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Psychosocial Interventions Against the Intergenerational Transmission of Family Violence: Pathways to Prevention Effectiveness. Systematic Review and Narrative Synthesis.

The intergenerational transmission of family violence (ITFV) or “cycle” of family violence describes the idea that individuals who were abused by their parents or other caregivers during childhood or adolescence, or who witnessed violence among these caregivers, are more likely to engage in violent behaviors against their own children (Crombach & Bambonyé, 2015; Greene et al., 2020; Hellmann et al., 2018) and/or partners (Rahmatian, 2009; Stith et al., 2000) as adults.

The phenomenon of intergenerational transmission has been attributed to many different descriptors of family-based violence, including child maltreatment (Assink et al., 2018), child abuse and neglect (Widom et al., 2015), domestic violence (Wagner et al., 2019), intimate partner violence (Ehrensaft & Langhinrichsen-Rohling, 2022) and family violence (Meyer et al., 2021). These descriptors are not always precise. The Council of Europe defines domestic violence as “[...] all acts of physical, sexual, psychological or economic violence that occur within the family [...]” (Council of Europe, 2011), which would include child abuse and neglect. On the other hand, research has commonly used the term “domestic violence” synonymously with intimate partner violence (IPV; e.g., Anderson et al., 2018). Research on the intergenerational transmission of child maltreatment often includes the child witnessing IPV between caregivers as a form of victimization (e.g., Altafim et al., 2021), but perpetration of child maltreatment usually only includes neglect and acts of violence aimed directly at the child (e.g., Assink et al., 2018). The present study additionally includes victimization through childhood witnessing of IPV, as well as subsequent perpetration of IPV in adulthood. Therefore, the term “family violence” (FV) is used in the remainder of the document, in accordance with the typology of violence presented by the World Health Organization (Krug et al., 2002).

Another distinction is made between intergenerational transmission and continuity of FV (Bartlett et al., 2017; Marshall et al., 2022). Intergenerational transmission refers to the link between childhood victimization and adult perpetration (e.g., Widom et al., 2015), whereas intergenerational continuity refers to the link between childhood victimization and adult victimization (e.g., Marshall et al., 2022), although the terms are sometimes used interchangeably (e.g., Assink et al., 2018;

Bartlett et al., 2017; St-Laurent et al., 2019). The present study focuses primarily on the concept of ITFV that associates childhood victimization with adult perpetration.

Although most people who have been subjected to FV do not become perpetrators themselves (Bartlett et al., 2017; Ertem et al., 2000; Hellmann et al., 2018; Kaufman & Zigler, 1987; Maxfield & Widom, 1996) and will thus “break the cycle”, research suggests that there is a significant relationship between a person’s childhood history of victimization and their risk of perpetration (e.g., Madigan et al., 2019). The transmitted violence can take on many different and often coinciding forms, like physical violence (Bevan & Higgins, 2002; Capaldi et al., 2019; Falb et al., 2022; Godbout et al., 2019; Herrenkohl et al., 2020; Madigan et al., 2019; Podaná, 2018; Schluter et al., 2011; Thornberry et al., 2013; Treves-Kagan et al., 2019), emotional or psychological violence (Bevan & Higgins, 2002; Godbout et al., 2019; Herrenkohl et al., 2020; Lakhdar et al., 2019; Madigan et al., 2019; Thornberry et al., 2013), sexual abuse (Bevan & Higgins, 2002; Godbout et al., 2019; Herrenkohl et al., 2020; Madigan et al., 2019; Reckdenwald et al., 2013; Scheid et al., 2020; Thornberry et al., 2013; Treves-Kagan et al., 2019), neglect (Bevan & Higgins, 2002; Godbout et al., 2019; Herrenkohl et al., 2020; Madigan et al., 2019; Thornberry et al., 2013) or witnessing IPV among one’s caretakers as a child (Cannon et al., 2009; Godbout et al., 2019; Podaná, 2018; Scheid et al., 2020). In addition to multiple types of FV coinciding, transmission can also happen with multiple types combined (Cort et al., 2011).

It is also worth noting that different types of FV can result in different transmission effects (Bartlett et al., 2017; Berzenski et al., 2014; Yang et al., 2018). The ITFV can either be homotypic, meaning that the type of FV experienced in childhood either does or does not match the type of FV perpetrated in adulthood, or heterotypic, meaning that the type of FV experienced in childhood is associated with perpetration of a different type of FV in adulthood (Yang et al., 2018). Rates of ITFV may be higher for homotypic than heterotypic transmission (Bartlett et al., 2017; Berzenski et al., 2014). Other factors, like psychopathology, may influence the process of transmission to differing degrees for different types of FV (Yang et al., 2018).

The present study aimed to examine psychosocial interventions for FV prevention that take the concept of ITFV into account, including all previously

mentioned forms of FV, as well as homotypic and heterotypic paths of intergenerational transmission. The following introductory sections provide an overview of theoretical and empirical attempts at explaining the ITFV, associated psychosocial risk and protective factors, different forms of psychosocial interventions designed to prevent FV perpetration, and examples of how FV interventions do and do not factor in an ITFV perspective.

Mechanisms of Intergenerational Transmission

There are multiple theories aiming to explain the underlying mechanisms of the ITFV (Alink et al., 2019; Widom & Wilson, 2015). One of the most impactful approaches is social learning theory, proposing that children tend to adopt violent behavior from their parents through so-called “modeling” (Bandura, 1969). Punishing children through the use of physical force (even if it is not perceived as abusive) can lead them to view violent behavior as normal and legitimize further and include different kinds of violence (Simons & Wurtele, 2010) and antisocial behavior (Braga et al., 2017; Patterson, 1986; Smith et al., 2014).

Attachment theory offers another influential perspective, assuming that the social and emotional connection between a young child and its parents or caretakers forms the foundation for the framework through which children perceive the world, and which influences their default attribution scheme in future interactions with the people they encounter (Bretherton, 1992). Individuals who are unable to form a secure attachment style because of FV victimization may acquire a distrustful worldview growing up, tending to expect hostility by default (Baer & Martinez, 2006; Pickreign Stronach et al., 2011; Shaver & Mikulincer, 2002). This may include interactions with children of their own, where ambiguous expressions of an infant are interpreted as hostile (Crouch et al., 2010; McCarthy et al., 2013). Parents with an insecure or disorganized attachment style may react to what they perceive as a threat with aggression of their own (Lo et al., 2019; Rodriguez & Tucker, 2011).

Building on the findings of attachment theory, social information processing theory posits that insecure or disorganized attachment styles lead to processing information in a negatively biased way (Dykas & Cassidy, 2011) and foster aggressive behavior (Dodge et al., 1990; Teisl & Cicchetti, 2008). Research indicates that this bias mediates the association between a caretaker’s childhood history of

maltreatment and their perpetration of FV against their own offspring (Berlin et al., 2011).

Another important factor that has been found to mediate the ITFV is trauma, either as a direct consequence of FV victimization (Anderson et al., 2018) or stemming from unrelated experiences (Milner et al., 2010). For example, the degree to which a traumatic experience becomes the central focus of an individual's life has been found to predict PTSD symptoms, which in turn predict IPV perpetration (Webermann et al., 2020). Transdisciplinary research spanning across psychology and neurophysiology suggests that traumatizing experiences of FV during childhood can interfere with individuals' regulation of their biological stress systems, leading to maladaptive outcomes in adulthood (De Bellis, 2001; De Bellis & Zisk, 2014). Especially during early childhood, when the human brain undergoes important developmental steps, persistent traumatic stress can have substantial adverse effects on brain development and adult brain functioning (Saleh et al., 2017; Teicher et al., 2002), as well as psychopathology (Carr et al., 2013; Heim et al., 2008; Schalinsky et al., 2019). FV is one of the most important factors contributing to these detrimental effects, most notably affecting the hypothalamic–pituitary–adrenal axis, as well as the hippocampus, the amygdala and other cortical areas (Choi et al., 2012; Teicher & Samson, 2016; Teicher et al., 2016). Some studies suggest a direct influence of the mother's maltreatment experiences on the development of the child's brain structure, coming into effect before the child is even born (Buss et al., 2017; Moog et al., 2018).

In contrast to the models mentioned above, which assume the cycle of FV to originate from environmental factors, the behavioral genetics discipline proposes that genetic makeup may be shaping human behavior in significant ways (Plomin et al., 2016). This includes perspectives on how genetic factors can be responsible for the ITFV (Hines & Saudino, 2002; Stuart et al., 2014). However, criticism from within the same field argues that the potential of genetic influence to explain differences in human behavior has often been overstated (Turkheimer, 2016).

The epigenetic perspective on intergenerational transmission holds that DNA methylation, and thereby gene expression, is itself profoundly influenced by environmental factors (Champagne, 2016; Champagne, 2018). Research suggests epigenetic effects on psychopathology (e.g., Kaut et al., 2017) and

neurodevelopment (Salinas et al., 2020) that may span across multiple generations (Curley et al., 2023). Recent studies on FV indicate that child maltreatment is associated with epigenetic changes (Parade et al., 2021; Serpeloni et al., 2020). For example, adverse childhood experiences (ACEs) of mothers may be associated with epigenetic acceleration of cell aging in their children (Nwanaji-Enwerem et al., 2021), which may in turn predict the children's development of posttraumatic stress disorder (PTSD; Shenk et al., 2021). These more recent findings indicate the need for more integrative approaches, including knowledge from both the biological and the social sciences (Van Wert et al., 2019).

In addition to a variety of theoretical models trying to explain the dynamics behind the ITFV, research in the past decades has focused extensively on identifying risk and protective factors (e.g., Langevin et al., 2021). A brief overview is provided in the following sections.

Risk Factors

Egeland et al. (1988) found evidence that mothers who had experienced abuse, and would go on to abuse their own children, would experience more stress in their lives, be more anxious, depressed and “immature” than those who did not pass on the violence. Stress was also found as a risk factor in more recent studies (Kaufman et al., 2011; Morelli et al., 2020; Niu et al., 2018). After analyzing data from pilot project sites of the Safe Start Initiative, results revealed that in families where child abuse occurs, both the abusing parents and the children involved were exposed to clinically relevant levels of stress (Kaufman et al., 2011). The same study found that 50% of the maltreated children were aged 3 years or younger. Signs of FV victimization would thus not be noticed by school or kindergarten staff, as young children are not yet attending these institutions, meaning the abuse is more likely to stay invisible (Kaufman et al., 2011). Young child age was also found as a risk factor for the ITFV (Clément et al., 2012). Maternal depressive symptoms and daily stress were found to mediate the association between mothers' childhood history of abuse and their use of abusive parenting strategies as adults (Morelli et al., 2020). Parenting stress was revealed as a risk factor for psychological aggression and corporal punishment (Niu et al., 2018). Emotional dysregulation was found to be associated with psychological aggression (Rodriguez et al., 2021). The intergenerational transmission of emotional dysregulation can in turn be mediated by

family stress and authoritarian parenting (Shaw & Starr, 2019). Poor parenting style (lack of positive or supportive interactions) was also found as a risk factor for the ITFV by Dixon et al. (2009), along with the maltreated mother's young age (under 21 years) at birth of their child, alcohol or drug dependency, depression and other psychiatric diagnoses and the presence of a violent adult in the same household (Dixon et al., 2009). The use of illicit drugs (but not alcohol or marijuana), as well as mothers' young age, were revealed as independent risk factors in a study by Linscott (2018), whereas alcohol consumption was found to be associated with the ITFV by Frias-Armenta (2002), along with maternal anxiety, depression, and antisocial behavior (Frias-Armenta, 2002). Different types of mental illnesses were found as risk factors (Leifer et al., 2004; Grunsfeld, 2018; Plant et al., 2013; Williams, 2015; Yang et al., 2018). Anxiety (Grunsfeld, 2018) and PTSD symptoms (Leifer et al., 2004) in mothers with a childhood history of sexual abuse were found to be risk factors for sexual abuse of their children by a male perpetrator, representing a so-called victim-to-victim cycle (Marshall et al., 2022). At the same time, anxiety increased the likelihood of mothers' own perpetration of physical child abuse and neglect when a childhood history of sexual abuse was present (Williams, 2015). Maternal depression was found as a risk factor for the transmission of physical abuse and harsh discipline (Plant et al., 2013; Yang et al., 2018), as well as a mediator between mothers' childhood abuse experiences and their children's victimization (Choi et al., 2019). Harsh punishment of children mediated the association between parents' violence-related trauma and their children's victimization of sexual, psychological and emotional abuse, as well as neglect (Scheid et al., 2020). Anderson et al. (2018) found IPV-related PTSD symptoms as a risk factor for the ITFV. Maltreated mothers' adult IPV victimization has also been indicated to directly increase the risk for child maltreatment perpetration (Barrett, 2010; Jaffee et al., 2013). Homeless parents with a childhood history of maltreatment were found to be at increased risk for the ITFV if they experienced additional ACEs unrelated to their maltreatment victimization (Narayan et al., 2017). Exposure to community violence, referring to the observation of acts of physical violence in the neighborhood, was revealed as a risk factor in a study by Valentino et al. (2012). Clément et al. (2012) found an increased risk for the ITFV among parents who held positive attitudes towards violence and felt that the maltreatment they experienced during childhood was deserved. Troubled relationships with romantic partners were found to be a risk factor for child abuse

perpetration (Adams et al., 2019; Labella et al., 2019) and lack of supportive parenting (Labella et al., 2019). Berlin et al. (2011) found that mothers' lack of a social support and their aggressive response bias elevated the risk for child maltreatment experienced by their children. Lack of support from the family was identified as a risk factor for low-income families in a study by St-Laurent et al. (2019). Some studies also found the witnessing of IPV among parents as an independent risk factor for the transmission of other forms of FV (Barrett, 2010; Heyman & Slep, 2002). Significantly more negative attitudes towards women and feminine characteristics, substance use and behavioral problems were found among male perpetrators of IPV with a childhood history of FV victimization, suggesting such attitudes as a risk factor (Lee et al., 2013; Reitzel-Jaffe & Wolfe, 2001). Childhood experiences of adversity like abuse and neglect may also leave men and women more vulnerable to stressors that increase the risk of perpetrating IPV in adulthood, like poverty, unemployment, or interpersonal conflicts (Roberts et al., 2011). Results on delinquency as a risk factor appear mixed, with Augustyn et al. (2019) having found evidence for adolescent delinquency as a mediator and Capaldi et al. (2019) having found no such connection.

Past research has found a wide variety of adverse psychosocial factors associated with the ITFV. Many of them are indicated to directly or indirectly elevate the risk for ITFV, which is why interventions designed to prevent FV may aim to reduce these assumed risk factors.

Protective Factors

Initial findings indicated maltreated parents' involvement in psychotherapy, a positive relationship with a supportive nonparent adult (Egeland et al., 1988), the variety of sources of social support, optimistic attitudes, and the ability to recognize and set boundaries as protective factors (Hunter & Kilstrom, 1979). Social support was also found to be protective in more recent studies (Bartlett & Easterbrooks, 2015; Dixon et al., 2009; Tracy et al., 2018), although the protective effect of social support for mothers may be hampered by additional IPV victimization as an adult (Tracy et al., 2018). In addition to social support, individuals with more financial resources and socioeconomic status are less likely to perpetuate the cycle of FV (Dixon et al., 2009; Jaffee et al., 2013). Mothers giving birth at an older age were less likely to maltreat their children in a study by Linscott (2018). Mothers' communication

effectiveness was found to be protective against their children's victimization of sexual abuse (Testa et al., 2011), whereas positive care and support by the father was found to predict reduced risk of engaging in harsh physical discipline as an adult (Herrenkohl et al., 2013). A prospective study by Schofield et al. (2017) found that parents with a childhood history of harsh treatment were less likely to engage in harsh parenting themselves if they scored higher on self-control measures and had positive relationships with their romantic partners and their children. Positive partner relationships were found to be protective against the ITFV in multiple studies (Conger et al., 2013; Jaffee et al., 2013; Thornberry et al., 2013). Qualitative research suggests that grandparents of victimized grandchildren may be able to play a protective role (Gottzén & Sandberg, 2019). Grandchildren may also expect their grandparents to intervene against IPV between their parents (Åkerlund, 2019), but quantitative studies on potential protective effects are still lacking. Narayan et al. (2019) and Narayan et al. (2021) found that if traumatized people had elaborate positive memories of situations in which a caregiver was perceived as very kind and supportive, it had a protective effect against the intergenerational transmission of trauma, as well as the potential psychopathological consequences of child abuse. Mielke et al. (2020) found that mothers who did not develop mental disorders in response to the experience of violence in their childhood showed more maternal sensitivity, less hostility, greater involvement and more responsiveness towards their children than non-resilient mothers. The authors (Mielke et al., 2020) suggested that interventions should address resilience building as an overall characteristic to reduce the risk of transmitting violence to the next generation. Genç (2021) found psychological well-being in adolescence to be a protective factor against adult IPV perpetration and victimization. Previously unexpected factors that were found to be protective include authoritarian parenting attitudes among African American mothers (Valentino et al., 2012) and the use of marijuana (Linscott, 2018).

Similar to risk factors, protective factors may be targeted by preventive interventions with the aim to reduce the risk of ITFV. Several instances of this are found in the following section.

Intervention Types

Psychosocial interventions include psychotherapeutic, psychological, social work and other interventions aimed at behavior change through interpersonal

interaction (e.g., Cohen et al., 2006; England et al., 2015) and stand in contrast to violence response through incarceration or medication. This section provides an overview of interventions found to have beneficial effects on proxy measures or direct measures of FV. Since assessing perpetration and victimization of FV directly may be subject to biases (Bennett et al., 2006; Freeman et al., 2015; Henning et al., 2005), researchers frequently use risk and protective factors as proxy outcome variables. These proxy measures are assumed to be indicative of individuals' risk of FV perpetration or victimization (Ben-Arieh et al., 2009; Seff, 2022). Since studies usually do not follow the children of study participants until they become parents themselves (Berzenski et al., 2014), potential ITFV is commonly investigated by assessing caregivers' childhood history of FV victimization retrospectively. Examples of intervention evaluation studies that assessed such history are included in the following subsections.

Psychotherapy

Consciously processing the traumatic experience of violence (Hunter & Kilstrom, 1979) and the use of therapeutic help (Egeland et al., 1988) were among the first empirical findings regarding protective factors. Consequently, early research on interventions against the ITFV also dealt with psychotherapy (Leifer & Smith, 1990). In a quantitative single case study, Leifer & Smith (1990) found a decrease in physically abusive parenting practices, as well as improvements in sensitivity and responsiveness, in a young mother who had a childhood history of maltreatment and participated in psychotherapy. In more recent years, researchers found that receiving any psychotherapeutic services at any point in time after being physically abused in childhood may result in a lower likelihood of perpetrating violence as an adult (Maxwell et al., 2016). Different types of therapy have been evaluated within FV research. Consistent with the idea of increasing protective factors and reducing risk factors and thus building psychosocial resilience (Mielke et al., 2020), much emphasis has been put on improving the mental health of FV survivors.

Studies on Cognitive Behavioral Therapy (CBT) have found positive effects on mental health and psychological functioning outcomes for survivors of childhood sexual abuse (Mannarino et al., 2012; McDonagh et al., 2005) and childhood physical abuse (Kolko, 1996; Kolko et al., 2011). CBT was also found effective in

improving mental health outcomes of perpetrators of IPV (Easton et al., 2018; Nesset et al., 2021; Smedslund et al., 2011).

Specific Trauma-Focused CBT includes separate and conjoint sessions for traumatized children and their caregivers (Cohen et al., 2018). Trauma-Focused CBT sessions are structured around skills for mental stability, describing and processing the traumatic experience, overcoming overgeneralized fear and avoidance, and practicing caregiver-child communication (Cohen et al., 2018). A review of RCTs, systematic reviews and meta-analyses found strong evidence for the effectiveness of Trauma-Focused CBT in reducing PTSD symptoms among children and adolescents (de Arellano et al., 2014). One RCT (Jensen et al., 2017) found that reductions in PTSD and other mental health symptoms were maintained after 18 months post-treatment. Despite having been developed for the treatment of children, Trauma-Focused CBT is indicated to be valuable for adult recipients with trauma histories (Lowe & Murray, 2014).

Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (Ortigo et al., 2020) is a shorter, more modular adaptation of Trauma-Focused CBT, that does not include conjoint parent-child sessions. The concept combines learning and practicing skills for emotional regulation and navigating relationships with guided integration of traumatic experiences into the life narrative (Ortigo et al., 2020). STAIR Narrative Therapy has been found to be associated with decreased PTSD symptoms in child abuse survivors with moderate and high levels of depression (Cloitre et al., 2017).

Guild et al. (2017) recommended psychotherapeutic interventions based on attachment theory for ITFV prevention and the improvement of protective factors. For example, Child-Parent Psychotherapy was found to improve maternal perception of infant emotion in IPV survivors (Bernstein et al., 2019). And in a multi-case study on Parallel Parent-Child Psychotherapy (Furber et al., 2013), mothers with traumatic childhood experiences who had been maltreating their children showed improvements in mental health and parent-child relationship outcomes.

Emotion-Focused Therapy was suggested as a promising therapeutic approach against the ITFV by Lopes et al. (2019) and has been found to prevent recidivism in male perpetrators of IPV (Pascual-Leone et al., 2011), as well as reduce IPV and improve family functioning (Shahmoradi et al., 2019). Emotion-Focused

Therapy has also been found to reduce distress from interpersonal sources, improve mental health outcomes and facilitate trauma resolution in survivors of child abuse (Paivio & Nieuwenhuis, 2001; Paivio et al., 2010).

Art therapy is another type of psychotherapy indicated to be relevant for intervening against the ITFV (Lev-Wiesel et al., 2022; Zimeray, 2022). Art therapy may improve communication and relationship outcomes for couples in which the male partner engages in IPV (Tucker & Treviño, 2011), and is indicated to improve mental health outcomes and resiliency in adult survivors of FV (Ikonomopoulos et al., 2017).

Animal-Assisted Therapy has also been suggested as a promising approach against the ITFV (Parish-Plass, 2008). It has been found to reduce PTSD symptoms in child abuse survivors (Dietz et al., 2012; Naste et al., 2018; O'Haire et al., 2015; Signal et al., 2017). Animal-Assisted Therapy has also been found to decrease depression, anxiety, anger, and sexual concerns among survivors of childhood sexual abuse (Dietz et al., 2012) and to increase attachment security among traumatized adolescents (Balluerka et al., 2014).

An approach that specifically aims both to prevent violence in and improve the mental health of families experiencing FV is Multisystemic Therapy for Child Abuse and Neglect (MST-CAN; Buderer et al., 2020; Hefti et al., 2020; Swenson et al., 2010). MST-CAN is based on Multisystemic Therapy, which was originally designed for children and adolescents exhibiting severe antisocial behavior that puts them at risk of being separated from their families (Henggeler, 2017; Henggeler & Schaeffer, 2016). Treatment is provided by a multidisciplinary team of psychotherapists and psychiatrists, with the therapist visiting the family in their home. The team is available for consultation 24 hours a day and works with all family members, as well as their social network (Buderer et al., 2020; Henggeler & Schaeffer, 2016). MST-CAN has been found effective in reducing parental stress, child neglect, psychological aggression, minor assault, and severe assault (Buderer et al., 2020; Hefti et al., 2020; Swenson et al., 2010). MST-Building Stronger Families, an adaptation for substance using & abusive families, was found to be associated with reductions in child-reported neglect (Schaeffer et al., 2021), and in substantiated CPS reports for child maltreatment (Schaeffer et al., 2013).

ITFV Perspective. Regarding psychotherapy as an intervention against the ITFV, the literature often offers only incomplete evidence. In many studies with children, adolescents and adults, childhood FV victimization among participants was identified, but differences in subsequent FV perpetration in adulthood were not investigated. Examples can be found in research on CBT (e.g., McDonagh et al., 2005) and its various adaptations (e.g., Cloitre et al., 2017; Jensen et al., 2017), Parallel Parent-Child Psychotherapy (e.g., Furber et al., 2013), Emotion-Focused Therapy (e.g., Paivio et al., 2010), art therapy (e.g., Ikonomopoulos et al., 2017) and Animal-Assisted Therapy (e.g., Signal et al., 2017). Studies that did investigate differences in FV perpetration typically did not assess childhood FV victimization. Examples can be found in research on Emotion-Focused Therapy (Pascual-Leone et al., 2011; Shahmoradi et al., 2019), MST-CAN (Buderer et al., 2020; Hefti et al., 2020; Swenson et al., 2010) and MST-Building Stronger Families (Schaeffer et al., 2021; Schaeffer et al., 2013). Studies having assessed both childhood FV victimization and adult FV perpetration tend to be relatively dated (e.g., Egeland et al., 1988). The only example in the past decade (Maxwell et al., 2016) did not specifically assess FV perpetration and only asked study participants retrospectively whether or not they had perpetrated physical violence against any other person in adulthood. Additionally, none of these studies (Egeland et al., 1988; Leifer & Smith, 1990; Maxwell et al., 2016) specified the kind of psychotherapy that was delivered.

Relationship Violence Intervention Programs

Witnessing IPV between caregivers during childhood is one form of FV victimization found to be a starting point of the ITFV (Cannon et al., 2009; Godbout et al., 2019; Podaná, 2018; Scheid et al., 2020). Preventing IPV would thus be beneficial in preventing the ITFV. A substantial part of the IPV intervention landscape consists of specific relationship violence intervention programs (RVIPs). In many different forms, RVIPs have been implemented around the world, including Africa (McCloskey et al., 2016), Asia (Niaz & Tariq, 2017), Australia (Vlais et al., 2017), Europe (Hamilton et al., 2013; Lilley-Walker et al., 2018; Loncarevic & Reisewitz, 2016), North America (Cannon et al., 2016) and South America (Santoveña & da Silva, 2016). One survey (Cannon et al., 2016) located 3246 programs in Canada and the USA alone.

Originating from women's rights movements in the 1970s, RVIPs or "batterer intervention programs" were designed to bring about attitudinal and behavioral change in (often the male) perpetrators of IPV (Murphy et al., 2022). Many past and present RVIPs were and are based on the Duluth model of patriarchal power and control (Murphy et al., 2022). This model traditionally embraced a second-wave feminist view of all IPV as an expression of the patriarchal structure of society (e.g., Dobash & Dobash, 1981). The theoretical underpinnings of and research around RVIPs have since undergone significant change (Bohall et al., 2016; George & Stith, 2014; Snead et al., 2018), expanding beyond the gender essentialism of the past (George & Stith, 2014; Martinez, 2011; Murphy et al. 2022; Snead et al., 2018).

Duluth model-based programs usually emphasize the educational-correctional aspect of their approach and were designed as explicitly distinct from treatment-oriented approaches like psychotherapy (Murphy et al., 2022). In recent years, IPV interventions tended to be more eclectic in their inclusion of psychoeducational and therapeutic elements (Cannon et al., 2016; Murphy et al., 2022; Phillips et al., 2013). More programs have adopted the usage of CBT treatment models for IPV intervention, either instead of or in conjunction with variants of the Duluth model (Cannon et al., 2016; Murphy et al., 2022). RVIPs based on CBT aim to help perpetrators change dysfunctional cognitive and behavioral patterns related to their self, their partner and violence in their relationship (Babcock et al., 2016).

The evidence-base for RVIPs based on the Duluth model remains mixed, as there is evidence supporting their effectiveness in changing men's negative beliefs about women and gender-roles (Herman et al., 2014), while their effects on IPV recidivism were found to be small and not significantly different from arrest and other interventions (Babcock et al., 2004; Stover et al., 2009). However, the same reviews (Babcock et al., 2004; Stover et al., 2009) also found CBT-based RVIPs to have small effects on IPV recidivism that were not significantly different from arrest and other interventions. Wilson et al., (2021) conducted a systematic review of experimental and quasi-experimental evaluation studies on court-mandated RVIPs for male perpetrators, including Duluth model- and CBT-based programs. For both study design categories, the meta-analysis found no significant beneficial effects on future IPV perpetration in studies using official reports, as well as victim reports (Wilson et al., 2021). The authors concluded by encouraging new research on innovative intervention approaches (Wilson et al., 2021).

Preliminary research on RVIPs based on Acceptance and Commitment Therapy (ACT; Hayes & Pierson, 2005) has shown promising results (Zarling et al., 2019; Zarling & Russell, 2022). ACT is a therapeutic approach based on mindfulness, experiential learning, and values-based behavior (Hayes & Pierson, 2005). Adaptations of ACT for IPV interventions devote specific sessions to values around gender, relationships and parenting, learning to step back from problematic thoughts, and mindful acceptance of traumatic experiences that can impact adult life (Zarling & Berta, 2017).

A non-randomized pilot study (Zarling et al., 2019) on the effects of Achieving Change Through Values-Based Behavior (ACTV), an ACT-based intervention, found significantly lower rates of criminal charge recidivism at 12-month follow-up among court-mandated ACTV participants than among participants in court-mandated RVIPs based on the Duluth model or CBT. A later RCT (Zarling & Russell, 2022), found no differences in criminal charges related to IPV between ACT-based and Duluth model-based RVIPs at 12-month follow-up. However, ACT participants were significantly less likely to receive criminal charges overall and victim reports indicated significantly lower rates of IPV perpetration at 12-month follow-up (Zarling & Russell, 2022).

Contemporary group CBT- and other mindfulness-based RVIPs that focus on perpetrators who voluntarily participate have also been indicated to be effective in reducing IPV as reported by perpetrators themselves (Easton et al., 2018; Nesset et al., 2020; Palmstierna et al., 2012) and their partners (Nesset et al., 2020). Individual psychotherapy with voluntary participants at the Norwegian Alternative To Violence (ATV) clinic has also been indicated to reduce IPV perpetration based on reports of perpetrators and their partners (Askeland et al., 2021). Psychotherapy at ATV employs an eclectic approach, integrating strategies from CBT and gender based IPV prevention (Askeland et al., 2021). Principles of ATV have been adapted for couple therapy in Finland, but related research has been primarily qualitative so far (Vall et al., 2018). Voluntary couples therapy in the US has been indicated to reduce situational IPV and maintain this effect at 12–18-month follow-up (Bradley et al., 2014; Bradley et al., 2012).

ITFV Perspective. Literature reviews have indicated ACT-based interventions (Reardon et al., 2020), voluntary IPV interventions that incorporate mindfulness into CBT (Mitchell & Wupperman, 2022) and voluntary couples therapy (Karakurt et al.,

2016) for IPV to be beneficial. However, their impact on the ITFV has not been explored by research. Although not all RVIPs do this, perpetrators' childhood FV victimization and trauma are, for instance, addressed in the treatment protocol of ACT-based RVIPs (Zarling & Berta, 2017). Yet, the presence of childhood FV victimization experiences and their potential effects on FV reduction outcomes have so far not been assessed in studies on novel RVIPs (e.g., Nessel et al., 2020; Zarling & Russell, 2022), prohibiting them from exploring the interventions' potential in disrupting the ITFV. A qualitative UK study found that practitioners working in RVIPs were divided on the topic of ITFV (Wagner et al., 2019). While some believed that a childhood history of FV victimization may influence adult perpetration, others believed that no such transmission exists (Wagner et al., 2019). Childhood trauma and FV victimization have been found to be associated with adult IPV perpetration (Fowler et al., 2016; Gilbar et al., 2019; Maldonado & Murphy, 2021; Semiatin et al., 2017). Thus, future research on novel approaches to RVIPs may benefit from exploring the effects of childhood trauma related to violence and the potential of RVIPs to break the ITFV.

Home Visitation, Parenting and Enhanced Care Programs

Research around FV prevention has been conducted on a variety of manualized psychosocial interventions that do not necessarily require professional psychotherapists but can instead, for example, be implemented by paraprofessional staff and scaled up more easily, as is outlined in this section.

Interventions Found to Impact Proxy Measures of FV. One of the earliest parenting programs is the Systematic Training for Effective Parenting (STEP; Dinkmeyer & McKay, 1975). The group-based program relies on parental education about child behavior and relationship dynamics and was designed to be facilitated by paraprofessionals (Dinkmeyer & McKay, 1975). A meta-analysis of multiple STEP instances found that their positive post-completion effects on child behavior change, parental attitudes and parent-child interaction tended to diminish at long-term follow-up (Gibson, 1993). Nonetheless, STEP is still in use and has been found to reduce child abuse potential and increase positive perceptions of child behavior (Fennel & Fishel, 1998). Implementation of STEP in Lithuania has been found to reduce authoritarian and permissive parenting styles, and to reduce negative perception of child behavior (Jonyniene et al., 2015). Studies of Iranian mothers (Saadati et al.,

2020a; 2020b) have found the program to improve cognitive flexibility (Saadati et al., 2020a; 2020b), decrease parenting stress and improve emotion regulation (Saadati et al., 2020a), as well as improve parenting self-efficacy (Saadati et al., 2020b).

A US-based RCT (Steele et al., 2019) comparing STEP to the Group Attachment-Based Intervention (GABI; Murphy et al., 2015) found GABI to be superior to STEP in improving parenting outcomes for mothers at risk of maltreating their offspring. GABI is a clinic-based, trauma-informed group intervention for parents and their children, designed to be implemented by clinicians and graduate students (Murphy et al., 2015). Group sessions are offered multiple times every week over 6 months and work with video feedback. Specifically, interactions filmed during parent-child sessions are reviewed under supervision in parent-only group sessions (Murphy et al., 2015; Steele et al., 2019). The RCT by Steele et al. (2019) found GABI to reduce maternal hostility and increase mothers' supportive presence, as well as reduce constriction and increase reciprocity within the mother-child dyads.

New Beginnings also targets attachment (Baradon et al., 2017; Sleet et al., 2013). The highly manualized group intervention is aimed specifically at incarcerated mothers and their infant children (Baradon et al., 2017). Group sessions delivered by psychologists and social workers in the prison context focus on improving relationship and attachment outcomes for the mother-child dyads (Baradon et al., 2017). New Beginnings was found to have positive effects on maternal reflective functioning and parent-child interaction in an RCT (Sleet et al., 2013).

Another group-based approach is the Heart and Shield (H&S) family violence prevention program, directed at adult survivors of IPV and their exposed children (Baker-Tingey et al., 2018). H&S employs psychoeducational elements, skills training and group-based exchange with other survivors. After a 5-year implementation period, preliminary evidence from an evaluation report indicated improvements to parent-child interaction, positive parenting and parental self-regulation (Baker-Tingey et al., 2018). Facilitators were faculty and assistants from the University of Nevada, Reno Cooperative Extension program (Baker-Tingey et al., 2018).

Mothers in Mind (Fogden et al., 2018) was designed for mother-child dyads experiencing IPV, who are under CPS investigation. The program addresses the potentially traumatic impact witnessing IPV can have on young children (ages 0-4), and aims to strengthen the mother-child relationship in order to improve mental

health outcomes for both mother and child (Jenney et al., 2022; Fogden et al., 2018). The clinician-supervised sessions use dyadic play and group discussions of traumatic experiences (Jenney et al., 2022; Fogden et al., 2018). A preliminary study indicated beneficial effects on positive parenting, parenting efficacy and mothers' mental health (Jenney et al., 2022).

The Australian intervention Tuning Relationships with Music (TRM; Colegrove et al., 2019b) is aimed at parents with a childhood history of FV victimization and their children. TRM is an eight-session therapeutic intervention utilizing music instruments, designed as a precursor to psychotherapy (Colegrove et al., 2019b). The structured sessions focus on teaching the parent-child dyads skills around emotional regulation, recognizing trauma responses, verbal and nonverbal communication, and problem-solving (Colegrove et al., 2019b). A pilot RCT with mothers and their adolescent children (Colgrove et al., 2018; Colegrove et al., 2019a) indicated TRM to reduce parent-child conflict and to increase maternal nonverbal communication and emotional responsiveness.

Frühe Hilfen is an umbrella network encompassing early intervention programs in German-speaking countries (Taubner et al., 2013; Taubner et al., 2015; Weber et al., 2012). Professionals can take Frühe Hilfen educational courses online (Weber et al., 2012). The programs offer varying combinations of psychological support, parenting skills training and enhanced early health care services for caregivers and their children (ages 0-3), beginning in the prenatal phase (Taubner et al., 2015). In a meta-analysis (Taubner et al., 2015), the Frühe Hilfen interventions were found to reduce maternal symptom burden and to slightly improve competency among participating mothers.

Developed in the Netherlands, Feel the Violence Beaten (Feel the ViBe; van Rosmalen-Nooijens et al., 2017; van Rosmalen-Nooijens et al., 2013) is an internet-based self-support method for children, adolescents and young adults exposed to IPV between their caregivers and other forms of FV. The intervention consists of an online platform offering several features. These include written information on IPV, sexual health, reproductive health and health care, a forum to facilitate peer support, themed group-chat sessions, and an "Ask the Expert" feature providing the possibility to direct specific questions at a general practitioner, a sexologist, a psychologist, and an FV expert (van Rosmalen-Nooijens et al., 2017). Feel the ViBe was associated

with reductions in depression and anxiety in a study with adolescents and young adults (ages 12-25) exposed to FV (van Rosmalen-Nooijens et al., 2017).

Interventions Found to Impact Direct Measures of FV. In addition to the research on manualized and public health intervention programs mentioned above that focused primarily on proximal factors related to FV prevention, there is also a substantial number of studies on psychosocial interventions comprised with the express purpose of FV prevention that assessed direct measures of FV as outcome variables. Earlier studies on the efficacy of home visitation and parenting programs have produced mixed results (Barth, 1991; Barth et al., 1988; Olds et al., 2000; Stevens-Simon et al., 2001). For example, Barth (1991) and Barth et al. (1988) collected high ratings of participant satisfaction but did not find significant differences in reports of child abuse between intervention and control groups.

Over the past decades, the body of literature has grown, and meta-analytic studies have supported the efficacy of home visitation and parenting programs (Altafim & Linhares, 2016; Avellar & Supplee, 2013; Chen & Chan, 2016; Coore-Desai et al., 2017; Mikton & Butchart, 2009) in reducing child maltreatment. Efficacy and effectiveness in primary FV prevention and prevention of FV recurrence has been studied for a number of manualized intervention schemes. An overview is provided below.

The Nurse Family Partnership (NFP) is a US-based primary prevention program for first-time mothers from low-income families (Eckenrode et al., 2017; Olds, 2006). Participants are connected to trained nurses who visit them in their homes on a regular basis, starting during pregnancy and continuing through infants' early years. NFP was designed to improve maternal and child health outcomes, as well as parenting competency (Olds, 2006). In addition to positive maternal life course outcomes, RCTs have found participation in the NFP program to be associated with fewer child injuries and fewer child protective service (CPS) reports for abuse or neglect (Eckenrode et al., 2017; Olds, 2006), as well as fewer cases of preventable-cause child death (Olds et al., 2014). VoorZorg, an adaption of the NFP program in the Netherlands, has been found to reduce the number of CPS reports for first-time mothers (Mejdoubi et al., 2015).

Healthy Families New York (HFNY; DuMont et al., 2010; Kirkland et al., 2020) is one example of several state-level instances of the Healthy Families America

(HFA) home visitation program (Harding et al., 2007). It bears similarities to the NFP program (Olds, 2006) in that it also provides mothers with regular home visits and was designed to improve a variety of parent and child outcomes related to physical and mental health, as well as parenting practices (DuMont et al., 2010). However, instead of professional nurses, HFNY employs paraprofessional service providers and is not restricted to first-time mothers (DuMont et al., 2010). The results of multiple RCTs have supported the program's effectiveness in reducing the frequency and prevalence of abusive behaviors (DuMont et al., 2010; DuMont et al., 2008; Kirkland et al., 2020), reducing engagement in harsh parenting among young, first-time mothers (DuMont et al., 2008; Rodriguez et al., 2010), as well as reducing the number of CPS reports for abuse recurrence (DuMont et al., 2010).

Hawaii-based Healthy Start (Duggan et al., 1999) was an earlier instance of the home-visitation program that had later been upscaled and implemented in many states throughout the USA under the name HFA (Harding et al., 2007). While participation in Healthy Start was found to be associated with improvements to several maternal health and functioning outcomes, no reduction in instances of FV was observed by Duggan et al., (1999). A later analysis by Bair-Merritt et al. (2010) found short-term reductions of IPV victimization and perpetration among intervention mothers, but no long-term benefits. And a retrospective study (Dew & Breakey, 2014) found that hospitalizations, which may be related to child maltreatment, did occur less often among Healthy Start families compared to unserved families. Bugental et al. (2002) examined the effect of adding a cognitive component to the program. The intervention consisted of cognitive retraining, countering parental misattributions of their children's communicative cues, and pragmatic problem-solving training addressing parent-child conflict situations (Bugental et al., 2002). Significant reductions in harsh parenting and physical abuse were found for mothers receiving the cognitive intervention in addition to regular Healthy Start services (Bugental., 2002). Informed by the NFP and HFA programs, the Early Start program in New Zealand has been found to reduce self-reported perpetration of physical child abuse, but not the number of CPS reports (Fergusson et al., 2005).

The Family Home Program (FHP) is a residential care program (Daly & Thompson, 2022; Huefner et al., 2007; Lazerle et al., 2004), run by Christian non-governmental organization "Boys Town". The program places youth with mental health problems or histories of delinquency into model families. Groups of up to eight

boys and girls (10-18 years old) live with a married couple ("Family Teachers") that takes care of them, aided by a full-time assistant ("Assistant Family Teacher"; Daly & Thompson, 2022). The program was designed to help at-risk youth with positive relationship building, positive social conduct and religious values-based morale development. In a long-term follow-up study of participants at elevated risk of IPV perpetration (Huefner et al., 2007), instances of adult IPV perpetration (16 years after program participation) were compared to US national normative rates (Bumpass & Sweet, 2018; Bumpass et al., 2017). The study found that IPV rates among individuals who had received treatment-as-usual (TAU) in their youth were significantly higher than the US national norm, whereas FHP participants did not differ from the national norm (Huefner et al., 2007). FHP participants with a childhood history of maltreatment also showed a rate of adult IPV perpetration that was significantly lower than the expected US national rate for individuals with a childhood history of maltreatment (Huefner et al., 2007).

Incredible Years (Webster-Stratton & Reid, 2017) is a program originally designed for children with conduct disorders, that has been adapted to provide training for parents, children, and teachers. The program can be implemented by therapists, as well as counselors, social workers, nurses, teachers, and physicians who received the required training (Webster-Stratton & Reid, 2017). In a study of children with oppositional defiant disorder (ODD) and their families (Webster-Stratton et al., 2004), the Incredible Years parent training was found efficacious in improving positive parenting, as well as reducing negative parenting, including physical and verbal aggression. An adaptation for maltreating families (Webster-Stratton, 2014) works with groups of parents that focus on learning positive, nonviolent parenting through video modeling. Incredible Years for maltreating parents has been found to improve positive parenting (Hughes & Gottlieb, 2004; Hurlburt et al., 2013), as well as improve discipline competence and reduce harsh/critical communication among parents with childhood histories of maltreatment (Hurlburt et al., 2013).

The Safe Environment for Every Kid (SEEK) model in the USA is aimed at preventing child maltreatment by providing pediatricians with specific maltreatment-related training and giving parents the option to receive additional support from a behavioral or mental health professional (Dubowitz, 2020; Dubowitz et al., 2009). SEEK training was found to increase child health care professionals' confidence in addressing issues related to child maltreatment with their patients (Dubowitz et al.,

2011). In a study by Dubowitz et al. (2009) the intervention was implemented through residents of a pediatric continuity clinic and program social workers. Participants were parents and their young children aged 0-5. The study (Dubowitz et al., 2009) found reductions in harsh punishment and outcomes related to medical neglect, as well as fewer CPS reports in the intervention group receiving SEEK model care. Another RCT (Dubowitz et al., 2012) found the implementation of SEEK in pediatric practices to be associated with fewer instances of psychological aggression and minor assault in a low-risk population. SEEK may be utilized across different settings, including family practices and health centers (Eismann et al., 2019). In addition to the US, the model is currently being implemented in Sweden (Engström et al., 2022).

SafeCare (Self-Brown et al., 2014) is a behavioral skills training program provided in the family home. The program may be delivered by health care professionals and paraprofessionals alike (Self-Brown et al., 2014). Parents are trained in positive and nonviolent parent-child interaction, identifying and responding to their children's medical needs, as well as identifying and removing child safety hazards in the home (Self-Brown et al., 2014). Parents receiving SafeCare have been found to receive fewer CPS reports in studies investigating recidivism of abuse and neglect (Chaffin et al., 2012; Gershater-Molko et al., 2002). A SafeCare adaptation for the high-risk population in a rural US-area was examined for its FV prevention potential, compared to TAU (Silovsky et al., 2011). For families receiving SafeCare, the study observed fewer child welfare reports related to child exposure to IPV between caregivers, but no difference was found in the overall number of reports (Silovsky et al., 2011). Across six different implementations of the SafeCare model, Rogers-Brown et al. (2020) found that the program effects significant change in the targeted parent behaviors. SafeCare has also been adapted to specifically target fathers (Self-Brown et al., 2015), but evidence for the adaptation's efficacy in reducing child maltreatment perpetration appears mixed (Self-Brown et al., 2017; Self-Brown et al., 2018).

For Baby's Sake (Rees & Evans, 2021; Trevillion et al., 2020) is a trauma-informed FV prevention program based in the UK, working with mothers and fathers who wish to co-parent their children, independent of whether or not they choose to live as a couple. The program delivers psychoeducational and therapeutic support for parents, starting during pregnancy and continuing until 2 years after childbirth. For Baby's Sake is explicitly aimed at preventing the ITFV, including the recurrence and

first-time occurrence of both child maltreatment and IPV (Trevillion et al., 2020). Content is partly universal and partly tailored to the male and female parent's perspective respectively (Trevillion et al., 2020). Professional and paraprofessional practitioners aid participants in acknowledging abusive behaviors, addressing the parents' own ACEs and traumata (and the emotional needs arising from them), as well as developing positive parent-child interaction (PCI) on the basis of parenting skills (Trevillion et al., 2020). For Baby's Sake is funded by the UK-based charity organization Stefanou Foundation (Trevillion et al., 2020). Evaluation of the program is still in a preliminary phase, but pilot studies have indicated that participants appreciated the whole-family approach and the voluntary character (Domoney et al., 2019) and that fathers participating in For Baby's Sake have started considering their conceptions of fatherhood, as well as their own experiences with and attitudes towards violence (Domoney & Trevillion, 2021). Preliminary reports indicated a reduction in the number of families whose children were under safeguarding supervision by the end of the program (Rees & Evans, 2021; Trevillion et al., 2020).

The Responsible, Engaged, and Loving (REAL) Fathers Initiative (Ashburn et al., 2017; U.S. Agency for International Development [USAID], 2021c) consists of a parent mentoring program and public poster campaign aimed at preventing IPV and violent discipline of children. Community volunteers are trained to mentor young fathers, educating them on nonviolent discipline strategies and positive partner communication (Ashburn et al., 2017). In parallel, posters portraying positive examples of fathers engaging in childcare are portrayed in public (Ashburn et al., 2017). Participation in the program was found to be associated with reductions in IPV perpetration and physical child punishment in a pilot study in Uganda (Ashburn et al., 2017). The program is currently being adapted for implementation in India (USAID, 2021a; 2021b).

Parenting for Lifelong Health (PLH) encompasses four parenting programs sponsored by the European Union, the World Health Organization and the South African Ilifa Labantwana Fund: PLH for Infants (Fearon et al., 2017; Murray et al., 2016a), PLH for Toddlers (Murray et al., 2016b; Vally et al., 2015), PLH for Young Children (formerly Sinovuyo Caring Families Program for Young Children; Lachman et al., 2017; Ward et al., 2020) and PLH for Teens (formerly Sinovuyo Teen; Cluver et al., 2018; Cluver et al., 2016). The latter two aim to prevent FV by helping parents and caregivers learn skills around positive relationship-building, limit-setting and

strategies for nonviolent discipline (Cluver et al., 2018; Ward et al., 2020). The adolescent children (ages 10-17 or 10-18) participate in group discussions in PLH for Teens, both during joint sessions and separate teen sessions (Cluver et al., 2018; Cluver et al., 2016). In PLH for Young Children, all sessions are delivered to the parents and caregivers, some including the child (ages 3-8 or 2-9) and others not (Lachman et al., 2017; Ward et al., 2020). The developers adopted elements of evidence-based interventions from high-income countries into a group-based framework suitable for the cultural and economic context of low- and middle-income countries (Lachman et al., 2017). For example, the strategies learned require little to no material resources and session content is adapted to the local cultural context by incorporating folk stories and images of typical families in the respective region (Lachman et al., 2017). Similar to the REAL Fathers Initiative (Ashburn et al., 2017), instead of facilitators with a professional background in psychology, social work or health care, both programs offer training to community volunteers who then become facilitators (Cluver et al., 2018, Lachman et al. 2017). When infrastructure for video presentations was not available, the programs used role-playing (Cluver et al., 2018; Cluver et al., 2016), and learning material was adapted to low literacy populations (Cluver et al., 2018; Ward et al., 2020). In a preliminary study (Lachman et al., 2017), PLH for Young Children was found to increase engagement in positive parenting but did not reduce harsh parenting. Ward et al. (2020) found participation in the program to be associated with reductions in physical and psychological discipline. PLH for Teens was found to reduce child abuse, as indicated by caregiver and adolescent reports in one study (Cluver et al., 2016). Reductions in child abuse and corporal punishment were also found in another, though only as reported by caregivers but not by adolescents (Cluver et al., 2018).

Parent-Child Interaction Therapy (PCIT) is implemented by psychotherapists, but its highly manualized nature placed it more in line with skills-focused parenting programs than with traditional forms of psychotherapy (Batzler et al., 2018; Kennedy et al., 2016; Lieneman et al., 2017; Warren et al., 2022). The treatment model includes two phases, based on dyadic play and skills training, wherein the parent receives live coaching by the psychotherapist. One phase is centered around child-directed interaction, designed to foster positive interaction and attention. The other is centered around parent-directed interaction, designed to teach the parent effective instruction and nonviolent discipline strategies to deal with difficult child behavior

(Lieneman et al., 2017; Warren et al., 2022). For maltreating families, more attention is placed on parental than child behavior change (e.g., Chaffin et al., 2011). PCIT has been found to be effective in reducing physical child abuse (Chaffin et al., 2004) and child abuse potential (Thomas & Zimmer-Gembeck, 2011). In a study with foster parents (Mersky et al., 2015), parts of the PCIT program were delivered in groups and participants received additional telephone consultation. Significant reductions in negative parenting were observed (Mersky et al., 2015), both for a group receiving 8 weeks and another receiving 14 weeks of PCIT. Hakman et al. (2009) found that significant reductions in negative parenting behaviors may already occur in the early stages of treatment. However, PCIT program completion was found to be associated with fewer child welfare reports compared to non-completion (Thomas & Zimmer-Gembeck, 2011). The addition of self-motivational group-sessions before the start of PCIT was associated with reduced child welfare recidivism compared to service-as-usual (Chaffin et al., 2011). Caregivers' childhood victimization and history of perpetration of FV were both found to be associated with more child welfare reports after PCIT completion (Lanier et al., 2014). On the other hand, an exploratory study (Blair et al., 2019) indicated that children whose caregivers had been exposed to four or more ACEs appeared to benefit more from PCIT than when parental levels of childhood adversity were lower.

Developed by the American Psychological Association, another highly manualized program is Adults and Children Together (ACT) Raising Safe Kids (formerly ACT Parents Raising Safe Kids; Porter & Howe, 2008). Implemented by psychologists with certified training, the group-based parenting program includes eight sessions with the explicit aim to prevent child abuse and neglect (Porter & Howe, 2008). Parents are educated about mechanisms around children's exposure to violence, children's communication, anger management and nonviolent discipline, and receive home assignments to put the knowledge into practice (Porter & Howe, 2008). ACT Raising Safe Kids has been found to reduce physical punishment (Knox et al., 2011; Porter & Howe, 2008; Portwood et al., 2011), reduce harsh verbal discipline and increase nurturing behavior (Portwood et al., 2011). The program was also found to be associated with beneficial effects for mothers with a childhood history of FV victimization or witnessing IPV (Altafim et al., 2021). In the study by Altafim et al. (2021), participants with such histories and those without saw the same increase in positive parenting, improved parent-child communication, as well as

improvements to their ability to regulate behaviors and emotions (Altafim et al., 2021). Participants' perpetration of FV was not assessed (Altafim et al., 2021). A systematic review of studies evaluating ACT Raising Safe Kids (Pontes et al., 2019) revealed that all articles found beneficial effects, including decreases in corporal punishment. However, a pilot observational study (Pontes & Brino, 2022) found no differences in observed parent-child interaction between the intervention group receiving ACT Raising Safe Kids and the wait-list control group. The authors concluded that further observational research is warranted (Pontes & Brino, 2022). ACT Raising Safe Kids has been implemented in several different regions, including the United States, Portugal, Japan and Brazil (Howe et al., 2017). The program is indicated to be feasible for online implementation (Lotto et al., 2022).

ITFV Perspective. The primary aim of many home visitation, parenting and enhanced care programs mentioned above is the prevention or reduction of FV perpetration and some program protocols even address the participants' childhood history of FV victimization as an important factor in the intervention process (e.g., For Baby's Sake; Trevillion et al., 2020). But research does not always examine the characteristics required to draw conclusions about an intervention's potential to prevent the ITFV. Some studies on manualized psychosocial interventions use direct measures of FV perpetration as outcomes but do not specifically assess participants' childhood history of FV victimization (e.g., Silovsky et al., 2011). Instead, these studies may report some variant of a composite risk score, that may include childhood history of FV victimization, but typically also includes other risk factors like substance use, mental health problems or socioeconomic factors (Geeraert et al., 2004). Others do specifically assess victimization history, but the parenting behaviors examined as outcomes (e.g., criticizing the child; parent-child conflict) do not classify as FV perpetration (e.g., Colgrove et al., 2018; Hurlburt et al., 2013). A pre-post-test study on PLH for Teens (Cluver et al., 2016) collected information on the childhood history of FV victimization among participating caregivers and used direct measures of FV as outcomes, but did not examine potential differences in FV reduction between maltreated and non-maltreated caregivers. The same is true for a number of studies that examined program effects on FV prevention or reduction for participants receiving the intervention of interest and for a comparison group provided standard treatment or a wait list condition (e.g., Ashburn et al., 2017; Bugental et al., 2002; DuMont et al., 2008). More illuminating results can be produced by studies

comparing the results of participants with a childhood history of FV victimization to those without (e.g., Huefner et al., 2007).

Study Objectives

As is outlined in the preceding sections, proxy measures of FV are widely used instead of direct measures of FV in research on interventions against the ITFV. Nonetheless, there is a substantial and growing body of literature including direct measures of FV perpetration, which ultimately allows researchers to make more definitive statements about the effectiveness of FV prevention efforts and is also the interest of the present review. However, only a subsection of these studies assessed the perpetrators' childhood history of FV victimization.

Past systematic reviews and meta-analyses of psychosocial interventions for individuals with a childhood history of FV victimization did not investigate intervention effects on adult FV perpetration, but examined mental health outcomes instead (Cohen et al., 2006; Ehring et al., 2014; Leenarts et al., 2013; Lindert et al., 2020).

Past systematic reviews and meta-analyses of psychosocial interventions that investigated intervention effects on adult FV perpetration, did not examine information on study participants' childhood history of FV victimization (Altafim & Linhares, 2016; Avellar & Supplee, 2013; Chen & Chan, 2016; Coore-Desai et al., 2017; Lundahl et al., 2006; Mikton & Butchart, 2009; Turner et al., 2020) with only one exception (Geeraert et al., 2004). One meta-analysis (Geeraert et al., 2004) reviewed child abuse interventions for caregivers „at risk” of FV perpetration. Factors constituting this risk included caregivers' childhood FV victimization, but also their mental health problems, substance use, negative attitudes towards the child, unwanted pregnancy, lack of social support and financial problems (Geeraert et al., 2004). The outcome examined in the meta-analysis was limited exclusively to first-time perpetration of physical child abuse (Geeraert et al., 2004).

To the author's knowledge, the present study is the first to systematically review the literature on psychosocial interventions for individuals with a childhood history of FV victimization and their efficacy and effectiveness in FV prevention or reduction. Since the number of studies matching eligibility criteria was expected to be small and their characteristics heterogenous, narrative synthesis of review results was employed instead of meta-analysis.

The present systematic review aimed at (1) identifying studies that used direct measures of FV to evaluate the efficacy or effectiveness of psychosocial interventions in preventing the occurrence or reducing recurrence of FV perpetration by individuals with a childhood history of FV victimization, (2) synthesizing reported effectiveness and characteristics of the interventions by narrative synthesis for quantitative data, and exploratively reviewing (3) how the relationship between childhood history of FV victimization and adult FV perpetration (ITFV) was assessed, (4) if and how intervention impact on the ITFV was examined and (5) if and how the impact of the ITFV on study efficacy or effectiveness was examined in the identified studies.

Methods

Eligibility Criteria

Studies were selected using to the inclusion and exclusion criteria described here, in accordance with the PRISMA-P 2015 guidelines (Moher et al., 2015).

Study Designs

Studies that collected quantitative data were included. Studies that collected qualitative data were excluded. Study designs had to be RCTs or quasi-experimental studies (QESs) with any form of comparison group in order to be included. Excluded were QESs without comparison, single case studies, cross-sectional studies, cohort studies and purely descriptive reports.

Participants

Study participants' childhood history of FV victimization had to be assessed either as a demographic variable, grouping variable, intervention inclusion prerequisite or study inclusion prerequisite. Population-based studies found childhood FV victimization rates of around 10-12% (Armfield et al., 2021; Finkelhor et al., 2014). Since FV is typically underreported (Follingstad & Rogers, 2013; Jordan & Steelman, 2015; Widom & Shepard, 1996), the more conservative number (12%) was used as a cut-off value for inclusion/exclusion. For inclusion, study participants' childhood history of FV victimization had to be found in at least 12% of the study sample or subgroup with victimization history. In studies eligible for inclusion, types of childhood FV victimization had to include emotional, psychological, or physical violence, sexual abuse, neglect, witnessing IPV or an unspecified umbrella variable

denoting any kind of childhood FV victimization. Studies were excluded if participants' childhood history of FV victimization had not been assessed or had been assessed but was found in less than 12% of the study sample.

Interventions

Included studies had to evaluate psychosocial interventions, including psychotherapy, as well as psychological, social work, enhanced primary care and public health approaches with FV prevention or reduction as either a primary or secondary aim. Studies on intervention types that provide violence response through incarceration (Stansfield et al., 2022) or medication (e.g., Eichelman, 1988; Walsh et al., 2004) were excluded.

Comparison Groups

Studies had to employ some form of control or comparison group (e.g., intervention vs. no intervention; maltreated vs. non-maltreated) to be included. Studies without comparison groups were excluded.

Outcomes

Study outcomes had to include either the first-time occurrence or recurrence of FV. The outcome FV had to be perpetrated in adulthood against a child or intimate partner. The outcome FV had to include emotional, psychological, or physical violence, sexual abuse, neglect, IPV or an unspecified umbrella variable denoting any kind of FV. Study outcomes had to be measured by either perpetrator report, victim report, researcher or intervention facilitator observation, or agency report. The search was not limited to specific instruments like the Conflict Tactics Scales (CTS; Straus, 1979) or the Severity of Violence Against Women Scales (SVAWS; Marshall, 1992), because this review's eligibility criteria were already very narrow, and the body of literature was expected to be small. Excluded were studies with outcomes that did not include primary prevention or reduction FV recurrence. Studies with elder abuse (Pillemer et al., 2016) or sibling violence (Perkins & Grossman, 2019) as their only outcome were excluded, since research suggested very different dynamics of transmission for these types of FV (Perkins et al., 2018).

Language

Publications in English and German language were included.

Publication Type

Since the means for quality assessment are limited in a systematic review conducted by only one author, only studies published in peer-reviewed journals were included. This decision was made to ensure a minimum of methodological quality in all included articles. Only original intervention studies were included. Other articles like editorials, conference papers, reviews and meta-analyses were excluded.

Information Sources

Three electronic databases (PsycINFO, PubMed & SCOPUS) were searched. PsycINFO was selected for psychological literature, PubMed for clinical literature, and SCOPUS for social and health science literature. Additionally, the reference lists of included studies were screened, as well as the articles included in relevant reviews identified by database searches. Databases were accessed through the u:access service provided the University of Vienna.

Search Strategy

PsycINFO was searched with the following search string: (intervention* OR therap* OR psychotherap* OR prevent* OR program*) AND ("intergenerational transmission" OR "cycle of") AND ("domestic violence" OR "family violence" OR "sexual violence" OR "emotional violence" OR "psychological violence" OR abuse OR maltreat* OR neglect* OR ipv OR "intimate partner violence"). The operators were adapted to equivalently fit PubMed and SCOPUS searches respectively. The search in PsycINFO was limited to English and German language publications, as well as peer-reviewed journals. The searches in PubMed and SCOPUS were limited to English and German language publications, but the option to limit to peer-reviewed journals was not available for either of the two databases. Searches were not limited to any specific time of publication, in order to capture both older and newer intervention approaches. Searches were performed for the first time on October 1, 2021, and last updated on June 30, 2022.

Study Records***Data Management***

Acquired documents were collected and sorted via bibliography management software Zotero, version 5.0 (Roy Rosenzweig Center for History and New Media,

2017). Relevant data items were collected in a Microsoft Excel spreadsheet. Automatic deduplication was not performed. Instead, all three databases were manually screened for inclusion.

Selection Process

Articles to include were selected by the author. Titles and abstracts of all references returned by database searches were screened against the eligibility criteria. All articles that were not excluded after title and abstract screening were subjected to full text screening. Specifically, many abstracts did not reveal whether or not study participants' childhood history of FV victimization was assessed. In this case, articles were subjected to full text screening.

Data Collection Process

Automatic data extraction by Zotero was supplemented by manual data extraction from full text versions of included articles. Contacting study authors to obtain missing information was omitted because of time and resource limitations.

Data Items

The following data items were collected, if available: Title, year of publication, name(s) of author(s), location, sample size, gender of participants, age of participants, child age, role of participants (e.g., biological parent, other caregiver), percentage of participants who reported childhood history of FV victimization, name of intervention, type of intervention (e.g., home visitation, parenting program, psychotherapy), indication (*universal prevention* for all families, *selective prevention* for families classified at risk of FV perpetration, or *indicated prevention* targeting prior perpetrators; e.g., O'Connell et al., 2009; Sheffield et al., 2006; Simon et al., 2009), outcome(s) representing FV, measure(s) of outcome(s) representing FV, study design, type of comparison group(s), measurement time points (e.g., baseline, end-line, 1-year follow-up), statistical significance supporting beneficial FV-related effect(s), effect size(s).

Outcomes and Prioritization

The primary outcome studies were screened for was adult FV perpetration, as assessed via standardized or non-standardized measures, including perpetrator

report, victim report, researcher or intervention facilitator observation, or agency report. Secondary outcomes were not screened for.

Risk of Bias

Risk of bias was assessed for quasi-experimental studies (QESs) via the JBI checklist for quasi-experimental studies (Barker et al., 2023a) and for RCTs via the revised JBI critical appraisal tool for the assessment of risk of bias for randomized controlled trials (Barker et al., 2023b). No other quality appraisal tools were used.

Synthesis

Since the pool of included studies is small and heterogenous, meta-analysis was not performed in order to avoid biased results. Instead, narrative synthesis according to Popay et al. (2006) was performed.

Meta-Bias

One of this study's greater limitations is the conduction by a single reviewer. To account for this, only peer-reviewed publications were included in the review. This is likely to introduce publication bias, as there might be unpublished literature that could be included in a more comprehensive search.

Larger systematic reviews often assess potential publication bias by means of funnel plots. However, this is not recommended for small review samples with high contextual heterogeneity (Sterne et al., 2011). Since both characteristics are true for the present study, assessment of potential publication bias was omitted.

To assess selective reporting of outcomes, review authors may search trial registries to compare trial protocols with the study reports included in the review. Because of time and resource limitations, this was omitted in the present study. Instead, the present review included only peer-reviewed publications. Selective outcome reporting in included study reports is assumed to have been addressed during the peer-review process, but cannot be excluded.

Results

Search Results

Database searches in PsycINFO, PubMed and SCOPUS yielded a total of 3073 results. References of all included studies were also screened, resulting in

additional 435 to be screened. The PRISMA flow diagram detailing the process is presented in *Figure 1*. At the end of the selection process, a total of 9 articles were included. Full text exclusion decisions are detailed in *Appendix A*.

Included Studies

Details of the included studies' samples are found in *Table 1* presented in *Appendix B*. Study designs and results are detailed in *Table 2*, also presented in *Appendix B*. This section provides a descriptive summary of recruitment processes and the interventions examined in the included study reports.

Study 1: Ashburn et al. (2017) – REAL Fathers Initiative

This QES (Ashburn et al., 2017) was conducted in post-war Northern Uganda. It evaluated an FV prevention scheme combining a community-based mentoring program with a local poster campaign. Based on social cognitive theory (Bandura, 1969), the "REAL Fathers Initiative" aimed to effect a modelling process by which male parents learn non-violent behaviors and skills from mentors (community volunteers selected by the participants). The mentors were trained on the topics of fatherhood, parenting and couple communication, including training before the start and in the middle of the intervention period. The training included the content to be delivered to mentees, clarification of mentors' own values on violence and gender, as well as an assessment of the mentoring quality. Recruitment of participants and training of mentors was implemented by the research team's partner NGO Save the Children International.

After selection, mentors were interviewed by program personnel for briefing and assessment of willingness and motivation to take part in the program. Residences of mentors and mentees were mapped to keep distances as short as possible. Bicycles were provided to the mentors. The intervention was implemented with 64 mentors, connected to up to four fathers each, and spanned across 6 months and included 2 sessions per month for every participant. Different sessions were held individually, in groups and in the presence of the participant's partner and were concluded by a celebratory community meeting where fathers had the opportunity to publicly pledge to stick to their non-violent ways and positive parenting goals.

Throughout the intervention period, posters were hung up on billboards located in areas the participants frequently visited or passed by. The posters showed

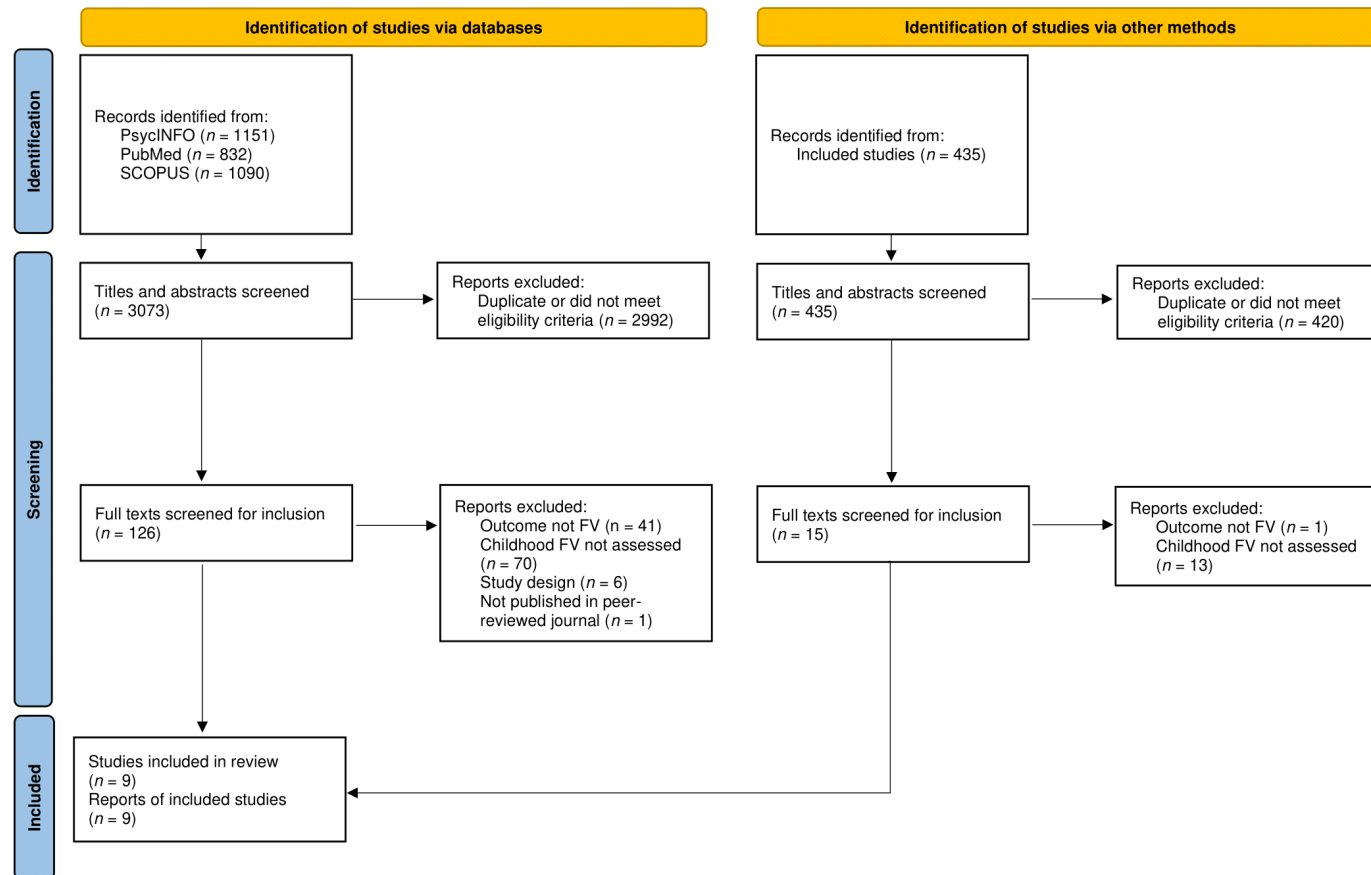
images of local fathers engaging in positive parenting behaviors, accompanied by appreciative text statements. Topics changed every month, according to the content currently addressed by the mentors.

The study had originally been planned as an RCT and included a control & intervention group, but for confidentiality reasons the researchers refrained from using identifying codes and therefore opted for a different approach. The authors compared an “exposed” group (participants of at least one single and one group session) to an “unexposed” group (participants who did not attend any session).

In addition to the post-conflict setting and other sociodemographic factors, the participants’ risk of FV perpetration had been indicated through prior FV perpetration. One month before baseline, 43% of the men had physically punished their children. And 3 months before baseline, 35% had reported yelling at, 20% had reported pushing, and 19% had reported slapping their partners. At baseline, 90% of the men were cohabitating with their partners. The sample was also characterized by a high rate of childhood FV victimization, with baseline reports indicating that 72% of participants had either experienced physical violence by a caregiver or threats thereof or witnessed IPV between caregivers. There were significant group differences in childhood FV victimization history at the two points of measurement: A higher percentage of the exposed group (80%) than the unexposed group (70%) had reported being threatened with physical punishment as a child at the first assessment after completion (4 months). At the second assessment after completion (8 months), more men in the unexposed group (90%) than in the exposed group (83%) had reported experiencing physical punishment as a child.

Study 2: Bugental et al. (2002) – Healthy Start Cognitive Component

This article (Bugental et al., 2002) reported on an RCT of an enhancement of US-based Healthy start. Healthy Start is a government-funded abuse prevention program that seeks to identify vulnerable families early on and utilizes paraprofessional home visitors to aid parents in coping with certain challenges in childcare & learning parenting skills, and to promote non-violent behavior (Duggan et al., 1999). This study (Bugental et al., 2002) investigated the benefits of expanding the default program by an additional component addressing cognitive appraisal processes of parents at risk for child maltreatment.

Figure 1*PRISMA flow diagram*

This cognitive component consisted of two parts. In the first one, parents learned to accurately understand children's communication related to discomfort (e.g. crying or turning away) and to counter misattributions like the belief that infants intentionally challenge a caretaker's power or make life difficult for them. The home visitor guided them in locating benign reasons for current caregiving problems. The second part consisted of a problem-solving training, aiming to provide parents with a framework applicable in the present and for challenging situations in the future.

The intervention was carried out over a 1-year-period (20 visits planned per family) and the home visitors were paraprofessionals. Participants were recruited at local health clinics before childbirth. The majority of the study sample (97%) consisted of families recently immigrated from Mexico. 50% of participants reported a childhood history of FV victimization. 52% of study families included a husband or male partner. Male caregivers were included in the program, but not in the study. Families at moderate risk of FV perpetration were the target population. The authors argued that this group would benefit the most from the intervention, as caregivers at high risk are typically better suited by staff with professional training. Risk was assessed via the Family Stress Checklist (FSC; Murphy et al., 1985).

Study 3: DuMont et al. (2008) – HFNY

Healthy Families New York (HFNY) was the subject of this RCT (DuMont et al., 2008). Unlike past evaluation studies of programs based on the Healthy Families America (HFA) model, this study (DuMont et al., 2008) included women who had not yet given birth as a subsample. In that population, prevention efforts may be able to take effect before any child abuse or neglect takes place, as opposed to interventions that aim to prevent violence from reoccurring. The authors additionally analyzed another subgroup, women with little psychological resources, since past research (Olds et al., 2002) had indicated high receptiveness to home visitation programs for this population.

Voluntary HFNY participants were recruited at local community health centers and hospitals and were selected through a two-part screening process. The first step pre-screened parents-to-be and parents with a child that was no more than 3 months old for child abuse & neglect risk and for whether they lived in areas characterized by risk factors. Those selected by the screening procedure were assessed for program eligibility in a second step by Family Assessment Workers (FAWs) via the Kempe

Family Stress Checklist (Kempe, 1976, as cited in DuMont et al., 2008). 48.7% of participants had a childhood history of FV victimization. Over half of the sample (54.2%) were first-time mothers. The article contains no information on the involvement of male caregivers.

The program itself was based on home visitation by paraprofessionals who underwent HFA training to become Family Support Workers (FSWs). FSWs were guided by HFA-approved curricula but were free to adapt them to specifically suit the needs of each individual family.

Participants were visited every two weeks until childbirth, with content focusing on health behavior during pregnancy. After the child was born, visits happened weekly but became less frequent over time. Content after childbirth included education about and support of positive parent-child interaction, child development and health, as well as parental problem-solving and the prevention of child abuse and neglect. The program ended after a maximum of 5 years.

Study 4: Fergusson et al. (2005) – Early Start

This RCT (Fergusson et al., 2005) was conducted to evaluate the effectiveness of the Early Start home visitation program operating in New Zealand. In addition to reducing parenting stress and improving child behavior and health, the prevention of child abuse and neglect was one of the main aims of Early Start. The program employed FSWs as home visitors. Unlike HFA models which used the same term for paraprofessional home visitors, Early Start required a professional background in social work or nursing.

Participants were recruited via the government-funded Plunket nurse service. This is a New Zealand-specific service designed to provide all families of newborn children with home visits by community nurses within the first 3 months after delivery. Plunket nurses screened the families for risk of FV and referred at-risk participants to the Early Start program. In this way, a representative study sample was acquired. While the majority of the sample were single caregivers (64.6% of intervention and 63.8% of control group), 35.0% of intervention and 25.6% of control group had reported IPV perpetrated by their current partner, indicating a high rate of IPV victimization among non-single participants. Childhood history of FV victimization was reported by 41.6-57.0% between different types of FV.

After enrollment in the program, FSWs assessed specific family needs and delivered home visits over a maximum of 3 years. Content of the home visits consisted of social and professional support in an array of areas including compliance with child health care, addressing caregivers' physical and mental health problems, parenting skills training, education about negative consequences of FV, and mentoring the caregivers on relationship and housekeeping topics.

Most study outcomes and demographic variables were only assessed for female caregivers, but the children's biological fathers' age, percentage of Māori ethnicity and educational qualifications are presented in the article. Fergusson et al. (2005) did not specify if the biological fathers also assumed a caregiver role. Additionally, the self-reported child abuse and neglect outcome is defined as perpetration by either caregiver, but the article does not specify whether this includes only the biological father or any caregiver.

Study 5: Huefner et al. (2007) – Family Home Program

This QES (Huefner et al., 2007) investigated adults who had in their youth taken part in a long-term residential care program (1981-1985). Interviews about their IPV perpetration were conducted in 2002. Some respondents had been admitted as adolescents but had not proceeded to join the program. The IPV perpetration rates of program completers and those who had not joined were checked against national normative data. In order to match the normative sample, only respondents who were married or in a relationship at time of the interview were included in the study.

The residential care program, operated by Christian NGO "Boys Town", employed a modified version of their Teaching Family Model, called the Family Home Program (FHP; Daly & Thompson, 2022). The program offered services to adolescents (10-18 years old) characterized by risk factors like childhood FV victimization (around 48% of the intervention group), behavioral disorders, or involvement in crime. Groups of up to eight boys and girls would live with a married couple that took care of them, aided by a full-time assistant. The average time youth spent in the residential care setting was 18 months. Together, the caregivers aimed to meet their protégés needs concerning physical & psychological health, as well as treatment they required. This included teaching them to fulfill household chores in a self-reliant fashion, as well as helping them develop positive relationships with others. Since the program was embedded in the framework of a Christian organization, the

participants' spiritual needs were also explicitly focused on via the regular attendance of religious services and school courses addressing values and morality.

Study 6: Lachman et al. (2017) – PLH for Young Children

This RCT (Lachman et al., 2017) conducted a preliminary evaluation of a low-cost, group-based FV prevention program. It took place in South Africa, aiming to test the program's effectiveness in a region representing low- and middle-income countries (LMICs). The intervention was developed by the authors, adopting elements of evidence-based interventions from high-income countries into a framework suitable for the local cultural and economic context. Goals were to teach parenting skills, reduce harsh parenting, child behavior problems and parental depression & stress, and improve positive parenting & social support.

The intervention used was PLH for Young Children (formerly the Sinovuyo Caring Families Program for Young Children), which aims to teach authoritative parenting in the form of positive relationship-building, limit-setting and strategies for nonviolent discipline. Caretakers learned to let their children lead play, to instruct and reward their children, to communicate (about) each other's emotions, to handle problematic child behavior, to work on chores together with their kids and to uphold rules in an authoritative manner. The program was adapted to fit the setting of families living in a deprived area, meaning that the strategies learned required no material to be owned or bought, other than pens, paper and recycled household material. Program contents were also adapted to the local cultural context by incorporating folk stories and images of typical South African families in the region. Caretakers were also directly involved by having them set individual goals for themselves and their families, which the program then helped them reach. Additionally, the program tackled specific regional issues like community violence and poverty, and the challenges they pose for child raising.

All participants were isiXhosa-speaking and had been recruited by local NGOs and via word of mouth. The program was delivered weekly over a three-month period in 2013 by local organization Clowns Without Borders South Africa. The isiXhosa-speaking facilitators received basic training before delivering the 2-3h sessions to three groups of caretakers (10-14 individuals each). Group sessions, among other things, included mindfulness exercises, illustrated stories, children's songs, parenting strategies and their benefits, as well as reflection of home assignments.

In addition to childhood history of FV victimization (72.1% overall) and sociodemographic factors, 32.4% of the intervention group and 35.3% of the control group (ns) reported experiencing current IPV victimization (within the past month).

Although perceived social support was measured (no group difference), the article contains no specific information on whether participants' partners or other additional caregivers were involved in the study. 73.5% of the sample had reported being unmarried.

Study 7: Rodriguez et al. (2010) – HFNY

This RCT (Rodriguez et al., 2010) is a follow-up to the one by DuMont et al. (2008) and reports on the evaluation of the HFNY home visiting program at year 3 after the start of the intervention. DuMont et al. (2008) had used self-report measures and CPS data to test the program's effectiveness in preventing child abuse & neglect during the first two years after childbirth. Around the children's third birthday, Rodriguez et al. (2010) went on to observe mother-child interactions at the microlevel, thus complementing the earlier research with an important additional dimension. However, since the samples and outcome measures were not identical, this report (Rodriguez et al., 2010) was included in the review as a separate study.

Assessment was conducted in the participants' homes. They were visited by trained interviewers who were blind to group allocation and followed a standard protocol for implementing and videotaping the set of semi-structured tasks. Mothers were asked to complete a so-called Puzzle Problem Solving Task (Chase-Lansdale et al., 2001), a Delay of Gratification Task (Mischel et al., 1989) and a Cleanup Task (Kochanska et al., 2001) together with their child. The first task requires the mother to guide and encourage her child, and deal with the child's negative reactions to failure in the process of solving a difficult puzzle. The Delay of Gratification Task has the mother fill out a questionnaire and at the same time keep her child from eating a snack that is placed close by, thus requiring to assist the child in regulating impulses. And finally, during the Cleanup Task, the mother holds a bag into which the child is supposed to put a number of toys they were allowed to play with before. The task requires the mother to elicit compliant behavior in her child.

In this observational study sample, participants were 55% first-time mothers. 72.9% of the intervention group and 64.8% of the control group reported having a

spouse or partner. The involvement of spouses and partners is not specified in the article. In addition to sociodemographic factors, 21% of participants had received a CPS report before baseline that identified them as the perpetrator. Within the whole sample, 49.4% reported a childhood history of FV victimization.

Study 8: Stevens-Simon et al. (2001) – CAMP Home-Visiting Module

This RCT (Stevens-Simon et al., 2001) evaluated the expansion of the clinic-based Colorado Adolescent Maternity Program (CAMP) by a home-visiting module conceived for the prevention of FV, specifically early child abuse & neglect. CAMP encompassed health care services delivered by a variety of professionals, centered around the prenatal and postnatal phases, as well as child delivery itself.

The program had the explicit goal to reduce adverse maternity outcomes for high-risk adolescent mothers and their children by facilitating access to social and health care services, as well as fostering school attendance. The primary aim of this study was to examine whether the home-visiting component added to the postpartum program would help in reducing the incidence of child maltreatment.

The home visitor (a middle-aged female paraprofessional health educator from the context of the CAMP clinic) created an individual program scheme with each mother-child dyad, set up to address those attitudinal and behavioral dynamics leading to an elevated risk for abuse. Visits were 1 to 2 hours long, took place weekly in the beginning and decreased in frequency over time. During home visits, she encouraged the young mothers to use non-violent parenting strategies and develop a caring, appreciative relationship with their children, and taught them healthy stress management techniques. Methods included role-play and small educational presentations and were based on a curriculum created by the CAMP staff, as well as the home visitor's personal experience as a mother.

The majority of the adolescent participants (98.7%) were first-time mothers. Childhood history of FV victimization was reported by 72% in the intervention group and 78% in the control group. Family support was also assessed, with 28% of intervention group mothers and 27% of control group mothers were supported by their own mother or the baby's father. The degree of family support was positively correlated with the rate of compliance with the home visitation schedule.

Study 9: Ward et al. (2020) – PLH for Young Children

This article (Ward et al., 2020) reports on an RCT of PLH for Young Children, the same intervention examined in the preliminary study by Lachman et al. (2017). PLH for Young Children was developed by the study authors in both cases (Lachman et al., 2017; Ward et al., 2020).

A description of PLH for Young Children can be found in the section “Study 6: Lachman et al. (2017)” in the present review. By the time of the study by Ward et al. (2020), the program had been revised, resulting in the following changes: “Content on positive reinforcement and discipline was subsequently refined, and additional training was provided to facilitators to strengthen competency in the collaborative process and in understanding social learning theory.”

The program was again delivered in the Cape Town area, this time between 2014 and 2016 and with a larger sample ($n = 296$). In addition to sociodemographic factors indicating risk, current IPV victimization (within the last month) was reported by 34.6% of intervention and 25.68% of control group participants. Self-reported social support was measured (no group difference), but the study did not specify any involvement of participants’ partners or other additional caregivers. Participants’ childhood history of FV victimization was assessed for experiences of physical abuse (45.3-49.3%), emotional abuse (31.8-34.5%) and sexual abuse (6.1-6.8%).

Quality Appraisal

In order to gain an overview of the overall methodological quality of included studies, systematic quality appraisal was conducted.

Quasi-Experimental Studies

Results of the quality appraisal process for included QESs are presented in *Table 3*. The full JBI checklist for quasi-experimental studies (Barker et al., 2023a) is provided in Appendix C.

Both QESs made clear assumptions about cause and effect (*item 1*) and study characteristics support the concept. Ashburn et al. (2017) employed baseline comparison to distinguish pre-treatment status from post-treatment status (IPV and physical child punishment). Huefner et al. (2007) had no baseline measures for the primary outcome (IPV), but the intervention took place before participants became of age, a time when they had not yet had the opportunity to perpetrate IPV.

Baseline group similarity (*item 2*) in terms of demographic variables was established through statistical significance testing in both QESs, although Huefner et al. (2007) did not fully report the variables which were tested for.

Table 3

Quality Appraisal of QESs

	Ashburn et al. (2017)	Huefner et al. (2007)
1 Clear cause and effect	yes	yes
2 Baseline group similarity	yes	yes
3 Isolation of treatment effect	yes	unclear
4 Control group	yes	yes
5 Multiple measurements	yes	no
6 Follow-up attrition analysis	yes	no
7 Measures identical for groups	yes	yes
8 Reliability of rating process	-	-
9 Appropriate statistical analysis	yes	yes
Comments	4: Non-random comparison group (exposed vs. unexposed) 5: One baseline measurement, but multiple follow-up measures after completion 8: No assessor rating employed	2: Variables not clearly defined 3: No information about comparison group 4: Non-random comparison group (treated as TAU) 5: No baseline, one follow-up compared to stratified normative data 8: Interrater reliability ($\kappa = .86$) for file review of childhood history of FV victimization, but no rating of primary IPV outcome

Neither study reported any differential treatment of groups beyond the manipulated conditions (*item 3*), although Huefner et al. (2007). Both QESs used comparison groups (*item 4*). It is worth noting that the QES by Ashburn et al. (2017) had initially been designed as an RCT and only later in the process altered to accommodate participants' concerns over violations of privacy related to the use of unique identifier codes including personal data. Without means of monitoring the

originally randomized group assignment over time, the intervention-control design was changed to a comparison of participants who had attended a minimum session amount ($n = 256$) and participants who had not ($n = 179$), following a sensitivity analysis including the 12 participants most similar to intention-to-treat for the group randomized to intervention at baseline (Ashburn et al., 2017). In the QES by Huefner et al. (2007), the sample consisted of individuals who were admitted to the program during adolescence and could be reached via telephone as adults. The comparison group was comprised of participants who had been admitted but never joined the FHP ($n = 23$). The intervention group ($n = 131$) consisted of those who had joined. It could be argued that this resembles drop-out/attrition, but the article states that the comparison group was treated as TAU (Huefner et al., 2007). The article does not discuss the comparison group any further.

Since the JBI checklist for quasi-experimental studies (Barker et al., 2023a) is designed to not only include QESs with comparison groups, but also pretest-posttest designs, *item 5* originally required multiple pretest measurements. Since this is not applicable to studies utilizing controls, *item 5* was changed to requiring only multiple measures in general. Ashburn et al. (2017) included a baseline assessment, as well as two follow-up measurements (t_1 : 4 months; t_2 : 8 months), whereas Huefner et al. (2007) were unable to utilize a baseline reference and instead compared the 16-year follow-up IPV data of both the intervention and comparison group to IPV rates of a random sample ($n = 417$) gathered from normative NSFH data (Bumpass & Sweet, 2018; Bumpass et al., 2017) stratified to match study sample characteristics (Huefner et al., 2007).

Analysis of attrition consequences (*item 6*) was adequately performed by Ashburn et al. (2017), but not by Huefner et al. (2007) who only reported that response rates to the survey did not differ between intervention and comparison group.

Measures of outcome variables were identical for all groups in both studies (*item 7*). Neither QES included observational measuring of primary outcomes that had to be rated, leaving *item 8* irrelevant to study quality.

Statistical analysis (*item 9*) was conducted via multiple logistic regression (Ashburn et al., 2017) and logistic regression (Huefner et al., 2007), as well as Student's t -tests and χ^2 -tests (Huefner et al., 2007).

QES Quality Summary. In summary, the report by Ashburn et al. (2017) fulfilled all eight applicable methodological requirements (*Table 3*). The report by Huefner et al. (2007) was of mixed methodological quality, fulfilling only five of eight applicable requirements.

If RCT standards (*Table 4*) were applied to the two included QESs (excluding *item 9, Table 4*), the study by Ashburn et al. (2017) would fulfill five out of 12 requirements (*items 3, 6, 8, 10 and 12, Table 4*) and the one by Huefner et al. (2007) would fulfill three out of 12 requirements (*items 3, 8 and 12, Table 4*).

Randomized Controlled Trials

Results of the quality appraisal process for included QESs are presented in *Table 4*. The full revised JBI critical appraisal tool for the assessment of risk of bias for randomized controlled trials (Barker et al., 2023b) is provided in Appendix D.

Table 4

Quality Appraisal of RCTs

	Bugental et al. (2002)	DuMont et al. (2008)	Fergusson et al. (2005)	Lachman et al. (2017)	Rodriguez et al. (2010)	Stevens- Simon et al. (2001)	Ward et al. (2020)
1 True randomization	yes	yes	yes	yes	yes	yes	yes
2 Concealed allocation process	unclear	yes	no	yes	yes	unclear	yes
3 Baseline group similarity	yes	yes	yes	yes	yes	yes	yes
4 Participant blinding	no	no	no	no	no	no	no
5 Facilitator blinding	no	no	no	no	no	no	no

	Bugental et al. (2002)	DuMont et al. (2008)	Fergusson et al. (2005)	Lachman et al. (2017)	Rodriguez et al. (2010)	Stevens- Simon et al. (2001)	Ward et al. (2020)
6 Isolation of treatment effect	yes	yes	yes	yes	yes	yes	yes
7 Assessor blinding	unclear	unclear	no	yes	yes	unclear	yes
8 Measures identical for groups	yes	yes	yes	yes	yes	yes	yes
9 Reliability of rating process	-	-	-	yes	yes	unclear	yes
10 Follow-up attrition analysis	yes	yes	yes	unclear	yes	yes	yes
11 Intention-to- treat approach	yes	yes	yes	yes	yes	yes	yes
12 Appropriate statistical analysis	yes	yes	yes	yes	yes	yes	yes
13 Appropriate RCT design	yes	yes	yes	yes	yes	yes	yes
Comments	2: Not specified 7: Not specified 9: No rating process	7: Not specified 9: No rating process 11: Analytic subgroups constructed a priori	7: Open trial 9: No rating process	9: ICC = .93 10: no results presented	9: $\kappa = .73$ (mean) 11: Analytic subgroups had been constructed a priori.	2: Not specified 7: Not specified 9: Not specified	9: $\kappa =$.7 :10

All RCTs reported usage of true 1:1 randomization (*Table 4, item 1*). Most RCTs also reported some variant of a concealment procedure via PC software (*Table 4, item 2*). Fergusson et al. (2005) stated that software-based allocation was conducted, but the open trial design made allocation status available to researchers. Other exceptions are Bugental et al. (2002) and Stevens-Simon et al. (2001), who only stated that randomization was conducted, without detailing the procedure. Computer randomization was conducted by an external researcher with no knowledge of trial contents in two RCTs (Lachman et al., 2017; Ward et al., 2020), which are two studies of the same intervention (PLH for Young Children). Two others had concealed randomization conducted within the study sites (DuMont et al., 2008; Rodriguez et al., 2010), also two studies of the same intervention (HFNY). These examples illustrate how researchers working on multiple studies of the same intervention approach can show a certain continuity of practices, while practices may differ between projects.

All RCTs determined similarity of their intervention and control groups at baseline via statistical tests (*Table 4, item 3*). Neither participants nor facilitators were blind to treatment group allocation (*Table 4, items 4 & 5*). This is typical of psychological intervention studies (Juul et al., 2021), where help-seeking individuals are immanently aware of the fact that they are being treated and facilitators are aware of whether they are delivering a treatment (i.e., intervention group) or not (i.e., control group).

All RCTs constructed trial conditions that allowed isolation of the treatment effect (*Table 4, item 6*), with minor exceptions: In the study by Fergusson et al. (2005), groups were treated largely identically but the control group received a small monetary reimbursement for interviews, which was not the case for the intervention group. Lachman et al. (2017) mentioned that some PLH for Young Children participants may have discussed the program with control group participants who lived near their homes. The authors concluded that this likely does not undermine the isolation of the treatment effect. The control group received program after the end of the study intervention period.

Staff assessing outcomes were blind to group allocation (*Table 4, item 7*) in most RCTs, but with some limitations in terms of clarity (Bugental et al., 2002; DuMont et al., 2008; Stevens-Simon et al., 2001). Only one RCT was conducted as

an open trial without assessor blinding. Bugental et al. (2002) did not report on assessor blinding at all. Stevens-Simon et al. (2001) described the use of standardized instruments for child health outcomes (not including FV) by a trained research assistant who was blinded to treatment group assignment. However, the article does not specify if FV outcomes were also assessed by this research assistant, by home visitors or by other CAMP staff. One other article (DuMont et al., 2008) provides information about assessor blinding for all of the study's self-reported outcomes but does not specify who had extracted CPS database entries and if they had been blind to allocation. Lachman et al. (2017) reported that concealment had been largely intact, but in a few cases (5.9%) study participants had revealed their group allocation to the interviewers, though the authors concluded that this was unlikely to have a substantial effect on trial fidelity.

Outcomes were measured in the same way for treatment groups in all included RCTs (*Table 4, item 8*).

Three RCTs (Bugental et al., 2002; DuMont et al., 2008; Fergusson et al., 2005) did not use observational measures (*Table 4, item 9*). Those who did (Lachman et al., 2017; Rodriguez et al., 2010; Ward et al., 2020) reported measures of interrater reliability. Only one study was unclear on the nature of the measures employed and did not report any reliability measures (Stevens-Simon et al., 2001). In the RCT by Lachman et al. (2017), the negative parenting outcome was operationalized as a continuous variable, thus intraclass correlation (ICC) was used instead of Cohen's κ . The other two RCTs (Rodriguez et al., 2010; Ward et al., 2020) reported on ratings for categorical variables. The individual interrater reliability coefficients for each of the tasks used by Rodriguez et al. (2010) are $\kappa = .69$ (Delay Task), $\kappa = .70$ (Cleanup Task) and $\kappa = .79$ (Puzzle Task).

The potential consequences of group attrition were analyzed by all but one of the included RCTs (*Table 4, item 10*). In the article by Lachman et al. (2017), attrition rates were reported, but no statistical test of significance presented to examine potential resulting differences. In the study by Rodriguez et al. (2010), differences to baseline were detected for the whole sample and the low prevention opportunity (LPO) subgroup. The authors reported accounting for this via propensity scores, which were utilized to reestablish the integrity of the random assignment study design. Ward et al. (2020) also found group differences due to attrition at follow-up

but did not employ any statistical remedy. The article discusses the finding by concluding that the “[...] small differences but may suggest a slightly more negative profile for parents who were lost to follow-up.”

Analysis was conducted with an intention-to-treat approach (*Table 4, item 11*) in all RCTs. All analytic subgroups had been constructed a priori (DuMont et al., 2008; Rodriguez et al., 2010).

All RCTs employed appropriate methods of statistical analysis matching the type of data and trial design (*Table 4, item 12*). Specific methods of analysis included analysis of variance (ANOVA; Bugental et al., 2002), logistic regression (DuMont et al., 2008; Rodriguez et al., 2010), log linear regression (DuMont et al., 2008), multilevel generalized linear modeling (Ward et al., 2020), multivariate mixed modeling (Lachman et al., 2017) and Student’s *t*-tests and χ^2 -tests (Fergusson et al., 2005; Stevens-Simon et al., 2001).

All RCTs fulfilled the conceptual prerequisites for an RCT design (*Table 4, item 13*), using parallel groups. The study by Lachman et al. (2017) used statistical tools to account for partial nestedness of data.

RCT Quality Summary. Among RCTs that included rating of behavioral observation (*item 9* applies), those fulfilling 11 out of 13 requirements (Rodriguez et al., 2010; Ward et al., 2020) were the soundest, followed by the report of Lachman et al. (2017) fulfilling 10 out of 13 requirements, and the report of Stevens-Simon et al. (2001) fulfilling only eight of 13 requirements. The RCT by Stevens-Simon et al. (2001) is also included in this category, since instruments for primary outcome measurement (outcomes: abuse, neglect, and abandonment of child) were not specified in the article and if they were observational in nature, no information about observation reliability was provided either.

Among RCTs that *item 9* (*Table 4*) did not apply to, the report by DuMont et al. (2008) was methodologically soundest, fulfilling nine out of 12 requirements, followed by the other two (Bugental et al., 2002; Fergusson et al., 2005), each fulfilling eight out of 12 requirements.

Since it was not applicable to all included studies, *item 9* (*Table 4*) is excluded from overall score comparison. Based on the remaining 12 items, the most methodologically sound RCT reports fulfilled 10 out of 12 requirements (Rodriguez et

al., 2010; Ward et al., 2020), followed by reports fulfilling nine out of 12 requirements (DuMont et al., 2008; Lachman et al., 2017) and reports fulfilling eight out of 12 requirements (Bugental et al., 2002; Fergusson et al., 2005; Stevens-Simon et al., 2001). It has to be noted that some lower scores result from lack of clarity of reports related to allocation concealment and assessor blinding (Bugental et al., 2002; DuMont et al., 2008; Stevens-Simon et al., 2001), reliability of measurement (Stevens-Simon et al., 2001), and adequacy of attrition analysis (Lachman et al., 2017). These may not reflect actual flaws in the conduct of study planning and data collection. But since correct reporting is recognized as an integral part of the research process, this comparative summary treated unclear reporting as equivalent to violation of the methodological requirement. Among all included RCTs, the only clearly reported methodological drawback is lack of allocation concealment in the study by Fergusson et al. (2005).

Summary of Quality Appraisal

Overall, the included studies are of mixed methodological quality. None fulfilled all requirements for the methodological “gold standard” of RCTs. This is partly attributed to the lack of participant and facilitator blindness, which is inherent to the type of person-to-person treatment that most psychosocial interventions provide. Participants receiving behavioral treatment are typically aware of being treated. The same is true for intervention facilitators.

The best possible adherence to methodological standards was found in the reports by Rodriguez et al. (2010) and Ward et al. (2020), followed by the reports by DuMont et al. (2008) and Lachman et al. (2017) that were of comparable quality, minus one instance of unclear reporting in each. Two instances of unclear reporting were found in the article by Bugental et al. (2002) and three instances in the report by Stevens-Simon et al. (2001). Only one RCT clearly reported the nonfulfillment of requirements in addition to unclear reporting (Fergusson et al., 2005). Of the QESs, one fulfilled all requirements of a high-quality QES (Ashburn et al., 2017) while the other contains instances of unclear reporting and nonfulfillment of requirements (Huefner et al., 2007). Both QESs fulfilled fewer methodological requirements than any RCT.

Operationalization of childhood history of FV victimization

All included articles reported on the percentage of participants with a childhood history of FV victimization within the study sample. *Table 7* provides an overview of proportions.

Table 7

Participants with Childhood History of FV Victimization

Study	Proportion
Ashburn et al. (2017)	72%
Bugental et al. (2002)	50%
DuMont et al. (2008)	48.7%
Fergusson et al. (2005)	41.6-57.0% ^a
Huefner et al. (2007)	48% ^d
Lachman et al. (2017)	72.1%
Rodriguez et al. (2010)	49.4%
Stevens-Simon et al. (2001)	72-78% ^b
Ward et al. (2020)	6.1-49.3% ^c

Note. The range of proportions within the study is reported if articles did not provide a mean percentage.

^a Child abuse (intervention: 44.7%; control: 41.6%), Witnessed IPV (intervention: 50.5%; control: 57.0%), no information on overlap between categories provided.

^b Intervention group (72%) and control group (78%)

^c Physical abuse (intervention: 49.32%; control: 45.27%), emotional abuse (intervention: 34.46%; control: 31.76%) and sexual abuse (intervention: 6.76%; control group: 6.08%), no information on overlap between categories provided.

^d Data only available for intervention group

Bugental et al. (2002) used the FSC (Murphy et al., 1985) to assess risk of perpetration, but did not specify if the information on childhood history of FV victimization was also collected through it.

DuMont et al. (2008) and Rodriguez et al. (2010) measured childhood FV victimization with a single item from the revised Conflict Tactics Scale (CTS2; Straus et al., 1996), asking participants to answer yes or no to “My mother swore at me more than twice.”

Fergusson et al. (2005) used a checklist for risk screening but did not specify if the information on childhood history of FV victimization was also collected through it.

Stevens-Simon et al. (2001) used a checklist that was assembled by the authors including questions about physical and sexual abuse experiences.

Lachman et al. (2017) used the ISPCAN Child Abuse Screening Tools Retrospective version (ICAST-R; Dunne et al., 2009), while Ward et al. (2020) did not specify any measure.

Ashburn et al. (2017) did not specify any measure.

Huefner et al. (2007) did not use a retrospective self-report measure but instead acquired the information through review of participants' program admission files. The article specifies that at their admission during adolescence, social history information was collected “from a variety of sources including the youth, parents, relatives, caseworkers, school records, psychological evaluations, clergy, police reports, and court records.”

The information about participants' childhood history of FV victimization was operationalized exclusively as a background characteristic in all but two studies (Ashburn et al., 2017; Huefner et al., 2007) and used to determine similarity of victimization rates in the intervention and control groups. Most studies found no baseline differences in terms of childhood history of FV victimization (Ashburn et al., 2017; Bugental et al., 2002; DuMont et al., 2008; Fergusson et al., 2005; Lachman et al., 2017; Rodriguez et al., 2010; Stevens-Simon et al., 2001) and did not discuss the variable anywhere else in the study reports (except Ashburn et al., 2017). Ward et al. (2020) mentioned that participants who had been lost to follow-up attrition were – among other differences – significantly more likely to report physical abuse as a child (58.3% vs. 51.8%) but did not draw conclusions beyond stating that this “may suggest a slightly more negative profile” for those lost to attrition (Ward et al., 2020). Ashburn et al. (2017) also found such group differences at follow-ups in the REAL Fathers Initiative study. More participants in the exposed than in the unexposed

group with experiences of being threatened with physical violence as a child (80% vs. 70%) were found at first follow-up. At second follow-up, more unexposed than exposed participants (90% vs. 83%) had experienced physical violence as a child.

The studies by Ashburn et al. (2017) and Huefner et al. (2007) are the only ones that explored the influence of participants' childhood history of FV victimization in further analyses. Both found higher rates of FV perpetration among individuals with a childhood victimization history than in those without one. Huefner et al. (2007) found FHP participants significantly more likely to report IPV perpetration if they had a childhood history of FV victimization (14.5% vs. 3.0%). In the overall sample of Ashburn et al. (2017), significantly more self-reports of physical child punishment were received by participants who had been threatened with physical violence as a child and those who had been physically punished as a child. Participants who had been threatened with violence as a child were also significantly more likely to perpetrate verbal and psychological IPV and scored higher on the composite for any IPV. Those participants who had experienced physical punishment as a child were found more likely to perpetrate any IPV, including the physical, psychological, and verbal subscales.

The only study that explored the effect of the intervention specifically for individuals with a childhood history of FV victimization was the FHP study (Huefner et al., 2007). The study exploratively compared IPV perpetration rate of those with a childhood victimization history (14.5%) to an expected rate (36%) extracted from an earlier report of a 20-year prospective study (Ehrensaft et al., 2003). A goodness of fit test with 36% as the expected value suggested a significant difference.

Summary Operationalization. The way in which childhood history of FV victimization was assessed varied widely across the included studies and reporting of measures was not always concise. Four studies reported using a standardized instrument specifically to assess childhood victimization history (Bugental et al., 2002; DuMont et al., 2008; Rodriguez et al., 2010; Lachman et al., 2017), of which two reported on the same baseline assessment (DuMont et al., 2008; Rodriguez et al., 2010). Instruments employed were the FSC (Murphy et al., 1985), CTS2 (Straus et al., 1996), and ICAST-R (Dunne et al., 2009).

Most studies operationalized childhood history of FV victimization as a background characteristic for determination of baseline group similarity (except for

Huefner et al., 2007). Only two studies explored the influence of the variable on FV perpetration and found higher perpetration rates of IPV (Ashburn et al., 2017; Huefner et al., 2007) and physical child punishment (Ashburn et al., 2017). And only one of the included studies explored intervention benefits specifically for participants with a childhood history of FV victimization (Huefner et al., 2007), which found an indication for a protective effect.

Due to the lack of studies using childhood history of FV victimization as their primary grouping variable, the remainder of this review examines intervention effectiveness in terms of general FV prevention.

Synthesis

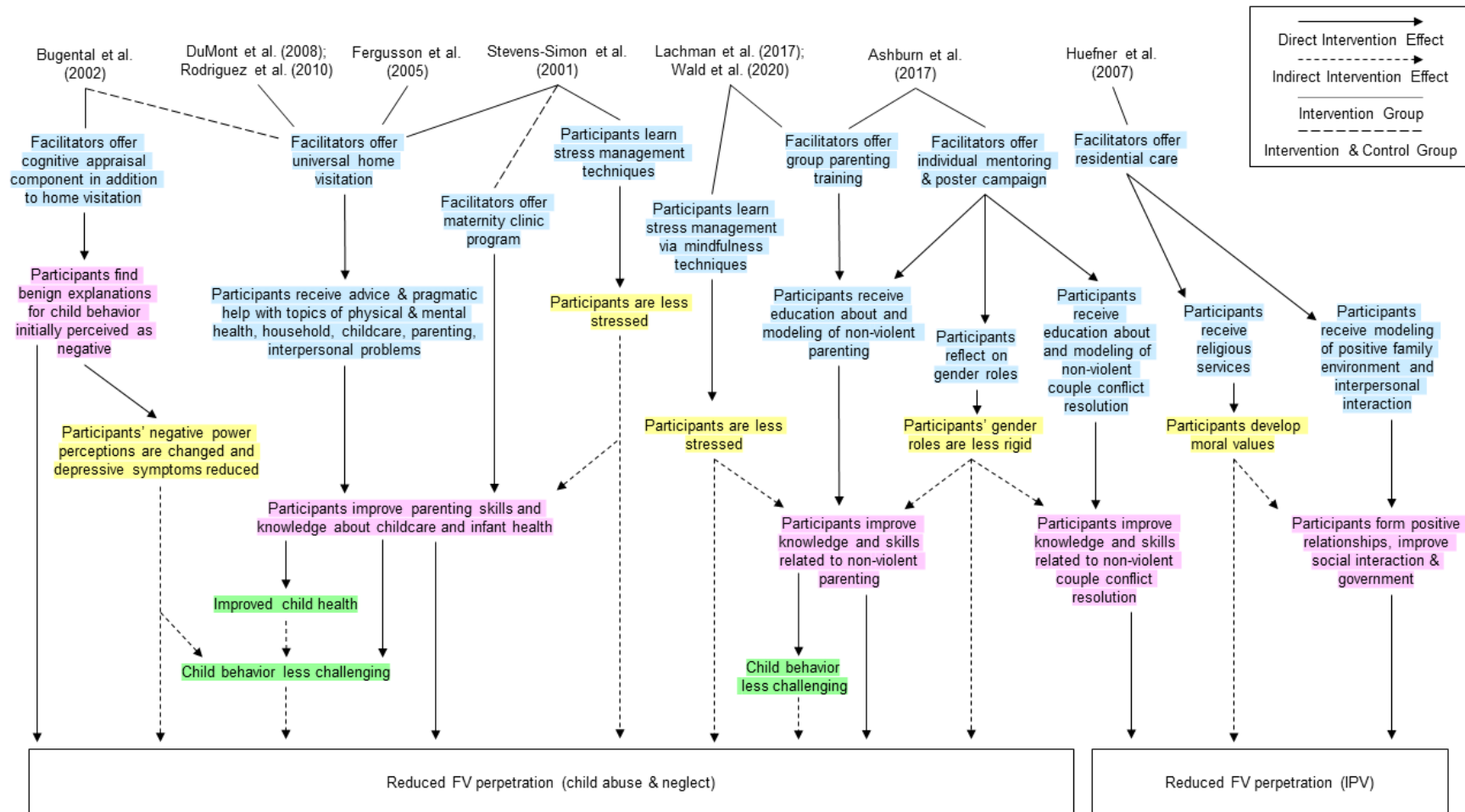
Synthesis was conducted following the guidance on the conduct of narrative synthesis in systematic reviews (Popay et al., 2006).

Theory of change

In order to create a synthesized theory of change model, related textual material was extracted from all included study reports. This section contains supplementary information for the graphical model presented in *Figure 2*.

In the graphical model, studies that examined the HFNY program (DuMont et al., 2008; Rodriguez et al., 2010) and PLH for Young Children (Lachman et al., 2017; Ward et al., 2020) are depicted in a combined column each, since interventions were identical, and theory of change models did not differ.

This synthesized theory of change model relies largely on textual descriptions in the articles. It is important to note that the individual model of each intervention may exhibit varying degrees of complexity that are beyond the scope of this review. And although narrative synthesis is aimed at representing study characteristics and contexts in more depth than meta-analysis, a certain degree of complexity reduction is inevitable in any synthesis process (Anderson et al., 2013; Popay et al., 2006). Consequently, the pathways depicted in *Figure 2* represent models of reduced complexity in an effort to synthesize commonalities between interventions. Primarily, the prevention and reduction of FV perpetration (direct measures of negative behaviors) are the focus of the present review. Therefore, other proximal behavior outcomes (e.g., positive parenting) were not included as ultimate outcomes in this model, albeit mentioned as an important intervention aim in many of the included

Figure 2*Synthesized Theory of Change*

Note. Program components in blue, proximal adult outcomes in pink, distal adult outcomes in yellow, distal child outcomes in green.

articles (Ashburn et al., 2017; Fergusson et al., 2005; Lachman et al., 2017; Rodriguez et al., 2010; Ward et al., 2020). Additionally, information about interventions' theory of change in the included articles was limited and mostly implicit. Only two articles directly use the term "theory of change" (Ashburn et al., 2017; Lachman et al., 2017). Only one study included a graphical model (Lachman et al., 2017), one included explicit mediation analysis (Bugental et al., 2002) and three included subgroup analyses to detect moderator effects (Bugental et al., 2002; DuMont et al., 2008; Rodriguez et al., 2010). Consequently, the synthesized model is an aggregation of *basic* theories of change (Mayne, 2015).

The graphical depiction of the PLH for Young Children theory of change model (Lachman et al., 2017) encompasses four different categories: program components, proximal adult outcomes, distal adult outcomes and distal child outcomes. The same categorization can also be applied to the synthesized model, as is denoted by color coding in *Figure 2*. Secondly, effect pathways can be divided into direct and indirect effects, which are related to component and outcome categorization: Lachman et al. (2017) posit that proximal adult outcomes have direct effects on ultimate outcomes, while distal adult and child outcomes have indirect effects on ultimate outcomes.

Target Population. Theory of change models typically include information about the intervention's target population (Popay et al., 2006). The defining feature of all included studies' participants is their childhood history of FV victimization. Sample size, gender distribution, age distribution (caregiver), age distribution (child), caregiver status (biological parent or other), treatment group allocation, and geographic location can be viewed in *Table 1* in *Appendix B*. Since the graphical model does not include the risk factors of each intervention's study population for layout reasons, they are described here. Every intervention examined by the included studies classifies as selective prevention, meaning prevention warranted by broad risk factors (e.g., poverty) that may not be present in all individuals of a sample but indicate risk in the population the sample is drawn from (O'Connell et al., 2009). In addition to childhood history of FV victimization indicating potential ITFV, the authors of all included studies characterized substantial parts of their samples as at risk for FV perpetration for the following reasons: Ashburn et al. (2017) mention a post-war setting, a deprived region, prior FV perpetration and low income. Bugental et al. (2002) mention single caregivers, high scores on family stress measures, premature birth and recent immigration (*Author's note*: associated with socioeconomic

disadvantages and increased psychosocial risk factors, e.g., Euser et al., 2011; Garcini et al., 2021). DuMont et al. (2008) and Rodriguez et al. (2010) mention low income, high scores on family stress measures, prior FV perpetration and young age at childbirth (< 19 years). Fergusson et al. (2005) mention low income, single caregivers, unplanned pregnancy and adult IPV victimization. Huefner et al. (2007) mention an unstable home environment, behavioral disorders and criminal activity. Lachman et al. (2017) and Ward et al. (2020) mention a deprived region, low income, adult IPV victimization, and HIV/AIDS infections. Lachman et al. (2017) additionally mention experiences of hunger. Ward et al. (2020) additionally mention alcohol and substance use, and parental concern about child conduct problems. Stevens-Simon et al. (2001) mention young age at birth (<19 years), high scores on family stress measures, poor family support, problematic behaviors, school dropout and depression/stress.

Pathways Supported by Statistical Test Results. The study of the Healthy Start home visitation program enhanced by a cognitive appraisal component (Bugental et al., 2002) is the only one that included mediation analysis based on mediation theory by Baron and Kenny (1986). Factors included in analysis were cognitions about a perceived power imbalance between caregiver and child, affect (represented by anxiety and depression), and quality of social support. Only power perception was predicted to mediate specifically the effect of the intervention group condition (addition of the cognitive appraisal component) on the FV outcome (harsh parenting). Affect and quality of social support were predicted to be associated with both intervention group and control group condition. Partial support was found for mediating roles of power perception and stronger, but also partial, support for depression in the intervention group condition (Bugental et al., 2002). No evidence was found for quality of social support. The results indicated support for the part of the study's theory of change assuming the cognitive appraisal intervention to change participants' power perceptions. However, power perceptions were not supported as a pathway to reduction of FV perpetration. The authors (Bugental et al., 2002) discuss empathy as the potential link underlying the stronger partial support for depression as a partial mediator: Reductions in depressive symptoms may be associated with higher capacity for empathy (Bugental et al., 2002). The cognitive appraisal intervention may increase caregivers' capacities to engage in reflective rather than automatic processing (Bugental et al., 2002). This could enable

caregivers to exhibit more empathy towards their child, which may in turn lead to reduced FV perpetration (Bugental et al., 2002). In addition to mediation analysis, Bugental et al. (2002) also conducted a subgroup analysis to examine child risk as a potential moderator. Child risk was defined by premature birth and low Apgar-score. These factors were assumed to be associated with more challenging child behavior. Subgroup analysis revealed a significant interaction between child risk and the FV outcome (harsh parenting), evidencing a moderator effect. Bugental et al. (2002) discuss how the cognitive appraisal intervention can benefit caregivers of “difficult” infants the most and that it might be worth targeting this population specifically. The intervention is designed to help participants to handle challenging child behavior in a more controlled manner, thus ultimately leading to a reduction of harsh parenting tactics (Bugental et al., 2002).

Logistic regression and log linear regression were employed by DuMont et al. (2008) for analysis of FV outcomes. Student’s *t*-tests and χ^2 -tests were used to analyze control variables, including the distal adult outcomes caregiver depression and caregiver physical health. The article mentions multiple proximal and distal outcomes as aims in the description of HFNY’s theory of change (e.g., improving parent-child relationship and increasing healthy behaviors) but does not report on any such secondary outcome measures or results. However, two subgroup analyses were conducted additionally. One consisted of young first-time mothers and one of psychologically vulnerable individuals (high depression scores and low sense of mastery). The two analytic subgroups consisted largely of two separate groups of participants, evidencing minimal overlap. Both sets of characteristics were found to moderate the differences between intervention and control groups of FV perpetration. The specific benefits HFNY can yield for young first-time mothers and the psychologically vulnerable are discussed with regards to potentially tailoring HFNY specifically for these subpopulations (DuMont et al., 2008).

The follow-up study on HFNY (Rodriguez et al., 2010) found significant improvements in positive parenting for the overall sample, but not for the subgroup limited to young (age < 19) first-time mothers. Analysis was conducted using logistic regression. The article contains no discussion of potential explanations for this non-significant finding. The overall significant effect of HFNY on positive parenting is explained as the result of the behaviors that constitute positive parenting on the microlevel (e.g., maternal responsivity and cognitive engagement with the child)

which are implied to be part of the theory of change (Rodriguez et al., 2010). The moderating effect found by DuMont et al. (2008) was replicated via subgroup analysis of young first-time mothers in this study (Rodriguez et al., 2010).

Fergusson et al. (2005) included several secondary proximal and distal outcomes indicated as aims of Early Start's theory of change. Student's *t*-tests and χ^2 -tests found significant improvements of positive parenting, caregiving attitudes, child health outcomes and child behavioral adjustment, as well as compliance with education and community services. The authors note that local public health promotion campaign had taken place at the time of the study, which may explain improvements in child health outcomes.

Stevens-Simon et al. (2001) included maternal and child health behaviors as secondary outcomes of their study on the CAMP home visitation module but found no statistically significant changes using, except for improvements in contraception use among intervention group mothers. Analysis was conducted via Student's *t*-tests and χ^2 -tests for all outcomes. Post-hoc analysis revealed an association between child abuse and high scores on the family stress measure. In accordance with the intervention's theory of change, stress management is discussed as a potential pathway to child abuse prevention.

Lachman et al. (2017) used multivariate mixed modeling to investigate intervention effects on primary and secondary outcomes, including the proposed elements of PLH for Young Children's theory of change. Among proximal outcomes, significant improvements were found for self-reported positive parenting, but neither for observed positive parenting nor self-reported or observed limit-setting behavior. Among adult distal outcomes, no statistically significant changes were found for caregiver stress, caregiver depression or perceived social support. Changes in child behavior were not statistically significant either, except for an increase in observed child-led play and a decrease in child positive behavior. This detrimental effect was discussed by the authors, assuming that facilitators placed too much focus on discipline during sessions.

Ward et al. (2020) mention changes made to PLH for Young Children in terms of session contents related to discipline and positive parent-child interaction. These are introduced as responses to the earlier preliminary findings (Lachman et al., 2017). Ward et al. (2020) used multilevel generalized linear modeling for analysis,

employing log link for variables that were not Gaussian-distributed. Models found significant improvements of observed positive parenting at immediate post-test (t1) and follow-up (t2), as well as for self-reported positive parenting at t1 but not t2. No changes were found for distal child outcomes, except for an increase in observed positive child behavior (t1 and t2). Consistent Lachman et al. (2017), no changes were found for distal adult outcomes, including caregiver stress, caregiver depression, perceived social support, and monitoring behavior (Wald et al., 2020). Results of the analytical model indicated a time association between increases in positive parenting and positive child behavior. The authors discuss the positive parenting as a potential step towards less challenging child behavior.

Ashburn et al. (2017) utilized multiple logistic regression analysis. Statistically significant beneficial effects on distal adult outcomes included increases in attitudes rejecting physical discipline, greater confidence in using non-violent discipline, improved couple communication, and reduced justification of IPV (both end line and follow-up). Improved proximal outcomes included parent-child interaction (both time points) and positive parenting (end line but not follow-up). No effects were found for rejection of traditional gender norms. The authors discuss that behavioral change may be easier accessible than change in societal norms. Couple communication was found to be associated with reduced odds of physical IPV perpetration and increased odds of attitudes rejecting use of physical violence, confidence in using non-violent discipline, positive parenting and positive parent-child interaction. The authors consequently discuss couple communication as a potentially important factor in the REAL Fathers Initiative's theory of change.

Huefner et al. (2007) mention that they surveyed participants on multiple secondary outcome areas including health and social functioning but provided no data in the article on what exactly these secondary outcomes were. Although no data are reported, the authors discuss potential pathways of change they suspect to explain the FHP's IPV prevention effect. Analysis of primary outcomes was conducted via logistic regression and χ^2 -tests. Huefner et al. (2007) report that multivariate analysis of variance was used to detect potential group differences on 17 demographic variables, but these variables are not reported in detail. The reported result denotes that all demographic variables were controlled.

Summary. The included studies vary in the degree to which a theory of change was made explicit and to which it was investigated. Articles about those studies that relied on Student's *t*-tests and χ^2 -tests (Fergusson et al., 2005; Stevens-Simon et al., 2001) did not contain inferences about indications for confirmation or rejection of assumptions underlying their theories of change, except for the discussion of post-hoc results related to caregiver stress (Stevens-Simon et al., 2001). Reports of studies that used more complex regression modeling to examine potential connections between different outcomes (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020) provided cautious interpretation of indicated pathways, including caregivers' couple communication (Ashburn et al., 2017) and positive parenting (Ward et al., 2020). Reports of studies that included mediation (Bugental et al., 2002) and moderation analyses (Bugental et al., 2002; DuMont et al., 2008; Rodriguez et al., 2010) contain more definitive inferences based on these specific results. Partial support was found for mediation of the intervention effect through reduced depression and reduction in perceived power imbalance between caregiver and child (Bugental et al., 2002). Child risk, defined as the combination of low Apgar-scores and birth of the child during preterm (Bugental et al., 2002), psychological vulnerability, defined as the combination of low sense of mastery and high depression scores (DuMont et al., 2008), and the combination of being a first-time mother and young (age < 19) at childbirth (DuMont et al., 2008; Rodriguez et al., 2010) were found to have moderating effects. Only the study report by Huefner et al. (2007) contains no information about analysis of any secondary outcomes related to the intervention's theory of change.

Preliminary Synthesis

Based on the synthesized theory of change model, the included studies are grouped into three categories based on the core components of the investigated intervention types: first, *home visitation* (Bugental et al., 2002; DuMont et al., 2008; Fergusson et al., 2005; Rodriguez et al., 2010; Stevens-Simon et al., 2001), second, *parenting programs* (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020), and third, *residential care* (Huefner et al., 2007).

Category 1. Studies in the first category all share the core component of universal home visitation. These interventions are aimed at caregivers with newborn children and start providing services immediately at, shortly after, or shortly before

birth (Bugental et al., 2002; DuMont et al., 2008; Fergusson et al., 2005; Rodriguez et al., 2010; Stevens-Simon et al., 2001). The sample demographics of all studies included in the home visitation category consequently represent this population. Mothers in the home visitation studies were also relatively young (mean age = 17,5-25,5) and intervention time periods of all programs are relatively long, covering the first 1 to 3 years of the children's life, HFNY even up to 5 years (DuMont et al., 2008; Rodriguez et al., 2010).

Category 1 studies were all set in high-income countries. Three out of the 4 programs (Healthy Start, HFNY & CAMP) are conducted in the USA, with Early Start in New Zealand as the only exception. However, Fergusson et al. (2005) mention that the development of Early Start was heavily influenced by US-based home visitation programs like HFNY and the NFP (e.g., Olds, 2006). This is reflected in conceptual similarity between the theory of change models described for Early Start (Fergusson et al., 2005) and HFNY (DuMont et al., 2008), with the exception that Early Start employs tertiary educated professionals and HFNY relies on paraprofessionals. Past this limitation, both programs follow a relatively similar concept of supporting caregivers of a newborn child in a range of everyday life challenges with advice and pragmatic help.

The other two programs in this category deviate a little further from the core concept. Stevens-Simon et al. (2001) studied the effects of home visitation as an expansion module of the CAMP maternity program. Participants of the study's intervention group thus not only received the home visitation service, but also had regular appointments with other health service providers at a clinic that form the basis of CAMP (Stevens-Simon et al., 2001). Bugental et al. (2002) on the other hand examined the effects of a microlevel enhancement module within a home visitation program. Intervention group participants received regular home visitation services, with the addition that home visitors provided them with a semi-manualized cognitive reappraisal intervention during every visit. The aim of this process is to elicit change in the caregivers' cognitions, towards a more benevolent perception of their child (Bugental et al., 2002). These variations from the connecting core of studies in the first category have to be addressed when drawing conclusions about grouping.

Category 2. The two parenting programs examined by the three studies in the second category, namely the REAL Fathers Initiative (Ashburn et al., 2017) and PLH

for Young Children (Lachman et al., 2017; Ward et al., 2020), both represent attempts to adapt content of parenting programs that were indicated to be effective in high-income countries to fit the context of low- and middle-income countries.

Both programs include group-based education on parenting strategies, facilitated by community volunteers. Session content is clearly structured, and participants are encouraged to independently transfer learnings from the program to the home environment. Both programs are relatively short (3-6 months) and focus on teaching specific strategies for positive and non-violent parenting (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020), which stands in contrast to the more involved, more extensive and more generalized support approach of the home visitation programs in category 1.

Some overlap between categories 1 and 2 can be seen in the graphical model, namely over stress management and child behavior. Stress management techniques as a program component are mentioned both in a home visitation study (Stevens-Simon et al., 2001) and parenting program studies (Lachman et al., 2017; Ward et al., 2020). Difficulty of child behavior is a distal outcome that all parenting and home visitation programs included in their theories of change.

There are a number of differences within category 2, meaning between the REAL Fathers Initiative (Ashburn et al., 2017) and PLH for Young Children (Lachman et al., 2017; Ward et al., 2020). The former targets prevention of IPV in tandem with child abuse, is designed specifically for male caregivers, and study participants were relatively young (ages 16-25, mean age = 23; Ashburn et al., 2017) while the latter does not include IPV-specific content and was studied with primarily female participants of a wider variety of age groups (mean age = 41-42; Lachman et al., 2017; and ages 18-60+; Ward et al., 2020). PLH for Young Children also incorporates fewer program components and is shorter (3 months) than the REAL Fathers Initiative (6 months). While PLH for Young Children includes mindfulness techniques for stress reduction (Lachman et al., 2017) next to the core parenting component, which the REAL Fathers Initiative does not, the latter makes use of multiple other components. Participants in the REAL Fathers Initiative receive individual mentoring sessions in addition to the group program, and mentors are selected by the participants. A public poster campaign depicting fathers engaging in positive parenting behaviors is conducted simultaneously during the intervention

period. And in addition to the content about parenting, the REAL Fathers Initiative also encourages participants to reflect on traditional gender norms critically. In addition to the aim of promoting positive and non-violent parenting strategies, which is shared among the two programs, the REAL Fathers Initiative also includes less rigid gender concepts, a positive image of fatherhood and improved couple communication as outcomes (Ashburn et al., 2017). And albeit both the REAL Fathers Initiative and PLH for Young Children were implemented and examined on the same continent, the contextual and regional differences were substantial. The study by Ashburn et al. (2017) was conducted in a rural area of post-war Northern Uganda, while the PLH studies (Lachman et al., 2017; Ward et al., 2020) were conducted in deprived, yet relatively peaceful urban areas within Cape Town, South Africa. Again, variations between studies within the category have to be accounted for when observing patterns between categories.

Positive couple relationship competency as a pathway to IPV prevention is a targeted outcome shared between the REAL Fathers Initiative (Ashburn et al., 2017) and the FHP (Huefner et al., 2007) as described in the articles. Nonetheless, they are not similar enough to warrant grouping them together, as is outlined in the section on category 3.

Category 3. The FHP (Huefner et al., 2007) has characteristics distinguishing it from all other interventions included in the present review. Participants do not participate in short-term behavior training like the parenting programs in category 2 or receive home visits like in category 1. Instead, the adolescent (ages 10-18) FHP participants who were surveyed for the study (Huefner et al., 2007) lived in the homes of intervention facilitators. What the study refers to as *residential care* thus resembles temporary foster care with an added focus on modeling relationship skills and positive social functioning. In contrast to the other two categories, the FHP does not include specific content on childcare or parenting and consequently does not address distal child outcomes. Neither does the program include techniques for stress management or cognitive reappraisal, nor critical reflection of gender norms.

The program is designed to buffer the negative effects which risk factors such as a childhood history of FV victimization, behavioral disorders, and involvement in crime may otherwise have on social, mental health and behavioral outcomes in adulthood (Huefner et al., 2007). The core program components lie in changing the

residency of participants to a stable home environment intended to be free from violence, and the modeling of positive family interaction through facilitator families. Being embedded within the framework of the religious organization Boys Town (Daly & Thompson, 2022), the FHP also includes spiritual development and the development of adjacent moral values as program aims.

There also is marginal overlap with the other categories. Like the home visitation programs in category 1, the FHP promotes self-government by teaching practical competencies related to household chores and health behaviors. The FHPs intervention duration (mean = 1,5 years; Huefner et al., 2007) is also similar to that of some home visitation programs (Bugental et al., 2002; Stevens-Simon et al., 2001). And like the REAL Fathers Initiative (Ashburn et al., 2017) in category 2, the FHP also targets IPV prevention, albeit pathways differ in that the FHP relies less on teaching specific skills to foster positive relationship behavior but rather aims to model generally harmonious style of family living (Huefner et al., 2007).

Summary Categorization. Three categories were created on the basis of the synthesized theory of change model. Five studies (Bugental et al., 2002; DuMont et al., 2008; Fergusson et al., 2005; Rodriguez et al., 2010; Stevens-Simon et al., 2001) were grouped together as category 1. Studies in this category all tested the effectiveness of interventions that share the core component *home visitation*. However, differences exist in terms of program concept (universal home visits vs. combination with a clinic-based program vs. addition of a cognitive appraisal component), program duration (1 vs. 2 vs. 3 years) and facilitator qualification (professional vs. paraprofessional). Category 2 contains three studies (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020) of two interventions that are both *parenting programs* at the core. Again, several differences exist, this time between program delivery (group only vs. group, individual & public campaign), setting (urban & no recent conflict vs. rural & recent conflict), targeted program outcomes (parenting only vs. parenting, IPV & gender norms), gender of target population (all genders vs. male only) and age (diverse vs. young). The *residential care* program in the single study making up category 3 (Huefner et al., 2007) differs so much from the rest in terms of core component, target population and context that it was not grouped together with any other study.

The distinctness of the categories from one another, as well as the variation within categories, highlight the heterogeneity of interventions examined by the included studies.

Exploring Relationships in the Data

Both the guidance on the conduct of narrative synthesis in systematic reviews (Popay et al., 2006) and the guideline for synthesis without meta-analysis (SWiM; Campbell et al., 2020) suggest the use of vote-counting if meta-analysis is not feasible. However, this method is highly vulnerable to a range of biases (Combs et al., 2011; Vadillo et al., 2016). In consultation with supervisor Prof. Lueger-Schuster a decision was made against the use of vote-counting as a tool for inference. Consequently, the present synthesis explores available data on effects found in the included studies without aggregating coefficients and only displays statistical significance as a descriptive tool.

Table 5 includes a broad overview of statistically significant beneficial effects found for any FV outcomes in the included studies, grouped by category and type of measure. *Table 6* extends this overview to effect sizes.

Table 5

Significant Beneficial Effects on FV Perpetration Outcomes

Intervention type	Study	Self-report ^{1,2,3}	CPS report ^{1,2,3}	Observation ^{1,2,3}
Category 1: Home visitation	Bugental et al. (2002)	✓		
	DuMont et al. (2008)	(✓)	✗	
	Rodriguez et al. (2010)			(✓)
	Fergusson et al. (2005)	✓	✗	
	Stevens-Simon et al. (2001) ⁴	(✓)		

Intervention type	Study	Self-report ^{1,2,3}	CPS report ^{1,2,3}	Observation ^{1,2,3}
Category 2 Parenting programs	Lachman et al. (2017)	×		×
	Ward et al. (2020)	×		×
	Ashburn et al. (2017)	(✓)		
Category 3: Residential care	Huefner et al. (2007)	✓		

Note. The available exact p -values and effect sizes of all included studies that provided them are listed in *Table 2* in *Appendix B*.

¹ ✓ denotes $p < .05$ for all outcome measures of this category.

² (✓) denotes $p < .05$ for at least one outcome measures of this category.

³ × denotes $p > .05$ for all outcome measures of this category.

⁴ Unclear reporting of measures. Self-report assumed.

Table 6

Effect Sizes for FV Perpetration Outcomes

Intervention type	Study	Self-report ^a	CPS report ^a	Observation ^a
Category 1: Home visitation	Bugental et al. (2002) ^b	0.54-0.57		
	DuMont et al. (2008)	Insufficient data provided.		
	Rodriguez et al. (2010)	Insufficient data provided.		
	Fergusson et al. (2005)	0.26	0.04	

Intervention type	Study	Self-report ^a	CPS report ^a	Observation ^a
Category 2: Parenting programs	Stevens-Simon et al. (2001) ^d	Insufficient data provided.		
	Lachman et al. (2017)	0.02		<i>0.34</i>
	Ward et al. (2020) ^c	0.01-0.08		0.01-0.04
	Ashburn et al. (2017) ^c	0.04-0.21		
Category 3: Residential care	Huefner et al. (2007) ^c	0.06-0.32		

Note. Levels of effect sizes are indicated as follows: very small to no effect ($d \leq 0.20$), *small effect* ($0.21 \leq d \leq 0.49$) (italicized) and **medium effect** ($0.51 \leq d \leq 0.79$) (bold). No large effects were included.

^a Cohen's d

^b Computed using the Practical Meta-Analysis Effect Size Calculator (Wilson, 2001)

^c Calculated using conversion formula (Borenstein et al., 2009)

^d Unclear reporting of measures. Self-report assumed.

All included studies that used self-report measures of FV perpetration used the CTS (Straus, 1979) and CTS-PC (Straus et al., 1998), except for Huefner et al. (2007) who used an IPV-related question item from the NSFH (Bumpass & Sweet, 2018; Bumpass et al., 2017) and Ward et al. (2020) who used the ICAST-Parent Report (Runyan et al., 2009). Three studies used observational measures (Lachman et al., 2017; Rodriguez et al., 2010; Ward et al., 2020). CPS reports were used by two studies (DuMont et al., 2008; Fergusson et al., 2005).

Category 1. Included studies found significant individual reductions in FV outcomes as follows: The addition of a cognitive appraisal component to standard home visitation of Healthy Start (Bugental et al., 2002) was found to be associated with post-intervention reductions of all measured outcome dimensions, including physical child abuse, legally non-abusive spanking/slapping, and a harsh parenting composite, when compared to home visitation only and the no-treatment control group. Reductions of harsh parenting also appeared for a subgroup of caregivers with high-risk infants when compared to caregivers with low-risk infants.

DuMont et al. (2008) measured eight different dimensions of FV outcomes 1 year (t1) and 2 years (t2) after childbirth, including very serious abuse and neglect, serious abuse and neglect, minor physical aggression, psychological aggression, neglect, harsh parenting in the past week, a serious abuse and neglect self-report composite, and substantiated CPS reports of abuse and neglect. HFNY home visitation was found to be associated with frequency reductions of very serious physical abuse (t1), psychological aggression (t1), serious physical abuse (t2), and minor physical aggression (t2) for the overall study sample, but no reductions in prevalence (DuMont et al., 2008). HFNY home visitation was found to reduce prevalence of minor physical aggression (t2) and harsh parenting in the past week (t2) for a subgroup of young (age < 19) first-time mothers when compared to the remainder of the sample. No reductions in FV frequency were found for this subgroup. A separate subgroup that consisted of psychologically vulnerable caregivers was found to benefit from HFNY home visitation in the form of reductions of a frequency reduction in terms of psychological aggression (t1) and both prevalence and frequency on the serious abuse and neglect composite measure (t2) when compared to the remainder of the sample.

The second study of the HFNY program (Rodriguez et al., 2010) used observational measures to assess harsh parenting during playful tasks at year 3 after childbirth. No significant reductions of harsh parenting behaviors were found for the overall sample, but a subgroup of young (age < 19) first-time mothers saw significant reductions of harsh parenting when compared to the remainder of the sample on two out of three tasks.

At the end of the 3-year home visitation program Early Start, Fergusson et al. (2005) found significant reductions in self-reported severe physical punishment by

either caregiver, compared to controls. No difference was found in CPS reports (Fergusson et al., 2005).

At end point of the CAMP maternity program – 2 years after childbirth – Stevens-Simon et al. (2001) found the addition of a home visitation module to be associated with a significant reduction of neglect when compared to CAMP only. No differences were found in terms of other child abuse (emotional, physical, and sexual) and abandonment. Details on how these behaviors were measured are not provided by the study report.

Category 1 Summary. All studies in category 1 that used self-reported FV outcome measures found significant reductions on at least one measure (DuMont et al., 2008; Stevens-Simon et al., 2001) or all measures (Bugental et al., 2002; Fergusson et al., 2005). Available effect sizes for self-report measures were in the small to medium range (Bugental et al., 2002; Fergusson et al., 2005). Studies that used CPS reports found no differences between interventions and controls (DuMont et al., 2008; Fergusson et al., 2005), accompanied by a very small effect size (Fergusson et al., 2005). The single study that used observational assessment, a follow up to the study by DuMont et al. (2008) found significant reductions of FV perpetration on two out of three measures (Rodriguez et al., 2010).

Splitting category 1 into two subgroups by separating the studies investigating programs that rely purely on home visitation (DuMont et al., 2008; Fergusson et al., 2005; Rodriguez et al., 2010) from studies of expanded home visitation (Bugental et al., 2002; Stevens-Simon et al., 2001) would leave each subgroup equally with one program that was found to reduce FV on all measures and one that was found to reduce FV on a fraction of measures.

Category 2. The preliminary RCT by Lachman et al. (2017) found no significant differences in caregivers' self-reported harsh parenting and observed negative parenting after the 3-month intervention period of PLH for Young Children.

The second trial of PLH for Young Children (Ward et al., 2020) measured outcomes 4-5 months after completion (t1) and once more at 17 months after completion (t2). No significant reductions were found, neither for physical punishment and psychological punishment, as measured by the ICAST-Parent Report (Runyan et al., 2009), nor for negative parenting as measured by observation.

The study of the REAL Fathers Initiative (Ashburn et al., 2017) measured outcomes 4 months after completion (t1) and 8 months after completion (t2) on the CTS (Straus, 1979) and CTS-PC (Straus et al., 1998). Significant reductions of physical child punishment (t2), any IPV (t1 & t2), psychological IPV (t1 & t2) and verbal IPV (t1 & t2) were reported by caregivers. No differences to the comparison group were found in terms of physical IPV.

Category 2 Summary. Only one out of the three studies in category 2 found significant reductions of FV perpetration on their self-report measures (Ashburn et al., 2017). Effect sizes were in the very small to small range (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020). Agency-report measures were not used. The two studies that used observational measures in addition to self-report (Lachman et al., 2017; Ward et al., 2020) found no significant differences in observed FV perpetration between intervention and control groups (Lachman et al., 2017; Ward et al., 2020). Effect sizes for observation were in the very small to small (Lachman et al., 2017; Ward et al., 2020).

Splitting category 2 into two subgroups by separating the study of the REAL Fathers Initiative (Ashburn et al., 2017) from the studies of PLH for Young Children (Lachman et al., 2017; Ward et al., 2020) would favor the former (Ashburn et al., 2017) in terms of significance of group differences. However, the greatest magnitude of reduction ($d = 0.34$) was found in the study by Lachman et al. (2017).

Category 3. The single study making up this category (Huefner et al., 2007) conducted their interviews at 16-year follow-up. The self-reported IPV rate of adults who had participated in the FHP during adolescence did not differ ($d = 0.06$ for < 18 months of stay; $d = 0.07$ for > 18 months of stay) from the IPV rate found in the normative data gathered by the NSFH (Bumpass & Sweet, 2018; Bumpass et al., 2017). Individuals who had been admitted to the program in adolescence, but had not joined, exhibited a significantly higher rate of self-reported IPV perpetration when compared to national normative data ($d = 0.32$).

Overall Summary. Significant beneficial effects on self-reported FV outcomes were found within all three categories. Studies that made use of CPS reports (DuMont et al., 2008; Fergusson et al., 2005) found no significant differences between intervention and control groups in terms of agency-reported FV perpetration. The pattern of observational measures was mixed, with significant reductions

reported in category 1 (Rodriguez et al., 2010), but not category 2 (Lachman et al., 2017; Ward et al., 2020). Effect sizes ranged from very small to medium in category 1 and only from very small to small in category 2 and category 3. The highest magnitude of a beneficial effect ($d = 0.57$) was found by a study within category 1 (Bugental et al., 2002) and the lowest ($d = 0.01$) by a study within category 2 (Ward et al., 2020). Since aggregation of coefficients was omitted, no inferences were made.

Discussion

The greatest issue of this systematic review may well be its most important finding: the low study availability ($k = 9$) in the area of interest. Extensive research has been conducted to investigate the phenomenon of FV (e.g., Tolan et al., 2009) and its prevention (e.g., Coore-Desai et al., 2017; Geeraert et al., 2004; Mikton & Butchart, 2009). But only a smaller field is concerned specifically with the prevention of ITFV (e.g., Schelbe & Geiger, 2017). And within that small fraction, the present study illustrated that there is only very little research that examined effectiveness of preventive interventions for childhood FV victims using direct measures of FV perpetration.

Studies identified by the present review did include the childhood FV victimization variable, but often only as a demographic characteristic (e.g., DuMont et al., 2008) or to detect its exacerbating influence on FV perpetration in the overall sample (Ashburn et al., 2017). Only one study (Huefner et al., 2007) conducted an exploratory subgroup analysis of the treatment effect for participants with a childhood victimization history and found indication for a beneficial treatment effect. However, this study was largely retrospective in nature and had to rely on normative data as a reference category against which to test the treatment effect (Huefner et al., 2007). None of the included studies used childhood history of FV victimization as the main grouping variable. Consequently, the contained information about the effectiveness of ITFV prevention can thus only be viewed as limited. However, even though fractional, the percentage of childhood victimization reports in the included study samples was high for most types of FV (31.8-78.0%) compared to the 10-12% found in population-based studies (Armfield et al., 2021; Finkelhor et al., 2014). Only childhood sexual abuse victimization was found in around 6% in one study (Ward et al., 2020).

Due to the small number and considerable heterogeneity in terms of intervention concept, target population and context of the studies included in the review, the aggregation of statistical coefficients was omitted.

Narrative synthesis of quantitative study end points produced largely inconclusive patterns: A number of studies found indications of intervention effectiveness via null hypothesis-testing (Ashburn et al., 2017; Bugental et al., 2002; Fergusson et al., 2005; DuMont et al., 2008; Rodriguez et al., 2010; Stevens-Simon et al., 2001) while others did not (Lachman et al., 2017; Ward et al., 2020). One pattern emerged across categories: None of the studies using CPS reports (DuMont et al., 2008; Fergusson et al., 2005) found any significant effects. However, since no inferential statistics were employed, no conclusions can be drawn from this. Reported effect sizes were in the very small to medium range with no discernible patterns across categories. Medium sized effects were only found by a single study (Bugental et al., 2002).

In addition to the effectiveness of interventions in the reduction of FV perpetration, the narrative synthesis performed in the present study was interested in the characteristics of the examined interventions.

A synthesized theory of change model was created which formed the basis of study categorization into three detected categories: *home visitation*, *parenting programs*, and *residential care*. The first category contained studies on interventions based on universal support for caregivers of young children in their home. Home visitation programs are relatively well researched in the US, initially producing rather mixed results (Bilukha et al., 2005), but receiving more support in recent years (Avellar & Supplee, 2013; Kirkland et al., 2020). Consequently, the studies in this category were evaluations of large government-funded US-American programs like Healthy Start (Bugental et al., 2002) and HFNY (DuMont et al., 2008; Rodriguez et al., 2010), as well as a home visitation expansion of the smaller-scale CAMP (Stevens-Simon et al., 2001) and New Zealand-based Early Start (Fergusson et al., 2005) which was modeled after the US-based NFP (Olds, 2006) and HFA (Harding et al., 2007) programs. These programs, albeit not identical, all share a relatively broad range of goals around the improvement of health and social outcomes for newborn or very young children and their caregivers. FV prevention is only one of these

outcomes and thus not always the primary concern of evaluation studies. Still, some information on the pathways to FV prevention was found in this category:

Stevens-Simon et al. (2001) found that lower family stress was associated with reduced likelihood of FV perpetration, but this was true for both participants receiving the standard maternity program (control group) and participants receiving the maternity program combined with a home visitation module (intervention group) which the study was interested in.

Based on finding partial support for two potential mediators (depression and power perception), Bugental et al. (2002) suspected a pathway between the intervention that addressed adult-to-child power perception, reduced depression, increased capacity for empathy, and reduced FV perpetration. This notion is complemented by more recent publications that found maternal depression as a risk factor for the ITFV (e.g., Plant et al., 2013; Yang et al., 2018), as well as a mediator between mothers' childhood abuse experiences and their children's victimization (Choi et al., 2019), and linked empathy in depressed caregivers to reductions in FV perpetration (Ojo et al., 2021).

The synthesis' second category was comprised of studies on interventions that aim to teach caregivers specific skills for non-violent parenting. Studies included in this category (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020) were concerned with the implementation of FV prevention programs in low- and middle-income countries, that were developed based on scientific findings in high-income countries. This endeavor tends to pose the challenge of adapting treatment conditions to a different economic but often also a different cultural context (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020) and has been the subject of a growing body of research in the past decade (e.g., Coore-Desai et al., 2017; Turner et al., 2020). All of the articles included in this category stated the preliminary nature of their research in the context of novel program development and first-time implementation in the respective region (Ashburn et al., 2017; Lachman et al., 2017; Ward et al., 2020).

Indications for the support of pathway assumptions mentioned in program theories of change were found for couple communication with regards to IPV prevention (Ashburn et al., 2017) and positive parenting with regards to child abuse prevention (Ward et al., 2020).

The former finding (Ashburn et al., 2017) is consistent with research supporting the use of voluntary couples therapy (Karakut et al., 2016), which promotes conjoint communication and relationship skills (Armenti & Babcock, 2016). The REAL Fathers Initiative (Ashburn et al., 2017) only posits positive couple communication as a pathway to IPV prevention for male perpetrators, whereas research on the ITFV additionally indicated supportive partner relationships and positive couple communication as a protective factor against the transmission of child abuse (Conger et al., 2013; Jaffee et al., 2013; Schofield et al., 2017; Thornberry et al., 2013).

The latter indication involves positive parenting (Lachman et al., 2017), which is typically constituted as a conglomerate of caring behaviors that form a kind of positive alternative to parenting styles that may result in FV (Seay et al., 2014). Caregivers with a childhood history of FV victimization may have trouble engaging in positive parenting when their mental health is impaired (Greene et al., 2020). Positive parenting is included as a primary or secondary outcome in many parenting programs (e.g., Knerr et al., 2013; Sanders & Pidgeon, 2011) and has been the focus of recent research on pathways to child abuse prevention (e.g., Gonzalez & Rodriguez, 2023).

The third synthesis category was created to capture the only remaining article (Huefner et al., 2007). The 16-year retrospective study of the Boys Town FHP used stratified random sampling to generate a reference category against which to compare participants (Huefner et al., 2007). Although far from best evidence (Slavin, 1995), this was the only included study which attempted any analysis of the intervention effect specifically for participants with a childhood history of FV victimization (Huefner et al., 2007). The results indicated benefits for FHP participants in the form of a lower likelihood of IPV perpetration than expected for this population (Huefner et al., 2007). However, this finding has to be contextualized. Firstly, the study exhibits relatively low methodological quality and is thus prone to various biases. There were no baseline tests and only one measurement time point 16 years after the treatment. Sample background characteristics were not adequately reported in the article and all participants who at the time of the interview were not married or in a relationship had been excluded from analysis. Conclusions about the FHP's potential for disrupting the ITFV would not be warranted. Additionally, the first author is a chairperson for Boys Town, the Christian NGO providing the FHP

program, and the study was conducted by a research facility operated solely by Boys Town (Huefner et al., 2007). Although this is not atypical, a certain researcher bias may be involved.

The overall quality of studies included in the review was mixed. While there were some examples of high methodological rigor (Rodriguez et al., 2010; Ward et al., 2020), most studies were at least unclear in some areas and at worst simply failed to report important data (Huefner et al., 2007).

A drawback that is inherent to most psychosocial intervention research is the lack of participant and facilitator blinding. While difficult to mitigate, there are ways of approaching this issue by creating control group conditions beyond a wait list or referral information. For example, controls in the studies by Bugental et al. (2002) and Stevens-Simon et al. (2001) received a TAU that was relatively close to the intervention group treatment. Of course, this is much easier to do in cases where the intervention of interest is merely an updated or modified version of an established concept (Bugental et al., 2002; Stevens-Simon et al., 2001) and may not be feasible during the early implementation phases of newly developed intervention program (e.g., Ashburn et al., 2017; Lachman et al., 2017). It could however be argued that including a somewhat comparable established program as an alternative control condition may in some cases be possible, especially as long as sample sizes are small. In large studies, this may become too great an economic liability and thus control group participants are usually just provided with referral information (e.g., DuMont et al., 2008).

Another pitfall is the sole reliance on self-report measures, which is still prevalent in many intervention studies. Four out of the nine studies included in this review (Ashburn et al., 2017; Bugental et al., 2002; Huefner et al., 2007; Stevens-Simon et al., 2001) used no alternative methods of measurement. In the context of violence prevention research where interviews often address sensitive topics, social desirability, underreporting, and other biases are prone to play a role (Follingstad & Rogers, 2013; Hamby, 2016; Jordan & Steelman, 2015; Seff, 2022; Zorza, 2001). To minimize biases, at least two different kinds (e.g., self-report, agency-report, or observation) would be advisable if triangulation of outcome data is not possible.

Limitations

There are a number of methodological limitations to this systematic review. Firstly, it is likely incomplete. Within the context of this master's thesis only three databases were searched. And although they were selected with representativeness in mind, there may be more studies in other databases like CINAHL, SocINDEX, or Web of Science that fit the eligibility criteria of this review. Secondly, only peer-reviewed articles were included. This was decided to ensure a minimum of methodological quality but the lack of awareness of grey literature makes the results of the systematic review process vulnerable to publication bias. Thirdly, only one reviewer conducted the literature search and made all exclusion decisions. This may have introduced selection bias and human error. Fourth, the study yield was small ($k = 9$) and the included studies rather heterogenous. This was somewhat expected, as the eligibility criteria for what exactly interventions could be conceptually were defined relatively broadly. The decision was made consciously to avoid unnecessary data loss from a body of research that was already assumed to be very small. The small number of included studies in combination with high heterogeneity also precluded any use of inferential statistics.

If heterogeneity had been lower and study yield only a little bit higher, meta-analysis may have been useful to determine an overall estimate of intervention effectiveness. Had heterogeneity remained the same, but study yield increased by a fair margin, subgroup meta-analysis could have been employed to make sensible comparisons between different categories. As an alternative, the use of vote-counting is recommended in the guideline for narrative synthesis by Popay et al. (2006) which was followed by this review and has again been brought up by the authors of the more recently published SWiM guidelines (Campbell et al., 2020). The case is made that faced with much heterogeneity within a small number of included studies, meta-analysis is typically also very limited in what conclusions can be drawn from results (Popay et al., 2006). The traditional argument goes that a vote-counting procedure means researchers simply relying on the results of null-hypothesis-testing to judge overall significance by the sheer number of studies reporting beneficial effects (Friedman, 2001). However, what Popay et al. (2006) refer to as vote-counting in narrative synthesis – and assumedly this is also what Campbell et al. (2020) refer to – is a descriptive tool that enables visual detection of patterns across groups of studies. The patterns then have to be contrasted against the methodological quality of the studies in question and the wider context of the existing evidence-base (Popay

et al., 2006). And although to exhaust all available methods in the absence of meta-analysis appears reasonable, vote-counting has been much criticized for being prone to selection bias, reporting biases, hypothesizing after results are known (HARKing), and *p*-hacking (Combs et al., 2011; Vadillo et al., 2016). For this reason, conclusions based on vote-counts have been avoided in the present study.

What remains in the synthesis section of this systematic review is an in-depth exploration of the characteristics of all included studies and the interventions they reported on. It may well serve as a small-scale scoping review of the (not so extensive) body of literature that is concerned with the intervening against the ITFV, but does not quite enable tangible conclusions as to whether enough is done to break the cycle – or not.

Implications

The potential of psychosocial interventions for the prevention of FV has been well-documented (e.g., Mikton & Butchart, 2009; Van der Put et al., 2018), but it is not yet clear whether individuals with a childhood history of FV victimization are adequately served by existing interventions, and which components are responsible. Further research is warranted to find the answer to these questions.

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Appendix A – Excluded reports

Automatisches Speichern

excluded

Suchen

StudentIn

Daten

Start

Einfügen

Seitenlayout

Formeln

Daten

Überprüfen

Ansicht

Automatisieren

Hilfe

Kommentare

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Daten abrufen

Abfragen und Verbindungen

Aktien

Währungen

Sortieren

Filtern

Text in Spalten

Was-wäre-wenn-Analyse

Alle aktualisieren

Eigenschaften

Verknüpfungen bearbeiten

Abfragen und Verbindungen

Datentypen

Sortieren und Filtern

Datentools

Prognose

Löschen

Erneut anwenden

Erweitert

Gliederung

A1

*Reason

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	*Reason	*Citation													
2	No Childhood FV	Askeland, I. R., Birkeland, M. S., Lømo, B., & Tjersland, O. A. (2021). Changes in violence and clinical distress among men in individual psychotherapy for violence against their female partner: an explorative study. <i>Frontiers in Psychology</i> , 12(1), 645821.													
3	No Childhood FV	Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Musuya, T., Kyegombe, N., & Watts, C. (2016). The impact of SASA!, a community mobilisation intervention, on women's experiences of intimate partner violence: secondary findings from the SASA! Study. <i>Journal of Interpersonal Violence</i> , 31(10), 1911-1928.													
4	No Childhood FV	Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., ... & Watts, C. (2014). Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent intimate partner violence in South Africa. <i>PLoS ONE</i> , 9(12), e112111.													
5	No Childhood FV	Acton, R. G., & During, S. M. (1992). Preliminary results of aggression management training for aggressive parents. <i>Journal of Interpersonal Violence</i> , 7, 410-417.													
6	No Childhood FV	Baggett, K., Davis, B., Feil, E., Sheeber, L., Landry, S., Leve, C., & Johnson, U. (2017). A randomized controlled trial examination of a remote parenting intervention: Engagement and effects on parenting behavior and child abuse potential. <i>Child Abuse and Neglect</i> , 68, 1-12.													
7	No Childhood FV	Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: a randomized controlled trial of the Hawaii Healthy Start Home Visitation Program. <i>Pediatrics</i> , 125(5), e111-e118.													
8	No Childhood FV	Barth, R. P. (1991). An experimental evaluation of in-home child abuse prevention services. <i>Child Abuse & Neglect</i> , 15(4), 363-375.													
9	No Childhood FV	Barth, R. P., Blythe, B. J., Schinke, S. P., & Schilling, R. F. (1983). Self-control training with maltreating parents. <i>Child Welfare</i> , 62, 313-324.													
10	No Childhood FV	Barth, R. P., Hacking, S., & Ash, J. R. (1988). Preventing child abuse: An experimental evaluation of the Child Parent Enrichment Project. <i>Journal of Primary Prevention</i> , 8(4), 201-217.													
11	No Childhood FV	Bradley, R. P. C., & Gottman, J. M. (2012). Reducing situational violence in low-income couples by fostering healthy relationships. <i>Journal of Marital and Family Therapy</i> , 38, 187-198.													
12	No Childhood FV	Buderer, C., Hefti, S., Fux, E., Pérez, T., Swenson, C. C., Fürstenau, U., Rhiner, B. & Schmid, M. (2020). Effects of Multisystemic Therapy for Child Abuse and Neglect on severity of neglect, behavioral and emotional problems, and attachment in children. <i>Child Abuse and Neglect</i> , 103, 105111.													
13	No Childhood FV	Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. <i>Pediatrics</i> , 129(3), 509-515.													
14	No Childhood FV	Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse report and improving parenting. <i>Journal of Consulting and Clinical Psychology</i> , 72(1), 100-110.													
15	No Childhood FV	Cluver, L. D., Meinck, F., Steinert, J. I., Shenderovich, Y., Doubt, J., Romero, R. H., Lombard, C. J., Redfern, A., Ward, C. L., Tsoanyane, S., Nzima, D., Sibanda, N., Wittesaele, C., De Stone, S., Boyes, M. E., Catanho, R., Lachman, J. M., Salah, A., ... & P. S. (2001). Effectiveness of a parent education intervention for at-risk families. <i>Journal for Specialists in Pediatric Nursing</i> , 6(2), 73-82.													
16	No Childhood FV	Cowan, P. S. (2001). Effectiveness of a parent education intervention for at-risk families. <i>Journal for Specialists in Pediatric Nursing</i> , 6(2), 73-82.													
17	No Childhood FV	Dew, B., & Breakey, G. F. (2014). An evaluation of Hawaii's Healthy Start Program using child abuse hospitalization data. <i>Journal of Family Violence</i> , 29(8), 893-900.													
18	No Childhood FV	Doyle, K., Levto, R. G., Barker, G., Bastian, G. G., Bingenheimer, J. B., Kazimbaya, S., & Shattuck, D. (2018). Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health care in Rwanda: a randomised controlled trial. <i>Lancet</i> , 391(10148), 101-110.													
19	No Childhood FV	Dubowitz, H., Feigelman, S., Lane, W., & Kim, J. (2009). Pediatric primary care to help prevent child maltreatment: the Safe Environment for Every Kid (SEEK) Model. <i>Pediatrics</i> , 123(3), 858-864.													
20	No Childhood FV	Dubowitz, H., Lane, W. G., Semiatin, J. N., & Magder, L. S. (2012). The SEEK model of pediatric primary care: Can child maltreatment be prevented in a low-risk population?. <i>Academic Pediatrics</i> , 12(4), 259-268.													
21	No Childhood FV	Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., Rosenberg, L. A., Buchbinder, S. B., & Sia, C. C. (1999). Evaluation of Hawaii's healthy start program. <i>The Future of Children</i> , 9(1), 66-90.													
22	No Childhood FV	Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. <i>American journal of public health</i> , 109(5), 729-735.													
23	No Childhood FV	Eckenrode, J., Campa, M. I., Morris, P. A., Henderson Jr, C. R., Bolger, K. E., Kitzman, H., & Olds, D. L. (2017). The prevention of child maltreatment through the nurse family partnership program: Mediating effects in a long-term follow-up study. <i>Child Abuse and Neglect</i> , 68, 1-12.													
24	No Childhood FV	Fergusson, D. M., Boden, J. M., & Horwood, L. J. (2013). Nine-year follow-up of a home-visitation program: a randomized trial. <i>Pediatrics</i> , 131(2), 297-303.													
25	No Childhood FV	Fergusson, D. M., Grant, H., Horwood, L. J., & Ridder, E. M. (2006). Randomized trial of the Early Start program of home visitation: Parent and family outcomes. <i>Pediatrics</i> , 117(3), 781-786.													
26	No Childhood FV	Fetsch, R. J., Schultz, C. J., & Wahler, J. J. (1999). A preliminary evaluation of the Colorado Rethink Parenting and Anger Management Program. <i>Child Abuse & Neglect</i> , 23, 353-360.													
27	No Childhood FV	Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. <i>Journal of child psychology and psychiatry</i> , 47(12), 1255-1265.													

Tabelle1

Automatisches Speichern excluded Suchen StudentIn

Datei Start Einfügen Seitenlayout Formeln **Daten** Überprüfen Ansicht Automatisieren Hilfe Kommentare Freigeben

Daten abrufen Abfragen und Verbindungen
 aktualisieren Eigenschaften
 Verknüpfungen bearbeiten

Aktien Währungen

Sortieren Filtern Löschen Erneut anwenden Erweitert

Text in Spalten Was-wäre-wenn- Analyse Prognoseblatt Gliederung

Daten abrufen und transfor... Abfragen und Verbindungen Datentypen Sortieren und Filtern Datentools Prognose

A1 *Reason

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
28	No Childhood FV	Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate project SafeCare: Teaching bonding, safety, and health care skills to parents. <i>Child Maltreatment</i> , 7(3), 277-285.														
29	No Childhood FV	Golub, J. S., Espinosa, M., Damon, L., & Card, J. (1987). A videotape parent education program for abusive parents. <i>Child Abuse & Neglect</i> , 11, 255-265.														
30	No Childhood FV	Gupta, J., Falb, K. L., Lehmann, H., Kpebo, D., Xuan, Z., Hossain, M., ... & Annan, J. (2013). Gender norms and economic empowerment intervention to reduce intimate partner violence against women in rural Côte d'Ivoire: a randomized c														
31	No Childhood FV	Gupta, J., Falb, K. L., Ponta, O., Xuan, Z., Campos, P. A., Gomez, A. A., ... & Olavarrieta, C. D. (2017). A nurse-delivered, clinic-based intervention to address intimate partner violence among low-income women in Mexico City: findings from														
32	No Childhood FV	Hakman, M., Chaffin, M., Funderburk, B., & Silovsky, J. F. (2009). Change trajectories for parent-child interaction sequences during parent-child interaction therapy for child physical abuse. <i>Child Abuse & Neglect</i> , 33(7), 461-470.														
33	No Childhood FV	Hefti, S., Pérez, T., Fürstenau, U., Rhiner, B., Swenson, C. C., & Schmid, M. (2020). Multisystemic Therapy for Child Abuse and Neglect: do parents show improvement in parental mental health problems and parental stress?. <i>Journal of Ma</i>														
34	No Childhood FV	Herman, K., Rotunda, R., Williamson, G., & Vodanovich, S. (2014). Outcomes from a Duluth model batterer intervention program at completion and long term follow-up. <i>Journal of Offender Rehabilitation</i> , 53(1), 1-18.														
35	No Childhood FV	Heyman, R. E., Slep, A. M. S., & Nelson, J. P. (2010). Empirically guided community intervention for partner abuse, child maltreatment, suicidality, and substance misuse. In <i>Risk and resilience in US military families</i> (pp. 85-107). New York,														
36	No Childhood FV	Hirani, S. S., Karmaliani, R., McFarlane, J., Asad, N., Madhani, F., & Shehzad, S. (2010). Testing a community derived intervention to promote women's health: preliminary results of a 3-arm randomized controlled trial in Karachi, Pakistan.														
37	No Childhood FV	Hossain, M., Zimmerman, C., Kiss, L., Abramsky, T., Kone, D., Bakayoko-Topolska, M., & Watts, C. (2014). Working with men to prevent intimate partner violence in a conflict-affected setting: a pilot cluster randomized controlled trial in r														
38	No Childhood FV	Huebner, C. E. (2002). Evaluation of a clinic-based parent education program to reduce the risk of infant and toddler maltreatment. <i>Public Health Nursing</i> , 19, 377-389.														
39	No Childhood FV	Hurlburt, M. S., Nguyen, K., Reid, J., Webster-Stratton, C., & Zhang, J. (2013). Efficacy of the Incredible Years group parent program with families in Head Start who self-reported a history of child maltreatment. <i>Child Abuse & Neglect</i> , 37(1), 1-18.														
40	No Childhood FV	Irueste-Montes, A. M., & Montes, F. (1988). Court-ordered vs. voluntary treatment of abusive and neglectful parents. <i>Child Abuse & Neglect</i> , 12, 33-39.														
41	No Childhood FV	Iwaniec, D. (1997). Evaluating parent training for emotionally abusive and neglectful parents: Comparing individual versus individual and group intervention. <i>Research on Social Work Practice</i> , 7, 329-349.														
42	No Childhood FV	Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A., & Duvvury, N. (2008). Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. <i>Bmj</i> , 337.														
43	No Childhood FV	Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A., & Duvvury, N. (2008). Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. <i>Bmj</i> , 337.														
44	No Childhood FV	Jones, D. L., Peltzer, K., Villar-Loubet, O., Shikwane, E., Cook, R., Vamos, S., & Weiss, S. M. (2013). Reducing the risk of HIV infection during pregnancy among South African women: a randomized controlled trial. <i>AIDS care</i> , 25(6), 702-709.														
45	No Childhood FV	Jouriles, E. N., McDonald, R., Rosenfield, D., Norwood, W. D., Spiller, L., Stephens, N., & Ehrensaft, M. (2010). Improving parenting in families referred for child maltreatment: a randomized controlled trial examining effects of Project Sup														
46	No Childhood FV	Kirkland, K., Lee, E., Smith, C., & Greene, R. (2020). Sustained impact on parenting practices: year 7 findings from the Healthy Families New York randomized controlled trial. <i>Prevention Science</i> , 21, 498-507.														
47	No Childhood FV	Knox, M. S., Burkhart, K., & Hunter, K. E. (2011). ACT Against Violence Parents Raising Safe Kids Program: Effects on maltreatment-related parenting behaviors and beliefs. <i>Journal of Family Issues</i> , 32(1), 55-74.														
48	No Childhood FV	MacMillan, H. L., Thomas, B. H., Jamieson, E., Walsh, C. A., Boyle, M. H., Shannon, H. S., & Gafni, A. (2005). Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: a ran														
49	No Childhood FV	Mejdoubi, J., van den Heijkant, S. C., van Leerdam, F. J., Heymans, M. W., Crijnen, A., & Hirasing, R. A. (2015). The effect of VoorZorg, the Dutch nurse-family partnership, on child maltreatment and development: a randomized controlled														
50	No Childhood FV	Mersky, J. P., Topitzes, J., Janczewski, C. E., & McNeil, C. B. (2015). Enhancing foster parent training with Parent-Child Interaction Therapy: Evidence from a randomized field experiment. <i>Journal of the Society for Social Work and Resear</i>														
51	No Childhood FV	Moore, J., & Finkelstein, N. (2001). Parenting services for families affected by substance abuse. <i>Child Welfare</i> , 80, 221-238.														
52	No Childhood FV	More, N. S., Das, S., Bapat, U., Alcock, G., Manjrekar, S., Kamble, V., & Osrin, D. (2017). Community resource centres to improve the health of women and children in informal settlements in Mumbai: a cluster-randomised, controlled trial														
53	No Childhood FV	Nesset, M. B., Lara-Cabrera, M. L., Bjørngaard, J. H., Whittington, R., & Palmstierna, T. (2020). Cognitive behavioural group therapy versus mindfulness-based stress reduction group therapy for intimate partner violence: a randomized co														
54	No Childhood FV	Olds, D. L. (2006). The nurse-family partnership: An evidence-based preventive intervention. <i>Infant Mental Health Journal</i> , 27(1), 5-25.														

Tabelle1

Automatisches Speichern excluded Suchen StudentIn

Daten | **Überprüfen** | **Ansicht** | **Automatisieren** | **Hilfe** | **Kommentare** | **Freigeben**

Daten abrufen | **Abfragen und Verbindungen** | **Datentypen** | **Sortieren und Filtern** | **Datentools** | **Prognose**

Daten abrufen und transfor... | **Abfragen und Verbindungen** | **Datentypen** | **Sortieren und Filtern** | **Datentools** | **Prognose**

A1 *Reason

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
55	No Childhood FV	Olds, D. L., Kitzman, H., Knudtson, M. D., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality: results of a 2-decade follow-up of a randomized clinical trial. <i>JAMA Pediatrics</i> , 168(9), 800-806.														
56	No Childhood FV	Olds, D., Henderson, C. R., Kitzman, H., & Cole, R. (1995). Effects of prenatal and infancy nurse home visitation on surveillance of child maltreatment. <i>Pediatrics</i> , 95 (3), 365-372.														
57	No Childhood FV	Olds, D., Hill, P., Robinson, J., Song, M. N., & Little, C. (2000). Update on home visiting for pregnant women and parents of young children. <i>Current Problems in Pediatrics</i> , 30(4), 109-141.														
58	No Childhood FV	Palmstierna, T., Haugan, G., Jarwson, S., Rasmussen, K., & Nøttestad, J. A. (2012). Cognitive-behaviour group therapy for men voluntary seeking help for intimate partner violence. <i>Nordic Journal of Psychiatry</i> , 66(5), 360-365.														
59	No Childhood FV	Pascual-Leone, A., Bierman, R., Arnold, R., & Stasiak, E. (2011). Emotion-focused therapy for incarcerated offenders of intimate partner violence: A 3-year outcome using a new whole-sample matching method. <i>Psychotherapy Research</i> , 21(4), 400-412.														
60	No Childhood FV	Peterson, L., Tremblay, G., Ewigman, B., & Saldana, L. (2003). Multilevel selected primary prevention of child maltreatment. <i>Journal of Consulting and Clinical Psychology</i> , 71, 601-612.														
61	No Childhood FV	Porter, B., & Howe, T. (2008). Pilot evaluation of the "ACT Parents Raising Safe Kids" violence prevention program. <i>Journal of Child & Adolescent Trauma</i> , 1, 193-206.														
62	No Childhood FV	Portwood, S. G., Lambert, R. G., Abrams, L. P., & Nelson, E. B. (2011). An evaluation of the Adults and Children Together (ACT) Against Violence Parents Raising Safe Kids program. <i>The Journal of Primary Prevention</i> , 32, 147-160.														
63	No Childhood FV	Saggurti, N., Nair, S., Silverman, J. G., Naik, D. D., Battala, M., Dasgupta, A., & Raj, A. (2014). Impact of the RHANI Wives intervention on marital conflict and sexual coercion. <i>International Journal of Gynecology & Obstetrics</i> , 126 (1), 18-22.														
64	No Childhood FV	Schaeffer, C. M., Swenson, C. C., & Powell, J. S. (2021). Multisystemic Therapy-Building Stronger Families (MST-BSF): Substance misuse, child neglect, and parenting outcomes from an 18-month randomized effectiveness trial. <i>Child Abuse and Neglect</i> , 115, 105445.														
65	No Childhood FV	Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Henggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. <i>Child Abuse and Neglect</i> , 37(4), 400-412.														
66	No Childhood FV	Schinke, S. P., Schilling, R. F., Kirkham, M. A., Gilchrist, L. D., Barth, R. P., & Blythe, B. J. (1986). Stress management skills for parents. <i>Journal of Child and Adolescent Psychotherapy</i> , 3, 293-298.														
67	No Childhood FV	Self-Brown, S., Osborne, M. C., Boyd Jr, C., Brown, N. D., Rostad, W., Patterson, A., Baker, E., Thomas, A., McAdam, E. M., Jackson, M., Glasheen, T. L. & Lai, B. (2018). The impact of SafeCare® Dads to Kids program on father maltreatment. <i>Child Abuse and Neglect</i> , 82, 105-115.														
68	No Childhood FV	Self-Brown, S., Osborne, M. C., Lai, B. S., De Veauuse Brown, N., Glasheen, T. L., & Adams, M. C. (2017). Initial findings from a feasibility trial examining the SafeCare Dad to Kids Program with marginalized fathers. <i>Journal of Family Violence</i> , 32(1), 1-10.														
69	No Childhood FV	Self-Brown, S., Osborne, M. C., Lai, B. S., De Veauuse Brown, N., Glasheen, T. L., & Adams, M. C. (2017). Initial findings from a feasibility trial examining the SafeCare Dad to Kids Program with marginalized fathers. <i>Journal of Family Violence</i> , 32(1), 1-10.														
70	No Childhood FV	Shahmoradi, S., Afshar, H. K., Goudarzy, M., & Lavasani, M. G. A. (2019). Effectiveness of Emotion-Focused Therapy in Reduction of Marital Violence and Improvement of Family Functioning: A Quasi-Experimental Study. <i>Iranian Red Crescent Medical Journal</i> , 23(1), 1-10.														
71	No Childhood FV	Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., Beasley, L., Doughty, D. & Lutzker, J. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. <i>Children</i> , 18(12), 2155-2165.														
72	No Childhood FV	Stevens-Simon, C., Nelligan, D., & Kelly, L. (2001). Adolescents at risk for mistreating their children: Part I: prenatal identification. <i>Child Abuse & Neglect</i> , 25(6), 737-751.														
73	No Childhood FV	Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. <i>Journal of Family Psychology</i> , 24(4), 497.														
74	No Childhood FV	Taylor, D. K., & Beauchamp, C. (1988). Hospital-based primary prevention strategy in child abuse: A multi-level needs assessment. <i>Child Abuse & Neglect</i> , 12, 343-354.														
75	No Childhood FV	Thomasson, E., Minor, S., McCord, D., Berkovitz, T., Cassle, G., & Milner, J. S. (1981). Evaluation of a family live education program for rural high-risk families: A research note. <i>Journal of Community Psychology</i> , 9, 246-249.														
76	No Childhood FV	Thompson, R. W., Ruma, P. R., Brewster, A. L., Besetsney, L. K., & Burke, R. V. (1997). Evaluation of an Air Force child physical abuse prevention project using the Reliable Change Index. <i>Journal of Child and Family Studies</i> , 6, 421-434.														
77	No Childhood FV	Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating children with early-onset conduct problems: Intervention outcomes for parent, child, and teacher training. <i>Journal of Clinical Child and Adolescent Psychology</i> , 33(1), 105-115.														
78	No Childhood FV	Weinman, M. L., Schreiber, N. B., & Robinson, M. (1992). Adolescent mothers: Were there any gains in a parent education program? <i>Family Community Health</i> , 15, 1-10.														
79	No Childhood FV	Whipple, E. E., & Wilson, S. R. (1996). Evaluation of a parent education and support program for families at risk of physical child abuse. <i>Families in Society: The Journal of Contemporary Human Services</i> , 77, 227-239.														
80	No Childhood FV	Wolfe, D. A., Edwards, B., Manion, I., & Koverola, C. (1988). Early intervention for parents at risk of child abuse and neglect: A preliminary investigation. <i>Journal of Consulting and Clinical Psychology</i> , 56, 40-47.														
81	No Childhood FV	Wolfe, D. A., Sandler, J., & Kaufman, K. (1981). A competency-based parent training program for child abusers. <i>Journal of Consulting and Clinical Psychology</i> , 49, 633-640.														

Tabelle1

Aktuelles Fenster: Microsoft Excel - Automatisches Speichern (ausgeschaltet) | Suchen | Studentin

Startleiste: Datei, Start, Einfügen, Seitenlayout, Formeln, **Daten**, Überprüfen, Ansicht, Automatisieren, Hilfe

Kommentare & Freigabe: Kommentare, Freigeben

Datenbereich:

- Daten abrufen und transferieren: Daten abrufen, Daten importieren, Daten aus anderen Quellen abrufen
- Abfragen und Verbindungen: Alle aktualisieren, Eigenschaften, Verknüpfungen bearbeiten
- Datentypen: Aktien, Währungen
- Sortieren und Filtern: Sortieren, Filtern, Löschen, Erneut anwenden, Erweitert
- Datentools: Text in Spalten, Was-wäre-wenn-Analyse, Prognoseblatt, Gliederung

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
82	No Childhood FV	Yang, C., Panlilio, C., Verdiglione, N., Lehman, E. B., Hamm, R. M., Fiene, R., & Levi, B. (2020). Generalizing findings from a randomized controlled trial to a real-world study of the iLookOut, an online education program to improve early c													
83	No Childhood FV	Zarling, A., & Russell, D. (2022). A randomized clinical trial of Acceptance and Commitment Therapy and the Duluth Model classes for men court-mandated to a domestic violence program. Journal of Consulting and Clinical Psychology, 9													
84	No Childhood FV	Zarling, A., Bannon, S., & Berta, M. (2019). Evaluation of Acceptance and Commitment Therapy for domestic violence offenders.													
85	Outcome not FV	Altafim, E. R. P., de Oliveira, R. C., & Linhares, M. B. M. (2021). Maternal history of childhood violence in the context of a parenting program. Journal of Child and Family Studies, 30, 230-242.													
86	Outcome not FV	Baker-Tingey, J., Powell, P., & Powell, C. (2018). Heart and shield family violence prevention program. Journal of Youth Development, 13(3), 136-161.													
87	Outcome not FV	Balluerka, N., Muela, A., Amiano, N., & Caldentey, M. A. (2014). Influence of animal-assisted therapy (AAT) on the attachment representations of youth in residential care. Children and Youth Services Review, 42, 103-109.													
88	Outcome not FV	Bernstein, R. E., Timmons, A. C., & Lieberman, A. F. (2019). Interpersonal violence, maternal perception of infant emotion, and child-parent psychotherapy. Journal of Family Violence, 34(4), 309-320.													
89	Outcome not FV	Blair, K., Topitzes, J., & Mersky, J. P. (2019). Do parents' adverse childhood experiences influence treatment responses to Parent-Child Interaction Therapy? An exploratory study with a child welfare sample. Child & Family Behavior Therap													
90	Outcome not FV	Bradley, R. P. C., Drummey, K., Gottman, J. M., & Gottman, J. S. (2014). Treating couples who mutually exhibit violence or aggression: Reducing behaviors that show a susceptibility for violence. Journal of Family Violence, 29, 549-558.													
91	Outcome not FV	Cloitre, M., Garvert, D. W., & Weiss, B. J. (2017). Depression as a moderator of STAIR Narrative Therapy for women with post-traumatic stress disorder related to childhood abuse. European Journal of Psychotraumatology, 8(1), 137702													
92	Outcome not FV	Colegrove, V. M., Havighurst, S. S., & Kehoe, C. E. (2019). Emotion regulation during conflict interaction after a systemic music intervention: Understanding changes for parents with a trauma history and their adolescent. Nordic Journal o													
93	Outcome not FV	Crooks, C. V., Scott, K., Ellis, W., & Wolfe, D. A. (2011). Impact of a universal school-based violence prevention program on violent delinquency: Distinctive benefits for youth with maltreatment histories. Child abuse & neglect, 35(6), 393													
94	Outcome not FV	De Arellano, M. A. R., Lyman, D. R., Jobe-Shields, L., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Huang, L., & Delphin-Rittmon, M. E. (2014). Trauma-focused cognitive-behavioral therapy for children and adolescents: Assessin													
95	Outcome not FV	Dietz, T. J., Davis, D., & Pennings, J. (2012). Evaluating animal-assisted therapy in group treatment for child sexual abuse. Journal of Child Sexual Abuse, 21(6), 665-683.													
96	Outcome not FV	Domoney, J., & Trevillion, K. (2021). Breaking the cycle of intergenerational abuse: A qualitative interview study of men participating in a perinatal program to reduce violence. Infant Mental Health Journal, 42(2), 206-221.													
97	Outcome not FV	Domoney, J., Fulton, E., Stanley, N., McIntyre, A., Heslin, M., Byford, S., Bick, D., Ramchandani, P., MacMillan, H., Howard, L. M. & Trevillion, K. (2019). For Baby's Sake: intervention development and evaluation design of a whole-family p													
98	Outcome not FV	Easton, C. J., Crane, C. A., & Mandel, D. (2018). A randomized controlled trial assessing the efficacy of cognitive behavioral therapy for substance-dependent domestic violence offenders: an integrated substance abuse-domestic violenc													
99	Outcome not FV	Egeland, B., Jacobvitz, D., & Sroufe, L. A. (1988). Breaking the cycle of abuse. Child development, 1080-1088.													
100	Outcome not FV	Fennell, D. C., & Fishel, A. H. (1998). Parent education: An evaluation of STEP on abusive parents' perceptions and abuse potential. Journal of Child and Adolescent Psychiatric Nursing, 11(3), 107-120.													
101	Outcome not FV	Furber, G., Amos, J., Segal, L., & Kasprzak, A. (2013). Outcomes of therapy in high risk mother-child dyads in which there is active maltreatment and severely disturbed child behaviors. Journal of Infant, Child, and Adolescent Psychotherap													
102	Outcome not FV	Hughes, J. R., & Gottlieb, L. N. (2004). The effects of the Webster-Stratton parenting program on maltreating families: Fostering strengths. Child Abuse & Neglect, 28(10), 1081-1097.													
103	Outcome not FV	Hutchings, J., Bywater, T., Daley, D., Gardner, F., Whitaker, C., Jones, K., Eames, C., & Edwards, R. T. (2007). Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controll													
104	Outcome not FV	Jenney, A., Scott, K., & Wall, M. (2022). Mothers in mind: exploring the efficacy of a dyadic group parenting intervention for women who have experienced intimate partner violence and their young children. International Journal on Child													
105	Outcome not FV	Jensen, T. K., Holt, T., & Ormhaug, S. M. (2017). A follow-up study from a multisite, randomized controlled trial for traumatized children receiving TF-CBT. Journal of Abnormal Child Psychology, 45, 1587-1597.													
106	Outcome not FV	Jonyniene, J., Kern, R. M., & Gfroerer, K. P. (2015). Efficacy of Lithuanian Systematic Training for Effective Parenting (STEP) on parenting style and perception of child behavior. The Family Journal, 23(4), 392-406.													
107	Outcome not FV	Kolko, D. J. (1996). Individual Cognitive Behavioral Treatment and Family Therapy for Physically Abused Children and their Offending Parents: A Comparison of Clinical Outcomes. Child Maltreatment, 1(4), 322-342.													
108	Outcome not FV	Kolko, D. J., Iselin, A. M. R., & Gully, K. J. (2011). Evaluation of the sustainability and clinical outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) in a child protection center. Child Abuse & Neglect, 35(2), 105-11													

Statusleiste: Tabelle1

Automatisches Speichern excluded Suchen StudentIn

Datei Start Einfügen Seitenlayout Formeln **Daten** Überprüfen Ansicht Automatisieren Hilfe Kommentare Freigeben

Daten abrufen und transfor... Abfragen und Verbindungen Datentypen Sortieren und Filtern Datentools Prognose

A1 *Reason

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
109	Outcome not FV	Lowe, C., & Murray, C. (2014). Adult service-users' experiences of trauma-focused cognitive behavioural therapy. <i>Journal of Contemporary Psychotherapy</i> , 44, 223-231.													
110	Outcome not FV	Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M. K., & Steer, R. A. (2012). Trauma-Focused Cognitive-Behavioral Therapy for Children: Sustained Impact of Treatment 6 and 12 Months Later. <i>Child Maltreatment</i> , 17(3), 231-241.													
111	Outcome not FV	Maxwell, K., Callahan, J. L., Ruggero, C. J., & Janis, B. (2016). Breaking the cycle: Association of attending therapy following childhood abuse and subsequent perpetration of violence. <i>Journal of Family Violence</i> , 31, 251-258.													
112	Outcome not FV	McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., Demment, C. C., Fournier, D., Schnurr, P. P. & Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder i													
113	Outcome not FV	McGilloway, S., Mhaille, G. N., Bywater, T., Furlong, M., Leckey, Y., Kelly, P., Comiskey, C., & Donnelly, M. (2012). A parenting intervention for childhood behavioral problems: a randomized controlled trial in disadvantaged community-bas													
114	Outcome not FV	Naste, T. M., Price, M., Karol, J., Martin, L., Murphy, K., Miguel, J., & Spinazzola, J. (2018). Equine facilitated therapy for complex trauma (EFT-CT). <i>Journal of Child & Adolescent Trauma</i> , 11, 289-303.													
115	Outcome not FV	Nesset, M. B., Bjørngaard, J. H., Whittington, R., & Palmstierna, T. (2021). Does cognitive behavioural therapy or mindfulness-based therapy improve mental health and emotion regulation among men who perpetrate intimate partner vic													
116	Outcome not FV	O'haire, M. E., Guérin, N. A., & Kirkham, A. C. (2015). Animal-assisted intervention for trauma: A systematic literature review. <i>Frontiers in Psychology</i> , 1121.													
117	Outcome not FV	Paivio, S. C., & Nieuwenhuis, J. A. (2001). Efficacy of emotion focused therapy for adult survivors of child abuse: A preliminary study. <i>Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studi</i>													
118	Outcome not FV	Paivio, S. C., Jarry, J. L., Chagigiorgis, H., Hall, I., & Ralston, M. (2010). Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. <i>Psychotherapy Research</i> , 20(3), 353-366.													
119	Outcome not FV	Pillhofer, M., Spangler, G., Bovenschen, I., Kuenster, A. K., Gabler, S., Fallon, B., Fegert, J. M. & Ziegenhain, U. (2015). Pilot study of a program delivered within the regular service system in Germany: Effect of a short-term attachment-bas													
120	Outcome not FV	Sidor, A., Kunz, E., Eickhorst, A., & Cierpka, M. (2013). Effects of the early prevention program "Keiner faellt durchs Netz" ("Nobody slips through the net") on child, mother, and their relationship: A controlled study. <i>Infant Mental Health</i>													
121	Outcome not FV	Signal, T., Taylor, N., Prentice, K., McDade, M., & Burke, K. J. (2017). Going to the dogs: A quasi-experimental assessment of animal assisted therapy for children who have experienced abuse. <i>Applied Developmental Science</i> , 21(2), 81-93.													
122	Outcome not FV	Sleed, M., Baradon, T., & Fonagy, P. (2013). New Beginnings for mothers and babies in prison: A cluster randomized controlled trial. <i>Attachment & Human Development</i> , 15(4), 349-367.													
123	Outcome not FV	Smedslund, G., Dalsbø, T. K., Steiro, A. K., Winsvold, A., & Clench-Aas, J. (2011). Cognitive behavioural therapy for men who physically abuse their female partner. <i>Campbell Systematic Reviews</i> , 7(1), 1-25.													
124	Outcome not FV	Steele, H., Murphy, A., Bonuck, K., Meissner, P., & Steele, M. (2019). Randomized control trial report on the effectiveness of Group Attachment-Based Intervention (GABI©): Improvements in the parent-child relationship not seen in the c													
125	Outcome not FV	Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment. <i>Child Development</i> , 82(1), 177-192.													
126	Outcome not FV	Van Rosmalen-Nooijens, K., Lo Fo Wong, S., Prins, J., & Lagro-Janssen, T. (2017). Young people, adult worries: randomized controlled trial and feasibility study of the internet-based self-support method "Feel the ViBe" for adolescents an													
127	Publication (no pee	DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., Layne, C. & Greene, R. (2010). A randomized trial of Healthy Families New York (HFNY): Does home visiting prevent child maltreatment. <i>Project re</i>													
128	Study design	Cluver, L., Meinck, F., Yakubovich, A., Doubt, J., Redfern, A., Ward, C., Salah, N., De Stone, S., Petersen, T., Mpimpilashe, P., Romero, R. H., Ncobo, L., Lachman, J., Tsoanyane, S., Shenderovich, Y., Loening, H., Byrne, J., Sherr, L., Kaplan, L. &													
129	Study design	Hunter, R. S., & Kilstrom, N. (1979). Breaking the cycle in abusive families. <i>The American Journal of Psychiatry</i> , 136(10), 1320-1322.													
130	Study design	Ikonomopoulos, J., Cavazos-Vela, J., Vela, P., Sanchez, M., Schmidt, C., & Catchings, C. V. (2017). Evaluating the effects of creative journal arts therapy for survivors of domestic violence. <i>Journal of Creativity in Mental Health</i> , 12(4), 496-													
131	Study design	Lanier, P., Kohl, P. L., Benz, J., Swinger, D., & Drake, B. (2014). Preventing maltreatment with a community-based implementation of parent-child interaction therapy. <i>Journal of Child and Family Studies</i> , 23, 449-460.													
132	Study design	Self-Brown, S., Cowart-Osborne, M., Baker, E., Thomas, A., Boyd Jr, C., Chege, E., Jackson, M., Meister, E. & Lutzker, J. (2015). Dad2K: An adaptation of SafeCare to enhance positive parenting skills with at-risk fathers. <i>Child & Family Beha</i>													
133	Study design	Tucker, N., & Treviño, A. L. (2011). An art therapy domestic violence prevention group in Mexico. <i>Journal of Clinical Art Therapy</i> , 1(1), 16-24.													
134															
135															

Tabelle1

Appendix B - Tables**Table 1***Study samples*

Authors (year)	Location	Sample size	Comparison groups	Childhood FV victimization	Participants' characteristics	Child age
Ashburn et al. (2017)	Uganda	n = 500	Exposed (n = 256), attended at least one individual and one group mentoring session Unexposed (n = 179)	72% of the sample "saw their mother or another woman in their home being beaten during their childhood or were spanked or threatened with physical punishment."	100% male 99.6% biological fathers Mean age = 23.0 (range: 16-25)	Mean = 3 (range: 1-3)
Bugental et al. (2002)	USA	n = 96	Enhanced home visitation (n = 32-35) Unenhanced home visitation (n = 31-34) Control (n = 25-27), referral information Analysis performed for enhanced group vs. unenhanced & control group combined	50% had been physically abused as a child.	100% female 100% biological mothers Mean age = 25.5 (SD = 6.1)	At intake (months): Enhanced: Mean = -1.91 (SD = 2.02) Unenhanced: Mean = -1.82 (SD = 2.81) Control: Mean = -2.56 (SD = 2.29)

DuMont et al. (2008)	USA	n = 1173	Intervention (n = 579)	48.7% answered “yes” to a single dichotomous recall item from the revised Conflict Tactics Scale (CTS2; Straus, Hamby, Bonney-McCoy, & Sugarman, 1996): “My mother swore at me more than twice.”	100% female	Children were followed from birth until age 2
			Control (n = 594), referral information		100% biological mothers	
			Analytic subgroups:		Mean age = 22.5 (SD = 5.5)	
			Prevention (n = 170), first-time mothers aged 19 or younger			
			Psychologically vulnerable (n = 122), high scores on the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) and low scores on the Mastery of Psychological Coping Resources Scale (Pearlin & Schooler, 1978)			
Fergusson et al. (2005)	New Zealand	n = 443	Intervention (n = 220)	Child abuse victimization, mothers: Intervention group: 44.7%	Female and male, distribution N/A	Children were followed from birth until 36-39 months of age
			Control (n = 223), unspecified control condition	Control group: 41.6%	Fathers and mothers, distribution N/A	
				Witnessed IPV, mothers: Intervention group: 50.5% Control group: 57.0%	Intervention group mothers: Mean age = 24.6	
				Child abuse victimization, fathers: N/A Witnessed IPV, fathers: N/A	Control group mothers: Mean age = 24.4	
					Intervention group biological fathers:	

					Mean age = 27.3	
					Control group biological fathers: Mean age = 26.6	
Huefner et al. (2007)	USA	n = 154	Intervention (n = 131)	Intervention group: “Almost 48%” (sic!) had at least one report of physical, emotional, or sexual abuse, neglect, or witnessing IPV in their program admission file.	90.5% male	N/A
			Comparison (n = 23), accepted for admission but did not participate in program		No information on parenthood	
					Age at time of admission = 10-18	
					Age at time of follow-up = 27–37	
			Analytic subgroups:	Comparison group: N/A		
			Shorter stay group (< 18 months of intervention; n = 54)	Shorter stay group: N/A		
				Longer stay group: N/A		
			Longer stay group (> 18 months of intervention; n = 77)	NSFH sample: N/A		
Victimized subgroup of intervention (n = N/A)						
Stratified random sample from NSFH (Bumpass & Sweet, 2018; Bumpass et al., 2017) matching respondent sample (n = 417)						
Lachman et al. (2017)	South Africa	n = 68	Intervention (n = 34)	72.1% of the sample experienced physical or emotional abuse as a child	98.5% female	Intervention group: Mean = 5.62 (SD =

			Control (n = 34), wait list	(n = 49), as assessed via ISPCAN Child Abuse Screening Tool-Retrospective (Dunne et al., 2009). Physical abuse: Intervention group: 73.5% (n = 25) Control group: 70.6% (n = 24) Emotional abuse: Intervention group: N/A Control group: N/A	60.3% biological parents of children targeted in the program, 30.9% grandmothers, 7.4% aunts and 1.5% foster mothers Intervention group: Mean age = 42.06 (SD = 13.16) Control group: Mean age = 41.09 (SD = 13.32)	1.65) Control group: Mean = 5.18 (SD = 1.73)
Rodriguez et al. (2010)	USA	n = 522	Intervention (n = 255) Control (n = 267), referral information Analytic subgroups: High prevention opportunity subgroup (HPO; n = 71) Limited prevention opportunity subgroup (LPO; n = 451)	49.4% answered "yes" to a single dichotomous recall item from the revised Conflict Tactics Scale (CTS2; Straus, Hamby, Bonney-McCoy, & Sugarman, 1996): "My mother swore at me more than twice."	100% female 100% biological mothers Mean age = 22.7 (SD = 5.7)	Children were followed from birth until year 3. Year 3 sample: Mean = 3.1 (SD = .15)
Stevens-Simon et al. (2001)	USA	n = 145	Intervention (n = 58) Control (n = 87), TAU	72% abused (intervention group) 78% abused (control group)	100% female 100% biological mothers	Children were followed from birth until year 2.

					Mean age = 17.5 (SD=1.4)	
Ward et al. (2020)	South Africa	n = 296	Intervention (n = 148)	Physical abuse:	99.66% female	Intervention group:
				Intervention group: 49.32%	81.1% biological mothers, remaining were aunts/uncles, grandparents or step-siblings	2-5 (55.41%)
			Control (n = 148)	Control group: 45.27%		6-9 (44.59%)
				Emotional abuse:	Intervention group age:	Control group:
				Intervention group: 34.46%	18-24 years (15.54%)	2-5 (53.38%)
				Control group: 31.76%	25-39 years (62.16%)	6-9 (46.62%)
					40-59 years (20.27%)	
					60+ years (2.03%)	
				Sexual abuse:	Control group age:	
				Intervention group: 6.76%	18-24 years (16.22%)	
				Control group: 6.08%	25-39 years (58.78%)	
					40-59 years (21.62%)	
					60+ years (3.38%)	

Table 2*Study designs and results*

Authors (year)	Intervention name & type	Study design	Assessment time points	Outcome	Outcome measure	p-value	Effect size ^{a,b}
Ashburn et al. (2017)	Name: REAL	Quasi- experimental design	4 months	Physical punishment of	CTS (Straus, 1979)	t1: ns	OR = 0.84 (CI = 0.55, 1.28)
	Fathers Initiative		after	child		t2: < .01	OR = 0.52 (CI = 0.32, 0.82)
			completion	Any IPV	CTS-PC (Straus et al., 1998)	t1: < .01	OR = 0.48 (CI = 0.31, 0.76)
	Type: Parenting		(t1), 8 after			t2: < .01	OR = 0.48 (CI = 0.31, 0.77)
	program &		completion	Physical IPV	CTS-PC, Physical IPV subscale	t1: ns	OR = 0.71 (CI = 0.46, 1.11)
	poster campaign		months (t2)			t2: ns	OR = 0.76 (CI = 0.38, 1.35)
				Psychological IPV	CTS-PC, Psychological IPV subscale	t1: < .01	OR = 0.55 (CI = 0.35, 0.86)
	Selective prevention			Verbal IPV	CTS-PC, Verbal IPV subscale	t1: < .01	OR = 0.51 (CI = 0.33, 0.79)
						t2: < .01	OR = 0.56 (CI = 0.35, 0.90)
Bugental et al. (2002)	Name: Healthy	Randomized controlled trial	Immediately	Physical abuse	CTS	t1: < .05	N/A
	Start cognitive		after				
	component		intended	Legally non-abusive	CTS	t1: < .05	N/A
			program end	spanking/slapping			
	Type: Home		point, 1 year	Harsh parenting (use or	CTS	t1: < .05	N/A
	visitation		after birth	threat of either of the			
			(t1)	categories above)			
	Selective prevention						
DuMont et al. (2008)	Name: Healthy Families New	Randomized controlled	1 year after birth (t1), 2	<u>Prevalence entire sample:</u>	<u>Prevalence entire sample:</u>		

York (HFNY)	trial	years after birth (t2),	Serious abuse & neglect composite	Composite of the neglect and severe/very severe physical abuse subscales	t1: ns t2: ns	N/A N/A
Type: Home visitation		program ongoing	Very serious physical abuse	CTS-PC	t1: ns t2: ns	N/A N/A
			Serious physical abuse	CTS-PC	t1: ns t2: ns	N/A N/A
Selective prevention			Minor physical aggression	CTS-PC	t1: ns t2: ns	N/A N/A
			Psychological aggression	CTS-PC	t1: ns t2: ns	N/A N/A
			Neglect	CTS-PC	t1: ns t2: ns	N/A N/A
			Harsh parenting in past week	CTS-PC	t1: ns t2: ns	N/A N/A
			Substantiated abuse or neglect	CPS reports	t1: ns t2: ns	N/A N/A
			<u>Frequency entire sample:</u>	<u>Frequency entire sample:</u>		
			Serious abuse & neglect composite	Composite of the neglect and severe/very severe physical abuse subscales	t1: ns t2: ns	N/A N/A
			Very serious physical abuse	CTS-PC	t1: .04 t2: ns	N/A N/A
			Serious physical abuse	CTS-PC	t1: ns t2: .03	N/A N/A
			Minor physical aggression	CTS-PC	t1: .017 t2: ns	N/A N/A
			Psychological aggression	CTS-PC	t1: .007 t2: ns	N/A N/A

Neglect	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Harsh parenting in past week	CTS-PC	t1: .04	N/A
		t2: ns	N/A
Substantiated abuse or neglect	CPS reports	t1: ns	N/A
		t2: ns	N/A
<u>Prevalence prevention subgroup:</u>	<u>Prevalence prevention subgroup:</u>		
Serious abuse & neglect composite	Composite of the neglect and severe/very severe physical abuse subscales	t1: N/A	N/A
		t2: N/A	N/A
Very serious physical abuse	CTS-PC	t1: N/A	N/A
		t2: N/A	N/A
Serious physical abuse	CTS-PC	t1: N/A	N/A
		t2: N/A	N/A
Minor physical aggression	CTS-PC	t1: ns	N/A
		t2: .02	N/A
Psychological aggression	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Neglect	CTS-PC	t1: N/A	N/A
		t2: N/A	N/A
Harsh parenting in past week	CTS-PC	t1: ns	N/A
		t2: .02	N/A
Substantiated abuse or neglect	CPS reports	t1: ns	N/A
		t2: ns	N/A
<u>Frequency prevention subgroup:</u>	<u>Frequency prevention subgroup:</u>		
Serious abuse & neglect	Composite of the neglect and severe/	t1: N/A	N/A

composite	very severe physical abuse subscales	t2: ns	N/A
Very serious physical abuse	CTS-PC	t1: N/A	N/A
		t2: N/A	N/A
Serious physical abuse	CTS-PC	t1: N/A	N/A
		t2: N/A	N/A
Minor physical aggression	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Psychological aggression	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Neglect	CTS-PC	t1: N/A	N/A
		t2: ns	N/A
Harsh parenting in past week	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Substantiated abuse or neglect	CPS reports	t1: ns	N/A
		t2: ns	N/A
<u>Prevalence psychologically vulnerable subgroup:</u>	<u>Prevalence psychologically vulnerable subgroup:</u>		
Serious abuse & neglect composite	Composite of the neglect and severe/very severe physical abuse subscales	t1: ns	N/A
		t2: < .05	N/A
Very serious physical abuse	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Serious physical abuse	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Minor physical aggression	CTS-PC	t1: ns	N/A
		t2: ns	N/A
Psychological aggression	CTS-PC	t1: ns	N/A
		t2: ns	N/A

				Neglect	CTS-PC	t1: ns t2: ns	N/A N/A
				Harsh parenting in past week	CTS-PC	t1: ns t2: ns	N/A N/A
				Substantiated abuse or neglect	CPS reports	t1: ns t2: ns	N/A N/A
				<u>Frequency psychologically vulnerable subgroup:</u>	<u>Frequency psychologically vulnerable subgroup:</u>		
				Serious abuse & neglect composite	Composite of the neglect and severe/very severe physical abuse subscales	t1: ns t2: < .05	N/A N/A
				Very serious physical abuse	CTS-PC	t1: ns t2: ns	N/A N/A
				Serious physical abuse	CTS-PC	t1: ns t2: ns	N/A N/A
				Minor physical aggression	CTS-PC	t1: ns t2: ns	N/A N/A
				Psychological aggression	CTS-PC	t1: < .05 t2: ns	N/A N/A
				Neglect	CTS-PC	t1: ns t2: ns	N/A N/A
				Harsh parenting in past week	CTS-PC	t1: ns t2: ns	N/A N/A
				Substantiated abuse or neglect	CPS reports	t1: ns t2: ns	N/A N/A
Fergusson et al. (2005)	Name: Early Start	Randomized controlled trial	Immediately after intended	Severe physical punishment (either parent)	Severe/very severe assault subscales of the CTS-PC	t1: < .01	d = 0.26 (CI = 0.07, 0.48)
				In contact with CPS for	CPS reports	t1: ns	d = 0.04 (CI = -0.15, 0.25)

	Type: Home visitation		program end point, 3 years after birth (t1)	child abuse or neglect			
	Selective prevention						
Huefner et al. (2007)	Name: Family Home Program	Quasi-experimental design	16 years after admission (t1)	IPV rate of shorter stay group vs. NSFH rate IPV rate of longer stay group vs. NSFH rate IPV rate of control group vs. NSFH rate IPV rate of victimized subgroup vs. expected rate	NSFH IPV question (Bumpass & Sweet, 2018; Bumpass et al., 2017) NSFH IPV question NSFH IPV question Expected IPV rate for adults with childhood FV victimization (Ehrensaft et al., 2003)	t1: ns t1: ns t1: < .05 t1: < .001	OR = 1.11 (CI = .42, 2.98) OR = 0.76 (CI = .29, 2.00) OR = 3.85 (CI = 1.43, 10.40) N/A
	Type: Residential care program						
	Selective prevention						
Lachman et al. (2017)	Name: Sinovuyo/PLH for Young Children	Randomized controlled trial	Immediately after completion (t1)	Harsh parenting Observation of negative parenting	CTS-PC Sinovuyo Observational Coding System	t1: ns t1: ns	d = 0.02 (CI = -0.46, 0.49) d = -0.34 (CI = -0.81, 0.14)
	Type: Parenting program						
	Selective prevention						
Rodriguez et al.	Name: Healthy Families New	Randomized controlled	3 years after birth (t1),	<u>Prevalence entire sample:</u>	<u>Prevalence entire sample:</u>		

(2010)	York (HFNY)	trial	program ongoing	Harsh parenting during Puzzle Task	Coded observational assessment	t1: ns	N/A
				Harsh parenting during Delay Task	Coded observational assessment	t1: ns	N/A
				Harsh parenting during Cleanup Task	Coded observational assessment	t1: ns	N/A
				<u>Prevalence HPO:</u>	<u>Prevalence HPO:</u>		
				Harsh parenting during Puzzle Task	Coded observational assessment	t1: < .05	N/A
				Harsh parenting during Delay Task	Coded observational assessment	t1: < .05	N/A
				Harsh parenting during Cleanup Task	Coded observational assessment	t1: ns	N/A
Stevens-Simon et al. (2001)	Colorado Adolescent Maternity Program (CAMP) Home visiting module	Randomized controlled trial	Immediately after intended program end point, 2 years after birth (t1)	Abuse (physical, sexual or emotional)	Unspecified measure	t1: ns	N/A
				Neglect	Unspecified measure	t1: .02	N/A
				Abandonment (leaving the child with someone else)	Unspecified measure	t1: ns	N/A
				Any maltreatment (any of the above mentioned)	Unspecified measure	t1: ns	N/A
	Type: Home visitation						
	Selective prevention						

Ward et al. (2020)	Name:	Randomized	4-5 months	Physical punishment	ICAST-Parent Report (Runyan et al., 2009)	t1: ns	$OR^* = 0.72$ ($CI = 0.58, 0.90$)
	Sinovuyo/PLH	controlled	after			t2: ns	$OR^* = 0.96$ ($CI = 0.75, 1.23$)
	for Young	trial	completion	Psychological punishment	ICAST-Parent Report	t1: ns	$OR^* = 0.86$ ($CI = 0.74, 1.02$)
	Children		(t1), 17			t2: ns	$OR^* = 1.05$ ($CI = 0.87, 1.26$)
			months after	Observed negative	Dyadic Parent–Child Interaction	t1: ns	$OR^* = 1.04$ ($CI = 0.89, 1.12$)
	Type: Parenting		completion	parenting	Coding System (Robinson & Eyberg, 1981)	t2: ns	$OR^* = 0.83$ ($CI = 0.69, 1.00$)
	program		(t2)				
	Selective						
	prevention						

Note.

^a Effect sizes as presented in the articles. For additionally computed effect size measures, see *Table 6*.

^b OR^* = Odds Ratio as estimated by $\exp(\beta)$ for interaction effect between group and time components. Results from multilevel generalized linear models with log link.

Appendix C – Quality Appraisal Tool for QESs

JBI CRITICAL APPRAISAL CHECKLIST FOR QUASI-EXPERIMENTAL STUDIES

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☐	☐	☐	☐
2. Were the participants included in any comparisons similar?	☐	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☐	☐	☐	☐
4. Was there a control group?	☐	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☐	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☐	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☐	☐	☐	☐
8. Were outcomes measured in a reliable way?	☐	☐	☐	☐
9. Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

Appendix D – Quality Appraisal Tool for RCTs

JBI CRITICAL APPRAISAL TOOL FOR ASSESSMENT OF RISK OF BIAS FOR RANDOMIZED CONTROLLED TRIALS

Assessor:	Date of Appraisal:	Record Number:
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Study Author:	Study Title:	Study Year:
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Internal Validity		Choice - Comments/Justification	Yes	No	Unclear	N/A
Bias related to selection and allocation						
1	Was true randomization used for assignment of participants to treatment groups?		☐	☐	☐	☐
2	Was allocation to treatment groups concealed?		☐	☐	☐	☐
3	Were treatment groups similar at the baseline?		☐	☐	☐	☐

Bias related to administration of intervention/exposure

4	Were participants blind to treatment assignment?		☐	☐	☐	☐
5	Were those delivering the treatment blind to treatment assignment?		☐	☐	☐	☐
6	Were treatment groups treated identically other than the intervention of interest?		☐	☐	☐	☐

Bias related to assessment, detection and measurement of the outcome

7	Were outcome assessors blind to treatment assignment?		Yes	No	Unclear	N/A
	Outcome 1 Outcome		☐	☐	☐	☐
	2		☐	☐	☐	☐
	Outcome 3		☐	☐	☐	☐
	Outcome 4		☐	☐	☐	☐
	Outcome 5		☐	☐	☐	☐
	Outcome 6		☐	☐	☐	☐
	Outcome 7		☐	☐	☐	☐
8	Were outcomes measured in the same way for treatment groups?		Yes	No	Unclear	N/A

	Outcome 1		☐	☐	☐	☐
	Outcome 2		☐	☐	☐	☐
	Outcome 3		☐	☐	☐	☐
	Outcome 4		☐	☐	☐	☐
	Outcome 5		☐	☐	☐	☐
	Outcome 6		☐	☐	☐	☐
	Outcome 7		☐	☐	☐	☐
9	Were outcomes measured in a reliable way		Yes	No	Unclear	N/A
	Outcome 1		☐	☐	☐	☐
	Outcome 2		☐	☐	☐	☐
	Outcome 3		☐	☐	☐	☐
	Outcome 4		☐	☐	☐	☐
	Outcome 5		☐	☐	☐	☐
	Outcome 6		☐	☐	☐	☐
	Outcome 7		☐	☐	☐	☐

Bias related to participant retention

10	Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?					
	Outcome 1		Yes	No	Unclear	N/A
	Result 1		☐	☐	☐	☐
	Result 2		☐	☐	☐	☐
	Result 3		☐	☐	☐	☐
	Outcome 2		Yes	No	Unclear	N/A
	Result 1		☐	☐	☐	☐
	Result 2		☐	☐	☐	☐
	Result 3		☐	☐	☐	☐
	Outcome 3		Yes	No	Unclear	N/A
	Result 1		☐	☐	☐	☐
	Result 2		☐	☐	☐	☐
	Result 3		☐	☐	☐	☐
	Outcome 4		Yes	No	Unclear	N/A

Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 5		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 6		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 7		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐

Statistical Conclusion Validity

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Were participants analysed in the groups to which they were randomized?					
Outcome 1		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 2		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 3		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 4		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐

Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 5		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 6		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 7		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐

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Was appropriate statistical analysis used?					
Outcome 1		Yes	No	Unclear	N/A

Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 2		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 3		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 4		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 5		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐

Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 6		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
Outcome 7		Yes	No	Unclear	N/A
Result 1		☐	☐	☐	☐
Result 2		☐	☐	☐	☐
Result 3		☐	☐	☐	☐
		Yes	No	Unclear	N/A
13 Was the trial design appropriate and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?		☐	☐	☐	☐

Overall appraisal:

Include: ☐Exclude: ☐Seek Further Info: ☐

Comments:

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Appendix E – Abstract English

The intergenerational transmission of family violence (ITFV) describes a link between childhood victimization and subsequent perpetration in adulthood. This can include childhood experiences of physical, psychological, emotional, and sexual abuse, as well as neglect and intimate partner violence. Extensive research has been devoted to identifying the underlying mechanisms, as well as risk and protective factors of the ITFV. Prevention science often claims to “break the cycle” when reporting on intervention concepts that succeeded in reducing the likelihood of family violence perpetration. But to confirm that psychosocial interventions like home visitation, parenting programs, and psychotherapy can achieve a disruption of the ITFV, they have to be tested for individuals with experiences of childhood abuse. A systematic review was conducted to identify psychosocial intervention studies that reported on effectiveness in reducing family violence perpetration of participants who were victimized during childhood. A total of 3508 references were screened using the PsycINFO, PubMed and SCOPUS databases. Included in the review were $k = 9$ articles. Methodological quality of the included studies was mixed and heterogeneity high. Narrative synthesis was performed to generate an aggregated theory of change model across all interventions examined by the included studies. Articles were grouped into categories based on intervention type and analyzed, allowing for a deeper understanding of program components and pathways to change. Effect sizes were in the very small to medium range. No conclusions on overall effectiveness were drawn since meta-analysis were precluded. Methodological perspectives and connections to existing research are discussed.

Appendix E – Abstract German

Die intergenerationale Transmission familiärer Gewalt beschreibt einen Zusammenhang zwischen Viktimisierung in der Kindheit und anschließender Gewaltausübung im Erwachsenenalter. Dies kann Kindheitserfahrungen mit physischem, psychischem, emotionalem und sexuellem Missbrauch sowie Vernachlässigung und Gewalt in der Partner*innenschaft umfassen. Viel wissenschaftliche Arbeit wurde bereits der Identifizierung von zugrunde liegenden Mechanismen sowie von Risiko- und Schutzfaktoren des in Bezug auf intergenerationale Transmission gewidmet. Die Präventionswissenschaften behaupten oft, „den Kreislauf zu durchbrechen“, wenn über Interventionskonzepte berichtet wird, die erfolgreich darin waren, die Wahrscheinlichkeit für die Ausübung familiärer Gewalt zu reduzieren. Um aber abzuleiten, dass psychosoziale Interventionen wie Hausbesuche, Elternprogramme und Psychotherapie die Übertragung zwischen den Generationen wirklich unterbrechen können, müssen diese für Personen mit Erfahrungen von Kindesmisshandlung getestet werden. Ein systematisches Review wurde durchgeführt, um psychosoziale Interventionsstudien zu identifizieren, die über Wirksamkeit bei der Reduktion der familiären Gewaltausübung von in der Kindheit misshandelten Teilnehmer*innen berichten. Insgesamt 3508 Titel und Abstracts wurden unter Verwendung der PsycINFO-, PubMed- und SCOPUS-Datenbanken gescreent. In das Review wurden $k = 9$ Artikel inkludiert. Die methodische Qualität der inkludierten Studien war gemischt und die Heterogenität hoch. Narrative Synthese wurde durchgeführt, um ein aggregiertes Modell der Theory of Change aller in den inkludierten Studien untersuchten Interventionen zu generieren. Die Artikel wurden basierend auf dem jeweiligen Interventionstyp in Kategorien gruppiert und analysiert, was ein tieferes Verständnis der Interventionskomponenten und Veränderungspfade ermöglicht. Effektgrößen lagen im sehr kleinen bis mittleren Bereich. Es wurden keine Schlussfolgerungen zur Gesamtwirksamkeit gezogen, da die Anwendung einer Metaanalyse ausgeschlossen wurde. Methodologische Perspektiven und Verbindungen zu bestehender Forschung werden diskutiert.