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Navigating treatment trajectories for families with young children after domestic violence: A Delphi-study exploring the priorities in terms of trauma-therapy and attachment-based intervention

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ABSTRACT

Background: In families with young children who have experienced domestic violence, both parents and children are at risk to develop post-traumatic stress disorder (PTSD) symptoms, and there is a risk for disrupted parent-child interactions.
Objective: To identify the factors on which expert-clinicians agree that they should be considered when deciding on the order of trauma therapy for the parent, trauma therapy for the child, and attachment-based intervention.
Participants: and settings: Participants were 16 experienced clinicians, trained in attachment-based intervention for parents and their young children, trauma therapy for adults, and trauma therapy for young children.
Methods: A classic three-round Delphi approach was used. Anonymous online surveys were filled out by the participants. Consensus was defined as agreement among 70% of the participants.
Results: After the third survey round, there were eleven factors for which there was consensus. These included the preference of the parent for one of the three individual therapies, impaired parental mentalizing capacity, insensitive/disrupted parenting, a problematic attachment history between parent and child, a high level of child PTSD symptoms, a high level of parental PTSD symptoms, severe risks for the development of the child, a very young age of the child, and exposure of the child to one or more traumatic events.
Conclusions: Agreement was found on which factors to consider in planning the order of treatments for families who have experienced domestic violence. These factors can provide a starting point from where clinicians can design a treatment plan with a specific family.

1. Introduction

Global prevalence estimates show that 30% of women are victims of physical or sexual intimate partner violence (IPV) (World Health Organization, 2021). For domestic violence in general, which includes any act of physical or sexual violence, coercive control, or stalking of an ex-partner within the home environment, prevalence estimates in the Netherlands show that one in 10 citizens experienced one or more forms of domestic violence in the past 12 months (Akkermans et al., 2023). Often, the whole family system is involved in or exposed to the violence, as domestic violence and other forms of child maltreatment co-occur in almost 50% of these families (Alink et al., 2018; Steketee et al., 2023). Consequently, all members of the family are at risk for developing far-reaching and possibly lifelong problems, such as behavioral and emotional problems, lower academic and social functioning, lower physical health and unemployment (see e.g. Carlson, Voith, Brown, & Holmes, 2019; Herzog & Schmahl, 2018; Vu et al., 2016). The current paper focuses specifically on three of the problems for which these families are at risk, namely parental post-traumatic stress disorder (PTSD) symptoms, children's PTSD symptoms, and problems in the parent-child relationship. PTSD symptoms are defined as symptoms falling under the classification of PTSD in the Diagnostic and Statistical

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Manual of Mental Disorders (DSM-5-TR), such as re-experiencing or avoiding the traumatic event or forming negative feelings in the aftermath of a traumatic event (American Psychiatric Association, 2022). Up until now, there is a lack of knowledge, specifically about how to provide treatment for these problems in families with young children (0–6 years old). The aim of the current study is therefore to identify *which* factors are at play in defining the order of trauma therapy for the parent, trauma therapy for the child, and attachment-based intervention, and also *how* these factors may be taken into account when planning the order of the treatment. When writing about parental trauma therapy and the parent-child interaction, the focus of this paper is specifically on the parent that is generally seen as the non-abusive parent. Therefore a need for parental trauma therapy or attachment-based intervention with the alleged abusive parent can also exist (see e.g. Semiatin et al., 2017; Stover, 2015), and needs to be further studied, but that is outside the scope of this article.

Domestic violence can be an extremely stressful and sometimes even life-threatening experience, and therefore increases the risk for PTSD symptoms in parents and children (Ehrensaft et al., 2017; Galano et al., 2021) (See Fig. 1). Approximately half of the young children (up to the age of 7) who are exposed to interparental violence, develop PTSD symptoms (Levendosky et al., 2013). There are two pathways through which these symptoms can manifest in young children: (1) as a direct response to this event, for instance if the child witnesses the violence between parents and this causes feelings of intense fear and helplessness (Fig. 1, pathway 1), or (2) in response to the PTSD symptoms that their parents show (Fig. 1, pathway 3) (Glaus et al., 2021; Scheeringa & Zeanah, 2001). In this second pathway, also referred to as 'relational PTSD', parents' PTSD symptoms can cause them to show harsh, extremely insensitive and/or disrupted parenting behavior (Fig. 1, pathway 4) (Scheeringa & Zeanah, 2001).

The children's behavior may be a posttraumatic trigger if it reminds parents of the behavior of the perpetrator (Schechter, 2003), which can result in parents showing frightening and/or disrupted behavior towards their children. In response, children can develop PTSD symptoms and other related psychopathology (Fig. 1, pathway 5) (Christie et al., 2019; Moser et al., 2023; Van Ee et al., 2016). Especially infants, as compared to older children, are thought to exhibit symptoms through this concept of relational PTSD, because they have limited coping skills and are dependent on their caregivers in almost all facets of life (De Young et al., 2011; Noonan & Pilkington, 2020).

In addition to treating PTSD symptoms, there is a need for an attachment focus in the treatment of these families. Children who have experienced domestic violence are at increased risk of developing insecure and/or disorganized attachment relationships with their parent (McIntosh et al., 2021; Noonan & Pilkington, 2020). The concept of 'relational PTSD' forms one example of how parents' experiences of domestic violence can affect relationships between parents and children (Fig. 1, pathways 4 and 6) (Galbally et al., 2022). Alternatively, the harsh and insensitive caregiving behavior might result from a change in parents' own attachment representations after violence (Levendosky et al., 2011). Due to traumatization resulting from domestic violence, parents can perceive close relationships, such as the relationship with their children, as unsafe.

Considering the negative short- and long-term consequences of domestic violence, the question arises how the course of treatment should be designed to optimally fit the needs of the victimized parents and children. The pathways as explained in Fig. 1 lead to three options: treatment focused on improving PTSD-symptoms of parents, treatment focused on improving the attachment-relationship, and treatment focused on improving PTSD-symptoms of children. Given the interrelatedness of these pathways, treatment focused on one domain might also cause improvement in one or both of the other domains. For example, parenting interventions can positively affect the quality of the attachment-relationship, but may also decrease children's PTSD symptoms (Love & Fox, 2019) or even both parental and children's PTSD symptoms (Hagan et al., 2017; Lieberman et al., 2005). Additional evidence implies that trauma-focused therapy for adolescents can improve both parental and children's symptomatology (Greene et al., 2023; Neill et al., 2016). Especially young children (under the age of 6) were found to be positively affected by the treatment that their parents received (McFarlane et al., 2005). At the same time, a history of parental (childhood) trauma is suggested to hamper the effectiveness of a parenting intervention (Moran et al., 2005; Steele et al., 2019; Van der Asdonk et al., 2021). A modular approach, in which different treatment approaches can be provided in an order that suits the needs of a family, might therefore offer a solution. There are approaches that aim to treat traumatized children (Bentovim & Elliott, 2014; Chorpita & Weisz, 2009). Comparison with the standard treatment suggests that such modular approaches, that are matched to the needs of children, outperform standard approaches in the treatment duration (e.g. relatively shorter treatment duration) and treatment effects (e.g. relatively higher decrease in internalizing and externalizing symptoms), even two years after treatment (Chorpita et al., 2013, 2017). These approaches, however, do not yet focus on parents' traumatization and/or are not for children 0–6 years old (Bentovim & Elliott, 2014; Chorpita & Weisz, 2009). Ideally, approaches such as these should be extended on the basis of 'theory, performance, feedback, and clinical reasoning' (Chorpita et al., 2017), but as empirical evidence is lacking about the factors that are at play specifically for young children, the current study started with consulting expert clinicians to form consensus. Consensus methods with clinical experts create a joint narrative (Courtois & Marotta-Walters, 2021) that reflects the perspective of clinicians, which facilitates the implementation of guidance (Cook et al., 2009). Therefore, the goal of the current study is to identify *which* factors they consider as relevant, and *how* these factors are relevant in determining the order of trauma therapy for the parent, trauma therapy for the child and attachment-based intervention in families with young children (0–6 years old) who experienced domestic violence.

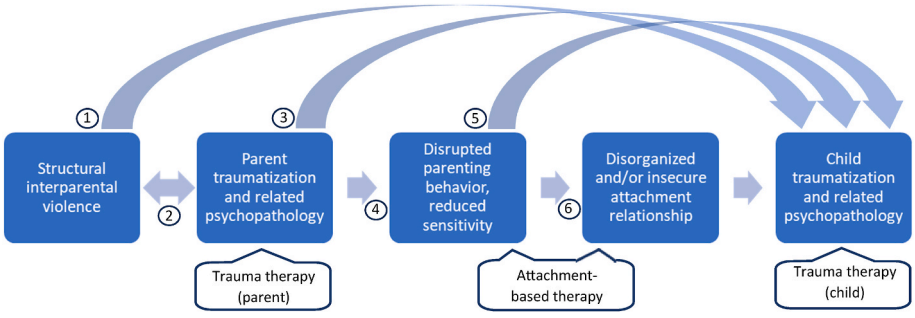

Fig. 1. Pathways that are at Play in the Aftermath of Domestic Violence, and Interventions Targeting these Outcomes.

2. Method

2.1. Design

The consensus method that was used in the current study is the classic – also called the traditional – Delphi approach (Skulmoski et al., 2007; Spranger et al., 2022), which is commonly used across disciplines (e.g. Keeney et al., 2011; Rowe & Wright, 2011). According to a critical realist perspective, the Delphi approach is a helpful tool in examining what the current state of 'true' knowledge is, by collecting different opinions and subsequently finding a common ground, by confronting the panelists with possibly opposite opinions (Spranger et al., 2022). A group of expert clinicians participated in three consecutive anonymous survey rounds. Each survey, except for the first one, started with feedback on the results from the previous survey. These results formed the basis for the next survey. The proposed reporting guidelines for Delphi studies by Spranger et al. (2022) were used to describe the current study.

All materials were developed by the research team. This team consisted of seven members, of whom five are researchers affiliated with two different universities. The other two members are highly experienced clinicians (CR and KZ) from organizations that offer trauma therapy for adults and (young) children and attachment-based intervention in families who experienced domestic violence. Both clinicians are also working as trainer and supervisor for either individual trauma therapy for adults and children or attachment-based intervention.

2.2. Participants

Recruitment of participants was performed with a purposive sampling technique. We sought a sample of participants who were trained in an attachment-based intervention for the parent and the child (using video-feedback), as well as a trauma therapy for adults and trauma therapy for children, as recommended in Dutch guidelines (De Wolff & Wildeman, 2020; Hein et al., 2021; Akwa, 2021). Part of the participants were recruited by e-mail through one of the clinicians within the research team (KZ), who is part of a national expertise group that consists of professionals who provide treatment to families after domestic violence, specifically in terms of trauma therapy and attachment-based intervention (in Dutch: Drakentemmers). In addition, members of the research team posted or shared a message through their LinkedIn account with a link through which professionals could indicate that they were interested in participation.

In total, 23 of the 43 professionals who were interested in participation met the inclusion criteria. All participants were at least trained in eye movement desensitization and reprocessing (EMDR) therapy for adults and for children (see Table A1 for a detailed overview of the therapies that participants were trained in). The participants had on average 14.8 years of work experience as a clinician (*range* = 9–25 years, *SD* = 4.8 years). The first survey was sent to all 23 participants, and we received 16 valid responses (70% response rate). After round one, three participants dropped out: one due to personal circumstances and two because they felt that they did not have enough expertise to answer the

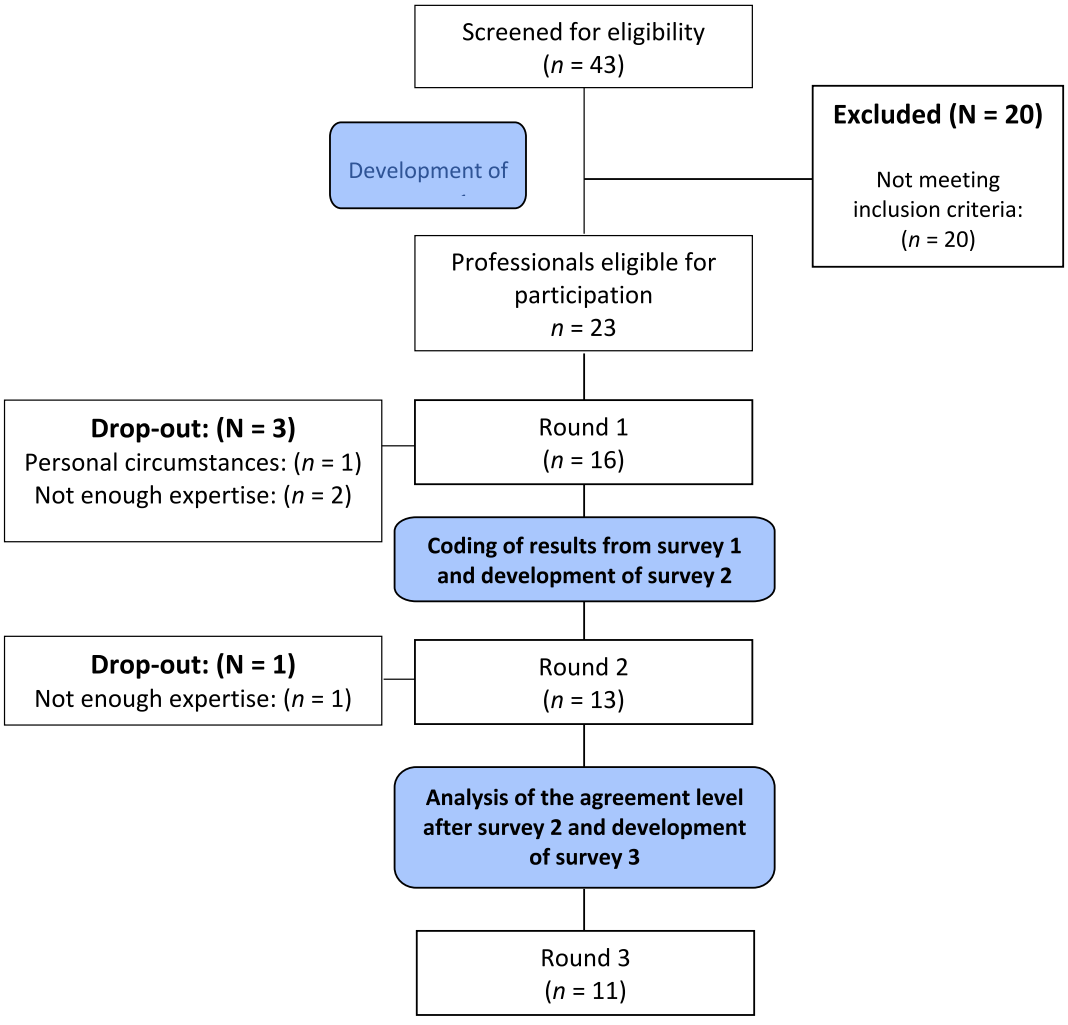

Fig. 2. Overview of the followed procedures, including participant flow throughout the study.

questions. The second survey was then sent to 20 participants, and there were valid responses from 13 participants (65% response rate). After round two, an additional participant dropped out because she felt that she did not have enough expertise to answer the questions. The third survey was then sent to 19 participants, and there were 11 valid responses (58% response rate). Fig. 2 displays the participant flow throughout the survey rounds. Because the surveys were filled out anonymously, it was not possible to follow-up specifically on the participants who did not respond to the surveys, and thus reminders for filling in the questionnaires were sent to all participants. The anonymization also prohibited the research team to check whether dropped-out participants had filled out the surveys that were sent to them before they dropped out.

2.3. Procedure

All three surveys were sent to the participants by e-mail. An information letter was attached to the first e-mail, in which the rationale of the study and the value of participation were explained. Subsequently, participants were asked to agree with a consent statement. If they did not agree with the statement, they could not participate in the study. Next, the first survey round started. The planned time between every survey round was 3 weeks, but this was extended with 1–2 weeks if we received many out-of-office e-mails from professionals (e.g., during public holidays).

After each survey round, the results were analyzed and extensively discussed within the research team, and the survey for the consecutive round was constructed. Ethical approval for this study was obtained from the Ethical Review Board of Education and Child studies at Leiden University (protocol number: ECPW-2022/342).

2.4. Survey rounds

2.4.1. Case description

All three surveys started with the following case description: *'A family, consisting of a mother and a young child (0–6 years old), is referred to you. The family has experienced severe domestic violence from the (ex-) partner of the mother. The family has a stable housing situation, and they receive a social welfare benefit. Additionally, an organization that has expertise in treating victims of domestic violence is involved with the family. The (ex-)partner lives somewhere else at this moment, and there are no immediate safety risks. Both mother and child have PTSD(-related) symptoms and the mother shows disrupted parenting behavior. Your goal is to help this family as well as possible, and to reach this goal, you can provide three different therapies: trauma therapy for the mother, trauma therapy for the child and/or attachment-based therapy for mother and child.'* This case description was included so that all participants would think about the same type of case.

2.4.2. Round 1

For survey one, the goal was (1) to collect background information about the participants and (2) to gain insight in the different factors that participants take into account when deciding the order of trauma therapy for the parent, trauma therapy for the child, and attachment-based intervention. The survey consisted of four closed-ended questions about the background of the participants, six closed-ended questions about how they provide treatment within these types of families and nine open-ended questions about factors that they take into account when planning the course of treatment. To structure these last questions, participants could mention factors in different domains: *safety*, *external stressors*, *parental factors*, *child factors*, *parent-child interaction*, *family factors* and *other factors*. Next, participants were asked to mention any additional factors they deemed relevant. In addition, they were asked whether, and to what extent they felt that existing guidelines supported them in deciding on the course of treatment in the target group. The results of the survey were discussed within the research team. Similar factors that were described in different words were grouped as one factor, and for all factors it was noted how often they had been mentioned.

2.4.3. Round 2

For the second survey, the goal was to determine consensus about *how* all the different factors, as collected in the first survey, affected the priority of the three different therapies. For each factor, participants were asked to indicate whether the presence of that factor *increased*, *decreased*, or *did not affect* the priority of trauma therapy for the parent, trauma therapy for the child, and attachment-based intervention. If they found that the specific factor was not applicable because it affected the start of treatment in general, and not the specific order of the different therapies, they could indicate that too (*'not applicable, in this case I would not start any treatment at all'*). All questions were presented in the form of side-by-side matrix questions. Lastly, participants were asked to mention relevant protective factors in an open question, and, if they had filled out any, to specify how these affected the priority for the different forms of therapy.

The results were analyzed, and the percentage of agreement between participants was computed. An agreement level of 70% was considered as consensus (Hasson et al., 2000; Keeney et al., 2011). Factors in round two with an agreement level between 50% and 69% were included again in the third survey.

2.4.4. Round 3

First, participants received feedback in the form of an overview of the factors for which there was already consensus (≥70%) that they increased or did not affect the priority for one of the therapies. For the factors with an agreement level between 50% and 69% (as resulted from round two), this percentage was reported to the participants, and they were asked whether the specific factors did or did not affect the priority of the therapy that this percentage applied to (yes/no). Similar to round 2, side by side matrix questions were used to do so.

3. Results

3.1. Round 1

Participants reported five different orders of therapy as either their first or second preferred order (Table 1). Furthermore, 75% of the participants reported that it was possible to offer trauma therapy and attachment-based intervention parallel within the same family.

For determining the order of treatment, participants mentioned on average 17.6 different factors (*SD* = 7.5, *range*: 7–33). Overall, 35 unique factors were distinguished. Each of these factors was mentioned one to twelve times. The 35 factors could be assigned to four overarching domains: a *practical domain*, a *parent domain*, a *child domain,* and an *other domain.* The *practical domain* included factors such as 'availability of the parent(s)', 'length of waiting lists for the different therapies' and 'judicial demands'. The *parent domain* included factors such as 'emotion

Table 1
Different Orders of Therapy that were Reported in the First Survey.

	First choice		Second choice		Total	
	n	%	*n*	%	*n*	%
Trauma mother ≫ Attachment ≫ Trauma child	6	38	8	50	14	88
Attachment ≫ Trauma mother ≫ Trauma child	5	31	4	25	9	56
Trauma mother ≫ Trauma child ≫ Attachment	5	31	2	13	7	44
Trauma child ≫ Trauma mother ≫ Attachment	–	–	1	6	1	6
Attachment ≫ Trauma child ≫ Trauma mother	–	–	1	6	1	6

Note. Trauma mother = trauma therapy for the mother; Trauma child = trauma therapy for the child; Attachment = attachment-based intervention for mother and child.

regulation of the parent', 'trauma symptoms of the parent', and 'treatment motivation'. The *child domain* included factors such as 'age of the child', 'IQ of the child' and 'events that the child had experienced'. The *other domain* included factors that could not be grouped under the first three domains, such as 'the immediate safety within the family', 'the number of other children within the family' and 'worries from other professionals about the family'. As the focus of this study was specifically on substantive factors, practical factors were not included in the second round.

3.2. Round 2

For each of the factors in the *parent domain*, *child domain,* and the *other domain*, participants were asked how these affected the priority for the different forms of therapy. There was consensus (i.e. 70% of participants agreed) on the contribution of nine factors (see Table 2).

Furthermore, there were seven factors for which the level of consensus was between 50% and 69% (factors 6, 7, 8, 9, 12, 15, and 16; Table 2). For the factor '*High level of acute unsafety'*, there was consensus that it did not apply because participants would not start any treatment at all in that case. For all other factors, there was no consensus that the factors *increased* the priority for one of the specific therapies (see Table A2 for the agreement levels of these factors). Because the focus of this study was on factors that *increased* the priority for one of the specific therapies, only the seven factors for which the agreement level about increasing the priority was between 50% and 69% were included in the last survey round.

Table 2
Factors for Which the Agreement Level after Round 2 was at least 50%.

Factors as listed in round 2 and 3	Agreement level after round 2 (%)	Agreement level after round 3 (%)
Factors that increase the priority for attachment-based intervention		
1. Insensitive/disrupted parenting	92	–
2. Strong preference of the parent for attachment-based intervention	92	–
3. Problematic attachment history between parent and child	85	–
4. Severe risks for the development of the child[a]	82	–
5. Impairments in parental mentalizing capacity	77	–
6. Very young age of the child[b]	67	82
7. Negative relationship between the child and the other parent	62	27
8. Comorbid psychopathology of the parent	55	36
9. High level of trauma symptoms of the child[c]	50	27
Factors that increase the priority for trauma therapy for the parent		
10. High level of parental trauma symptoms	100	–
11. Strong preference of the parent for trauma therapy for themselves	100	–
12. One or more traumatic experiences in parent's own youth	64	45
Factors that increase the priority for trauma therapy for the child		
13. High level of trauma symptoms of the child[c]	100	–
14. Strong preference of the parent for trauma therapy for the child	75	–
15. The child has experienced one or more traumatic events	69	73
16. Very young age of the child[b]	58	45

Note. The rows with bold text reflect the factors for which consensus has been reached.
[b] and [c] indicate factors that applied to two forms of therapy.
[a] This factor refers to the Dutch term 'ontwikkelingsbedreiging', which is one of the conditions on which a child protection measure could be summoned (Dutch Civil Code, 2017).

3.3. Round 3

The results of round 3, as displayed in Table 2, show that the agreement level after round 3 ranged from 27% to 82%. Consensus was reached for two additional factors: one that increased the priority of attachment-based intervention (factor 6), and one that increased the priority of trauma therapy for the child (factor 15). After round 3, there was thus a set of 11 factors for which there was consensus. For all therapies, the priority increased if the *preference of the parent* was to start with that specific therapy. Additionally, *insensitive or disrupted parenting behavior*, *impairments in parental mentalizing capacity*, *severe risks for the development of the child*, a *problematic attachment history between parent and child,* and a *very young age of the child* increased the priority of attachment-based intervention for the family. The priority of trauma therapy for the parent increased if *the parent experienced a high level of trauma symptoms*, and the priority of trauma therapy for the child increased if *the child experienced a high level of trauma symptoms* and if the *child had experienced one or more traumatic events*.

4. Discussion

Within a group of expert-clinicians, we found consensus on the relevance of a total of eleven factors that play a role in deciding about the order of trauma therapy for a parent, trauma therapy for a child, and attachment-based intervention for the parent-child relationship in families with young children (0–6 years old) who experienced domestic violence. These factors included the preference of the parent for one of the specific therapies (i.e. for attachment-based intervention, trauma therapy for the parent or trauma therapy for the child), impaired parental mentalizing capacity, insensitive/disrupted parenting, problematic attachment history between parent and child, high level of child PTSD symptoms, high level of parental PTSD symptoms, severe risks for the development of the child, very young age of the child, and exposure of the child to one or more traumatic events.

Some of the factors that were identified are inherent to the target population and were therefore not thought to uniquely add to the other factors. Experiencing or being exposed to domestic violence is in itself regarded as a severe risk for the development of the child. Furthermore, the focus of this study was already on young children (aged 0–6 years old) who experienced domestic violence (which is a traumatic event). The relevance of these factors thus aligns well with the theoretical basis of this study.

The expert clinicians agreed that the preference of the parent for one of the specific therapies was a factor of influence for the order of therapies. For example, parents' preference to start with attachment-based intervention increased the priority for attachment-based intervention. Clients' preferences in treatment have been found positively associated with treatment satisfaction, treatment completion, and treatment outcome (such as lower depressive symptoms and improved quality of life) (Lindhiem et al., 2014). In other studies that specifically targeted families with multiple problems, taking into account parents' preference was related to improved engagement, and was also associated with more positive outcomes (e.g. improved family functioning) of family-focused interventions (Van Beek et al., 2023; Visscher et al., 2022). Especially for these families, for which problems are persistent and improvement after treatment is generally low (Al et al., 2012; Van Assen et al., 2020), the results of this study, combined with previous empirical evidence, imply that special attention should be given to the preference of the parents when deciding on the treatment order. A next step could be to examine whether the preference of children about the order of treatment could also affect treatment effects. Although this study specifically focused on children under the age of 6 years and those may not always have the

verbal and mental abilities to give their preference about the order of treatment, they might for example be able to give their preference in how the sessions of their individual therapy are designed.

The priority of attachment-based intervention increased if there was an impaired parental mentalizing capacity, insensitive/disrupted parenting, and/or a problematic attachment history between parent and child. This corresponds well with the general literature regarding factors of influence in attachment-based interventions (Bakermans-Kranenburg et al., 2003; Camoirano, 2017). The ability of parents to mentalize, which is the ability to recognize, distinguish, and reflect on the mental state of themselves and their child, and to show adequate behavior as a response (Slade, 2005), is a key predictor for children's attachment security (Zeegers et al., 2017). The same goes for parental sensitivity, which is also positively related to attachment security (Madigan et al., 2024; Zeegers et al., 2017).

Furthermore, the experts agreed that a high level of PTSD symptoms of the parent increased the priority of trauma therapy for the parent, and a high level of PTSD symptoms of the child increased the priority of trauma therapy for the child. If left untreated, PTSD symptoms resulting from domestic violence can have a severe and lifelong impact, both for adults and children. Untreated PTSD symptoms are for example related to an obstruction or set-back in children's development, but also to all kinds of mental health problems, a diminished quality of life and high economic costs for society (Ehlers et al., 2009; Rosenbaum, 2004; Scheeringa et al., 2005). The consensus about these factors reflects that clinicians are aware of the importance of treating PTSD symptoms and thus take these into account when deciding on the order of therapy.

From a clinical perspective, the identified factors can support clinicians in determining the optimal order of treatment for the complex population of victimized parents and children after domestic violence. As described in the Introduction, there can be a need for all three therapies in these families, but the optimal timing of treatment can be different for different families. The current study gives insight in which specific factors should be taken into account to individualize treatment to the needs of individual families. To be of further clinical use, additional specification of the factors is necessary. Most often, multiple factors will play a role at the same time in the same family, and the choice to start with a certain therapy should therefore depend on the combination and interplay of the different factors. Our next step will therefore be to translate the findings of the current study into a guidance document that helps to decide on treatment order, and to test whether this document is sufficient in helping therapists to determine the treatment order.

In a broader sense, the findings could be of use in developing new or informing current available modular treatment programs, specifically focused on the target group of families with young children (aged between 0 and 6 years old) who have experienced domestic violence. The factors could for example complement approaches such as the 'Hope for Children & Families (HfCF)'-approach (Bentovim & Elliott, 2014), or the 'Integrative Attachment Trauma Protocol for Children' (Wesselman et al., 2014). While these approaches focus on selecting and applying specific treatment modules to the needs of specific families, our study points out what the factors are that underly these needs. Additionally, because treatment approaches such as HfCF are focused on families with older children, combining our findings with such an approach could help to make this approach applicable to families with children aged 0–6 years as well. A next step in optimizing treatment for these families could be to investigate what treatment elements (e.g., specific elements in trauma therapy and/or attachment-based interventions) specifically target the factors as were found in the current study. Furthermore, as other interventions than trauma- and attachment-focused therapy are also applied in this target group (see e.g. Anderson & Van Ee, 2018; Howarth et al., 2016), it could be explored how interventions that focus on other problems should be timed in relation to trauma- and attachment-focused therapy. Ideally, these steps could result in treatment trajectories that are highly efficient, both in terms of time and money, because they are specifically focused on the factors that are at play in these families.

4.1. Limitations

The sample of participants in this study was rather small and the response rate was lower than intended. Of the 23 participants who were eligible for participation, 11 participated in the last survey round. The sample of participants could have been larger if the focus of the study would have been broader, (i.e. if the eligibility criterium for the types of treatment would have been broader). Trauma- and attachment-based therapies, however, have been repeatedly recommended for parents and young children after domestic violence in both national and international guidelines (see e.g. International Society for Traumatic Stress Studies Guidelines Committee, 2018, Vink et al., 2020; World Health Organization, 2013). In addition, the question as for whom to treat first, the parent, the child or both of them in interaction, has been raised several times now (Stolper et al., 2024; Van Ee et al., 2016), but has not been investigated nor answered yet. Therefore, the choice was made to first focus on these types of therapy. The pool of experts who are trained in specifically these types of therapy, however, might not be that large, which would justify the small sample size. In mental health care in the Netherlands, but also internationally, there is often a strict separation between child versus adult mental health care (Signorini et al., 2018). This means that parents and children are supported by different professionals with different specialisms. Although policy makers start to encourage youth and adult mental health care to collaborate and work more cohesively (e.g., Ministry of Health Welfare and Sports, 2022), there are still a lot of challenges in this area (Nooteboom et al., 2021).

Some participants dropped out during the study. At least for a few of them, this was because they did not feel enough of an expert to answer the questions. Although not all dropped out participants had contacted the researchers to give a reason for their drop-out, it is possible that there were more participants for whom this reason applied. This might implicate that the findings of this study do reflect the consensus within a group of 'true' experts in this field. Alternatively, the drop-out and non-response, might be a result of the high workload for professionals who work in youth care in the Netherlands (Statistics Netherlands, 2022), which might have withheld some of the professionals from filling out the questionnaires because of a lack of time. Another reason for the low response rate in this study is that, because the surveys were sent to the participants anonymously, it was not possible to send personalized reminders to the non-responders, nor was it possible to provide personalized feedback to the participants. This might have resulted in a higher level of non-response, and has limited our ability to address non-response bias. At the same time, the anonymity of the participants may have resulted in collecting the most honest opinion of the participants, whereas they might have been more inclined to give socially desirable answers if the surveys were not anonymous. Although we had expected more than 11 participants to fill out all surveys, sample sizes such as these are not entirely uncommon in Delphi studies (see e.g. Chan et al., 2009; Skulmoski et al., 2007). To increase the validity of the findings of this study, it would be recommended to replicate the current study in another comparable sample of experts.

A second limitation is that the choice for the population from which we sampled the participants might limit the representativity of the sample of experts. Although we recruited participants via a national platform, this platform was only recently (i.e., in 2019) set up. Experts who did meet the inclusion criteria but could not be included because they were not connected to the network of our research team could thus be missed. On the other hand, the use of purposive sampling, and more specifically the inclusion criterium regarding participants' training in specific types of therapy (i.e., therapies with a certain level of evidence-base as recognized by national guidelines for practitioners), might have been a strength. The choice for this criterium does not only strengthen the scientific basis of this study, but might also have improved the

validity of our findings.

4.2. Recommendations and conclusion

Problems of the parent (e.g. parental PTSD symptoms) as well as of the child (e.g. child PTSD symptoms) and in the parent-child relationship (e.g. parental mentalizing capacity and problematic attachment history) need to be considered to determine the order of treatment, according to expert clinicians. Clinicians should be aware of these factors and implement assessment of these factors in treatment planning for these families. Therefore, clinicians should at least have some level of understanding of these factors or collaborate with knowledgeable clinicians with the necessary expertise. Not only might this increase the knowledge of clinicians, more importantly it can improve the support that families receive and subsequently their treatment outcomes. Families with experiences of domestic violence present with a range of complex problems and stressors and therefore require specialized care. This study, and the guidance document that will be developed on the basis of this study, helps clinicians to see the forest for the trees and set up integrated treatment trajectories that will ideally result in effective treatment.

CRediT authorship contribution statement

Willemien M. van den Dorpel: Formal analysis, Investigation, Writing – original Draft, Visualization, Project administration. **Lenneke R.A. Alink:** Conceptualization, Methodology, Writing – review & editing, Supervision, Funding acquisition. **Anja van der Voort:** Methodology, Formal analysis, Writing – review & editing, Supervision. **Carlo Schuengel:** Conceptualization, Methodology, Writing – review & editing, Supervision, Funding acquisition. **Ashwina R. Kesarlal:** Methodology, Investigation. **Carlijn de Roos:** Writing – review & editing. **Karine Zuidgeest:** Resources, Writing – review & editing. **Sabine van der Asdonk:** Conceptualization, Methodology, Writing – review & editing, Supervision, Funding acquisition.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A

Table A1
Overview of the Therapies that the Participants were Trained in

Trauma therapy for adults
Eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2001)
Trauma focused cognitive behavioral therapy (TF-CBT)
Cognitive therapy (CT; Ehlers et al., 2005)/Cognitive processing therapy (CPT; Resick & Schnicke, 1993)
Exposure therapy (Richard & Lauterbach, 2011)
Imagery rescripting (ImRS; Sloan et al., 2012)
Attachment-based interventions
Mother-baby intervention (Van Doesum et al., 2005)
Dutch short-term intervention on atypical parenting behavior (NIKA; Draaisma & Zuidgeest, 2014)
Basic trust method (Colonnesi et al., 2013)
Parent-child interaction therapy (PCIT; Eyberg, 1988)
Trauma therapy for children (0–6 years old)
EMDR therapy (for children (e.g. Tinker & Wilson, 1999)
TF-CGT/WriteJunior (Lucassen & Van der Oord, 2008)
Exposure therapie (Schauer et al., 2017)

Note. Because of the relatively high amount of non-response, and to prevent a biased view, the exact number of participants that was trained in each therapy is not given.

Table A2
Factors for which no Consensus was Reached that the Factor did **Increase** the Priority for one of the Treatments

	Not applicable		Atttachment-based intervention			Trauma therapy mother			Trauma therapy child		
Factors as displayed in round 2	0 No (%)	1 Yes (%)	0 No effect(%)	1 Priority ↓ (%)	2 Priority ↑ (%)	0 No effect (%)	1 Priority ↓ (%)	2 Priority ↑ (%)	0 No effect (%)	1 Priority ↓ (%)	2 Priority ↑ (%)
A lot of prior treatment for the parent, that was not effective	85	15	73	–	27	73	–	27	100	–	–
Low level of parental capacity to learn	92	8	36	55	9	58	–	42	92	–	8
Low IQ of the parent	92	8	77	–	23	100	–	–	92	–	8

(*continued on next page*)

Table A2 (*continued*)

Factors as displayed in round 2	Not applicable		Atttachment-based intervention			Trauma therapy mother			Trauma therapy child		
	0 No (%)	1 Yes (%)	0 No effect(%)	1 Priority ↓ (%)	2 Priority ↑ (%)	0 No effect (%)	1 Priority ↓ (%)	2 Priority ↑ (%)	0 No effect (%)	1 Priority ↓ (%)	2 Priority ↑ (%)
A lot of divorce-related problems between parents	62	38	67	11	22	70	10	20	100	–	
Parents' personal capacity to cope[a]	100	–	27	36	36	42	25	33	67	25	8
Little confidence of the parent in care providers	85	15	64	9	27	90	10	–	90	10	–
Little motivation of the parent for treatment	85	15	73	9	18	80	20	–	100	–	–
Low effect of prior treatment for the child	100	–	67	–	33	83	–	17	77	23	–
No age-appropriate development of the child	100	–	62	–	38	100	–	–	91	–	0
The child resists to treatment	100	–	55	–	45	100	–	–	69	31	–
No evidence base for the effectiveness of trauma therapy for the parent	77	23	89	–	11	75	25	–	100	–	–
No evidence base for the effectiveness of trauma therapy for the child	85	15	100	–	–	100	–	–	75	25	–
No evidence base for the effectiveness of attachment-based intervention	85	15	75	25	–	100	–	–	89	–	11
Too little/negative social support	85	15	70	20	10	40	60	–	50	50	–
Many other children within the family	92	8	89	–	11	80	–	20	90	10	–
Housing problems of the family	69	31	60	30	10	20	80	–	30	70	–
Worries from the social network about the family	92	8	67	8	25	58	25	17	58	33	8
Other children in the family experience a lot of symptoms too	100	–	54	15	31	62	23	15	75	25	–
Problems with the residential status of the family	92	8	64	27	9	64	36	–	55	45	–

Note. Factors as were presented to the participants in survey 2. As no consensus was reached for that the factors *increased* the priority for one of the therapies, they were not presented again in round 3.

[a] This factor refers to the Dutch term 'draagkracht'.

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