CPS WORKERS' PERSPECTIVES ON MST-IPV AND OTHER INTERVENTIONS FOR CHILD MALTREATMENT AND INTIMATE PARTNER VIOLENCE: A REFLEXIVE THEMATIC ANALYSIS

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ABSTRACT

CPS WORKERS' PERSPECTIVES ON MST-IPV AND OTHER INTERVENTIONS FOR CHILD MALTREATMENT AND INTIMATE PARTNER VIOLENCE: A REFLEXIVE THEMATIC ANALYSIS

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Although the co-occurrence rate of intimate partner violence (IPV) and child abuse and neglect (CAN) is about 40% (Appel and Holden, 1998; Herrenkohl et al., 2008), little research currently exists on integrated treatment for these concerns. Furthermore, no known published studies investigate child protective services (CPS) workers' perspectives on such treatment. The present study explores the perspectives of CPS workers on treatment for co-occurring IPV and CAN, specifically focusing on Multisystemic Therapy for Intimate Partner Violence (MST-IPV). A total of 18 Connecticut CPS workers participated in semi-structured interviews. Seven participants had experience working with MST-IPV treatment providers, while 11 participants had no experience with MST-IPV. The interviews were transcribed and analyzed using Reflective Thematic Analysis, resulting in five main themes: "Complexity of IPV Cases," "Recommending What's Available Rather Than What's Best," "Varied Treatment Effectiveness," "Importance of Digging Deep," and "Above and Beyond." The findings of this study highlight CPS worker satisfaction with MST-IPV and underscore the importance of developing, researching, and funding treatments for co-occurring IPV and CAN. This

dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: Multisystemic Therapy, Multisystemic Therapy for Intimate Partner Violence, intimate partner violence, child maltreatment, child protective services, reflexive thematic analysis

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"No [wo]man is an island." —John Donne

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CHAPTER I: INTRODUCTION

Health risks such as substance misuse, suicide attempts, and many of the most prevalent causes of death in adulthood have been linked to experiences of adverse events in childhood (Felitti, 1998). Included in possible adverse exposures are child maltreatment and repeated violence against a child's parent. Estimates from the National Child Abuse and Neglect Data System (NCANDS) indicated that approximately 4.4 million referrals of child abuse and neglect were made to child protective services (CPS) in the United States in 2019 (Children's Bureau, 2021). Of those referrals, 54.5% were screened in for investigation. Additionally, meta-analyses conducted by Appel and Holden (1998) and Herrenkohl et al. (2008) demonstrated co-occurrence rates for child abuse and neglect and intimate partner violence (IPV) of 40%. Therefore, the need to address co-occurring child maltreatment and IPV in ways that are effective, efficient, and frugal is significant. Efficacious intervention for families involved with CPS can minimize repeat instances of child maltreatment, preserve families, and mitigate unfavorable outcomes such as moving between multiple out of home placements, poor mental health, and challenges with physical health (Heriot & Kissouri, 2018).

Despite the prevalent overlap between child abuse and neglect and IPV, both research and treatment for these issues have historically been siloed to distinct fields of study and programs for treatment (Edleson, 1999). Scholars tended to focus on either IPV or child maltreatment, and IPV advocates handled IPV services while the child welfare system oversaw services for child maltreatment. Within the past two decades, researchers have made significant strides in better understanding the co-occurrence. Among these strides have been efforts to develop a shared conceptualization of family violence (Slep & O'Leary, 2001). This conceptualization has included an understanding of shared risk and protective factors between

the two forms of family violence (Guedes et al., 2016). In light of a deeper understanding of the IPV/child maltreatment co-occurrence, a discourse has emerged within the literature about the need for treatment modalities that address both kinds of family violence at once (Guedes et al., 2016; Slep & O'Leary, 2001). An integrated approach to treatment and prevention can save time, money, and resources and enhance levels of safety for the CPS-involved families in ways that siloed treatments cannot.

The lack of a unified approach to co-occurring child maltreatment and IPV has led to contention between CPS workers and IPV advocates (Alaggia et al., 2015; Armstrong & Bosk, 2021; Beeman et al., 1999). The two kinds of service providers differ in their priorities. The top concern of IPV advocates is providing advocacy and services for victims of IPV, whereas CPS workers are primarily concerned with the safety of the child. CPS' workers prioritization has often resulted in punitive responses toward victims of IPV involved in child welfare cases (Johnson & Sullivan, 2008; Rebbe et al., 2021). After a landmark lawsuit case in which an IPV survivor sued the city of Brooklyn for removing her children from her custody while she was being hospitalized for IPV injuries, nationwide attempts have been made to remedy the disconnect between the child welfare system and IPV services (Moles, 2008). Among these attempts include the implementation of the "harm or threatened harm" guideline (Victor et al., 2019). This guideline obligates CPS workers to assess the extent to which children have been harmed or are under the threat of harm due to IPV in the home when deciding if the IPV qualifies as child maltreatment. Although more work is required to bring this collaboration into effective practice, progress is being made in closing the divide between the child welfare system and IPV agencies during the investigative process. Additionally, discourse has expanded to

include a shared conceptualization of family violence. However, little research exists on integrated approaches to treating both kinds of family violence (Renner, 2021).

A potential remedy for this dearth of services is Multisystemic Therapy for Intimate Partner Violence (MST-IPV). MST-IPV is a new adaptation of Multisystemic Therapy for Child Abuse and Neglect (MST-CAN), an intensive family-based treatment for child abuse and neglect (Swenson & Schaeffer, 2014). MST programs are influenced by Bronfenbrenner's social ecological systems theory of development (1979), feature a unique teams-based approach with small caseloads, and address multiple systems affecting the problem of concern (Henggeler, 2001). MST-IPV integrates Domestic Violence Focused Couples Therapy (DVFCT; Stith et al., 2016) with MST-CAN to treat co-occurring IPV and child maltreatment (Swenson & Schaeffer, 2024). MST-IPV has been implemented in Connecticut, United States for six years and is currently the subject of a quasi-experimental pilot program at Wheeler Clinic. Only one published study on MST-IPV currently exists, outlining the process by which MST-IPV was developed and can be replicated (Swenson & Schaeffer, 2024). Research about MST-IPV would add to the understanding of its use and effectiveness and add to the greater discourse surrounding integrated treatment for co-occurring IPV and child maltreatment.

CPS workers are vital stakeholders in treatment for child welfare-involved families. They are directly exposed to the effects of services on the families with whom they work and may provide valuable insight into what they have seen to be beneficial. A variety of qualitative studies pertaining to the perspectives of CPS workers are currently available. Many of these studies explored CPS workers' perspectives of what their employment is like by examining components such as stress, burnout, and job retention and turnover (Ellet et al., 2007; Ezell, 2019; Radey et al., 2022; Tavormina & Clossey, 2015). Additional studies have explored CPS

workers' perceptions of child welfare policies and processes (Lee et al., 2013; Rollins, 2020). Finally, multiple studies have looked at CPS workers' perspectives of and experiences with co-occurring child maltreatment and IPV (Fusco, 2013; Olszowy et al., 2020; Risser et al., 2022). Despite the variety of qualitative explorations into the perspectives of CPS workers, no known studies examining CPS workers' perspectives on treatment for co-occurring IPV and child abuse and neglect exist.

Statement of the Problem

Despite evidence of high co-occurrence rates of IPV and child abuse and neglect, little research currently exists on integrated treatment for these concerns. Additionally, no known studies are currently published examining CPS workers' perspectives on such treatment. The intention of the current study is to highlight the perspectives of CPS workers with experience working with MST-IPV teams on treatment for co-occurring IPV and child maltreatment, highlight the perspectives of CPS workers with no experience working with MST-IPV teams, and compare and contrast the two perspectives. In doing so, the study seeks to provide information on how CPS workers view MST-IPV and other treatments and how CPS workers with experience with MST-IPV's perceptions of treatment may be similar or different from those with no exposure to MST-IPV.

Research Questions

The current study will seek to answer the following research questions:

RQ1: What are CPS workers' perspectives on treatment for co-occurring CAN and IPV?

RQ2: What are CPS workers' perspectives on MST-IPV?

RQ3: How do the perspectives on treatment for co-occurring CAN and IPV of CPS workers with experience with MST-IPV and no experience with MST-IPV compare and contrast?

Significance of the Study

This study may contribute to the fields of psychology and social work in a variety of ways. First, by providing information on CPS workers' perspectives of MST-IPV, it may inform future implementation of the intervention. It may also highlight questions to ask in future clinical trials of the intervention. Second, it may contribute to the greater discourse surrounding integrated treatment for co-occurring child abuse and neglect and IPV. Finally, it may fill the research gap pertaining to qualitative studies exploring the perspectives of CPS workers on treatment for the co-occurring concerns.

Definition of Terms

The following terms are defined to establish a unified understanding throughout the study.

Child abuse and neglect (CAN): "The physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby" (Child Abuse Prevention and Treatment Act, 1974, p. 5).

Child Protective Services (CPS): A social services department branch aimed at investigating, assessing, and providing intervention for cases of child abuse and neglect (Children's Bureau, 2020).

CPS Worker: A social worker employed by a state's CPS social services department branch.

Child Welfare System (CWS): "a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families" (Children's Bureau, 2020).

Domestic Violence (DV): A pattern of physical violence and/or psychological intimidation and/exploitation within a relationship (Gover & Moore, 2021).

Intimate Partner Violence (IPV): "A pattern of abusive behavior in a relationship that is used by one partner to maintain power and control over another current or former intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behavior that intimidates, manipulates, humiliates, isolates, frightens, terrorizes, coerces, threatens, hurts, injures, or wounds someone" (Office on Violence Against Women, 2016).

Treatment provider: A treatment professional who is employed by an organization or is in private practice outside of a state's CPS branch. For the purpose of this study, treatment will be referring to mental health treatment (e.g., therapy).

Violence Against Women (VAW): Sexual violence, IPV, stalking, and dating violence (Violence Against Women Act, 1994).

Reflexivity Statement

As a co-constructor of knowledge in the research process, I bring my sociocultural context and a variety of values and biases into my engagement with participants and the data I will analyze in this study. I approach this study embodying intersections of privileged and oppressed identities. I am a white, able-bodied, cisgender woman with United States citizenship. I was raised in a Christian household and am able to move with ease in a Christianity-dominated society but am no longer religious. Additionally, I have previous experience working with

families involved in the child welfare system. These past experiences exposed me to the nuances and complexities within child maltreatment cases and instilled in me the value of effective services for the families involved. I hold the belief that child safety and family preservation are not always mutually exclusive and should be weighed carefully with each individual case. I believe that parents involved with CPS should be given the opportunity to accept support to keep their children safely in their home or reunify with them.

Organization of the Study

This dissertation will be divided into five chapters and an appendix section. The first chapter provides an introduction to the dissertation topic, a problem statement, research questions, significance of the study, definitions of terms, and a reflexivity statement. The second chapter contains a review of pertinent research and literature regarding Multisystemic Therapy for Intimate Partner Violence and the perspectives of CPS workers. The literature review consists of an overview of child maltreatment and child welfare, intimate partner violence, co-occurring child maltreatment and intimate partner violence, Multisystemic Therapy for Child Abuse and Neglect, alternative evidence-based treatments, and perspectives of child protective services workers. The third chapter discusses the methodology and procedures utilized to collect and analyze data. The fourth chapter presents the results of the data analysis and an overview of the study and research findings. The fifth chapter includes a discussion and recommendations for future research.

CHAPTER II: LITERATURE REVIEW

Chapter II presents a review of the relevant research and literature pertaining to Multisystemic Therapy for Intimate Partner Violence (MST-IPV) and the perceptions of CPS workers. This chapter consists of seven sections including (a) child maltreatment and child welfare, (b) intimate partner violence, (c) co-occurring child maltreatment and intimate partner violence, (d) CPS treatment referral process, (e) Multisystemic Therapy for Child Abuse and Neglect, (f) alternative evidence-based treatments, and (g) perspectives of child protective services workers.

Child Maltreatment and Child Welfare

Although a variety of foster care practices were present in the United States from the time it was colonized, the first federal legislation specifically for child welfare was originally enacted in 1974 (Child Abuse Prevention and Treatment Act, 1974). The Child Abuse Prevention and Treatment Act (CAPTA) established a National Center on Child Abuse and Neglect and provides funding for states to improve child protective services. In order to receive funding under the act, states are required to have processes by which child maltreatment is reported and investigated, and state definitions for child maltreatment must be consistent with the definition outlined in CAPTA. Child abuse and neglect was defined by CAPTA as:

> the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby. (p. 5)

CAPTA has since been amended to include victimizing children through sex trafficking or severe human trafficking in the definition of abuse and neglect.

Implemented more than two decades after CAPTA, the Adoption and Safe Families Act of 1997 (ASFA) holds implications for the treatment of child abuse and neglect in the United

States. ASFA was enacted in response to perceived flaws of the previous attempt at child welfare reform, the Adoption Assistance and Child Welfare Act of 1980 (AACWA; Herring, 2000). AACWA aimed to increase placement permanency for children in foster care by prioritizing reunification with biological families over other permanent options such as adoption. AACWA did not explicitly speak to child safety, and children often remained in foster care for extended periods of time due to the emphasis on family reunification before other permanent options could be pursued. In contrast, ASFA asserts the goal of child safety first (Adoption and Safe Families Act, 1997; Herring, 2000). Under ASFA, agencies are allowed to pursue multiple options for placement permanency simultaneously with reunification, and agencies are to pursue parental right termination within a specific timeframe. Therefore, best treatments for child abuse and neglect are effective within a limited timeframe and prioritize child safety in all attempts to preserve families.

Intimate Partner Violence

Intimate partner violence (IPV) received little attention in the political and scientific discourses until the revival of the feminist movement in the 1970s (Kilpatrick, 2004; Tjaden, 2004). Although physical and sexual violence by intimate partners has been present for centuries (Pleck, 2004; Renzetti & Bergen, 2004), it was previously considered to be a personal affair that should be handled within the family. The feminist movement began to change societal perceptions of violence against women (VAW) by raising awareness about its gravity and prevalence. Included in the burgeoning conversations were the topics of sexual assault, woman battering, and stalking. Feminist activists arranged events in which survivors shared openly about their experiences with violence against them and being dismissed by police and the court system, and feminist social scientists began writing about and researching the societal structures of

power lead to VAW. The Battered Women's Movement emerged from these efforts, leading to services for victims of domestic abuse (Renzetti & Bergen, 2004). For example, feminist activists created crisis lines for guidance and support for victims of IPV, and the first shelters for women and children fleeing IPV opened in 1973. Such efforts have expanded over the past decades to address policy, treatment, and support for IPV survivors.

Despite nearly half a century of public, scholarly, and legal discourse surrounding IPV, no consensus exists about its definition and what it encompasses (Gover & Moore, 2021). Some researchers include both physical violence and psychological intimidation and exploitation in their definitions of IPV, while others only include physical violence. Additionally, according to Danis (2003), IPV is both a social and criminal justice problem, prompting a need for a broad social definition and more specific criminal justice definition. This lack of agreement has resulted in a plethora of terms within research to describe the same actions of violence between intimate partners (Gover & Moore, 2021). Frequently used labels include "abuse, violence, domestic violence, interpersonal violence, and intimate partner violence" (Gover & Moore, 2021, pp. 10–11). The term intimate partner violence (IPV) will be the term used throughout the current study.

Congress passed the Violence Against Women Act (VAWA) in 1994, marking an important milestone in defining, prosecuting, and treating IPV and other VAW (Modi et al., 2014). VAWA dispenses funding for the prevention and treatment of and research about VAW. It also provides direction for the criminal justice response to VAW. Four kinds of violence against women are defined under VAWA: sexual violence, IPV, stalking, and dating violence. Created under VAWA, the Office on Violence Against Women (OVW) clarified VAWA's definition of IPV (Gover & Moore, 2021). OVW (2016) defined IPV as a:

> pattern of abusive behavior in a relationship that is used by one partner to maintain power and control over another current or former intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behavior that intimidates, manipulates, humiliates, isolates, frightens, terrorizes, coerces, threatens, hurts, injures, or wounds someone. (p. 2)

IPV is defined similarly by the World Health Organization (WHO; 2021) as "behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors" (para. 1). Both of these definitions include both physical and psychological forms of abuse. However, many legal definitions of IPV only encompass threats to physical safety (Danis, 2003).

The history of defining and treating IPV has focused primarily on VAW (Kilpatrick, 2004; Pleck, 2004; Renzetti & Bergen, 2004; Tjaden, 2004). However, for decades, scholars have debated whether IPV is truly a VAW issue or if men and women perpetrate IPV equally in heterosexual relationships (Ahmadabadi et al., 2021; Dobash et al., 1992; Tjaden & Thoennes, 2000). Additionally, more recent research has established a common pattern of mutual IPV, demonstrating flaws in the view of IPV as primarily VAW (Caetano et al., 2008). Research on IPV has shown conflicting results on gender differences in perpetration, which could be in part due to the diverse ways IPV has been theorized and defined. For example, Ahmadabadi et al. (2021) identified how broadly utilized measures for IPV such as the Abusive Behavior Inventory (Shepard & Campbell, 1992), which was developed from a feminist lens, and the Contact Tactics Scale (Straus, 1979), which captures "*the act of violence* rather than its *consequences*" (Ahmadabadi et al., 2021, p. 917), gather information in a way that might result in an overrepresentation of a specific gender in estimates of IPV perpetration. Additionally, current research on IPV might not sufficiently represent alternative versions of IPV other than physical violence, and some debate exists on whether asking research participants about current IPV alone

results in an overrepresentation of male victims since women may be more afraid to report current IPV (Ackerman, 2012).

Co-occurring Child Maltreatment and IPV

The co-occurrence of child maltreatment and intimate partner violence (IPV) is a significant treatment consideration due to its high prevalence rate (Appel & Holden, 1998; Guedes et al., 2016; Herrenkohl et al., 2008). Edleson (1999) first noted a fragmentation in research on interventions for child abuse and violence against women (VAW). He argued that research and services are generally siloed to either abused children or battered women despite evidence of overlap. Slep and O'Leary (2001) expanded the argument by contending for the integration of IPV and child abuse in conceptualization and research. They proposed hypotheses for shared risk factors between the two forms of violence, unique etiological factors for both child maltreatment and IPV, an influence of each form of violence over the other, and protective factors that can minimize the influence of one form of violence over the other. Their hope was that inquiring into these hypotheses would provide frameworks for integrated intervention for CAN and IPV and prevention for both kinds of violence.

Additionally, in a narrative review of connections between VAW and child abuse, Guedes et al. (2016) determined six commonalities. Two of the six commonalities were that child abuse and VAW share many of the same risk factors and often occur simultaneously in the same home. These findings further emphasize the importance of integrated treatment for co-occurring IPV and child maltreatment; time and resources may not be used efficiently when treatment of the same risk factors is allocated to separate agencies rather than being addressed simultaneously through an integrated approach. Although the fields of psychology and social work have expanded in their understanding of co-occurring IPV and CAN, little research exists

on the implementation of integrated treatment for both kinds of family violence (Renner, 2021). Such research would have practical implications for agencies disseminating services for family violence, CPS workers, and policy.

The fragmentation between responses to CAN and IPV has resulted in conflict between CPS workers and IPV advocates (Alaggia et al., 2013; Armstrong & Bosk, 2021; Beeman et al., 1999). Instances of co-occurring CAN and IPV are more complex for CPS workers than cases addressing child maltreatment alone. In cases of co-occurrence, the parent who maltreated the child might also be the recipient of aggression in the domestic violence relationship. Additionally, in many state policies, exposing a child to IPV is considered to be a form of maltreatment in and of itself (Cross et al., 2012). CPS workers' priority of protecting children often leads to punitive action toward victims of IPV (Armstrong & Bosk, 2021; Beeman et al., 1999; Johnson & Sullivan, 2008; Rebbe et al., 2021). These punitive actions are further exacerbated by the tendency for women to be the primary caregivers of children and CPS workers' reliance on alternative systems to hold male IPV perpetrators accountable (Beeman et al., 1999; Moles, 2008).

Tension between the CWS and IPV services is well exemplified by the Nicholson case in which CPS removed Brooklyn resident Shawrline Nicholson's two children from her custody while she was hospitalized from IPV injuries, and she was charged with two counts of child neglect (Moles, 2008). Nicholson, along with other recipients of IPV who had experienced similar punitive action against them by the CWS, filed a class action lawsuit against the city of Brooklyn. The results of the lawsuit were in favor of Nicholson and the other IPV survivors. This case resulted in nationwide attempts to improve collaboration between CPS and IPV services and CPS workers' responses to IPV. One important change coming out of the Nicholson case has

been the CWS' adoption of the "harm or threatened harm" guideline, which requires CPS workers to assess the extent to which children have experienced harm or threatened harm due to IPV in the home when determining if the IPV should be considered child maltreatment (Victor et al., 2019). The "harm or threatened harm" standard is an attempt to balance the consideration of the harm to children exposure to IPV can cause while also avoiding unnecessary consequences for victims of DV. However, implementing a supportive framework when working with families with IPV remains a challenge in practice (Armstrong & Bosk, 2021).

For example, Armstrong and Bosk (2021) conducted a grounded theory study with interviews from 36 CPS workers in a midwestern state to determine when CPS workers use a punitive framework and how risk assessment tools affect decision making in IPV/CAN cases. The Midwestern State in which the study was conducted was one of 10 states in the United States that employs the Safe and Together Model for handling IPV/CAN cases. The Safe and Together Model involves three principles that promote collaboration with the non-offending parent, keeping the child safely with the non-offending parent, and intervention for the offending parent. Armstrong and Bosk (2021) found that "contradictions between the Safe and Together Model, policy definitions, and investigative procedures allow workers to select between punitive and supportive approaches on a case-by-case basis" (p. 448), which often results in negative outcomes for recipients of IPV in CPS cases. Additionally, other studies have demonstrated an over-representation of Black and Indigenous families in CPS investigations involving IPV, "a significantly higher number of DV-involved cases remain[ing] open for CPS than cases for other forms of child maltreatment" (Alaggia et. al., 2015, p. 91), and a greater risk for out-of-home placement for families who reported IPV (Ogbonnaya & Guo, 2013). These findings suggest that efforts to minimize punitive treatment for adult recipients of IPV in CPS-involved families might

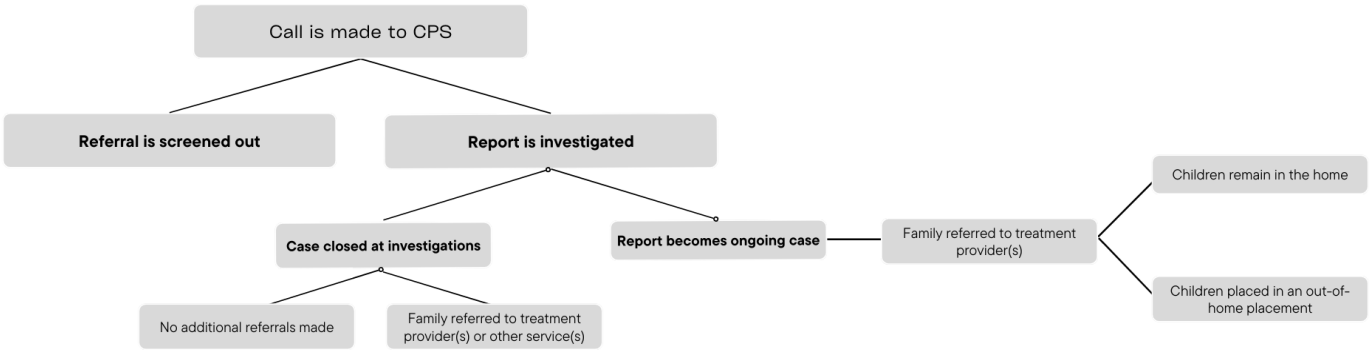
not be as successful as hoped. Greater focus on collaborative efforts between CAN and IPV systems in treatment and response is still needed.

CPS Treatment Referral Process

An important function of CPS agencies is to connect caregivers and families with social services to address the reasons for CPS involvement. Families can be linked to such services at multiple points during CPS oversight. However, not every report made to CPS will lead to further involvement in the CWS or referrals to treatment (Children's Bureau, 2021). Calls made to CPS first go through a screening process whereby CPS workers determine if the call meets agency criteria for investigation or will be screened out. Investigated reports may either be closed after the investigation is complete or become an ongoing case. CPS workers at the investigations level may refer families and/or caregivers to treatment providers or other services if the case is closed or transferred to an ongoing worker. Regardless of if referrals are made at the investigation or ongoing level, caregivers with ongoing cases are required to engage with social services based on identified needs. Social services could include things like mental health treatment, parenting classes, substance use treatment, or employment support.

Figure 2.1

CPS Treatment Referral Process



Although ongoing CPS workers provide treatment for families in some countries, it is not typical practice in the United States. Instead, caregivers and families are referred to community agencies or treatment providers to receive treatment, and CPS workers remain in contact with treatment providers to monitor engagement and progress. This is just one responsibility of many for ongoing CPS workers who often carry high caseloads (Children's Bureau, 2021). Although treatment providers referred by CPS sometimes operate within group or private practices depending on availability and the caregivers' insurance, they generally work for community mental health and/or nonprofit organizations receiving state or donor funding. Within such agencies, they often also carry heavy caseloads and receive lower pay than treatment providers funded by private insurance or employed by hospitals, often leading to emotional exhaustion and high turnover rates (Kim et al., 2018).

Multisystemic Therapy for Child Abuse and Neglect

One promising intervention for child maltreatment is Multisystemic Therapy for Child Abuse and Neglect (MST-CAN). MST-CAN is a family-based treatment for child maltreatment adapted from Multisystemic Therapy (MST), originally an intensive intervention for youth with significant behavioral and emotional concerns (Henggeler, 2001; Swenson & Schaeffer, 2014).

MST programs are based on Bronfenbrenner's social ecological systems theory of development (Bronfenbrenner, 1979; Henggeler, 2001). According to Bronfenbrenner, development is affected by a complex interplay of the numerous systems in a person's life such as family, community, culture, and policy. Therefore, presenting concerns and problem behaviors are determined by a variety of systemic factors and interactions between systems. In light of its theoretical grounding, MST-CAN strengthens existing protective factors against child abuse and neglect and addresses contributing influences on child maltreatment across multiple systems (Swenson & Schaeffer, 2014). The goals of MST-CAN are to "keep families together safely" (Swenson & Schaeffer, 2014, p. 239), extinguish future occurrences of abuse and neglect, and intervene on risk factors for child maltreatment.

Two additions have been made to MST-CAN since its development. The first, called Multisystemic Therapy-Building Stronger Families (MST-BSF), combines Reinforcement Based Treatment (RBT; Tuten et al., 2012) with MST-CAN in an effort to address co-occurring parental substance abuse and child abuse and neglect (Schaeffer et al., 2013, 2021). Most recently, the developers of MST-BSF have developed a new program integrating DVFCT (Stith et al., 2016) with MST-CAN in an effort to address co-occurring child maltreatment and IPV (Swenson & Schaeffer, 2024). Named Multisystemic Therapy for Intimate Partner Violence (MST-IPV), the treatment modality is currently in use in a quasi-experimental pilot program at Wheeler Clinic in Connecticut, United States.

MST-CAN programs, including MST-IPV, are "licensed through the Medical University of South Carolina" (Swenson & Schaeffer, 2014, p. 241) and are disseminated by MST Group LLC, a company that manages all MST dissemination and works to ensure treatment fidelity (Swenson & Schaeffer, 2014). A standardized process is in place for all organizations interested

in administering MST-CAN services. The process includes steps such as a site visit from the developer of MST-CAN, the completion of a feasibility checklist, and an agreement to the terms of MST-CAN implementation. Agencies are responsible for securing funds for MST programs, generally through a combination of grants, state funding, and federal funding (MST Services, n.d.). MST-CAN programs have been implemented by agencies in the following countries: The United States, The United Kingdom, Australia, Norway, Switzerland, The Netherlands, and Germany (MST Services, n.d.).

MST-CAN programs are targeted at families involved with CPS for recent child physical abuse and neglect toward at least one child between the ages of six and 17 (Schaeffer et al., 2013, 2021; Swenson et al., 2010; Swenson & Schaeffer, 2014). Families who receive MST-CAN services also have a variety of significant clinical concerns. MST-CAN services are delivered through clinical teams. The teams consist of a full-time supervisor with no case load, three therapists, a full-time family resource specialist, and 10% to 20% of a psychiatrist's time designated to the team (Swenson & Schaeffer, 2014). There is also an MST-CAN expert at MST Group LLC dedicated to training teams and ensuring treatment fidelity. The caseload of each team is a maximum of four families.

MST-CAN programs are flexible to the needs of the families and based on nine treatment principles (Swenson & Schaeffer, 2014). The nine principles are:

1. The primary purpose of assessment is to understand the "fit" between the identified problems and their broader systemic context.
2. Therapeutic contacts should emphasize the positive and use systemic strengths as levers for change.

3. Interventions should be designed to promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions should target sequences of behavior within and between multiple systems.
6. Interventions should be developmentally appropriate and fit the developmental needs of the youth.
7. Interventions should be designed to require daily or weekly effort by family members.
8. Intervention efficacy should be evaluated continuously from multiple perspectives.
9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change. (Swenson & Schaeffer, 2014, p. 242)

The entire family is the target for treatment, and the focal point of treatment are the parents. However, services are also administered to children when needed (Swenson & Schaeffer, 2014). Interventions can be delivered in the family's home, community, or other settings convenient to the family. Services are administered at times convenient to the family, and families are also provided with 24/7 crisis services. Procedures of MST-CAN programs include tailored safety planning, weekly safety assessments, and parents taking responsibility for abusive and neglectful behaviors.

Utilized interventions are determined by the developmental stages of the children in the family and sources of key concerns within the family. Some interventions used are behavioral family systems therapy, cognitive behavioral therapy for anger management and/or trauma, and

reinforcement-based treatment for adult substance misuse. Behavioral family systems therapy addresses conflict between parents and adolescents by strengthening family problem-solving and communication skills, restructuring distorted thinking, and attending to unhealthy family structures (Robin et al., 1994). Additionally, cognitive behavioral therapy has been adapted to strengthen anger management and minimize symptoms of trauma through the use of cognitive restructuring, coping skill building, and exposure to distressing events (Cohen et al., 2012; Feindler, 2006; Feindler et al., 1986; Foa et al., 2007). Finally, reinforcement-based treatment incorporates behavioral techniques with motivational interviewing and provides case management and personalized treatment plans for clients with substance use disorders (Tuten et al., 2012).

The first randomized effectiveness trial of MST-CAN showed it to be significantly more effective than enhanced outpatient treatment at reducing negative mental health of youth, parenting behaviors linked with child abuse and neglect, psychological distress in parents, and the instances of youth being placed outside of the home (Swenson et al., 2010). Similar positive results were found in a pilot study (Schaeffer et al., 2013) and randomized effectiveness trial (Schaeffer et al., 2021) comparing MST-BSF with Comprehensive Community Treatment. Further, studies facilitated in Switzerland by Bauch et al. (2022), Buderer et al. (2020), and Hefti et al. (2020) confirmed MST-CAN's effectiveness in reducing levels of neglect, psychological distress in parents, and emotional and behavioral difficulties in youth. Parental mental health has also shown improvements during MST-CAN treatment (Bauch et al., 2022). Additionally, Dopp et al. (2018) found that every dollar spent on MST-CAN recovered $3.31 in savings to participants, taxpayers, and society at large. Thus, the initial upfront expenses of MST-CAN services more than pay for themselves in a relatively short period of time.

In addition to quantitative studies, two qualitative studies about MST-CAN have been published. The first was a case study on a family enrolled in MST-CAN in which interviews with family members and objective measures of symptomology supported the effectiveness of MST-CAN in helping the case-study family achieve their therapeutic goals (Stallman et al., 2010). The second qualitative study explored the agency collaboration between an MST-CAN pilot program and a CPS team (Hebert et al., 2014). The results of this study indicated that CPS workers maintained positive perceptions of their collaborations with MST-CAN, that CPS workers experienced no changes in their perceptions of parents through working with MST-CAN teams, and that CPS workers' approaches to treatment were influenced by their collaboration with MST-CAN teams.

Alternative Evidence-Based Treatments

Although numerous evidence-based treatments exist for child maltreatment (Kolko, 1996, 2011, 2018; Lowell et al., 2011; Parra et al., 2016; Scott & Crooks, 2007; Turner et al., 2017; Whitaker et al., 2020; Wood et al., 1988), MST-CAN programs offer an approach not found in other interventions. Not only does MST's social-ecological systems theoretical orientation provide a distinctive framework for conceptualizing and treating families, but the procedures of MST-CAN programs are unique as well (Schaeffer et al., 2021; Swenson et al., 2010). MST-CAN programs are delivered in teams with small caseloads, are customizable to the needs of the families served, and offer 24/7 access to crisis services. Like MST-CAN programs, other child maltreatment treatments such as Child FIRST (Lowell et al., 2011) and wrap-around services such as C.A.R.E.S. (Schneider-Muñoz et al., 2015) offer team-delivered and community-based interventions to families with multiple risk factors for child maltreatment. However, Child FIRST is targeted at families with children between the ages of 6 to 36 months,

and C.A.R.E.S. focuses on prevention rather than treatment for preexisting child maltreatment. Further, many treatment protocols are available for treating perpetrators of IPV (Stare & Fernando, 2014), but there appears to be a paucity of intensive programs outside of MST-IPV that are built to simultaneously address IPV and child maltreatment.

Perspectives of Child Protective Service Workers

As on-the-ground responders to family violence and witnesses to the impact of treatment on CPS-involved families, CPS workers are important stakeholders in child welfare policies and treatment. Researchers have published qualitative studies about CPS workers' perspectives on a variety of aspects of child welfare due to their frontline position. Many such studies focused on CPS workers' perceptions of factors such as burnout, stress, and job turnover and retention (Ellet et al., 2007; Ezell, 2019; Radey et al., 2022; Tavormina & Clossey, 2015). CPS worker participants reported experiences of institutional stressors such as unpleasant interactions with police officers and organizational cultures of fear and lack of support. Additionally, the job of CPS worker comes with unique stressors such as verbal abuse and threats from parents, being on the receiving end of occasional physical violence, secondary traumatic stress, and dealing with constant crisis. These unique challenges often cause difficulties with maintaining a work-life balance. CPS workers reported often working 50–60 hours per week, feeling like they could not relax when home due to being on-call, and having difficulty leaving the emotional aspects of their job at work when they go home at the end of the day. Factors that contribute to CPS worker retention include good job benefits, flexibility with work hours, remembering that the work is important and meaningful, and being a good fit for the position in terms of knowledge, skills, and personality.

Other qualitative studies exploring the perspectives of CPS workers have focused on their perceptions of policies and procedures. For example, Lee et al. (2013) conducted a qualitative study utilizing focus groups with 36 participants to gain information about CPS workers' perceptions of effective policies and practices for investigations. The CPS workers in their study named a variety of barriers to effective investigations. These barriers included lack of specificity or full information in initial intake documentation, limited time and resources to dedicate to building relationships with families, misalignment between policies and on the ground practices, difficulty coordinating with other institutions (e.g., police, hospitals, schools, and the general community), and an overall negative view of the standardized risk assessment tool used in their county. Additionally, in another focus group qualitative study conducted by Rollins (2020), 10 child welfare workers in Australia stressed the importance of building strong relationships with their clients. They touted client-worker relationships as crucial to strengthening clients' trust in the child welfare system and instilling hope. In the perspectives of the CPS workers, a collaborative approach to investigations and services is a vital component for developing that trust. Additionally, disruptions and ruptures are everyday parts of their work, and mending those ruptures as they arise is a valuable piece in maintaining relationships with their clients.

Several qualitative studies have also examined CPS workers' perceptions of and experiences with co-occurring CAN and IPV. Fusco (2013) researched CPS workers' experiences with IPV cases on their caseloads through a phenomenological qualitative study. They individually interviewed 19 CPS workers and found CPS workers to perceive multiple complications with cases involving IPV. These complications included challenges with allowing victims of IPV the self-determination to make their own choices, substance use adding further complications to IPV cases, and CPS workers' fear of perpetrating parents. Additionally, hurdles

were exacerbated when a parent was both the victim of IPV and a perpetrator of CAN. CPS workers reported feeling more comfortable working with families for whom a single parent perpetrates both kinds of family violence. Themes also included challenges with working with the police due to their perceived lack of concern toward child protection and lack of respect toward child welfare workers. Finally, CPS workers in this study felt ill-prepared to deal with co-occurring IPV and CAN overall. However, personally knowing survivors of IPV made them more sensitive toward the nuances of the issue.

Olszowy et al. (2020) found similar themes in their qualitative study examining challenges to effective responses to IPV. Their sample consisted of 29 participants who took part in individual interviews. Their results indicated an overall lack of confidence in CPS workers' knowledge of how to assess for risk in cases involving IPV. The CPS workers in their study reported fear for their own safety when interacting with perpetrating parents, difficulties working with police, and lack of specific protocols for risk assessment in IPV cases. Mitigating factors to these challenges included relationship building, collaboration within and across agencies, clear protocols, and more in-depth training. Finally, Risser et al. (2022) recently published a qualitative study exploring CPS workers', IPV advocates', and CPS administrators' perceptions of the impact of COVID-19 on children. They identified themes of COVID-19 allowing perpetrators to further isolate their victims and their children or attempt to change custody agreements, school closures causing stress for children experiencing family violence, and marginalized children and adolescents being disproportionately impacted by COVID-19. Despite the existence of multiple qualitative studies examining the perspectives of CPS workers, no known studies exist pertaining to their perceptions of treatments for co-occurring IPV and CAN.

CHAPTER III: METHODOLOGY

Despite decades of discourse surrounding the need to implement comprehensive treatment for co-occurring child abuse and neglect (CAN) and intimate partner violence (IPV; Edleson, 1999; Guedes et al., 2016; Slep & O'Leary, 2001) due to the high co-occurrence rate of these two issues (Appel & Holden, 1998; Herrenkohl et al., 2008), few interventions seek to address them simultaneously. Multisystemic Therapy for Intimate Partner Violence (MST-IPV) is a recently developed intensive intervention that provides a promising remedy to the dearth in treatment by integrating DVFCT with MST-CAN (Swenson & Schaeffer, 2024). However, no published research currently exists on MST-IPV due to the recency of its development. Additionally, little is known about the perspectives of CPS workers on the treatment of co-occurring CAN and IPV generally and the use of MST programs within the child welfare system specifically. The current study sought to address these gaps in research by inquiring into the following questions:

RQ1: What are CPS workers' perspectives on treatment for co-occurring CAN and IPV?

RQ2: What are CPS workers' perspectives on MST-IPV?

RQ3: How do the perspectives on treatment for co-occurring CAN and IPV of CPS workers with experience with MST-IPV and no experience with MST-IPV compare and contrast?

Study Design

A qualitative research design was chosen for this study due to the focus of the research questions being on the perspectives of participants. Gathering qualitative data and employing qualitative analysis methods are the most effective ways to obtain a nuanced and in-depth understanding of specific perspectives in research (Creswell & Posh, 2018). The current study

utilized qualitative comparison subgroups within a reflexive Thematic Analysis (TA) design. Although the use of comparison groups is uncommon in qualitative research, the number of published qualitative studies with comparison groups is growing (Lindsay, 2019). Comparison groups offer unique strengths within qualitative research such as illuminating how the experience of a phenomenon differs between different groups and comparing and contrasting perspectives (Askew, 2009; Makela et al., 2009; Whitley, 2016). Relevant to the current study, comparison in research is useful for "ident[ifying], develop[ing], and deliver[ing] specific services to patients and caregivers" (Lindsay, 2019, p. 455). The current study gathered data from two different subgroups: CPS workers who have collaborated with MST-IPV teams and CPS workers with no experience with MST programs. Gathering data from two distinct subgroups allowed me to compare and contrast CPS workers' experiences with and perceptions of working with interventions for CAN and IPV. Doing so allowed the study to provide practical utility in the treatment of co-occurring CAN and IPV, as it sought to highlight CPS' workers perspectives on treatment in general as well as MST-IPV specifically. Conclusions determined from the comparison may help inform future delivery of MST-IPV.

The qualitative comparison was conducted within a reflexive Thematic Analysis (TA) design. Reflexive TA was developed by Braun and Clarke (2006, 2019, 2021a, 2021b, 2022) as a framework from which to do TA research as a "subjective, situated, aware and questioning researcher" (Braun & Clarke, 2022, p. 5). Multiple kinds of TA are present within qualitative research methods, and, historically, little consensus or guidance existed on how to do TA. Braun and Clarke's (2022) work provides guidance on how to conduct a qualitative study using TA well, how to assess and determine the theoretical assumptions from which the research will be conducted, and how to develop a practice of reflexivity in the research process. Reflexive TA

was chosen for the study due to its flexibility on the ontological and epistemological approaches it can be employed within and the types of research questions it can be used to address (Braun & Clarke, 2022). Rather than a complete methodology with an in-place theoretical framework, specific kinds of questions that can be addressed, and a set sampling strategy (as seen in designs such as Interpretative Phenomenological Analysis and Grounded Theory), reflexive TA is a method of data analysis. As a method rather than a methodology, reflexive TA researchers are tasked to build and disclose the theoretical groundings for their research based on the aim of their design.

Theoretical Framework

The current research was approached from a variety of theoretical assumptions. First, this study was conducted from an interpretive paradigm (Grant & Giddings, 2002). In the interpretive paradigm, researchers seek to interpret meaning from the participants' understanding and perspectives. Data collection takes place interpersonally between the researcher and participants in an attempt to better understand the viewpoint of the participants, and the researcher's interpretation is privileged in the analysis. Further, the research was approached from an experiential orientation (Braun & Clarke, 2022). In experiential versions of qualitative research, researchers pay attention to the experiences and perspectives of participants and how participants make sense of a phenomenon. Experiential approaches are grounded in a hermeneutics of empathy. Hermeneutics of empathy is a philosophical perspective of interpretation that encompasses the desire to "understand and make sense of the reality captured in the data" (Braun & Clarke, 2022, p. 160), in which empathy is the purposeful positioning of oneself toward the experiences of another (Hooker, 2015). Finally, this study was conducted under the intentional view of language (Hall, 1997). Within the intentional approach to language, it is believed "that it

is the speaker, the author, who imposes his or her unique meaning on the world through language" (Hall, 1997, p. 25). In this way, language is seen as a portrayal of the speaker's distinctive reality.

An important theoretical consideration in research is the ontology, or the theory of reality, from which the research is being conducted (Braun & Clarke, 2022). Since ontology describes what is believed to be real, it holds implications for what research is thought to reveal and how research is conducted. The current study was conducted from the ontology of critical realism. Critical realists acknowledge a reality that exists outside of "our perceptions, theories, and constructions" (Maxwell, 2012, p. 5). However, unlike the naive realism present in traditional empiricism, critical realists also acknowledge that one's comprehension of reality is bound by one's context and perspectives (Pilgrim, 2014). In this way, data through a critical realist ontology does not depict an unmediated and transparent image of reality but instead one translated by the participant through context. Additionally, values and perceptions cannot be bracketed from science to uncover objective truth. Instead, critical realist researchers view the context and value-bound understandings of researchers and those being researched as part of what they want to comprehend through research (Maxwell, 2012). Finally, critical realist researchers recognize the presence of "distal and impersonal social forces . . . operating alongside contingent and immediate subjective meanings" (Pilgrim, 2014, p. 17).

In the perspective of some, critical realism collapses traditional distinctions between ontology and epistemology due to assumptions made about knowledge within critical realism (Braun & Clarke, 2022; Pilgrim, 2014). Whereas ontology describes beliefs about reality, epistemology delineates "assumptions about what constitutes meaningful and valid knowledge and how such knowledge can (and should) be generated" (Braun & Clarke, 2022, p. 175). Others

contend for distinction between ontology and epistemology. They assert critical realism to take an ontological realist and epistemological relativist approach in its acceptance of an objective reality and rejection of an objective understanding of that reality (Maxwell, 2012). The current study will be conducted through the latter perspective on critical realism.

Although critical realism contains both ontological and epistemological implications, an epistemological theory from which the study will be conducted is important to identify. The current study employed the epistemology of contextualism. Within contextualism, which is attributed to the philosopher Stephen Pepper (1942), knowledge is embedded within the context of the people studying and being studied (Braun & Clarke, 2022). Numerous understandings of reality are possible, and conflicts between accounts do not invalidate them. However, "some accounts may be more valuable and persuasive than others" (Braun & Clarke, 2022, p. 178). Therefore, knowledge is frequently assessed through its usefulness instead of its correctness. Additionally, knowledge cannot be removed from the values and experiences of participants and researchers. Instead, knowledge and meaning are viewed as being co-constructed within the relationship between participants and researchers. Although data and analysis are perceived to be context-bound and subjective, data analysis is thought to connect patterns across data. The process of data collection and analysis within contextualism requires both reflexivity and transparency on the part of the researcher. The researcher is responsible for reflecting on the ways their context affects the research process and communicating their reflections to the reader.

Sample

To examine the perspectives and experiences of both CPS workers with experiences with MST-IPV teams and without, purposive stratified sampling was employed (Robinson, 2014). Purposive sampling strategies are utilized when specific kinds of participants within a sampling

universe (i.e., study population/target population) are desired. Additionally, stratified sampling allows for both subgroups of participants to be represented in the sample. The sampling universe of the current study is CPS workers who are employed in the state of Connecticut. All participants were at least twenty-one years of age, spoke English, and have worked for CPS within the last two years. Two categories of CPS workers will be recruited: those with experience working with MST-IPV teams and those with no experience working with MST-IPV teams.

Although the idea of data saturation is deemed the "gold standard" of sample size selection in qualitative research, Braun and Clarke (2021b, 2022) argued against its conceptual consistency for all types of TA. Originating in Grounded Theory to refer to the point at which no new data is contributing to the development of a theory (Glaser & Strauss, 1967), saturation has become a hallmark of academic rigor and a means by which sample sizes are justified within qualitative research (Braun & Clarke, 2021b; Malterud et al., 2016; Sebele-Mpofu, 2020). However, little consensus exists about its definition and utility for sample-size justification for qualitative research designs not based on theory development. Additionally, saturation's common conceptualization of "no new" takes a realist ontological approach (Braun & Clarke, 2021b). The idea of "no new" assumes that meaning is found within the data and there will be a point at which all meaning has been uncovered. This assumption is inconsistent with reflexive TA which, although ontologically flexible, is based on the assumption that "meaning requires *interpretation*" (Braun & Clarke, 2021b, p. 210) rather than being objective and discoverable. Therefore, the notion of information power (Malterud et al., 2016) is a more useful measure by which sample size is determined within a reflexive TA design (Braun & Clarke, 2021b, 2022).

Malterud et al. (2016) defined "information power" as a model from which to estimate sample size in which "the more information the sample holds, relevant for the actual study, the lower number of participants is needed" (p. 1753). They proposed five factors that help determine the number of participants required for sufficient information power: the breadth of the study aim, specificity of the knowledge or experience of participants included, whether an established theory is in use, quality of the interview conversation, and whether cross-case analysis will be utilized. The current study has neither a broad or narrow study aim and used purposive sampling to ensure sample specificity. Additionally, it was informed by established theories about shared risk and protective factors in co-occurring IPV and CAN and employed a cross-case analysis. Further, the interviews were conducted by the author of this dissertation. Although I have some experience gathering data through interviews, I am still relatively new to the discipline of qualitative research. Therefore, limitations in my experiences were considered when examining the strength of the quality of the interview dialogues.

Taking into account the interaction of the aforementioned information power considerations, which were continuously reevaluated during data collection and analysis, the sample for this study included seven participants in the MST-IPV experience subgroup and 11 participants in the no MST-IPV experience subgroup, for a total *n* of 18. More interviews were included in the no MST-IPV experience group since this group contained less sample specificity and, therefore, less information power.

Data Collection

Recruitment

Participants were identified through a gatekeeper. Gatekeepers in qualitative research serve as an access or mediation point between researchers and participants (De Laine, 2000). The

gatekeeper for the current study was a child welfare supervisor in Connecticut. The gatekeeper contacted CPS workers within their network and invited them to a meeting in which I presented on the purpose of the study, expectations for participation such as time commitment and compensation, and limitations of confidentiality. Interested parties then contacted me directly and privately, and I emailed them the informed consent document describing the purpose of the study, predicted risks and benefits for participation, confidentiality, and the study procedure. The informed consent form also included a notice that participation is voluntary and participants may withdraw from the study at any time without penalty. Once informed consent was signed and returned, participants were emailed a demographic questionnaire, and individual interviews were scheduled with each participant. Data was collected through individual interviews, a demographic questionnaire, and a reflexive journal.

Demographic Questionnaire

Participants were asked to complete a demographic questionnaire. The questionnaire included information about age, gender identity, racial or ethnic identity, number of years employed with CPS, and level of education.

Interviews

Individual semi-structured interviews were utilized to gather information about participants' experiences with and perspectives on engaging with treatments for CAN and IPV. The interviews ranged from 20 to 75 minutes in length and took place over a HIPAA compliant video conferencing platform (Zoom). The interviews were recorded and stored on the hard drive of the researcher's password-protected computer. Recordings were immediately deleted after they were transcribed, and the data was de-identified. Notes were also taken during the interviews and stored with the interviews.

Two interview guides were used for the current study: one for the MST-IPV experience subgroup and one for the no MST-IPV experience subgroup. The interview guides were developed with guidance from Magnusson and Marecek's (2015) chapter on designing interview guides. Both interview guides include items inquiring into participants' experiences and perspectives with treatment options for co-occurring child maltreatment and IPV. The guide for the MST-IPV experience subgroup contains additional questions pertaining to participants' experience with and perspectives on MST-IPV specifically.

Reflexive Journal

A reflexivity journal was kept throughout the research process. Reflexivity, or the act of reflecting on the researcher's effects on all parts of data collection and interpretation, is a crucial component of reflexive TA (Braun & Clarke, 2022; Trainor & Bundon, 2021). Reflexive journaling allows a researcher to acknowledge their role in the construction of knowledge by examining how power, politics, social positionality, biases, values, and assumptions impact the research process. These influences are not identified in an attempt to "bracket" them off in reflexive TA, an idea stemming from a positivist assumption that knowledge can become decontextualized (Pilgrim, 2014). Rather, they are identified and interrogated in a practice of continuous self-reflection throughout all stages of research. Additionally, reflexive journaling is a means of deep engagement with data, which is an integral piece of reflexive TA (Braun & Clarke, 2019; Braun & Clarke, 2022). Therefore, reflexive journaling is both a means of transparency toward oneself and consumers of one's research and a source of data.

Data Analysis

Before engaging in data analysis, the interviews were transcribed, and each participant was assigned a number code for de-identification. Participants in the MST-IPV experience

subgroup were assigned a number ending with “one” and participants in the no MST-IPV experience group were assigned a number ending with “two” to keep the groups differentiated. Transcriptions and the reflexive journal were organized into files on a two-step authentication protected Google Drive, and transcriptions were uploaded to NVivo coding software for data analysis. Braun and Clarke’s (2022) six phases of reflexive TA was followed in the thematic analysis: (1) familiarization with the dataset; (2) coding; (3) generating initial themes; (4) developing and reviewing themes; (5) refining, defining, and naming themes; and (6) writing the report. The stages of data analysis within reflexive TA are called *phases* due the nonlinear nature of reflexive TA (Braun & Clarke, 2022). Although each phase is important to address, revisiting various phases as new thoughts or interpretation arise is encouraged to do reflexive TA well. The transcripts were coded at both the semantic and latent levels and by concepts rather than line-by-line, in alignment with the coding process outlined by Braun and Clark (2022). Finally, the transcripts were coded inductively, or from the data up, since the data was not approached from an existing explanatory theory.

The qualitative comparison portion of the data analysis followed examples of previous studies that use comparison groups in reflexive TA, such as Whitley’s (2016) qualitative comparison of ethno-racial variation in recovery and Moola’s (2012) qualitative comparison of the experiences of two groups of parents of youth with different health concerns. All data was coded together, and themes were developed based on shared patterns of meaning (Braun & Clarke, 2021a). The experiences of the two groups were then compared and contrasted within the themes.

Quality Strategies

Quality strategies are useful for facilitating rigor in qualitative research (Braun & Clarke, 2022). In reflexive TA, quality strategies "center on ways to foster depth of engagement, researcher reflexivity and theoretical knowingness" (Braun & Clarke, 2022, p. 268). The approaches of reflexive journaling, peer debriefing, and reviews with my dissertation chair during all stages of the research process were employed to create a practice of deep engagement with the data. Additionally, a detailed electronic trail of the analysis was kept to demonstrate quality. Finally, I routinely referred to Braun and Clarke's (2022) "15-point checklist for good *reflexive* TA–version 2022" to assess for quality throughout the research process:

1. The data has been transcribed to an appropriate level of detail; all transcripts have been checked against the original recordings for "accuracy."
2. Each data item has been given thorough and repeated attention in the coding process.
3. The coding process has been thorough, inclusive and comprehensive; themes have not been developed from a few vivid examples (an anecdotal approach).
4. All relevant extracts for each theme have been collated.
5. Candidate themes have been checked against coded data and back to the original dataset.
6. Themes are internally coherent, consistent, and distinctive; each theme contains a well-defined central organizing concept; any subthemes share the central organizing concept of the theme.
7. Data have been *analyzed*—interpreted, made sense of–rather than just summarized, described or paraphrased.
8. Analysis and data match each other—the extracts evidence the analytic claims.

9. Analysis tells a convincing and well-organized story about the data and topic; analysis addresses the research question.
10. An appropriate balance between analytic narrative and data extracts is provided.
11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase, or giving it a once-over-lightly (including returning to earlier phases or redoing the analysis if need be).
12. The specific approach to thematic analysis, and particulars of the approach, including theoretical positions and assumptions, are clearly explicated.
13. There is a good fit between what was claimed, and what was done—i.e. The described method and reported analysis are consistent.
14. The language and concepts used in the report are consistent with the ontological and epistemological positions of the analysis.
15. The researcher is positioned as *active* in the research process; themes do not just "emerge." (p. 269)

Ethical Considerations

Privacy and Confidentiality

This study was approved by the researcher's dissertation committee, the Institutional Review Board (IRB) at Antioch University Seattle, and the IRB at the Department of Children and Families (DCF) in Connecticut. No participants were involved in the study before approval.

Participants were recruited from DCF offices in Connecticut and required to give written and verbal consent before completing interviews. Participants were not discriminated against or excluded from recruitment based on identity factors (e.g., race, gender, ability status, etc.).

The researcher interviewed each participant over a HIPAA compliant video conferencing platform (Zoom). Before each interview, the researcher emailed the participant an individual link for the meeting as well as directions for accessing the meeting. Each participant was provided their own link, and meetings employed the "waiting room" feature to prevent public access to the meeting and protect privacy. Informed consent forms were provided to each participant in advance of their interview to allow time to review the information and correspond with the researcher regarding any questions before the interview. The beginning of each interview included a review of the informed consent form and the opportunity for participants to ask questions or voice concerns. The researcher then obtained both written and verbal consent from participants before continuing with the interviews. Participants also consented both verbally in a discussion of recording during informed consent review and when signing the informed consent form for the researcher to audio record their interviews. The researcher reminded participants of the voluntary nature of participating in the study and participants' rights to withdraw from the study at any time.

Audio recordings were stored under code names on the researcher's password protected computer hard drive in a locked room and immediately deleted after transcribed. The researcher was the only individual with access to identifying information such as names, email addresses, and consent forms, which were stored separately from audio recordings and transcripts in a password-protected file on the researcher's password-protected computer.

Although all data was de-identified to protect participant identity, some direct quotes from interviews were used to illustrate themes in the final report. The researcher informed participants of this possibility when reviewing informed consent, and all participants were

amenable. All data will be deleted from devices upon completion of the study to maintain privacy and confidentiality.

Risks

Participants were not exposed to any significant risks by participating in this study. However, due to the specific type of experience required to participate in the study (e.g., experience working with MST-IPV teams as a CPS worker), participants were informed of the possibility that quotes from interviews included in the results may somehow be linked to them. Steps taken to prevent this from occurring included presenting data as a whole outside of short quotes used to illustrate themes, removing identifying information from transcripts (e.g., names of DCF offices in which participants worked), and avoiding connecting participant demographic information with interview quotes. Additionally, the researcher acknowledged the possibility of discussing topics such as child maltreatment and IPV causing psychological distress. Participants were encouraged to use crisis resources to obtain emotional support if needed (Appendix E) and were welcome to withdraw from the study at any time without consequence. However, no participant expressed difficulty during or following their interview. No adverse effects were elicited from participating in this study, and the study did not require the use of invasive procedures or deception.

Benefits

Participants were unlikely to directly benefit from their contributions to the study. However, information gathered from the study may contribute to the fields of psychology and social work by advancing the understanding of CPS workers' perspectives on treatments for co-occurring child maltreatment and intimate partner violence in general and MST-IPV, specifically. Such understanding may inform the development and dissemination of treatment for

CPS-involved families with co-occurring child maltreatment and IPV, which may benefit such families and the CPS workers managing their cases. Participants were not compensated for their participation in response to guidance from the Connecticut DCF IRB.

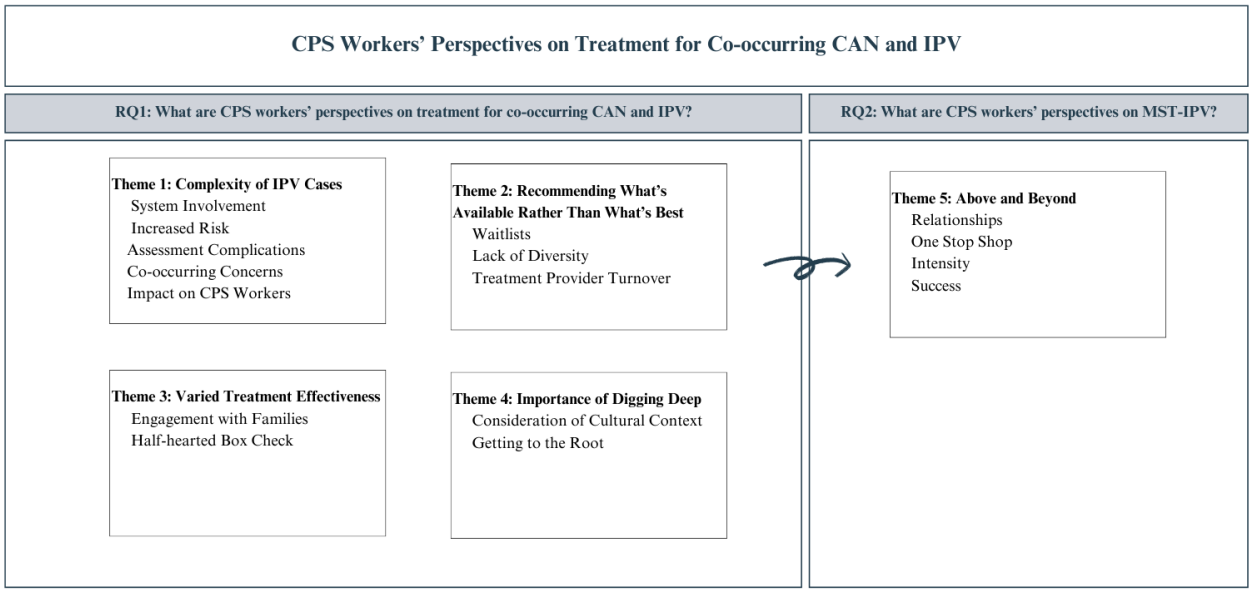
CHAPTER IV: RESULTS

A total of 18 participants were included in this study. Two individuals dropped out of the study before completing interviews. Seven participants had experience working alongside Multisystemic Therapy for Intimate Partner Violence (MST-IPV) teams, and 11 participants had no experience working with MST-IPV teams. The participants were between the ages of 28 and 55, and the majority (n = 11) were women. In terms of racial and ethnic identity, eight participants identified as white, five as Black or African American, two as Latina/o, one as "other," and two chose not to disclose. The number of years working for CPS ranged from 2 to 20, with the majority of participants (n = 12) having over 10 years of experience working for CPS. All participants had a minimum of a bachelor's degree, and the majority (n = 14) had at least one master's degree.

Reflexive thematic analysis of individual interviews resulted in a total of five themes. The first research question for this study is answered by the first four themes, and the second research question is answered by the final theme as well as aspects of Theme 2. To respond to the third research question, I provide further analysis of existing themes. All themes consist of at least two subthemes due to the complexity and multifaceted nature of their content. The order in which themes and subthemes are organized is not indicative of a hierarchical ranking of information. Rather, all themes represent equally relevant points identified in the data. Organization of themes and subthemes addressing the first two research questions are outlined in Table 4.1.

Table 4.1

Overview of Themes in Response to Research Questions



CPS Workers' Perspectives on Treatment for Co-occurring CAN and IPV

The first research question is: What are the perspectives of CPS workers on treatment for co-occurring child maltreatment and intimate partner violence (IPV)? Reflexive thematic analysis of data gathered during individual interviews resulted in four themes in response to this research question: (1) Complexity of IPV Cases, (2) Recommending What's Available Rather than What's Best, (3) Varied Treatment Effectiveness, and (4) Importance of Digging Deep. Each theme contained at least two subthemes. Themes corresponding to the first research question are described in detail below.

Theme 1: Complexity of IPV Cases

A recurring theme present in the interviews for all participants in both subgroups was additional complexity associated with IPV cases when compared with cases without IPV concerns. The complexity of such cases highlighted the importance of effective treatment for CPS-involved families with IPV concerns. Multiple layers of complexity were named by participants. These layers were described in the following subthemes: system involvement, increased risk, assessment complications, co-occurring concerns, and effects on CPS workers.

System Involvement

Participants in both subgroups identified multiple systems including police, family court, and criminal court with which families with IPV concerns were often involved. Involvement with these additional systems requires increased contact between CPS workers, the families, and professionals of other agencies. For example, Participant 4-1 described interacting more with both police and the family when IPV concerns were present:

> for the most part, they're way more intense. So, say another case might be oh, a child's not going to school or getting to school late. Well that might be the only thing a family has going on versus IPV, I find myself having more contact with the family, more—even doing more checks for like protective orders, police calls. We generally have more contact with the police; sometimes, in a lot of my cases there's usually really young children, and that raises the risk too. Yeah, there's usually just way more involved.

Participant 18-2 echoed the sentiment and added that cases with IPV concerns require additional review documentation from previous systems: "There are certainly more monitoring with judicial factors with the case, doing more court orders and recent arrests, collaborate with the police department more and to a different extent than we would for some other kinds of cases."

Increased Risk

Participants in both subgroups also identified increased risk involved with IPV cases. Several participants spoke about additional risk being associated with responses of the families with IPV concerns. Participant 7-1 described initial pushback from families with IPV concerns for a variety of reasons:

> Initially when the calls come through to us, there's like a pushback, you know? Trying to protect the other person, trying to avoid DCF from filing neglect or trying to remove from the home or trying to have the other person leave the home.

Other participants shared stories of primary aggressors hiding in the home when they were supposed to be out of the home. Still other participants spoke on the cycle of violence and risk associated with primary aggressors using manipulation to return to the relationship or family's home. For example, Participant 15-2 stated:

> the victim want[s] to be cooperative and is upset about what happened and is less forgiving, but in ongoing, as we know with these cycles of violence, as time goes by and people seem to be doing better and seem to be manipulating their way back in, again, there's less of a sense of urgency and less of a freshness about what happened. And people are more willing to downplay the issue of violence in their relationship and focus more on that with the incident–that happened a long time ago, we're past that, kind of thing.

Over half of participants in the subgroup with no experience working with MST-IPV teams shared concerns with the potential lethality of IPV itself. Six participants in this subgroup shared stories about IPV cases they were part of or had learned about in which there were IPV casualties or near casualties. Participant 11-2 expressed particular concern about two recent deaths due to IPV in their city and wondered, "how are we keeping these people safe in their own communities?"

In contrast, participants with experience collaborating with MST-IPV teams described feeling less concern about IPV risk and lethality since working with MST-IPV. For example,

Participant 2-1 shared that MST-IPV reduces the rate of families being hurt, and Participant 6–1 shared, “I thought [MST-IPV] was great because it alleviated so much of my concern of risk and safety because we had somebody in the home all the time that we were always communicating with.” Participant 3-1 further elaborated that, “once someone is going into the home 2–3 times a week, they’re eyes for us as well. So, if they see something that’s going on in the home, they’re going to tell.”

Assessment Complications

Participants in both subgroups highlighted the impact of complexity of IPV cases on the assessment process. There were no deviations in perspectives between participant subgroups. However, some participants viewed additional complexity of IPV cases as an aid to the assessment process, while others described increased assessment difficulties associated with IPV cases. Participants 10-2 and 12-2 found IPV cases easier to assess due to the commonality of corroborating evidence from things like police reports and protective orders. Participant 12-2 shared, “in IPV cases, we’ll have a lot of information up front about what had occurred and things like that just due to the nature of police reports. I can speak to a police officer who was there on scene.” Seven participants found IPV cases to be more difficult to assess due to the range of IPV presentations and frequent lack of concrete evidence. For example, Participant 9-2 stated:

> I think that IPV cases are the most difficult to work with. When you have something that’s really acute–a physical abuse case, there’s a physical marker there, whatever. Those are, I don’t want to say easy, but they are what they are. I find IPV cases difficult because they’re all different ranges, they all look different. It’s really hard to kind of sort through sometimes. I just find them very tricky. You know, we have our safety factors and our tools to evaluate things. I always find that the IPV safety factor we always find is really hard because again, they all look so different.

They later added:

> I think it's interesting that you're focusing on IPV because it's really difficult to assess. Again, I've been doing it however many years now and there's days where I don't know what to do. I don't know how to assess it, or I've never seen it before. I'm also jaded by my experiences as well. . .There have been several unfortunately where something really tragic happened.

Several participants referenced secrecy surrounding IPV as a barrier to assessment. Some families minimize IPV while others attempt to hide it all together. According to Participant 15-2, "You know, it's something that people are not always acknowledging, people are not always honest about, people feel like they have to hide–that's typical." Additionally, multiple participants mentioned children being coached to deny IPV in the home: "you already have the kids who are coached not to say anything because if you do say something, you will get removed, right?" (Participant 13-2).

Co-Occurring Concerns

Participants primarily in the subgroup with experience collaborating with MST-IPV teams discussed increased complexity in IPV cases due to frequency of co-occurring concerns, especially mental health challenges and substance use. Participant 4-1 stated:

> It is not just IPV. There's usually so much going on that leads to the IPV. So, the IPV is often a symptom of the 10 other things a family has going on. . . Like mental health, substance use, housing instability, issues with employment, housing, yeah. Issues like getting to school, education. It's usually not attending medical appointments, things like that.

Participants 3-1, 6-1, and 7-1 specifically named substance use and mental health difficulties as common co-occurring concerns. Participant 2-1 shared a story to demonstrate the co-occurrence:

> I had a family who the dad was abusive. He used [name of drug] and with [name of drug], he would abuse it. He would finish it in two days. And while he's on the [name of drug], he would hit mom, be abusive, verbally abuse her, that kind of stuff.

Only participant 11-2 in the subgroup with no experience working with MST-IPV teams mentioned increased complexity due to co-occurring concerns: “as a primary worker, a lot of those cases had to do with IPV and drugs.”

Impact on CPS Workers

Participants primarily in the subgroup with no MST-IPV experience shared about the personal impact of working with IPV cases. Some found the work traumatic and weighty, others found it rewarding. Participants 2-1, 9-2, 11-2, 12-2, 14-2, and 16-2 shared stories of particularly difficult cases they carried or IPV injuries they witnessed and how those cases affected them:

> It’s always difficult on a personal level when you’re meeting with a person who has some significant injuries, you know, bruising on them. I just remember there was a case where the [primary aggressor] had stalked [recipient of aggression] through friends, you know, learned where [recipient of aggression] was residing and kind of sat outside [their] apartment. [Primary aggressor] didn’t know exactly which apartment [recipient of aggression] was in, but [primary aggressor] saw [recipient of aggression]’s car, and when [recipient of aggression] left the complex, got inside the car, [primary aggressor] kidnapped [recipient of aggression], dragged [them] back into [their] apartment, assaulted [them] pretty significantly. The neighbors were around and had contacted the police, but by the time we were there, the police had left and you’re there a day or so after the incident, the [recipient of aggression] had–you know, [they] couldn’t talk to me because the swelling on [their] face was so bad. [They] had a missing tooth and things like that. It’s always frustrating to see situations like that. (Participant 12-2)

After sharing a particularly gruesome story of a case that left a lasting impact on them, Participant 9-2 shared that they have “personally seen some really horrific, horrific things. . . This is obviously a case that sticks with me and was pretty traumatic.”

Participant 1-1 was the only participant in the subgroup with experience working with MST-IPV teams who shared a story about the personal impact of working with IPV cases:

> The biggest one that pops into my head I remember is going out to a home and [saying], ‘okay let’s check out this report,’ and [recipient of aggression] opens the door with a huge black eye, and I was out there—I mean that was an all-day investigation from like nine in the morning to nine at night. And it was a tough one.

In contrast to participants who shared stories of times in which working with IPV cases was difficult and at times traumatic, Participant 13-2 discussed the emotional energy she received from working with families with IPV concerns:

> It's rewarding for everybody, especially when families call you after a couple years and want to bounce things off of you. It talks about the trust they built with you and that they value your opinion to the point where they're—who calls their DCF worker investigator who can remove your children or has removed your children? To talk about what can I do to make things better? That's it.

Theme 2: Recommending What's Available Rather than What's Best

All participants in both subgroups discussed limited availability of treatment for CPS-involved families with IPV concerns. Subsequently, participants found that families were often referred to treatment based on availability rather than best fit or that treatments that once fit well with the needs of their families changed in a way that made them less effective. Three subthemes captured the specific frustrations of participants that were included in this theme: waitlists, lack of diversity, and treatment provider turnover.

Waitlists

Participants in both subgroups expressed frustration with long waitlists for treatment providers who are experienced and effective at treating IPV, resulting in increased safety risk and decreased motivation to engage from families. Participant 9-2 shared that "sometimes there's just never enough services. Because the need is great. . . the clinical staff will make recommendations for not just what's best, but unfortunately what's available at the time." Some participants reported that due to the cycle of violence, families settle back into old relationship patterns and become less motivated to engage with treatment as time goes on. Therefore, the longer the waitlist, the greater the concern for a family's safety and motivation to participate in

treatment. Participant 16-2 also named concerns with the ability of treatment providers to provide the best services to each family knowing that there are always more who are waitlisted: "how effective is this service going to be when they know that as soon as they discharge this family, there's another family and then another family and then another family?"

Lack of Diversity

Participants in both subgroups identified lack of diverse treatment providers to be a significant barrier to appropriate treatment for CPS-involved families with IPV concerns. Many participants spoke to a lack of treatment providers of specific identities such as Black men or LGBTQIA individuals, leading to barriers with obtaining buy-in from families of such identities. Others mentioned that lack of identity match can be overcome if treatment providers addressed power and privilege differences in the therapy space: "I think just coming in and addressing there's an elephant in this room. We do not look the same and you don't think we can relate, but here's how I can help" (Participant 16-2). However, participants reported mixed experiences with the ability of treatment providers with more social agency (e.g., white, English-speaking, cisgender, and heterosexual) to engage in such conversations. Notably, Participant 16-2 spoke about losing credibility and trust with Black families when they recommend a certain treatment, and the treatment provider ends up being someone with whom the family feels they are unable to relate due to cultural or racial factors:

> It's tough because as a Black woman and I'm talking to someone as a Black woman and I'm telling them, "You guys need to do this program. This is really helpful." And then insert, I come to do a joint home visit and then it's someone that they don't think they can relate to or someone they feel like doesn't understand. Or it's that general fear of judgment because we have to take into consideration that race does matter, and it's a matter of diversity and a matter of being culturally competent. It's hard for a Family of Color to believe that someone who's not of their culture or of their race would be helpful in their home. So, I think that's one of the biggest barriers that we have when they're initially like, "Sure I'll do it because you say so," and then they're met with that.

Lack of linguistic diversity was especially highlighted by many participants, and several participants spoke of minimal effectiveness of treatment through translation services. For example, Participant 18-2 shared:

> I do not think that having an interpreter replaces the actual communication that would occur in the same language. I experienced that myself with this particular case. I don't think that I was able to get to know that client as well even though we were communicating through the interpreter. There is a breakdown and there are things that get lost in translation. And particularly for clinical work to be going through an interpreter, you lose something. You lose something when there's inflection and there's tone, and some of that just cannot get translated appropriately.

Treatment Provider Turnover

All participants in both subgroups spoke of high rates of treatment provider turnover. Several participants shared that although turnover rates have always been high for the treatment providers with whom they refer families, they have seen an increase of turnover since the beginning of the COVID-19 pandemic. Many participants discussed the detrimental effects of high turnover rates including challenges with transferring from a seasoned treatment provider to one with less experience, difficulties building trust with new treatment providers, and setbacks in treatment progress which, in turn, leads to delays in CPS cases being closed. Participant 6-1 stated,

> I think also in this field, there's so much turnover, and everybody's always moving, and you know, there's 15 interns over here, and so they'll be working with somebody for four months, and then they'll be gone, and then they'll get a new clinician, and that person will leave after 2 months, and they get a new clinician. So, it's like, you've been in six months of treatment, but what have you really gotten accomplished? And have those accomplishments really kind of followed you through all of these changes? Typically, we see that they don't.

All participants in the subgroup with experience working with MST-IPV teams reported high turnover to be especially detrimental for MST-IPV and the biggest weakness of the

program. For some participants, high turnover rates meant that not all families who would benefit from MST-IPV were able to participate in the program. Participants 4-1 and 6-1 shared that treatment provider turnover made MST-IPV much less effective for families than it was when fully staffed with experienced clinicians.

Theme 3: Varied Treatment Effectiveness

A salient theme across participants in both subgroups was variability in effectiveness of treatments for CPS-involved families with IPV concerns. Apart from MST-IPV, participants named several available treatment options for such families including court-ordered groups for primary aggressors, community mental health organizations, and another intensive in-home program. Participants shared that effectiveness often varied from treatment provider to treatment provider or program to program. Additionally, participants' views on specific programs (e.g., court-ordered groups or IPV Fair) frequently conflicted with each other. The variability between treatment providers was attributed to multiple factors. The main two factors, engagement with families and half-hearted box check, are described as subthemes below.

Engagement with Families

Seven participants across both subgroups identified engagement style of the treatment provider or program as a crucial factor to treatment effectiveness. Participant 5-1 spoke of the importance of treatment providers approaching families non-judgmentally to promote trust and buy-in to the treatment process. Other participants discussed the commonality of ambivalence toward treatment from CPS-involved families in general and primary IPV aggressors, specifically. They highlighted the value of building relationships with the families and allowing time for trust to form before assuming families do not want the treatment and discharging them. Participant 13-2 shared, "Some providers are not invested in the clients, right? I guess they're

quick to close, quick to say, 'Oh, this family doesn't want the service,' so they don't try to engage. I think that's a big issue." Participant 7-1 told a story of their experience working with a treatment provider who went above and beyond to involve an often-traveling truck-driving parent in treatment and described how other treatment providers would have handled the situation:

> He would be discharged. Because their excuse would be, he can't make it, he's not making an effort, he's a driver, he's on the road, so therefore, see you, done. When he has time, we'll refer him. But really, you kind of got to meet him where he's at because he too can benefit from the program.

Half-hearted Box Check

Seven participants across both subgroups identified treatments they believe do not lead to lasing change. Rather, they view these treatments as ways for the court system or CPS to say families have met expectations. Such treatments or programs "check the box" for bare-minimum criteria to satisfy court recommendations or show to CPS that caregivers are engaging in required services. However, participants were skeptical about the effectiveness, especially long-term, of these treatments and programs. For example, Participant 1-1 shared, "I can't recall any benefits from anger management except a dad kind of saying 'Well, I did what you told me to.'"

Some participants spoke to the way in which many groups and programs applied the same curriculum and treatment methods to each case despite often significant differences between families. They highlighted the impact fit between families and standardized programs has on the effectiveness of programs for those families. Participant 13-2 believed there to be some benefits to a standardized approach as long as they were adapted to the specific needs of each family:

> Yes, we need that cookie cutter, so we know we're addressing exactly what is happening, but yes, the approach has to be different because the case is different. So, you want the

> family, you want the victim, you want the children to understand that even though this is a cookie cutter, this is why it fits.

Other participants discussed the prevalence of individual treatment providers addressing IPV as a supplementary rather than a primary goal. Although meeting with individual treatment providers often satisfies minimum criteria for the court systems or CPS, effectiveness of such treatment is often dependent on whether or not treatment providers are addressing the primary concern.

Theme 4: Importance of Digging Deep

A common theme among participants in both subgroups was the importance of treatment for CPS-involved families with IPV concerns "digging deep" to disrupt cycles of violence within the families. Participants spoke of the value of treatment providers going beyond surface level, psychoeducation on its own, or "half-hearted box check" treatments to facilitate lasting change for the families with whom they work. This theme encompasses two subthemes characterizing the ways in which participants described digging deep: consideration of cultural context and getting to the root.

Consideration of Cultural Context

Eight participants across both subgroups spoke to the necessity of treatment providers considering cultural context in interactions and conceptualizations of CPS-involved families to facilitate lasting change. Some participants emphasized the value of examining cultural differences when conceptualizing relational dynamics to assess what is and is not IPV. For example, Participant 13-2 shared:

> That doesn't take away from how you were raised in a cultural sense where people mistake the fact that there are some women who are subservient to their husbands and make it seem like, "oh my god–that's domestic violence!" Like no, that's how she was raised. And people really need to think about how the culture and ethnicity really kind of makes its way into what's going on, right?

Other participants argued for the necessity of treatment providers engaging in self-reflection and self-education regarding the cultural context of themselves and their clients. Participant 11-2 found investigating and addressing their own implicit biases to be particularly beneficial in their work as a CPS worker. They highlighted the importance of treatment providers and other CPS workers doing the same:

> Maybe talk to people about their own implicit biases. I talked today about how I always believed IPV was a man and a woman but not now as I've grown. I think implicit biases, putting our own biases aside when it comes to stuff like that. Because it's like, "Oh, she should have just left" or "Oh, that always happens," you know.

Participants discussed the utility of treatment providers talking about cultural context with families. Several participants shared that incorporating such factors into treatment strengthens relationships with families, which in turn leads to greater effectiveness. Participants 3-1 and 13-2 spoke of the importance of getting to know a family's culture and values, showing respect toward the families and their values, and being transparent with them. Participant 16-2 echoed the need for transparency, specifically regarding addressing differences of race between treatment providers and families, and Participant 5-1 underscored the benefit of having continuous conversations about cultural context.

Getting to the Root

Across both subgroups, 12 participants identified trauma treatment to be an especially critical piece in getting to the root of IPV and disrupting the cycle of family violence. Some spoke of the prevalence of parents in IPV relationships having histories of trauma themselves. For example, Participant 9-2 shared:

> Our experiences as kids completely impact how we are as adults. It's unfortunate, and sometimes we scratch our heads, but a lot of these adults that are in these relationships were kids that experienced it as kids. That's why addressing this trauma is really important.

In the perspectives of many of the participants, trauma is one of the main contributors to family violence in the home. Some participants shared that an individual witnessing IPV as a child sometimes leads to being in IPV relationships as an adult due to never being taught or modeled healthy conflict resolution. Others discussed how untreated trauma symptoms can result in engaging in either or both sides of IPV regardless of IPV exposure as a child. Regardless of exposure to trauma in childhood, participants acknowledged that being in an IPV relationship can be traumatizing in and of itself. Participants highlighted the need for treatment providers to take time to treat trauma due to frequent client avoidance of reminders of traumatic events and reluctance to talk about it.

CPS Workers' Perspectives on MST-IPV

The second research question—what are CPS workers' perspectives on MST-IPV?—was primarily addressed by theme five: Above and Beyond. However, aspects of Theme 2 addressed CPS workers' experiences of some of the challenges of MST-IPV. Themes corresponding with this research question are discussed below.

Theme 5: Above and Beyond

Participants in the subgroup with experience working with MST-IPV teams described their perspectives on MST-IPV and its effectiveness with the families they serve. The final theme captures participant experiences with the model. All participants in this subgroup described benefits of MST-IPV that they felt went "above and beyond" other treatments for co-occurring child maltreatment and IPV. Four subthemes—relationships, one-stop shop, intensity, and success—encapsulated their perspectives.

Relationships

All participants with experience working with MST-IPV teams spoke of a strong relationship-building component to the treatment model. Five out of seven participants discussed the relationships MST-IPV team members developed with the families they served. They described MST-IPV team members as being relational, compassionate, and engaging with clients, leading to strong and trusting relationships between them. For example, Participant 3-1 shared, "for the most part, they do very well with the families. They're very sensitive and show empathy and compassion toward the families." Some participants elaborated on this, stating that they have seen improvements in trust between themselves and the families they serve because of the relationships MST-IPV team members built with the families. Participant 4-1 shared:

> Sometimes clinicians or programs are kind of seen as like you know, do this program so you can get DCF out of your life kind of thing. But it was really nice for [MST-IPV] to work with us together but were still able to build these strong trusting relationships with the clients. So that yes, they do talk to DCF, and they are going to tell DCF what is going on, but the relationship was a lot better and more trusting, and I had good relationships with the clients, too. Like say something happens you know, police were involved, like okay, "Let's figure out a plan. I don't want to take your kids away, let's figure it out."

All participants in this subgroup particularly emphasized the unique and valued nature of the relationship between CPS workers and MST-IPV treatment providers. Participants described meeting weekly with MST-IPV teams to discuss cases and provide each other with updates. However, most participants found that they were in constant contact with MST-IPV team members and collaborated with them in the moment as any issues arose. The frequency and quality of the communication and partnership between CPS workers and MST-IPV treatment providers was described as being unlike the relationship with any other treatment providers. When speaking of the collaboration between CPS workers and MST-IPV treatment providers,

Participant 5-1 stated:

> It really compares to no other—and this is prior to my time in my current role, it's going back to being a social worker, an intake worker, all the different specialty units, as well as all the time that I've spent as [current role]. It doesn't come close in terms of the intensity, and when I say intensity, I mean the collaboration has been that way from the very beginning. How often we're talking to each other, sharing with each other, partnering with each other. There's no comparison with any other program.

Participant 6-1 further elaborated:

> I think the teamwork was great, how we would meet whatever it was, quarterly or whatever, to do kind of team trainings and those kinds of things. Those were good because it was like a little team. We had more stability when I was around it seemed like then after I had left so like you know, for a period there where we had clinicians, and my team, and their team, it felt like a little—we were like a team, you know? And you don't ever feel that with providers in this agency, ever. I've never felt that way and I never will feel that again, I don't think, where it was kind of like, we are one team: like these guys and us here are a team. And so that was kind of a cool little experience that I got to be a part of.

One-Stop Shop

A common phrase shared by all participants in the subgroup with experience working with MST-IPV teams was "one-stop shop." This phrase alluded to the ability of MST-IPV to treat a variety of different concerns such as IPV, child maltreatment, substance use, and trauma. Participants shared that, without MST-IPV, services for each of these concerns would likely be siloed to separate providers, leading to multiple appointments with multiple providers per week:

> Whereas with the others, you have a provider for mental health, a provider for substance abuse, then a provider for IPV, so the family is much more overwhelmed, because now you want me to attend three different providers all in the same week. Whereas there's one provider multiple times per week, but there's one provider. (Participant 7-1)

In the perspectives of participants, the ability within MST-IPV to address multiple issues resolves barriers they often see with families who are not enrolled in MST-IPV. Participant 3-1 shared that "some of these families are not going to make it to their appointments with other

providers because now they'll have maybe two or three providers they have to go to." Some participants discussed how difficulties attending appointments with multiple providers can lead to lasting consequences in their CPS cases. Participant 3-1 added:

> How are you going to get to appointments? Now I'm going to have to report that you're not being compliant with your services. Now there's a risk that I might have to do a neglect detention, now there's a risk that I'll have to do a hold on your child, a risk that your child might come into care.

In contrast, families enrolled in MST-IPV are only required to keep track of and attend appointments with a single treatment provider.

Intensity

All participants in the subgroup with experience with MST-IPV described benefits to the intensity of the program. Participants appreciated that MST-IPV treatment providers met with families multiple times per week, gave families access to a 24/7 crisis number, and met with families in their homes. Although other programs or providers provided some of the same aspects, MST-IPV was the only treatment option for child maltreatment and IPV participants with which participants had experience that included all the aspects in one place. Some participants shared that the intensity of MST-IPV was helpful for treating the most complex cases. When speaking about the intensity of MST-IPV, Participant 6-1 shared:

> I thought it was great because it alleviated so much of my concern of risk and safety because we had somebody in the home all the time that we were always communicating with. . . So, to me, MST-IPV is the one that I had worked with that I thought was the strongest that I had ever been a part of.

Success

All participants in the MST-IPV experience subgroup found it rewarding to work with MST-IPV teams due to the program's success with families. Five participants talked about

witnessing CPS cases being successfully closed that may have otherwise resulted in children being removed from the home if not for intervention from MST-IPV:

> To see the positive outcomes, and often times, in my opinion, families that very likely could have resulted in children being removed, remaining with their caretakers and families, successfully being discharged in a place where they are thriving and doing well. (Participant 5-1)

In the opinion of Participant 6-1, MST-IPV helped CPS workers avoid the need to use punitive measures with families such as reminding families that they need to comply with CPS otherwise their children may be removed. Other participants spoke to the transformation they saw in families' ability to maintain safety in the home through MST-IPV. Participant 7-1 shared:

> There was a family that we had that we were constantly working on the safety plan and enacting the safety plan. We went from enacting, enacting, enacting, to [primary parent] just turning around and saying, "I'm gonna show you. You don't have to enact the safety plan anymore." So, [they] understood that if [they] needed to kind of like go out, have a drink, do XYZ, because with MST-IPV, there is zero drinking. You can't drink or do anything like that. So, this [parent] now started to be proactive and say, "Okay, [other parent] will watch. Grandma will watch." You know? And there came a time when [they] said, "Well I knew I was going to go out and have a drink, so I didn't want the child around with me." So, [other parent] would kind of, keep this child. So, [other parent] had certain days and [primary parent] had certain days. So, it was those kinds of things that we were like okay, you realize that don't put yourself and your kid in that kind of position. So, if you can, in your life, enact this safety plan and these things that you've seen us do, so that we don't have to enact the safety plan if you mess up.

Challenges with MST-IPV

The "Treatment Provider Turnover" subtheme within the second theme of the current study highlighted frustrations and challenges associated with the high treatment provider turnover rates currently present for treatments that work with CPS-involved families. This subtheme was particularly salient for the subgroup of participants with experience working with MST-IPV teams. All participants in this subgroup believed treatment provider turnover to be

even more damaging to MST-IPV than other treatment models due to the team structure of the program and the intensity of the program. Thus, treatment provider turnover was perceived to be the biggest weakness of the program, at times resulting in diminished treatment effectiveness.

Comparing and Contrasting Perspectives

To answer RQ3—How do the perspectives on treatment for co-occurring CAN and IPV of CPS workers with experience with MST-IPV and no experience with MST-IPV compare and contrast?—the perspectives and experiences of participants in the two subgroups were compared and contrasted within themes. Overall, the perspectives of participants were more similar than different between subgroups. Participants in both subgroups shared comparable perspectives on barriers such as waitlists, lack of treatment provider diversity, and high treatment provider turnover affecting the quality of treatment for co-occurring child maltreatment and IPV. They also described similar perspectives on variability in treatment effectiveness and the importance of treatment providers addressing trauma and cultural context for families with co-occurring child maltreatment and IPV.

The main theme in which participant perspectives differed between subgroups was Theme 1: Complexity of IPV Cases. Although participants in both subgroups agreed that IPV cases were often more complex and multifaceted than other kinds of CPS cases, their experiences with those complexities differed. When discussing increased risk associated with IPV cases, many of the participants in the subgroup with no experience working with MST-IPV teams expressed concerns and worries about the potential lethality of IPV. They shared stories about cases in which IPV resulted in death or serious injury. In contrast, participants in the subgroup with experience working with MST-IPV discussed risk in terms of the relief they felt that MST-IPV team members frequented the homes of families on their caseloads. They reported

that working with MST-IPV alleviates uneasiness regarding safety concerns and risk. Additionally, participants in the subgroup with experience working with MST-IPV more commonly named co-occurring concerns such as substance use and mental health challenges as additional complexities to IPV cases.

CHAPTER V: DISCUSSION

The purpose of the current study was to identify the perspectives of child protective services (CPS) workers on treatments for co-occurring intimate partner violence (IPV) and child maltreatment generally and Multisystemic Therapy for Intimate Partner Violence (MST-IPV) specifically. I also wished to compare and contrast perspectives of CPS workers with and without experience working with MST-IPV teams. Data were collected through semi-structured interviews with 18 participants (seven of whom had experience working with MST-IPV teams, and 11 of whom had no experience with MST-IPV), and themes were through reflexive thematic analysis. This section includes a review and interpretation of study results, a discussion of study implications and limitations, and suggestions for directions for future research.

Review of Results

Perspectives on Treatment for Co-occurring IPV and Child Maltreatment

Results of the current study highlight the importance of effective treatment for co-occurring IPV and child maltreatment, particularly because CPS workers find cases with IPV concerns to be more complex than cases without IPV concerns. Such cases are more complicated for a variety of reasons. Participants in the current study specifically named increase in system involvement, risk, assessment complications, co-occurring concerns, and emotional impact on CPS workers as contributors to the complexity. Although researchers in the fields of psychology and social work have identified value in integrating once siloed areas of child abuse and IPV because of the high prevalence rate of the co-occurrence (Appel & Holden, 1998; Edleson, 1999; Guedes et al., 2016; Herrenkohl et al., 2008; Slep & O'Leary, 2001), there are still few treatment models that address the co-occurrence (Renner, 2021).

In addition to findings about the complexity of IPV cases for CPS workers, results of the current study call attention to CPS workers' view that they are often required to refer families to treatments based on availability rather than best fit. In the perspectives of participants, barriers such as waitlists, lack of treatment provider diversity, and high levels of treatment provider turnover lead to limited treatment options for CPS-involved families with IPV concerns. CPS workers' perspectives on lack of treatment provider diversity are consistent with existing research. The American Psychological Association (APA) reported that 80.85% of the U.S. psychology workforce identifies as white (2022). Additionally, a 2015 survey conducted by the APA found that only about 5.5% of therapists are able to provide services in Spanish (Hamp et al., 2016), the language in which therapy is most commonly provided in the US after English. Therefore, participants' challenges with matching CPS-involved families with treatment providers of preferred race/ethnicity or language align with the national trends. Further, perspectives on high rates of treatment provider turnover also align with existing research about community mental health agencies (Brabson et al., 2020), which often serve CPS-involved clients. Reasons for high treatment provider turnover in community mental health agencies include both individual job dissatisfaction/burnout and agency level issues. Existing problems with turnover were further exacerbated during the COVID-19 pandemic when mental health clinicians experienced more burnout and frequent staff shortages (Crocker et al., 2023). Additionally, the state of Connecticut saw a significant shortage of applicants for community mental health positions.

Study results also brought forth CPS workers' concerns with significant variations in treatment effectiveness. One factor that participants viewed as a particular determinant of treatment outcomes was the way in which treatment providers engaged with families.

Participants discussed ambivalence toward treatment often present in CPS-involved families in general and primary IPV aggressors, specifically. Other qualitative studies have noted challenges treatment providers have with building therapeutic relationships with CPS-involved clients due to the involuntary nature of their treatment (Yoo et al., 2023). In the perspectives of participants in the current study, effective treatment providers approached clients with a non-judgmental stance, problem-solved, and took time to strengthen rapport with them. This view is consistent with the transtheoretical model, which acknowledges that there are multiple stages of change for clients in therapy and that style of approach is very important for clients who are just contemplating or have not yet begun to contemplate change (Norcross et al., 2011). Moreover, participants found treatment providers who fail to adapt the treatment to individual families, use programs that only satisfy the bare minimum court requirements for treatment, and/or fail to make IPV a priority in treatment to be ineffective.

Outcomes of the current study emphasized the importance CPS workers place on interventions for co-occurring IPV and child maltreatment going beyond the surface level to address core issues associated with IPV. One area in which participants identified the importance of treatment providers "digging deep" was considering the cultural context in conceptualizations of and interactions with CPS-involved families. This perspective is supported by a strong foundation of research identifying positive outcomes associated with treatment providers approaching the work with cultural humility (Anders & Kivlighan, 2023; Holyoak et al., 2019; Owen et al., 2016). Participants of the current study also highlighted the need for interventions for co-occurring IPV and child maltreatment to include trauma treatment to help families disrupt cycles of violence. In the perspectives of many participants, previous trauma is one of the main predictors of violence in the home and an important treatment consideration. Indeed, many

studies have identified associations between experiences of childhood trauma and both enacting IPV and IPV victimization (Crawford & O'Dougherty Wright, 2007; Green et al., 2010; Widom et al., 2014). Therefore, trauma is an important aspect of treatment for CPS-involved families.

Perspectives on MST-IPV

Participants with experience working with MST-IPV had positive perspectives of the program overall. They described MST-IPV as "above and beyond" other treatment options for co-occurring IPV and CAN. Participants especially appreciated the strong relationships MST-IPV clinicians built with their clients and with CPS workers, the ability for clients to have all their treatment needs met by the same program, the intensity of the program, and the transformations they saw in the families who completed the program.

Participants spoke highly of the ability of MST-IPV team members to build strong relationships with both the families they served and CPS workers. The relationships between MST-IPV clinicians and the families they served facilitated increased quality in the relationships between CPS workers and those families. Additionally, participants appreciated the level of collaboration between MST-IPV treatment providers and CPS workers. They reported meeting weekly with MST-IPV teams and communicating with them frequently in between meetings. They felt a sense of camaraderie and teamwork with MST-IPV teams that was unique to this program and beneficial for all parties involved.

Participants with experience working with MST-IPV teams named benefits when all of a family's treatment needs can be addressed by a single provider. MST-IPV was developed by combining information learned from a listening exercise of important stakeholders in the treatment for CPS-involved families with IPV and child maltreatment and a literature review on treatments and risk factors for IPV (Swenson & Schaeffer, 2024). At the time of the listening

exercise, CPS-involved families with IPV concerns had trouble attending their treatment appointments due to their various treatment needs being addressed by separate providers. This information highlighted the need for an intervention in which all treatment aspects could be addressed by the same provider. Results of the current study indicate that, in the perspective of CPS workers, the developers of MST-IPV effectively responded to this need.

Another important subtheme was the value of the intensity of MST-IPV. Participants found the possibility of multiple appointments per week, the fact that MST-IPV was provided in the homes of families, and the 24/7 crisis number provided to families to be beneficial aspects of the treatment model. This perspective was unsurprising given that these components are all standard to the original MST model and adaptations and have shown to be effective (Borduin et al., 2016; Henggeler, 2001; Swenson & Schaeffer, 2014). Additionally, when creating MST-IPV, the developers had the most complex CPS cases with IPV concerns in mind (Swenson & Schaeffer, 2024). Results of the current study demonstrate that CPS workers believe that the intensity of the model is beneficial for treating the most complex cases.

Belief in the success of MST-IPV was a perspective shared among participants with experience with MST-IPV. Participants identified successes of safely closing cases, witnessing transformation in the perspectives and behaviors of the families involved with MST-IPV, and the belief that MST-IPV prevented them from needing to take punitive measures with some families. These perspectives align with previous studies demonstrating a variety of positive outcomes of Multisystemic Therapy for Child Abuse and Neglect (MST-CAN; Bauch et al., 2022; Buderer et al., 2020; Hefti et al., 2020; Swenson et al., 2010) and Multisystemic Therapy Building Safer Families (MST-BSF; Schaeffer et al., 2013; Schaeffer et al., 2021). Future research can

investigate if these anecdotal perspectives on the effectiveness of MST-IPV, a new adaptation of MST-CAN, can be corroborated by treatment outcome data.

Comparing and Contrasting Perspectives

As a whole, the perspectives of CPS workers with and without experience working with MST-IPV teams were more alike than they were different. Regardless of if they had experience working with this particular intervention, all participants were embedded in the same CPS department in the same state. Thus, it is unsurprising that their overall experiences with treatments for co-occurring IPV and child maltreatment were more similar than contrasting. A somewhat unexpected result was that participants' biggest critique of MST-IPV, treatment provider turnover, was also a significant issue for treatments in general across both subgroups. I expected more feedback regarding areas of improvement specific to MST-IPV. However, it appears that, in the perspectives of CPS workers, high rates of treatment provider turnover more heavily impact MST-IPV than other interventions given the team-based structure of the model and emphasis on collaboration with CPS workers.

During to the COVID-19 pandemic, MST-IPV services from March 2020 to December 2021 were strictly virtual, and members of MST-IPV teams were not allowed to enter the homes of clients (C. Swenson, personal communication, June 3, 2024). Fully home-based services did not resume until July 1, 2022. Due to the intensiveness of the program and the high-risk population it served, the inability of MST-IPV to function as a full in-home service affected the longevity of treatment providers and applications to open positions. Although treatment provider turnover increased nation-wide during the COVID-19 pandemic (Brabson et al., 2020), CPS workers collaborating with MST-IPV treatment providers might have been more heavily

impacted by the effects of COVID-19 on the mental health workforce because of the traditionally strong collaboration between CPS and MST-IPV teams.

The most distinct contrast between subgroups was perspectives on increased risk associated with IPV cases. Participants in the subgroup with no experience working with MST-IPV treatment providers more commonly discussed concerns and worries about the added risk that comes with IPV as well as potential lethality of IPV. On the other hand, participants with experience working with MST-IPV teams spoke of increased risk through the lens of the relief they felt when family on their caseload was involved in the MST-IPV program. As discussed in the subtheme about relationships, participants with experience working with MST-IPV teams felt that the collaboration between CPS workers and MST-IPV treatment providers was above and beyond their collaboration with other treatment providers. This enhanced collaboration likely results in trust between CPS workers and the treatment providers, allowing MST-IPV treatment providers to alleviate some of the emotional and mental burden CPS workers experience when working with families with IPV concerns.

Another perspective deviation between subgroups was that participants with experience with MST-IPV more commonly identified co-occurring concerns alongside the IPV (e.g., substance use and mental health challenges) as additional case complexities. This may be due, in part, to the fact that the most complex cases with a variety of issues to address are referred to MST-IPV. CPS workers with experience with MST-IPV likely come into contact with cases with multiple co-occurring issues simply because they work alongside MST-IPV teams while other CPS workers do not.

Notable Unique Perspectives

Semi-structured interviews often result in participants sharing information that, although fascinating and important, may not be relevant to the study's research questions or fit with the primary themes identified. Several such interesting and valuable thoughts and experiences arose during data collection for the current study that could not be included in the primary results. Consistent with findings from previous studies (Ellet et al., 2007; Ezell, 2019; Radey et al., 2022; Tavormina & Clossey, 2015), many participants in the current study identified high rates of burnout and turnover among themselves and their fellow CPS workers. Burnout was attributed to factors such as high caseloads, heaviness of the work, and lack of sufficient systemic support. Notably, some participants also shared aspects of their own habits or perspectives on their work that provided them with sustaining emotional energy.

Participant 11-2 shared particularly interesting thoughts on the intersection between their social justice work and work with CPS-involved families with IPV concerns. By addressing IPV on multiple levels, they were able to access their passion for the work and the value of it within their home and community. In their components for enhancing clinician engagement and reducing trauma (CE-CERT) model, Miller and Sprang (2017) argued that the mainstream recommendations for self-care (e.g., taking a bath, doing a face mask) are ineffective for preventing or addressing burnout and secondary traumatic stress. Instead, they provided five components of practice with actions that can be followed to sustain clinicians in trauma work. Although these components are geared toward a mental health clinician audience, I posit that they are applicable to CPS workers as well, as they regularly come into direct contact with trauma, either directly or through hearing the stories of others. One of the components of CE-CERT is developing a conscious narrative about the meaning and experience of one's work

to protect "against what will otherwise be a reactive and incoherent experience of the arousing events" (Miller & Sprang, 2017, p. 151). Participant 11-2 appeared to have a conscious narrative about the meaning of the work they do for their community, their place in the work, and the pieces they find fulfilling. This narrative appeared to have a positive impact on the sustainability of their work and the emotional energy they derive from it.

Participant 11-2 named several levels of systems at which they address IPV. On the individual level, Participant 11-2 examines their internal biases about IPV and how it intersects with factors such as gender and race. They shared about encountering families who did not fit their preconceived idea of how IPV presents and the effects those experiences had on their thinking. On the level of family, Participant 11-2 discussed having open dialogues with their child about the differences between IPV and healthy relationships. Participant 11-2 talked about addressing IPV on the community level through their work with CPS. Finally, Participant 11-2 engages with marches and protests to enact change on the level of political policy. Participant 11-2's approach is consistent with Bronfenbrenner's social ecological systems theory (1979), the theory on which MST programs are based (Henggeler, 2001). This theory posits that an individual's development and behavior are impacted by multiple levels of systems in which they are embedded, and an individual's behavior also affects these systems. Therefore, the greatest change is going to take place from intervening on an issue from multiple levels. Another contributing factor to Participant 11-2 maintaining energy for their work is their intentional engagement with multiple systemic levels.

Implications

The first implication of this study is that greater efforts should be made to develop, research, and fund interventions for co-occurring IPV and child maltreatment. Results of this

study show that CPS workers are frustrated with the lack of effective options available to the families on their caseloads. It is often difficult to connect the families on their caseloads with treatment providers to address IPV, and when they do, the fruitfulness of treatment varies significantly. This can be detrimental to families who would greatly benefit from interventions that can successfully address their treatment needs, particularly given the layered complexity present for CPS-involved families with IPV concerns. It is hoped that amplifying the concerns voiced by CPS workers may encourage researchers to contribute to the evidence base about current interventions and develop new ones. It is also hoped that it will solidify the need for funding to be invested in disseminating such interventions and paying community mental health treatment providers competitively to help decrease turnover.

The second implication of this study is that mental health agencies should implement hiring practices that promote increased diverse and multilingual treatment providers. Participants in this study identified lack of diverse and multilingual treatment providers in their area to be a significant barrier in treatment progress for the families on their caseloads. CPS-involved families with IPV concerns may benefit from mental health agencies intentionally seeking out diverse and multilingual staff and providing hiring incentives for treatment providers who are multilingual and ethnically representative of the communities they serve.

Third, meaning procured from Participant 11-2's interview may provide CPS workers and treatment providers working with CPS-involved families with strategies for mitigating burnout and deriving emotional energy from their work. Results of the study show that, in the perspectives of CPS workers, high rates of treatment provider turnover significantly impact the effectiveness of services for CPS-involved families with IPV concerns. Additionally, although not included in the main themes of the current study due to lack of fit with the research

questions, many participants spoke of burnout experienced by themselves and their fellow CPS workers. CPS workers and treatment providers may, like Participant 11-2, benefit from developing a meaningful conscious narrative of their work and place within it and finding ways to incorporate their values into multiple systemic levels of their lives, including work. Such shifts in internal monologue and behavior may help them to rebalance the ratio between energizing and emotionally taxing aspects of their work.

Lastly, the fourth implication of the current study is that MST-IPV may be an effective option for treating CPS-involved families with IPV concerns. Results of the study demonstrate that CPS workers with experience with MST-IPV have an overall positive impression of the program. In sum, they have had worthwhile experiences collaborating with MST-IPV teams, find value in the ability within MST-IPV to address multiple issues, see benefits in the program's level of intensity, and believe the program to be effective in helping their families stay together safely. Most notably, CPS workers reported reduced worry about risk with families enrolled in MST-IPV. CPS departments would likely benefit from disseminating MST-IPV in their districts, and the state of Connecticut would likely see positive outcomes from the expansion of the program within the state.

Limitations

As with all research, and particularly qualitative studies utilizing purposive stratified sampling, some limitations exist with the current dissertation. The first limitation is the study's sample size. Due to the recency of MST-IPV's development and the fact that it was provided in a pilot program, the number of participants included in the subgroup with experience working with MST-IPV was likely a large percentage of overall CPS workers with such experience. Thus, themes and subthemes reflecting CPS workers' perspectives on MST-IPV are likely

generalizable to CPS workers' current perspectives on the model broadly. However, the study sample included a small number of CPS workers in Connecticut whose experiences with other treatments for co-occurring IPV and child maltreatment may not be fully representative of CPS workers nationally and globally. Therefore, themes regarding CPS workers' perspectives on treatments for co-occurring IPV and child maltreatment as a whole should be considered with this limitation in mind.

Geographical limitations also result in limited exposure to different kinds of treatments for co-occurring IPV and child maltreatment. Participants in the current study had experience working with the specific treatments and programs regionally available to them. Alternative themes may have developed regarding CPS workers' perspectives if participants from additional regions of the country or world were included in the study.

Many of the participants in the current study's experience with MST-IPV took place during the height of the COVID-19 pandemic, a unique time in the field of mental health treatment generally and the implementation of MST-IPV specifically. Therefore, CPS workers' perspectives may differ now that the MST-IPV program has restabilized from COVID-19 and is fully staffed and operational as a home-based program.

Finally, due to concerns about providing CPS workers with compensation for participating in a study for which they were recruited through a gatekeeper at their place of employment, participants did not receive an incentive to contribute to the study. Therefore, CPS workers with positive experiences with MST-IPV or who were particularly interested in IPV cases may have been more motivated to participate than others. If so, the current study may only be presenting a specific kind of perspective.

Directions for Future Research

The current study provides a foundation for future research by bringing forth pertinent issues on co-occurring IPV and child maltreatment in the perspectives of CPS workers. Future quantitative studies could build upon this foundation by investigating the relationship between outcomes for CPS-involved families with IPV concerns and barriers to effective treatment identified in this study including waitlists, lack of diverse treatment providers, and treatment provider turnover. Such studies may clarify specific needs for treatments programs and providers. Other studies could investigate the treatments and programs to which CPS-involved families with IPV concerns are most often referred and their effectiveness with this particular population. In the perspectives of participants in this study, many of the treatment options existing for this population in Connecticut are not meeting their treatment needs. Further research can identify which treatment models are empirically supported for addressing these specific concerns with a CPS-involved population. Further, the current study supports the idea that MST-IPV is a promising intervention that may lead to significant benefit for CPS-involved families with IPV concerns. Additional research in the form of clinical trials and quasi-experimental studies are needed to determine the effectiveness of MST-IPV.

Conclusion

This study provided an in-depth exploration into the perspectives of CPS workers on treatments for co-occurring IPV and child maltreatment generally and MST-IPV specifically. The sample included a total of 18 participants, seven with experience working with MST-IPV teams, and 11 with no experience with MST-IPV. Results of the study identified the importance of effective treatment for IPV and child maltreatment due to the complexity of such cases, barriers to matching CPS-involved families with IPV concerns to well-fitting interventions,

variations in treatment effectiveness, and CPS workers' opinions on important treatment factors when working with this population. Further, the study highlighted the overall positive perspectives CPS workers have on MST-IPV.

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APPENDIX A: INFORMED CONSENT

Dear Participant,

You are invited to participate in a research study that will attempt to explore the perspectives of child protective services (CPS) workers on treatment for co-occurring intimate partner violence and child abuse and neglect. You may choose not to participate. *Neither signing this consent form nor participating in this study is a condition of your job. Your participation is not related to your job performance or any evaluation of your job performance.* The following information is provided to equip you with information you may need to make an informed decision about participating in the study. You are welcome to ask any questions as they arise. You are asked to participate in this study because you are or have recently been a CPS worker in the state of Connecticut, are above the age of 21, speak English, and have at least three years of experience working in the child welfare system.

Study: CPS Workers' Perspectives on MST-IPV and Other Interventions for Child Maltreatment and Intimate Partner Violence: A Qualitative Comparison

Purpose of the Study: This study will examine the perspectives of CPS workers on treatment for co-occurring child maltreatment and intimate partner violence. Participants with experience working with Multisystemic Therapy for Intimate Partner Violence (MST-IPV), a new integrated intervention for child maltreatment and intimate partner violence, will be asked about their perceptions of the program and treatment overall. Participants without experience with MST-IPV will be asked about their perspectives on treatment for co-occurring child maltreatment and intimate partner violence in general. Perspectives of participants with different experiences will then be compared and contrasted.

Procedures: You will be asked to participate in a 60-minute interview over Zoom, a HIPAA compliant video conferencing platform. The interview will be recorded. The interview will consist of a series of questions designed to allow you to share your perspectives on treatment for co-occurring child abuse and neglect and intimate partner violence. You will also be asked to fill out a demographics questionnaire in which you will answer questions about your age, gender identity, racial or ethnic identity, number of years employed with CPS, and level of education.

Risks and/or discomfort: Due to the specific type of experience required to participate in this study, the primary risk is that comments reported in the results of the study may somehow be linked to you. If this were to occur, it may impact you in your workplace. All available steps will be taken to prevent this from occurring. For example, data will be presented as a whole, no identifying information will be reported, and demographic information will not be connected to participant quotes. Additionally, you will be asked to share your perspectives on treatment for child abuse and neglect and intimate partner violence. Due to the nature of this topic, participation in this study may elicit difficult memories or emotions.

Benefits: Information gained in this study may contribute to the fields of psychology and social work by advancing our understanding of CPS worker's perspectives on treatments for co-occurring child maltreatment and intimate partner violence in general and MST-IPV, specifically. Although you may not receive direct benefit from your participation, others may ultimately benefit from the knowledge obtained in this study.

Confidentiality: Your interview recording will be transcribed and then deleted immediately after your interview. Your interview transcript and demographic questionnaire will be assigned a pseudonym to maintain your anonymity. The interview transcript and demographic questionnaire will be stored on the primary investigator's password-protected computer hard drive in a password-protected file. The information obtained in this study may be published in a scientific journal or presented at scientific conferences, however data will be presented as a whole and not identifiable.

Compensation: You will not receive compensation for participating in this study.

Contact for Questions: You are encouraged to ask any questions about this study before agreeing to participate or throughout the research process. You may call or email Malea Lash at any time at xxx and xxx. Additionally, any questions about your rights as a research participant that have not been answered by the principal investigator or any concerns about the study may be directed to Melissa Kennedy, Ph.D. at the Antioch University Seattle Institutional Review Board. Her email address is xxx.

Freedom to Withdraw: You are free to decide against participating in this study and to withdraw from the study at any time without penalty or loss of benefits to which you are entitled.

Consent: If you decide to participate in this study, you will be interviewed and will fill out a demographic questionnaire.

You are making a voluntary decision to participate in this study. Your signature confirms that you decided to participate having read and understood the purpose, risks, benefits, and procedures presented in this document. You will be given a copy of this consent form for your own records.

I have read and understand the information explaining the purpose of this research and my rights and responsibilities as an adult participant. My signature below designates my consent to participate in this research study, according to the terms and conditions outlined above.

_____ _____

Signature of Participant Date

I give consent to record my interview.

_____ _____

Signature of Participant Date

APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE

Age:

Gender Identity:

Racial and/or Ethnic Identity:

Number of Years Employed with CPS:

Level of Education:

APPENDIX C: INTERVIEW GUIDE 1—NO MST-IPV EXPERIENCE SUBGROUP

1. What is your role in child protective services?
2. I would like for you to tell me about your experiences with families involved with intimate partner violence on your caseload without disclosing names or identifying information.
    1. How do these experiences compare to cases without intimate partner violence?
3. What treatment or service options are available for families with co-occurring child abuse and/or neglect and intimate partner violence?
4. What are your perspectives on the available treatment and service options?
    1. Can you explain that further?
    2. What do you perceive to be helpful about available options?
    3. What do you perceive to be unhelpful about available options?
5. What is your take on available programs' approaches to cultural differences and diversity?
    1. What do you perceive to be helpful about their approaches?
    2. What do you perceive to be unhelpful?
6. What is your take on available programs' approaches to trauma?
    1. What do you perceive to be helpful about their approaches?
    2. What do you perceive to be unhelpful?
7. What components do you view as important for treatment for families with intimate partner violence?
8. How would you like to be involved in the treatment process for families with intimate partner violence?

1. To what extent would you like to be involved?

APPENDIX D: INTERVIEW GUIDE 2—MST-IPV EXPERIENCE SUBGROUP

1. What is your role in child protective services?
2. I would like for you to tell me about your experiences with families involved with intimate partner violence on your caseload without disclosing names or identifying information.
    1. How do these experiences compare to cases without intimate partner violence?
3. What treatment or service options are available for families with co-occurring child abuse and/or neglect and intimate partner violence?
4. What are your perspectives on the available treatment and service options?
    1. Can you explain that further?
    1. What do you perceive to be helpful about available options?
    2. What do you perceive to be unhelpful about available options?

4. What is your take on available programs' approaches to cultural differences and diversity?
    a. What do you perceive to be helpful about their approaches?
    b. What do you perceive to be unhelpful?

5. What is your take on available programs' approaches to trauma?
    1. What do you perceive to be helpful about their approaches?
    2. What do you perceive to be unhelpful?

6. What components do you view as important for treatment for families with intimate partner violence?

7. How would you like to be involved in the treatment process for families with intimate partner violence?
    1. To what extent would you like to be involved?

8. Tell me about your experiences collaborating with MST-IPV teams.

    1. What are your perspectives on the program?

9. What do you perceive to be its strengths?

10. What do you perceive to be its weaknesses?

11. How does it compare with other available treatment and services?

APPENDIX E: MENTAL HEALTH RESOURCES

Mental Health Resources/Crisis Lines

If at any point you feel that you are unable to keep yourself or others safe as a result of participating in this study, please utilize these resources to get you the help that you need:

For Immediate 24-Hour Help:

1. Call 911 for a life-threatening emergency

2. Action Line for 24/7 crisis services: 1-800-HOPE-135 (1-800.467.3135) or 2-1-1

For Additional References, please contact:

Malea Lash: xxx, xxx

**If you choose to communicate information via email that could identify you as a participant, please be aware you are consenting to the associated privacy risks. Email is not a secure medium, and we cannot guarantee that information transmitted will remain confidential.*