from more open communication. Both the child and caregiver may have benefited from receiving support to approach sensitive issues and explore various ways to address them through playful activities and language, as well as to develop and try out emotional regulation strategies and correct cognitive misrepresentations together. This process may have provided the caregivers with exposure and an opportunity to emotionally process their trauma history and reactions. Hence, our studies may demonstrate the importance of a combined approach with a joint caregiver–child and direct-trauma focus, along with relational support, to reduce avoidance of trauma reminders and enhance the development of mutual dyadic regulation strategies. Our findings align with the assertion that the most urgent need for young children after trauma exposure is their caregiver’s ability to accurately recognize, understand, and respond to the child’s symptoms (Scheeringa & Zeanah, 2001).

### **Addressing trauma within the child–caregiver relationship**

Involving caregivers in child trauma treatment is generally recommended, as caregiver factors have the potential to positively influence the treatment (Landolt et al., 2017). However, meta-analytic research on caregiver participation in trauma therapy for children shows a lack of consistent operationalization of caregiver factors and types of participation (Clark & Nadeem, 2022). Similar outcomes regarding child psychological problems—such as internalizing and externalizing

problems, PTSD symptoms in children and caregivers, and positive changes in attachment—have been reported in evaluations of various treatment methods for young children exposed to adversities (e.g., ABC, PCIT, and Project Support). These methods include the caregivers in treatment, without explicitly addressing the trauma. Despite the positive outcomes, the opportunity to improve communication and regulation related to trauma reminders within the caregiver–child relationship is overlooked.

Like CPP, TF-CBT explicitly addresses trauma within the caregiver–child dyad, albeit with a different approach. Both methods give caregivers psychoeducation about topics such as trauma-related problems in children and developmentally appropriate behaviors. However, the therapist conducts the trauma narrative work in TF-CBT individually with the child, often as a book completed through playful mediums. This method emphasizes that the child should be reminded of that the narration should focus on what actually happened. Toward the end of the treatment, the narrative is shared with the parent in a conjoint session (Pollio & Deblinger, 2017). Emotional support from the therapist to the caregiver and from the caregiver to the child has been found to predict positive outcomes in TF-CBT treatment (Cohen & Mannarino, 1998). Although TF-CBT does not include the attachment perspective, it applies therapeutic support for parenting skills such as positive attention, praising, and rewarding. These skills are mainly used to modulate adaptive child behaviors in an effective and sustainable way and to encourage caregivers to create a structured home environment to help the child cope (Pollio & Deblinger, 2017).

Parenting skills are not specifically taught in CPP, but caregivers are supported to develop their general capacity to reflect and understand the needs of their dysregulated child. Moreover, the caregivers' increased awareness of their own history and its influence on their caregiving and perceptions of their child is assumed to improve parenting behavior (Alto et al., 2021). In CPP, play is central and is viewed as the child's main way of telling and experimenting with different ways to deal with emotions, thoughts, and questions associated with reality. The use of play in trauma-focused psychotherapy with young children

is considered beneficial, regardless of treatment method, and has been described as serving as a form of exposure (Muller & Midgley, 2015; Tessier et al., 2016). Neurocognitive developmental research and theory indicate that play contributes to the development of self-regulation strategies (Gaskill & Perry, 2014; Panksepp & Panksepp, 2013). In CPP, the therapist's role is to help the child share the emerging narrative and support the caregiver in receiving the story in a constructive way, such as by joining in the play as someone who can protect and comfort. The joint creation of the trauma narrative can help the child construct more adaptive and developmentally supportive meanings of traumatic events while improving dyadic emotional processing and regulation.

CPP's simultaneous joint focus on trauma and attachment is a unique approach based on the importance of attachment for young children's health and development in both the short and long term; thus, it offers an interesting contribution to the field of child trauma treatment. Caregiver traumatic stress can diminish sensitivity and responsiveness to the child's needs. If a caregiver has PTSD-related arousal or avoidance symptoms, they may become dysregulated by trauma cues in play or other expressions of the child, which may limit the capacity to respond accurately. By targeting the child-caregiver relationship in the treatment, CPP helps caregivers become more aware of how to manage their own difficulties, which may have positive effects on their relationship with the child (Chu et al., 2021).

There is an ongoing discussion on the primary treatment target, whether it should focus on behavior or mental representations, and what the optimal number of sessions of trauma-focused interventions for young children may be (McMahon & Maxwell, 2021). Longer treatment duration is often a response to severe child symptoms and safety concerns (Hagan et al., 2017). Findings from research with an attachment perspective indicate that shorter interventions are more effective in improving caregiver sensitivity and child attachment (Bakermans-Kranenburg et al., 2003), while other meta-analyses report that the number of treatment sessions does not significantly moderate outcomes (Facompré et al., 2018). TF-CBT treatment is typically completed in 8–20 sessions. In our effectiveness study (Study II), the

number of dyadic sessions varied from 7 to 20. Treating trauma in young children involves several complex processes, such as child development, attachment, caregiver mental health, and caregiving capacities, which are unlikely to be effectively addressed by a single approach. Children and caregivers in varying circumstances will likely require different types of interventions (McMahon & Maxwell, 2021).

### **Methodology—Strengths and limitations**

The naturalistic multi-site design of the studies in this thesis is a significant strength, as the results are representative of Swedish clinical settings. These settings feature diverse therapist training and experience, mixed workloads, and patients with presumably high prevalence of comorbidity. These conditions amplify the external validity of the studies, which is particularly important when exploring feasibility. Limited clinical resources and the need to apply measures that could easily be distributed to the participating caregivers were persistent challenges in the studies included in this thesis, as they would be in typical naturalistic settings. Hence, measures were selected based on the criterion of being quick to complete, thus ensuring their suitability for the naturalistic clinical context. These considerations regrettably make it difficult to compare the results of these studies with those of previous studies, due to differences in study designs and measures. Furthermore, the relatively small sample sizes, sole reliance on caregiver reports, lack of non-direct measurements of relational aspects, and absence of therapist assessments warrant caution when drawing conclusions. The inclusion of a control group, such as “treatment as usual,” or an active control condition, along with more advanced measurements combined with observational and therapist assessments, would strengthen future studies, as would a larger sample size.

### ***The use of self-report questionnaires***

The use of caregiver self-report questionnaires and response bias is a key issue in psychometrics (Rosenman et al., 2011). Discrepancies between our findings and previous research may be due to the use of different measures. For example, we applied the IES (Creamer et al., 2003; Weiss, 2004) to investigate trauma symptoms in caregivers and found a general decrease in PTSD symptoms. In comparison, Lieberman and colleagues (2005;2006) used the *Clinician-Administered PTSD Scale (CAPS)* (Blake et al., 1995) and primarily decrease in avoidance symptoms. Both instruments provide information on the occurrence and frequency of each symptom of the disorder, possess reliability and validity, and are well-established. The CAPS is a thorough instrument that provides specific and complex data; however, it is time consuming, as an interview takes 45 minutes or more, and a briefer self-report instrument was preferred to match the resources in our study.

Meta-analytic studies show that questionnaires are often the sole method used to assess parenting aspects following child trauma. However, questionnaires are subject to bias, and the use of independent, observational assessments is encouraged (Williamson et al., 2017). A meta-analysis on associations between parental and child PTSD symptoms showed that studies using parent interviews had larger effect sizes than studies using self-report measures (Morris et al., 2012). This difference may be linked to research showing that caregivers often underestimate the level of trauma exposure their child has experienced, as well as their child's degree of PTSD symptoms (Woolgar et al., 2021). Furthermore, there is an ongoing discussion on whether the symptoms used to diagnose PTSD can adequately capture post-traumatic stress in young children. It has been argued that subclinical forms of PTSD should be included in research on the effects of treatment and trauma symptoms in children (Gutermann et al., 2016; Scheeringa et al., 2005).

## ***Measuring attachment in a clinical context***

Standardized observational methods are preferable for assessing and classifying attachment and caregiving quality, as such methods require trained and certified coders in validated settings (Forslund et al., 2021). Positive changes in attachment quality and a shift from disorganized to secure attachment have been found in children who received CPP treatment (Cicchetti et al., 1999, 2006; Guild et al., 2021; Stronach et al., 2013) by utilizing observational measures, such as the Strange situation (Ainsworth et al., 1978) and the Attachment Q-set (Waters & Deane, 1987). However, these methods are time-consuming and costly. In our studies, we applied the less-sophisticated and less-time-consuming caregiver self-report measure CHQ (Solomon & George, 2011). This screening tool is intended to facilitate and assist researchers and clinicians in assessing caregiving disorganization under circumstances that discourage the use of more extensive methods. From a theoretical perspective, the child's attachment system is completed by a reciprocal caregiving system, guiding the caregiver to protective responses to the child. Disruptions in this system may lead to disorganized caregiving. While knowledge about disorganized caregiving remains incomplete and is often reliant to time-consuming and costly interviews, the use of CHQ shows promise as an efficient screening tool (Toscano et al., 2018).

The results based on CHQ (Study II) showed significant reductions in the total scale and in the subscales Helplessness and Fear, but no significant reductions on the subscale Reversed parenting. The latter finding could be explained by the fact that most disorganized children develop a controlling role-reversed attachment strategy by the time they reach school age (Cyr et al., 2010). Solomon and George (2011) discussed the possibility that problems related to child caregiving strategies and role reversal sometimes may not surface until children are older. Finally, the findings could also reflect different cultural values regarding the responsibilities placed on children. A future Swedish validation study of CHQ would be valuable to further explore these differences and assess the applicability of this instrument. Regardless, the non-direct measurement may have clinical advantages, as it is easy to

understand and provides the therapist and caregiver with the opportunity to discuss and reflect upon meaningful caregiving issues. In sum, our findings show a reduction in signs of disorganized caregiving that may support findings regarding attachment change in previous research.

### ***The naturalistic study approach***

The studies' naturalistic design, combined with the relatively small sample sizes and the sole reliance on caregiver reports, limits the use of certain statistical methods and restricts comparisons with previous research, thereby affecting the conclusions that can be drawn. However, the use of a naturalistic approach in our studies provides essential knowledge about how CPP functions in a Swedish clinical context. The collaboration with multiple clinics in both rural and urban areas, along with the involvement of many therapists, demonstrates that this method is effective across various settings, which strengthens the external validity and generalizability of our results. This finding holds value for the continued dissemination of CPP and is crucial for the implementation of complex interventions in child mental health services (Beidas & Kendall, 2014). Furthermore, given that the Swedish population is only a fraction of the American population, and that traumatized young children seldom get access to treatment in Swedish healthcare, our findings should be considered representative in the context.

Another strength of the studies in this thesis is its combination of designs and methods of analysis. The use of caregiver interviews alongside standardized questionnaires provides a triangulation of data sources, increasing the internal validity. The low attrition rate in the pre-post measurements also strengthens the internal validity of our studies. That said, the attrition was higher at follow-up. Meta-analytic research has shown that dropout rates tend to be higher for community mental health services compared with more controlled settings (Dorsey et al., 2017). To further strengthen the internal validity of our studies,

various methods to handle attrition were applied: the simpler and more conservative last-observation-carried-forward (LOCF), which has statistical limitations (Study II), and Restricted Maximum Likelihood Estimation as a more modern approach to missing data (Study III). Statistically significant changes and effect size analyses of the average change must be translated into clinical implications to be useful (Lambert & Ogles, 2009). Our use of clinical cut-off scores, along with caregiver interviews and symptom reports, reflects our aim to combine statistical and clinical perspectives with the patients' own experiences, thus providing a comprehensive understanding of the outcomes and strengthening the internal validity of this research.

The sample in our studies is skewed in terms of gender, with most participating caregivers being women. Despite Sweden's reputation for high levels of gender equality, parenting responsibilities remain unequal in many areas. The care and responsibility of young children largely falls on mothers; for example, 70% of parental leave is taken by mothers (Swedish Social Insurance Agency [Försäkringskassan], 2024). Furthermore, about half the caregivers in our studies reported being exposed to IPV. While IPV may be experienced by both men and women, there is clear gender asymmetry, with more women reporting IPV exposure. Women also experience more severe and frequent instances of IPV compared with men (Fanslow et al., 2023). Given this background, we conclude that the sample can be considered representative.

### ***Further dissemination of CPP in Sweden***

Our results may support the broader dissemination of CPP, which would increase the availability of effective treatment for young children. Given the current lack of trauma-informed knowledge and accessible treatment options for young children in Sweden (Furmark & Neander, 2018; SBU, 2018), addressing this need is particularly urgent. This research project was carried out in a naturalistic multi-site setting that represents Swedish clinical settings. As a result, the project reflects the diversity of the therapists' training and experience, along with their



varying practices and mixed workloads, and has demonstrated effectiveness and sustainability. The patients involved also represent those in a typical clinical practice, with a prevalence of comorbidity. These factors are crucial for further dissemination efforts. Despite the reported limitations, our results are encouraging and provide additional support for the implementation of CPP in Sweden.

Nevertheless, barriers to implementing CPP have been identified, including organizational challenges related to client recruitment and referral processes, staff turnover, and complexities associated with juridical processes (Almqvist et al., 2018; Broberg et al., 2015; Hooker et al., 2022; Pernebo et al., 2024; Skale et al., 2020; Smith et al., 2020). We conclude that these barriers are likely to be common for all types of child trauma treatment. These challenges are highlighted in meta-analysis research, which indicates that implementation and sustainability are primary issues in the field of child trauma treatment, regardless of the treatment method (Dorsey et al., 2017). A robust and sustained dissemination effort must rely on the organization's dedication to training therapists and recognizing the treatment needs of young children, as well as their right to access these services.

### ***Directions for future research***

Studies examining the implementation of a treatment method in a new context and in a naturalistic clinical setting frequently report lower effect sizes compared with those observed in earlier research. While the previously mentioned limitations apply, our findings do not align entirely with this trend, as they are in line with the results demonstrated in prior research on CPP for both children and caregivers. To further validate these results, a larger study within a similar naturalistic context is essential.

The use of a control group—such as treatment as usual (typically provided as caregiver counselling) or, ideally, an active control group—would significantly increase the strength of future studies. Considering

the limited treatment options available for this target group, a Nordic collaboration could be particularly advantageous. Further exploration is also required to understand the reasons behind the symptoms remaining in the children after treatment, which could point to various inhibiting factors that are critical to the effectiveness of the treatment. Mediating factors, such as the severity of trauma-related symptoms, treatment dosage, and caregiver-related aspects, should also be analyzed in greater depth to provide insights into areas where treatment can be improved. This knowledge will be valuable in refining therapeutic approaches and improving outcomes for both children and caregivers.

Various interventions take different approaches to address the underlying mechanisms of change. CPP is one of several evidence-based, trauma-focused, and attachment-based interventions with the potential to support both children and caregivers. Thus, it has been emphasized that future studies should carefully select methods for assessing change (Alto et al., 2021). Future research would benefit from employing more advanced attachment assessments, in combination with observational or therapist evaluations and follow-up measures. In addition, incorporating young children's experiences of the treatment process is essential. Conducting interviews with young patients would provide valuable knowledge and contribute clinically by offering a more comprehensive understanding of the impact of CPP from the child's perspective. This would enrich future research and help refine therapeutic approaches.

### **Clinical and theoretical implications**

The thesis demonstrates that young children (aged 2–6) exposed to various adversities and traumatic events and exhibiting high levels of symptoms benefited significantly from CPP treatment together with their caregivers. Their caregivers, many of which faced mental health challenges, also exhibited increased wellness, while the child–caregiver relationship showed notable improvement. The observed reductions in

caregiver-reported caregiving disorganization and improved perceived control over the child's behavior underscore the theoretical premise that secure attachment and caregiver sensitivity are crucial for mitigating the adverse effects of trauma in young children (Scheeringa & Zeanah, 2001). The studies' emphasis on CPP's dyadic model supports the use of attachment-based treatment by showing that improving the caregiver-child relationship can significantly reduce trauma-related symptoms in both the child and caregiver (Lieberman et al., 2015).

The relatively high number of children who had remaining symptoms after treatment highlights the need for a thorough assessment and continued follow-up to ensure their ongoing support and progress. The results emphasize the importance of developing routines for trauma screening, assessment, and referral to ensure that traumatized young children in need of treatment are directed to the appropriate care and support. In clinical practice, initial assessments are often routine; however, trauma exposure screening, post-intervention assessment, and follow-up are rarely conducted.

The studies in this thesis reveal the importance of acknowledging young children, their symptoms, and their need for treatment, and ensuring that appropriate treatment is made accessible to them. Children's rights to receive support and treatment and to participate in these processes are protected by both international and national conventions and laws. For instance, the UN Convention on the Rights of the Child asserts that child victims of abuse have the right to physical and psychological recovery, the Swedish Social Services Act mandates that society must support abused children, and the Swedish Patients and Health and Medical Care Acts require the best interest of the child to be considered in treatment decisions. Our findings extend the theoretical discourse on trauma-informed care by highlighting the persistent symptomatology in young children and caregivers despite treatment. This indicates a need for ongoing evaluation and adaptation of trauma interventions, in line with theories of resilience and developmental psychopathology that advocate continuous support and flexible therapeutic approaches.

The findings support the importance of the child–parent relationship as a key change mechanism in treatment to increase caregiver sensitivity and reduce problematic child behavior (Dozier et al., 2006; Facompré et al., 2018), as they demonstrate positive outcomes in caregivers’ perceived ability to manage their child’s behavior and a reduction in signs of disorganized caregiving. Awareness of the significant impact of caregiver factors on child trauma treatment is crucial for clinical practice. Interventions for traumatized young children should include both the child and the caregiver, addressing their relationship, rather than being limited to caregiver counseling, which is currently the common approach (Gutermann et al., 2016; Landolt et al., 2017).

CPP is considered to focus on “speaking the unspeakable” within the dyad, thereby facilitating open expressions of pain and difficulties. By supporting caregivers and children in sharing painful experiences and emotions and developing mutual regulation within the dyad, this approach can increase the sense of safety and protection for both parties, improve communication, and repair mismatches in situations that provoke conflict, stress, and dysregulation, which are often associated with trauma. By emphasizing the significance of mental representations and the link to the attachment relationship, CPP adds an important dimension beyond behavior-focused treatment that is particularly relevant for young children. The joint construction of the trauma narrative also appears to contribute to the treatment process. Although it requires further study, the role of the trauma narrative as a central component in trauma treatment is emphasized, despite being a sometimes-questioned element, particularly in the treatment of young children (Deblinger et al., 2011).

The findings regarding the equal benefits of CPP for children participating with foster parents and those with biological parents contribute to the theoretical understanding of attachment disruptions and the potential for therapeutic repair. These results support the notion that attachment is a dynamic and reparable process, even in the context of severe adversities, which is a critical consideration in attachment and trauma theories. Clinically, there is a need to prioritize treatment for these children and recognize the importance of including foster

caregivers in treatment (Dalgaard et al., 2022). The results indicate that significant positive outcomes can be achieved with a relatively limited number of therapy sessions, which is particularly important to clinics that often operate with constrained resources.

Lastly, the sustained positive outcomes observed at follow-up reinforce the theoretical validity of CPP's core components, such as promoting dyadic affect regulation, addressing maladaptive representations and behaviors, and supporting developmentally appropriate activities. These findings advocate for CPP's integration into regular CAMHS and call for further theoretical exploration through RCTs to comprehensively validate its efficacy.

## **Summary and conclusions**

The findings of the studies in this thesis showed that treatment with CPP benefits Swedish children and caregivers who have been profoundly affected by adversities and trauma. Improvements were found in general psychological symptoms and post-traumatic stress symptoms in both children and caregivers. Children participating with foster caregivers benefited equally as children participating with biological caregivers. The caregivers' sense of their own ability to control their child's behavior increased, and the signs of caregiving disorganization decreased. Correlations were found between the outcomes in children and those in caregivers, with the strongest associations being between reduced signs of caregiving disorganization and reductions in child PTSD symptoms. Strong associations were also revealed between reductions in general psychological problems in caregivers and those in children.

The changes in the children's post-traumatic stress symptoms exhibited sustained positive effects from pre-treatment to 6-month follow-up. The percentage of children with possible PTSD dropped from 78% at pre-treatment to 32% at follow-up. The decrease in the caregivers' post-traumatic stress symptoms was also sustained, going from 47%

pre-treatment to 17% at follow-up. Moreover, changes in the perceived signs of caregiving disorganization in caregivers showed sustained positive effects at follow-up.

Exploratory analyses of possible predictors of outcome (i.e., type of trauma exposure, trauma symptom severity, and number of therapy sessions) showed no significant child predictors. However, significant interactions were shown between child trauma symptoms and changes in caregiver trauma symptoms, with greater trauma symptoms in the child predicting less change in caregiver trauma symptoms during the treatment.

In the interviews, the caregivers reported positive effects concerning child mental health and development, as well as the child–caregiver relationship. The caregivers’ degree of acceptance of CPP was high, and the intervention could be realized practically. The caregivers were satisfied with their cooperation with the therapists and their own degree of involvement in the intervention. However, the caregivers suggested extended individual parental support. They also described barriers to treatment, which included juridical challenges, parental collaboration issues, joint custody, and visitations. No need for significant amendments to the CPP method when implemented in the Swedish clinical context was found.

The results of our studies support findings from previous research showing that CPP addresses and reduces the symptoms of the individual child and caregiver and improves aspects of the child–caregiver relationship. Our results demonstrate the sustainability of this method when implemented in a naturalistic clinical context in a new culture. Conclusively, CPP is a promising method for the treatment of traumatized preschool children, regardless of whether they undergo treatment with a biological parent or foster parent. Our studies thus contribute to developing current knowledge of therapeutic interventions for traumatized young children and their caregivers in Sweden.

A long-term goal of this thesis was for CAMHS and other services to be able to offer evidence-based and effective treatment for preschool-aged

children affected by adversities and trauma. There is a need to better integrate knowledge about the available treatment models specifically designed for this target group, the benefits of dyadic interventions including both the child and caregiver, and our findings from the Swedish clinical context. Such integration could improve the possibility for vulnerable groups of children to be identified in various services and eventually gain access to effective treatment. Finally, our studies may contribute to the conditions for a future randomized controlled study by supporting therapists and services with the reported results.

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# Trauma Treatment for Young Children

Many children exposed to adversities and trauma are under six years old, yet most trauma-focused treatments target older children. Child-Parent Psychotherapy (CPP) is one of few interventions designed for traumatized children under six, focusing on the child-caregiver relationship as the foundation for recovery. This doctoral thesis aimed to evaluate the outcomes and experiences of CPP when applied in a Swedish clinical context. Caregiver experiences when taking part in the treatment and how CPP meets the demands for dissemination were examined, as well as the impact of CPP on general psychological symptoms and post-traumatic stress in children, caregivers, and caregivers' perceptions of their relationship with their child. Finally, the long-term effects of CPP were examined. Overall, the findings were positive. The caregivers were satisfied with CPP, and the intervention was practical to implement. Reductions in general psychological symptoms and post-traumatic stress were observed in children and caregivers. Caregivers also reported improvements in the relationship with their child. The results were stable at follow-up. The findings highlight CPP's sustainability in a clinical setting in a new culture, indicating its promise for further dissemination and evaluation in Sweden.

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Many children exposed to adversities and trauma are under six years old, yet most trauma-focused treatments target older children. Child-Parent Psychotherapy (CPP) is one of few interventions designed for traumatized children under six, focusing on the child–caregiver relationship as the foundation for recovery.

This doctoral thesis aimed to evaluate the outcomes and experiences of CPP when applied in a Swedish clinical context. Caregiver experiences when taking part in the treatment and how CPP meets the demands for dissemination were examined, as well as the impact of CPP on general psychological symptoms and post-traumatic stress in children, caregivers, and caregivers' perceptions of their relationship with their child. Finally, the long-term effects of CPP were examined. Overall, the findings were positive. The caregivers were satisfied with CPP, and the intervention was practical to implement. Reductions in general psychological symptoms and post-traumatic stress were observed in children and caregivers. Caregivers also reported improvements in the relationship with their child.

The results were stable at follow-up. The findings highlight CPP's sustainability in a clinical setting in a new culture, indicating its promise for further dissemination and evaluation in Sweden.



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