Walking children through a minefield.

Qualitative studies of professionals' experiences addressing abuse in child interviews.

Ane Ugland Albæk

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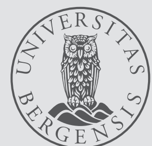

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ABSTRACT

Background: Ample research document that child abuse is widespread and that it is harmful to victims' physical, psychological and social well-being. Protecting the victims from further abuse and offering them restorative care can reverse these negative effects, but evidence suggests that numerous children exposed to child abuse remain undetected, even if they have been in contact with health or social services. Further, research on explaining why professionals fail to reveal child abuse seem scarce. The aim of this thesis is to explore aspects important to better understand professionals' lived experiences of addressing abuse in child interviews.

Methods: We conducted two qualitative studies to realize this aim. The first study was a metasynthesis of international empirical, qualitative research on professionals' experiences addressing child adversity, where our systematic literature search yielded eight eligible studies (paper I). We utilized meta-ethnographic comparative method and performed reciprocal translations by principles of thematic analysis and interpretative translation, as well as a line-of-argument synthesis. In the second study, we performed in-depth interviews with ten social workers in child protective services (CPS) and nine psychologists in child and adolescent mental health services (CAMS) (papers II and III). We approached the research interviews within a hermeneutic phenomenological epistemology and used interpretive description to examine the data.

Results: To convey the participants' struggles exploring child abuse, we developed the metaphor "walking children through a minefield" in paper I. Three overarching themes supported the metaphor: (a) *feeling inadequate,* (b) *fear of making it worse, and* (c) *facing evil*. Metaphorically, the participants felt exploring child abuse resembled maneuvering through an unknown minefield without knowledge or training in how to avoid or to defuse mines. They felt lacking in competence, organizational support and/or recourses. Addressing abuse, the participants risked hurting both themselves and the child because they lacked control over outcomes. Moreover, they reported strong negative emotions exploring abuse and subsequent avoidance patterns.

Because a dominant feature in our interview data was the participants' negative reactions to explorative work, we explored their emotional experiences addressing child abuse in paper II.

We captured the participants' experiences in five themes: (a) *facing children's suffering caused by adults,* (b) *feeling mean*, (c) *doubting one's ability and skills*, (d) *feeling one is betraying children*, and (e) *being obstructed by heavy workload and dysfunctional structure.* Findings in paper II is illustrated with the image that addressing child abuse felt like plunging into a dark sea of emotions. Encountering emotion-provoking challenges both within themselves and from their environment made the participants feel guilty for not providing children the standards of care and support they believed the children needed and deserved.

In paper III, we explored the participants' experiences with facilitators to address abuse in child interviews. Based on the participants' accounts we revealed that various facilitators relative to the stage of the skill development and intrinsic motivation of the professional ease explorative work. We developed five themes to convey these facilitators: (a) *alleviating personal choice*, (b) *collective accountability*, (c) *sharing vulnerability*, (d) *finding your own way*, and (e) *doing it for the right reasons*. The findings suggest that professionals' facilitators for addressing abuse are two-dimensional; some facilitators alleviate their emotional strain and doubt, while other facilitators promote their job satisfaction.

Conclusion: Overall, our findings show that addressing child abuse is challenging work due to its inherent complexity, unpredictability, and lack of control, and because it involves children's suffering. These challenges inflict professionals with doubt, guilt, and frustration. To support professionals and reduce their challenges, it is important to offer help that can alleviate their emotional strain and promote their job satisfaction. Firstly, to remedy the situation organizations should be adapted to meet children's needs, offer a supportive culture with shared vulnerability, and develop a culture and an organizational structure that promotes professionals' autonomy. Secondly, services should implement goal-directed reflective practice with feedback on performance, as well as train professionals in adaptive emotion regulation strategies and relationship-building skills.

PREFACE

WHY THIS STUDY?

My involvement in improving the detection, protection and care for abused children motivated the initiation, solicitation of funding and supervisors, application for admission to a PhD-program, and execution of this research project. The origin of this PhD's was thus personal, and I will therefore briefly share my point of departure.

Studies in developmental psychology and complex trauma and my work experience counselling professionals who work with trauma survivors, fueled my motivation to improve children's protection from abuse. I find the overwhelming evidence regarding the detrimental consequences of child abuse combined with the indications that we fail to help the majority of abused children alarming. Knowing that child abuse is one of our society's largest public health challenges sparked my commitment to make an effort towards improving abused children's situation. Both empirical studies and my work experience made me aware of how difficult it is to find these children in order to help them. Thus, I wanted to provide empirical knowledge on this issue to hopefully unveil insights applicable to inform and improve professional practice.

Motherhood and volunteer work with children have had an impact my attitudes, values and focus. Especially becoming a mother has made me more passionately engaged in children's right to live happy lives where they are loved and respected by their caretakers. My sense of urgency in helping abused children has thus increased, which probably has facilitated the realization of this study in terms of persuading funders and collaborators.

This research project was driven by an ambition for change. I anticipated that the results could alert us to organizational, systemic or individual elements influencing professionals' exploration of psychological trauma eligible for improvement. My overarching goal naturally follows that such improvements will make us able to identify and help more children with traumatic experiences and give them a better future.

Throughout the research process I have tried to stay close to the data in order to respect and convey the lived experiences of the participants. Because of my appreciation of the participants' contribution and my admiration for the important and challenging work they do, I felt obligated to publish the research results both in renowned academic journals and in a popular science format accessible to both professionals, policy makers and the general public.

LIST OF PUBLICATIONS

Albaek, A. U., Kinn, L. G., & Milde, A. M. (2018). Walking Children Through a Minefield: How Professionals Experience Exploring Adverse Childhood Experiences. *Qualitative Health Research, 28*(2), 231-244. doi:10.1177/1049732317734828

Albaek, A. U., Binder, P. E., & Milde, A. M. (2019). Plunging into a dark sea of emotions: Professionals' Emotional Experiences addressing Child Abuse in Interviews with Children. *Qualitative Health Research,* doi.org/10.1177/1049732318825145

Albaek, A. U., Binder, P. E., & Milde, A. M. (2019). Entering an Emotional Minefield: Professionals' Experiences with Facilitators to Address Abuse in Child Interviews. *BMC Health Services Research.* https://doi.org/10.1186/s12913-019-4128-8

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INTRODUCTION

For the last decades we have seen a surge of new research on the prevalence and detrimental effects of child abuse on children's physical and psychological health, their social and cognitive functioning, and their emotional well-being (Berens, Jensen & Nelson, 2017; Heim, Entringer & Buss, 2018; LeDoux & Pine, 2016). Sadly, research also convincingly document childhood adversity's long-term effects, whereas severe and/or prolonged exposure to stressors in childhood seem to be the most potent factor for predicting psychological illness in adulthood (Fosse, 2009). In psychotraumatology, several disciplines including neuroscience, endocrinology, epigenetics, developmental psychology, psychological stress-research, psychotherapy, and epidemiology join forces and document the detrimental and long-term effects of child abuse (Shonkoff et al., 2012). When we also know that at least 2 in 10 children experience some form of abuse in childhood (Wildeman et al., 2014; Aakvaag & Hjemdal, 2015), the gravity of the situation must be recognized.

All of these children meet professionals that could reveal their torments in pre-school or school activities, and many are even enrolled in health and social services. Still, it appears that most abused children do not disclose their adversity until their adulthood, or they never disclose at all (London, Bruck, Wright & Ceci, 2008). We therefore fail to help numerous children in need of protection and restorative care. This study sought to increase our understanding of why we so often fail to reveal ongoing child abuse even when we have access to the children. Studies of professionals' lived experiences exploring abuse while performing child interviews seem scarce, thus our aim was to investigate how professionals experience barriers and facilitators to address child abuse.

This PhD-project includes three published papers. The first paper is a metasynthesis of international, empirical, qualitative research on how professionals experience addressing childhood adversity. In papers II and III, we present findings from qualitative interviews with Norwegian professionals from Child Protective Services (CPS) and Child and Adolescent Mental Health Services (CAMHS). These professionals' experiences of emotional strain addressing abuse in child interviews are presented in paper II and their experiences of facilitators to address child abuse are conveyed in paper III.

CHILD ABUSE

Compelling and abundant multidisciplinary research has documented the long-term detrimental consequences of exposure to highly stressful experiences in childhood (Berens, Jensen & Nelson, 2017; De Bellis & Zisk, 2014; Felitti et al., 1998; LeDoux & Pine, 2016; Thomas & Hall, 2008). Child abuse can disturb children's neurobiological development and cause cognitive, emotional, and relational impairments both in childhood and in adulthood as well as increased mortality (e.g., Van Niel, Pachter, Wade, Felitti & Stein, 2014). Commencing this study we included the types of Adverse Childhood Experiences (ACE) listed in the ground-breaking study by Felitti and Anda (1998) where a large number of informants (n=17.000) from a non-clinical population established a convincing dose-effect relationship between the number of ACEs experienced in childhood and suffering from numerous physical and psychological health issues, social problems, and traumatic exposure in later adulthood. The ACE-definition of childhood stressors was applied in paper I and included psychological, physical and sexual abuse, violence against mothers, living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. However, in recent years the listed ACEs from the original study and its utility as a checklist for assessing stressful childhood experiences has been questioned by several researchers. The reason is that the ACE study deems all ACEs equally important for negative outcomes. For instance, some critics argue that the impact of parents' divorce or separation on children's development and wellbeing is considerably less than the impact of systematic parental abuse (Finkelhor, 2017; Finkelhor et al., 2012). Also, the original ACE research omitted impactful stressors for children such as bullying and discrimination (Finkelhor et al., 2012; Purewal et al., 2016). Being alerted to this debate, we chose to substitute the ACE-terminology with child abuse in papers II and III. This was also defendable in terms of the data material, because although the participants were asked open questions that included many types of hardships, they talked about child abuse, and more specifically physical and sexual abuse. Potentially traumatizing events in childhood appear to be frequent both in Europe and in the US (Finkelhor, Turner, Shattuck & Hamby, 2013; Janson, Jernbro & Långberg, 2011; Thoresen, Myhre, Wentzel-Larsen, Aakvaag & Hjemdal, 2015). When we know the overwhelming array of negative effects from child abuse it becomes crucial to shield children from abuse and to swiftly offer abused children restorative care to reduce both short- and long-term harmful effects. Shonkoff (2016) contends that there is enough evidence to infer that it is more cost effective and efficient to identify and intervene towards abuse early in life than to modify negative health behaviors or provide health care in adulthood.

Disclosure of child abuse

The low number of official reports of child abuse to authorities stands in contrast to the high rates of child abuse reported in prevalence studies. For instance, a meta-analysis of global prevalence of child sexual abuse including 217 studies, revealed that rates of child sexual abuse were more than 30 times greater in studies relying on self-reports (127 in 1000) than in official report investigations (4 in 1000) (Stoltenborgh, van Ijzendoorm, Euser & Bakermans-Kranenburg, 2011), or put differently; one in eight people retrospectively reveal child sexual abuse experiences, while official incidence estimates indicate that only one in 250 people have been exposed to child sexual abuse. Research on adult survivors of child sexual abuse indicates that as many as 60-70 per cent delay disclose into adulthood (London et al., 2008). A recent Norwegian study discovered that on average, victims of child sexual abuse waited approximately 17 years to reveal their experiences (Steine et al., 2017). In a nationally representative sample of Swedish adolescents (n=3202) only eleven per cent of adolescents exposed to physical abuse had disclosed the abuse to a professional (Jernbro, Otterman, Lucas, Tindberg & Janson, 2017). Similarly, a South African study of adolescents (n=3515) show that only 20 per cent of the adolescents exposed to physical, emotional, and sexual abuse disclosed the abuse, even though 98,6 per cent of the adolescents could name suitable confidants or formal services for abuse disclosure (Meinck et al., 2017).

Given the low disclosure rates, few abused children who manifest symptoms that warrant clinical attention receive effective treatments (Campbell, Olson, Keenan & Morrow, 2017; La Greca, 2009; Meinck et al., 2017; Steinberg et al., 2014). To protect children from abuse and/or offer them treatment to reduce the harmful effects of abuse it is necessary to assess children’s adversity properly and systematically. Hence, a contributing factor to the failure to comprehensively help abused children may be that aid services seldom include routine exploration of traumatic exposure (Blount et al., 2008; Cameron, Elkins & Guterman, 2006; Foster, Ofsted, 2011; Olson-Dorff, Reiland & Budzak-Garza, 2017; Reigstad, Jorgensen & Wikstrom, 2006).

Evidence indicates that children’s decision to disclose abuse comes from a complex interplay of facilitators and barriers. Abused children tend to blame themselves and feel ashamed about what happened thus hindering them from disclosure (Collins-Vezina, Sablonniere-Griffin, Palmer & Milne, 2015; Lemaigre, Taylor & Gittoes, 2017; McElvaney, Greene & Hogan, 2014). Moreover, they feel afraid of negative consequences such as increased violence, punishment and ruptured relationships should they disclose the abuse (Collins-Vezina et al.,

2015; Lemaigre et al., 2017; McElvaney et al., 2014; Schaeffer, Leventhal & Asnes, 2011). Of particular importance to our study is how children need direct questions from adults to tell (Lemaigre et al., 2017; McElvaney et al., 2014; Schaeffer et al., 2011), and they need relational support and dialogically oriented sensitivity from adults to facilitate disclosure (Flåm & Haugstvedt, 2013; Lemaigre et al., 2017; McElvaney et al., 2014). To enable such achievement, professionals need to acknowledge and attempt to restore the distrust children and adolescents have towards professionals and child protection systems with regards to their ability and will to help (Jernbro et al., 2017; Lemaigre, 2017).

Previous research on professionals' experiences addressing child abuse

Piltz and Wachtel (2009) reviewed quantitative research and found that nurses' reporting of suspected child abuse to CPS depended on individual factors, such as knowledge, experience, fear of perceived consequences, lack of emotional support, and low opinion of CPS. Equivalent findings emerged in an integrative review of nurses' experiences keeping children safe (Lines, Hutton & Grant, 2016); whereas nurses felt they lacked knowledge, skills and support which made them feel inadequate and disempowered to intervene on behalf of potentially abused children. A study based upon questionnaire of Danish dental workers revealed that although they had received formal training on child abuse, frequently reported barriers were uncertainty about observations, signs and symptoms of abuse and neglect, and uncertainty about referral procedures (Uldum, Christensen, Welbury & Haubek, 2017). On a similar note, a study of dentists in Saudi-Arabia found that the respondents demonstrated good knowledge of child abuse and neglect (Al-Dabaan, Newton & Asimakopoulou, 2014). However, they seldom reported suspicions to either their workplace, social services or the police due to fear of family reprisal, lack of certainty about their abuse assessment, and uncertainty about case management.

Qualitative interviews with child healthcare nurses in Sweden show that the participants were afraid of negative reactions from parents when voicing suspicions of abuse, even if they stressed the importance of focusing on the child's best interest and being honest with the parents (Dahlbo, Jakobsson & Lundqvist, 2017). In addition, the participants shared that they needed to discuss suspicions with colleagues, and they wanted feedback from the results of their reported suspicions. The same tension between strong commitments to protect the child while lacking control over outcomes for the child was found in interviews with neonatal nurses in New Zealand (Saltmarsh & Wilson, 2016). They too solicited discussions with

colleagues to relieve doubt in suspected abuse cases and they feared reprisals from parents. A Brazilian study of nurses in primary care revealed the same elevated fear and insecurity regarding how to identify and handle cases of suspected violence (Leite, Beserra, Scatena, Silva & Ferriani, 2016).

Paper I presents a review of eight empirical qualitative studies published prior to 2015 with participants from various professions (see Albaek et al., 2018). The study show that the participants found it difficult to address maltreatment in interviews with children due to task complexity, emotional strain, and perceived lack of knowledge, training and skills.

The small number of published empirical studies illustrates a substantial knowledge gap in this area. Although a few studies have addressed professionals' difficulties working with or reporting potential child abuse, very little research specifically targets addressing abuse in child interviews and the lived experience of the professionals performing these interviews.

AIMS

The overall aim of this thesis was to explore aspects important to better understand professionals' lived experiences of addressing abuse in child interviews. In "lived experience", assessment, screening, identification and reporting behaviors as well as intrapersonal (e.g. attitudes, values, beliefs, knowledge, and biases), and contextual aspects were included. Consequently, these research questions were addressed:

- What are professionals' lived experiences of facilitators and barriers to addressing adverse childhood experiences, as reported in international research so far?
  Paper I: Walking children through a minefield: How Professionals Experience Exploring Adverse Childhood Experiences.
- How do professionals experience the emotional distress of exploring abuse in interviews with children?
  Paper II: Plunging into a dark sea of emotions: Professionals' Emotional Experiences Addressing Child Abuse in Interviews with Children.
- What are the professionals lived experiences of facilitators for exploring child adversity?
  Paper III: Entering an emotional minefield: Professionals' Experiences with Facilitators to Address Abuse in Child Interviews.

METHODOLOGY

METHODOLOGICAL APPROACH

Searching for insight into professionals' thoughts and feelings rather than measure the prevalence of pre-constructed factors or testing specific hypothesis calls for a qualitative research design. Identifying the five major qualitative research traditions to be: biography, case study, ethnography, grounded theory, and phenomenology (Creswell, 1998), this study developed a phenomenological approach. Phenomenological methodology was chosen to gather an understanding of the complex interplay of aspects that constitute the participants' lived experiences addressing child abuse. To investigate the clinical phenomenon of explorative work in child interviews we opted for a qualitative metasynthesis using the comparative meta-ethnographic method (Noblit & Hare, 1988), and qualitative in-depth interviews utilizing the interpretive description method (Thorne, 2016). Qualitative metasynthesis seemed suitable as it enables overarching insights and augmented understanding of a topic or phenomenon through systematic knowledge generation from primary qualitative data (Sandelowski, 2012). Similarly, interpretive description fit the study aim because it allows for an interpretative account of the themes, patterns and structure within subjective perceptions of addressing child abuse generated by informed questioning, reflexive critical examination, and contextualized interpretations (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004). Both interpretive description and meta-ethnographic method invite abstracted theoretical interpretations that can expand clinical understanding of professionals' challenges and facilitators for exploring child abuse and that can propose practical applications (Hunt, 2009; Zimmer, 2006).

Epistemologically, this thesis recognizes knowledge to be systemic and based on emergence, whereas novel structures, patterns and features continuously form through the process of self-organization (Kauffman, 2000). Hence, our topic of interest involves complex evolving systems unavailable to best practice solutions (Van Beurden, Kia, Zask, Dietrich & Rose, 2013). Especially when searching for new empirical insights into human interaction and experience, attention to agency, complexity and meaning in the research process is paramount. Agency is important, as knowledge is constructed continuously through human interaction and made possible by consciousness and creativity. Agency captures individuals' capacity to act and modify their environment on their own behalf and it constitutes the origin

of meaning and values (Kauffman, 2000). Moreover, phenomenologically based methodology emphasizes discovering the array of interrelated, subjective and often conflicting understandings (Ussher, 1999).

Hermeneutic phenomenological methodology is perceived to be consistent with a constructionist ontology, although the issue is debated (Finlay, 2012). In constructionism, reality is not considered as naturally given but rather a product of our active and purposeful interpretation of the meanings that are available to us (Gergen, 1999). Our biology, neurology and physiology are only a framework for possible emotions, thoughts and behaviors that need cultural and social activation to take on meaning. We continuously assign meaning to what we see and experience every day in the form of signs, symbols and language. The constructivist paradigm calls them *objectivations* (Alvesson & Skjoldberg, 2009). Our habits, routines, organizations and categorizations in our social relations become *institutions* that over time are perceived as something external and given, even though we create them and human enactment in roles effectuates the institutions and preserves their existence. The human need for coherence and meaning in life lead to *institutional logic* that legitimizes these institutions. Thus, this thesis explored the participants' institutions and their institutional logic through analysis of their objectivations as they emerged in our data.
Social realities and constructions are manifold, at times conflicting, and they are the products of human minds. They are therefore susceptible to change and can become more informed and sophisticated (Guba & Lincoln, 1994). The belief that human thinking, behavior, and relations can evolve and become more advanced is an important motivation for my research. The axiology will be further discussed in the reflexivity section.

Key theorists in phenomenology can be divided into two branches. In a rough outline Edmund Gustav Albrecht Husserl (1859-1938) and Maurice Merleau-Ponty (1908-1961) were ontologically *essentialists* searching for descriptions of a phenomenon, while Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002) advocated a hermeneutic phenomenological or *interpretative* approach striving to understand the meaning people allocate to a phenomenon (Laverty, 2003). This division also encompass differing epistemology whereas Husserl and Merleau-Ponty thought a phenomenon should be investigated through phenomenological reduction and bracketing the researcher's foreknowledge, while Heidegger and Gadamer believed meaning should be pursued through reflexive dialogue. In line with the constructionist viewpoint outlined above, this thesis was

situated in the hermeneutic phenomenological approach. Heidegger (1962) stressed that our process of assigning meaning to ourselves and the world is a continuous interpretative dialogue between our pre-understanding and our contextual interactions with the world. In other words; the hermeneutic circle involves actively searching for meaning through moving back and forth between the interpreted and the interpret, the parts and the whole of the experience, and between our implicit pre-understanding and our explicit contextual understanding (Kvale, 1996). Gadamer (1960/2004) elaborated Heidegger's work and highlighted how our understanding comes from interpreting the combination of horizons (our own and the participants') generated through language and questioning. This understanding is constantly evolving as our questioning informs about participants' partial experiences from within that we interpret from our background of shared meaning and historicity. A pre-requisite for researchers is therefore awareness of our own pre-judgements and bias, as hermeneutic phenomenology demands reflexive hermeneutic dialogue (Laverty, 2003).

In this project, the hermeneutic-phenomenological approach guided the choice of method, data collection, and analysis of data. The hermeneutic component is evident in the process of interpreting the participants' accounts when creating meaning (Binder, Holgersen & Moltu, 2012), and the phenomenological element is apparent in the attitude of letting the participants' voices be heard and understand their lived experience throughout the research process (Binder et al., 2012; Van Manen, 2015). Additionally, the constructivist perspective anchors the project with the view that knowledge comes from the complex interplay between the participants, the research process, the context, and the participation of the researchers (Alvesson & Skoldberg, 2009). This stance can also be described by the term reflexive research, where the quality of the research will be contingent upon the reflection and reflexivity of the researcher. Therefore, reflexivity, trustworthiness and potential pitfalls will be discussed in a separate section. In line with the hermeneutic-phenomenological approach, comparative meta-ethnographic method (Noblit & Hare, 1988) was applied in paper I and interpretive description (Thorne, 2016) in paper II and III.

Research design

Qualitative metasynthesis and comparative meta-ethnographic method

Sandelowski (2012) describe qualitative metasynthesis as a method of systematic investigation in which research findings in completed qualitative studies are summarized or joined to make them more suitable to enlighten practice, policy, or future research. The key

objective is to juxtapose, contrast, interpret into each other, and synthesise empirical, qualitative findings from individual studies to acquire novel insight, overarching meaning and increased understanding of a topic; by doing so, these studies are allowed to be more than just isolated pieces of a big puzzle (Zimmer, 2006). In health-care sciences, Noblit and Hare's (1988) meta-ethnographic comparative method is the most frequently used methodology for qualitative evidence synthesis method in healthcare and social work research as it enables new interpretation, model or theory that goes beyond the findings from the primary studies (France et al., 2019). Noblit and Hare's (1988) meta-ethnography involves seven recommended steps: (1) isolate a research question to explore with qualitative data; (2) identify relevant studies through literature review; (3) read the studies thoroughly; (4) find how the studies are interrelated, (5) translate the studies into each other and extract overarching themes; (6) synthesise translations, and, (7) communicate findings. They contend that step four can involve three main approaches for synthesizing qualitative evidence: (a) *reciprocal translation analysis*, where the accounts from the individual studies are directly comparable and translated into each other, (b) *refutational synthesis*, where the accounts contrast with one another, and (c) *line of argument synthesis*, striving to develop an understanding of a "whole" among the sets of parts. We chose this method because rather than producing a mere summary of findings, meta-ethnography can offer theory development and new insight into how participants experience a phenomenon and thereby increase our understanding of how and why interventions work or fail in various settings (Campbell et al., 2011).

Qualitative research interview and interpretive description

The qualitative research interview is well suited to capture the subjective experiences of the participants and to understand their perception of their social context, which explains why it is the most widespread method of qualitative inquiry in human and social sciences (Brinkman & Kvale, 2015; Thorne, 2004). Qualitative research interview within the framework of interpretive description (Thorne, 2016; Thorne, Reimer Kirkham & O'Flynn-Magee, 2004) was chosen for paper II and III. Interpretive description fits well within a phenomenological hermeneutical framework, although Thorne (2004) emphasize that the study design departs from phenomenological essentialism. The search for patterns and themes within human experience is not to grasp its essence, but to better understand what we likely come across in clinical practice and develop a meaningful approach towards it. In interpretive description the clinical experience and knowledge of the interviewer is a strength applicable to build rapport

in participants, as well as enhance depth and clarifications within the narratives of the participants. When combining clinical expertise with necessary humility and reflexivity, it also becomes a tool for expanding, clarifying and altering your preliminary understandings and interpretations (Thorne, 2004). We therefore attempted to be as reflexive as possible throughout the project to identify our preconceptions and sensitivities and their potential effect on our interpretations (Alvesson & Skoldberg, 2009; Finlay & Gough, 2003).

Interpretive description is a qualitative research approach that derives integrity from (a) a clinical practice goal and (b) an empirical and clinical understanding of the knowledge base in question. This assumed knowledge forms the starting point for a logical and systematical interpretive endeavor to see beyond the self-evident and generate new insights. These new insights can inform practice and shape future inquiries. Key to the approach is the emphasis on building a solid and defensible basis from which knowledge on clinical phenomena can be attained within a disciplinary conceptual frame that stands on its own rather than being presented as a modified version of phenomenology, grounded theory or ethnography (Thorne et al., 2016; Thorne, 2004). Decisions in health and social services are made in a predominantly evidence-based context. This enforces the need for knowledge regarding subjective, implicit and patterned aspects of human experience. Such knowledge can provide essential contextual understanding that can guide future decisions affecting both the quality of services and people's lives. Interpretive description does not have strict guidelines, rather it attempts to model a design logic and rationale that has integrity both with regards to acceptable science and to the applied disciplinary world.

STUDY SITES

Participants for paper II and III were recruited from Child Protective Services (CPS) and Child and Adolescent Mental Health Services (CAHMS). Further details regarding locations, regions and size of the services from which the participants were recruited are omitted to preserve their full anonymity. CPS is a municipal service aimed at protecting children from adversity like violence, abuse and neglect and offer interventions to children and families. The main function of CPS is to monitor the conditions in which children grow up and to initiate interventions that prevent neglect (§ 3-1.; Norwegian Ministry of Children and Equality, LOV-1992-07-17-100). CPS have the right and obligation to investigate the living situation of children and adolescents if there are reasonable grounds for concern (§ 4-3.; Norwegian Ministry of Children and Equality, LOV-1992-07-17-100). It is responsible for

initiating interventions and measures if a child is at risk in order to contribute to positive change within the child or the family (§ 4-4.; Norwegian Ministry of Children and Equality, LOV-1992-07-17-100). CAMHS is a state second line service assigned to provide assessment, therapy, and counselling services to children and families with child mental health challenges. Health and social services for children in Norway, including CAMHS and CPS, have undergone a bureaucratization process where services have been specialized according to tasks and recipients. For instance, larger CPSs have separate departments for investigation, support, foster care, and acute services, and sometimes also subdivisions clustered by age or intervention method. Similarly, most CAMHS have several subunits divided by assignment, work method or age group (i.e. acute help, youth clinic or family interventions). Thus, children may have to deal with many different departments and professionals during their contact with CPS and CAMHS (Andrews, Lindelof & Gustavsen, 2015).

Participants

The participants and the empirical data included in the metasynthesis are thoroughly described in paper I. The empirical data included three studies from the US (counsellors, n=21; health clinic workers, n=14; and pediatric emergency department workers, n=26), two from the Netherlands (hospital workers, n=33; health care workers, n=14), two from Sweden with overlapping informants (school nurses, n=23); and one from the Great Britain (CPS workers, n=41). Six studies were published in medical or health journals, and two in thematic journals on abuse. The data collection methods used in these studies included in-depth and semi-structured interviews (three studies), semi-structured focus group interviews (three studies), questionnaire with open-ended questions combined with in-depth interviews (one study), and small group seminars with open-ended questions and case discussions (one study). Together, the studies covered responses from 172 professionals, including men and women, with varying work experience and different levels of education. Only four of the studies listed gender hence, we could not quantify gender distribution. The professionals worked with children or adolescents in physical healthcare (four studies), school nursing (two studies), CPS (one study), and counselling (one study).

In paper II and III purposive sampling was chosen. With an emphasis on quality and diversity within the sample groups, the objective was to become “saturated” with information on the topic (Padgett, 1998, p. 52). The study collected data from two groups of informants. After

interviewing ten subjects from CPS and nine subjects from CAMHS, a preliminary analysis revealed apparent trends throughout the data material as well as limited novelty in the final interviews. In agreement with the co-authors the assumption that the data material was satisfactorily saturated was made and the data collection ended.

In paper II and III the total sample consists of 19 participants, 16 females and three males, with 10 social workers from CPS and nine psychologists specialized in clinical child psychology from CAMHS. The participants from CPS were recruited from three CPSs of varying size, geographical location, organization, and demographic area (urban, suburban and rural). Only CPS workers who worked with suspected child abuse cases were included. The participants' years of work experience from CPS ranged from one to 35 years (median was 14), they worked with differing client age groups (pre-school, elementary school, and adolescents) and two of them were male. All of them were ethnic Norwegian and their age ranged from 25 to 58 years. The participants from CAMHS were recruited from four CAMHSs of different size and geographical location. They had between ten and 35 years of work experience (median was 20) and certain also had work experience with clients > 18 years of age; one was male. All of them were ethnic Norwegian and their age ranged from 35 to 62 years. All these participants had supervisor responsibilities for colleagues with lower educational degrees and they had work experience with clients exposed to violence and/or abuse. They received no compensation for their participation and the interviews were conducted during work hours.

Determining recommended sample size in qualitative research is still a matter of debate, although many agree with the concept of saturation as the guiding principle for deciding sample size (Mason, 2010). However, researchers debate the meaning of saturation. Some argue that qualitative research reports often claim saturation without describing what it means or how it was achieved (Bowen 2008), and that researchers may claim saturation too early due to inexperience or lack of expertise in the chosen topic. Others suggest that saturation is always a matter of degree, and that problems developing a conclusion to a study might be due to an excess of data rather than a lack of it (Strauss & Corbin, 1998). Guest, Bunce and Johnson (2006) suggest that *although the idea of saturation is helpful on a conceptual level, it provides little practical guidance for estimating sample sizes for robust research prior to data collection* (p. 59). Mason (2010) reviewed the application requirements for PhD-candidates in some of the top 50 universities of the world and concluded that it is common to require applicants to explicitly document their intended sample size, prior to registration, and

the same goes for much sponsored research. Morse (1994) suggests that the sample size for phenomenological research should be at least six. A study by Guest et al. (2006) concluded that for studies with a high level of homogeneity among the population, *a sample of six interviews may be sufficient to enable development of meaningful themes and useful interpretations* (p. 78). The two participant samples for paper II and III were assumed to have a high level of homogeneity as they shared educational background as well as roles and responsibilities at work within each sample group respectively. To ensure enough data to allow for insightful interpretations, our initial proposal aimed for 8-10 interviews within each sample group with the intent to adjust the number along the way in accordance with appraisal of saturation.

RECRUITMENT PROCEDURE

Telephone calls were made by the first author to the executive leaders of the CPSs and CAMHSs (n=7) with a presentation of the project, followed by an oral request to interview some of their subordinates. Then the executive leaders received information by e-mail shortly after the call. Some of them chose employees for participation and made meeting arrangements, others shared information about the study by e-mail and told their employees to contact the first author if they were willing to participate, and one executive leader provided the contact information to potential participants for direct inquiry. Thus, there is no record of any professionals who declined to participate, or of how many professionals who received a request to participate and elected not to sign up.

DATA COLLECTION

For the data material in paper II and III, the first author conducted 19 separate semi-structured, in-depth interviews whom also developed an interview guide to safeguard that the interviews covered the study's key areas of interest. The mean duration of the interviews was 68 min (range 44-97 min and median 74 min). A thorough description of the recruitment of participants, the data collection, the data management, and the interview guide, is provided in paper II. In addition, the interview guide is included in Appendix I.

Geographical dispersion of the participants resulted in travel distance. To increase the response rate the interviews were performed in a quiet room at the participants' work site. All the interviews with the CAMHS-workers were performed in their own office except for one

who took place in the participant's home private practice office. The interviews with CPS were done in meeting- or interview rooms.

DATA ANALYSIS

In paper I the first author initiated the data analysis by creating a mind map of each study's results section, noting key themes and compelling participants' quotes. These were shared with the co-authors. Next, the first author organized the findings into three categories: individual factors, factors related to the ACE or child abuse, and organizational factors. Then the first author invited the other authors to join in a creative proceeding attempting to reveal patterns and commonalities across the concepts, themes, and key quotes from the included studies. We contrasted our ideas of themes or meanings to explore how the studies could be interrelated and searched for findings that supported one another and findings that seemed to contest one another. At the end of this process, we arrived at a pattern of meanings that seemed to mutually agree although they discussed various facets of our inquiry. Because of the apparent concurrence in the data set, we opted to undertake our next analysis step by means of reciprocal translation using proceedings from thematic analysis and interpretative translation. We revealed some repeating meaning units, and we used significant concepts from one study and interpreted them into findings of the other studies to further our emersion into the meaning underlying the themes. Three main categories of themes were collectively developed through these translations: external barriers, concern for the child's well-being, and the participants' emotional discomfort. The first author shared a written delineation of the themes with the other authors and these were subjected to critical and reflexive discussion. Based on the discussion the theme descriptions were revised. We repeated this process several times before landing the final version. Next, all authors performed a line-of-argument synthesis to capture the themes as a whole with a meaningful metaphor or concept. The synthesis yielded an overall description of what an overarching metaphor would need to encompass if it were to efficiently convey the findings. Several metaphors were discussed. The first author suggested the minefield-metaphor and elaborated a proposed description of the metaphor and the main themes. All authors debated this description and proposed revisions until we reached consensus.

In paper II and III interpretive description constituted the framework for our analysis. Initially, the first author adhered to an inductive coding approach and coded the transcripts by organizing text passages into wide categories representing their meaning content in line with

interpretive description, assisted by Nvivo 8 software. Emerging insights from the data material guided the construction of meaning units, and diverse perspectives were actively explored towards interpretations of the data (Thorne, 2016). New codes developed and the first author assigned them broad and descriptive titles to maximize their potential to expand the analysis. Next, all authors read every transcript to form an impression of the material and the participants' experiences. We gathered in a joint creative session to discover preliminary themes through exploration of possible conceptual linkages in the transcripts in relation to the research question. Next, we furthered our interpretations by engaging in a dialogue with the data material and with our different understandings of emerging patterns and meanings in the data set. As our aim was to extract findings applicable to inform practice, we explored different relationships and patterns in the data to find an organizing structure to conceptualize the most meaningful set of findings (Thorne, 2016). We elected to perform the analysis as a group, informed by critical reflexive discussions, and enhanced and tested by our varied experiential and professional backgrounds. Afterwards the first author elaborated tentative themes with descriptions and representative quotes and shared them with the other authors for re-examination and critical discussion. The other authors suggested different names for some themes and proposed some themes could be merged while other themes could have sub-themes. Following the discussions, the first author made new descriptions of the themes and the thematic structure several times until we agreed all key meanings answering the research question was clearly conveyed.

Quality in qualitative research

We pursued this study's objective with qualitative inquiry. In the words of Linda Finlay: *the strength and special contribution of qualitative research lies in the way it can capture the richness and ambiguity of lived experience, the diversity and complexity of the social world* (2006 p. 322). But therein also lies the biggest challenge of qualitative research; how to ensure quality and trustworthiness. Unlike research within the positivist tradition, where validity, reliability and objectivity seem to be universally agreed upon as measures of quality, the qualitative tradition propose several sets of quality measures and are far from unanimous agreement on a common list of quality measures.

Early on, Lincoln and Guba (1985) proposed four criteria for qualitative research; *credibility, transferability*, *dependability,* and *confirmability*. *Credibility* is the concept they propose to replace *internal validity* with reference to whether the findings make sense. Researchers'

engagement in the field researched as well as knowledge of and comparison to other related research add credibility, as do staying close to the participants' accounts when interpreting and presenting the findings. *Transferability* replaces the concept of *external validity* and can be attained by providing enough information about the research process and the participants for the readers to infer the findings' validity and applicability to other settings. The transparency of data analysis invites the audience to judge for themselves the logic and coherence between the research process, the data material and the interpretations (Binder et al., 2012). *Dependability* replaces the concept of *reliability*. A study's dependability depends on whether the readers can gain insight into all decisions and actions taken during the research process and evaluate whether the conclusions seem reasonable given the context. Some refer to this as providing an "audit trail" or having a transparent research process. *Confirmability* replaces the idea of *objectivity* and involves *reflexivity*. Reflexivity refers to the researcher's evaluation of the way intersubjective elements impact on data collection and analysis (Finlay, 2002). Based on the *thesis of theory ladeness*, research on human experience can never be purely objective or void of explanation (Hanson, 1958). Observations are influenced by the beliefs of the observer and cannot represent neutral information. This makes *reflexivity* paramount in managing the challenges in qualitative research related to the intersubjective role of the researcher. These criteria for quality in qualitative research will be utilized to evaluate the strengths and weaknesses of this thesis in the discussion section.

Stige, Malterud and Midtgarden (2009) are skeptical towards the utility of general checklists or common criteria for evaluating qualitative research. They propose an evaluation agenda instead where reflexive dialogue on themes that warrant discussion replaces rule-based judgement. In their evaluation agenda the challenges or themes that should be subjected to reflexive scrutiny are embodied in the acronym EPICURE; *engagement, processing, interpretation, critique (self- and social-), usefulness, relevance* and *ethics*. Engagement involves the researchers' motivation and preunderstanding; their interaction with the phenomenon studied; and their ability to partake, relate and reflect particularly when effecting reflexivity on subjective and contextual influences. Processing involves the accuracy, diligence and systematic effort put into the process of producing, organizing, analyzing and reporting empirical material. Interpretation refers to the analytical rigor of the research process starting with the choice of focus and the production of data material and continuing with the act of creating meaning and recognizing patterns in the material. Critique represents the evaluation of strengths and limitations of research and it includes both self-

critique and social critique. Self-critique is reflexivity in relation to individual aspects and actions of the researcher, whereas social critique examines problems of power and privilege. Usefulness refers to the value of the research in relation to real-world problems both in terms of implementation of new knowledge generated and in terms of enhanced understanding. Relevance involves the study's contribution to the field's understanding and development and how the study relates to existing knowledge. Ethics relates to the scrutiny of upholding values and moral principles in the research process. The key to improving quality with regards to this evaluation agenda, especially in the first four themes (engagement, processing, interpretation and critique), is reflexivity and transparency. A thorough reflexivity section is therefore warranted.

REFLEXIVITY

In qualitative research, we recognize that interpretative knowledge generation can never be free from subjectivity or bias from the researcher(s). Reflexivity is the process of scrutinizing all subjective experiences, values, motivations, attitudes and so on and discuss openly how these may have influenced our data and our findings. The argument is that known and recognized influence increases transparency and trustworthiness, while unknown and unrecognized researcher influence is detrimental to research quality. Gough (2003) explains that *"reflexivity facilitates a critical attitude towards locating the impact of the research(er) context and subjectivity on project design, data collection, data analysis, and presentation of findings"* (p. 22). Thus, when researchers reflect openly on their influence and potential bias upon their research it enables readers to evaluate possible researcher bias. Thus, researchers come closer to presenting "objective" knowledge than if researcher reflections on influence are lacking or hidden. Trustworthiness is attained through being reflexive about one's contribution as a researcher to knowledge generation. Thus, *"objectivity in qualitative inquiry means striving for objectivity about subjectivity"* (Kvale & Brinkmann, 2009, p. 242). Reflexivity is where the researcher must be self-aware, critical, and in continuous reflection on how subjective factors and intersubjective dynamics affect the research and our active construction of knowledge (Finlay, 2002). Qualitative researchers are positioned in the field they study. Reflexivity takes into consideration the researcher's prejudices whenever this is relevant for the research project and makes these prejudices explicit (Kvale & Brinkmann, 2009). The trustworthiness and utility of data obtained through qualitative research interview relies heavily on the skills and qualifications of the interviewer. More specifically, knowing

how to establish trust and a sense of ease for the participant through verbal and non-verbal communication, assessing when to use silence, rephrasing, open questions, and knowing how to convey understanding of the informant's perspectives is a matter of emotionally involved intuitive behavior from the interviewer (Kvale, 1997).

My influence as a researcher on this project will be discussed in three interrelated forms of reflexivity; (1) reflexivity on the political/ideological character of the research, (2) reflexivity regarding relationships, and (3) personal reflexivity (Gough, 2003).

Reflexivity should review the possible legitimizing or changing role of the research as research can have a political or ideological agenda. My preconceptions and past experiences working with professionals from various child services led me to have an agenda beyond simply describing and understanding phenomena and how they are interrelated. I wanted my research to reveal something applicable to evoke change in the research venue. The ultimate goal was, and still is, to improve our society's failure to identify and help abused children through increased knowledge about individual, organizational or systemic issues that influence professionals when exploring psychological trauma. My role, however, is not to apply this knowledge in my own practice. Rather, I wish to reach as many professionals as possible with effective practice changing interventions to improve their ability to facilitate children's disclosure of traumatic experiences. In addition, I want to influence the professionals of tomorrow by providing relevant empirical knowledge adapted to implementation into the academic educational system.

My training as an organizational psychologist, my work experience with competence development in helping services, and my academic fields of interest have convinced me that to implement lasting change in organizations one must work with both organizational culture and individual skills simultaneously. Working with professionals, my experience indicate that collective work on improved self-knowledge and self-awareness enhances an organization's constructive communication and team cooperation. Accordingly, I was open for revealing insights into underlying structures, mechanisms or value/belief-systems that the participants may not be consciously aware of. One could argue then that my aim for this inquiry expands beyond solely *understanding* or *reconstruction* within the constructivism paradigm and verge upon *critique* and *transformation* or *restitution* and *emancipation* within the critical theory paradigm (Guba & Lincoln, 1994; Alvesson & Skoldberg, 2009).

Personal factors like my work experience, my motivation for doing the research, and my prospective outcome of the research project, may have influenced the project: My dedication to the objective and potential usefulness of the project may have facilitated recruiting financial support for the project as I secured partial funding from a department previously unfamiliar with sponsoring academic research. Marketing the potential practical usefulness of the solicited knowledge may also have been influential in recruiting supervisors for the project.

The next level of reflexivity involves reflexivity in relationships and cooperation examining relevant social roles and viewpoints as my experience and theoretical knowledge may affect my appearance, interpretations and analyses in the research process, whether intentionally or not. Years of experience with teaching and competence development have led me to automatically start analyzing what people say, how they say it, and move on to make inferences about their problems and how these can be solved. Being aware of this matter, I therefore tried to be as neutral and non-directional as possible in my first interviews. I avoided verbal comments and used non-verbal encouragement instead. I tried to use solely open questions or paraphrasing. Reflections on my first interviews, as well as studying theories of interview methodology, lead me to be more alert to the participatory nature of the interview process where the interviewer is an influential participant in the creation of knowledge, and to realize that this can also be an asset. While still being conscious about trying not to be directional in my questions, I began to comment or paraphrase more and be a little more active in the conversation. My impression is that these subtle changes made the participants feel more at ease and allowed for more trust to develop in the relationship, which in turn lead to an added amount and depth of information. Additionally, the participants may have felt more understood, valued and recognized by my increased involvement, thus enhancing their openness. Surprisingly, several of the participants commented that the interview had given them extended knowledge and awareness about themselves, their work, and their values.

Lastly, personal reflexivity investigates my potentially influential preconceptions and experiences. My academic background is in social and organizational psychology with varied work experience from different roles or positions within several types of help services, but the largest part of my working life has revolved around designing and providing competence development to workers in helping professions. My assignments have included improving the

quality of care given by professionals through competence development programs, team development, teaching, client-based counseling, and organizational development. Many of the professionals in my assignments have provided services to individuals exposed to severe stress or psychological trauma, thus adding an intrusive emotional aspect to their working conditions. Having worked with professionals in emotional turmoil makes me especially alert to how the emotional challenges in many helping professions are under-communicated and accordingly remain largely unattended to. Early in my career I worked directly with mentally ill or challenged clients and acquired personal experience with emotion work. To be exposed to clients' strong emotions daily, whether it is empathizing with their pain or being the target of their tantrums, demands a strong sense of self-worth and highly evolved emotion regulation skills from professionals. Thus, I have counselled several professionals on prolonged sick-leave due to work-related emotional strain. That may have steered my attention towards the participants' emotions both in the data collection and in the analysis of data.

To improve the quality of my work, I have studied psychotraumatology, conditions for change in people, and implementation science. Both academic studies and my work experience point to individual skills and motivation (or will) being paramount to produce enduring quality improvements. Although my assignments have been group based, I have directed more and more attention towards individual skill development, like emotion regulation, introspection and attuned communication, as I find these elements essential for efficient competence development. Thus, my work has fueled my interest in how professionals change and improve, especially those who work under challenging emotional conditions in helping services. My interest in the clinical relevance and application of this study's findings have probably influenced the choice of method for data analysis and the presentation of findings.

Work experience from health and social services have led me to be skeptical to how both cause and solution to challenges too often are pursued within the attributes of the child at hand, instead of investigating the child's care environment and history. This agenda to increase focus on causality rather than symptomology, combined with my dissatisfaction with these services' current practice, may have increased my focus on systemic aspects in the data collection and analysis.

Having a dedication towards helping abused children makes it easier for me to empathize with the professionals when they report struggles that come from their commitment to help children. On the other hand, a strong involvement in the children can make it more difficult to fully grasp the perspectives of the professionals and their avoidance of discomfort. Strong feelings and motivations must be reflected upon continuously as they involve a risk for becoming so involved that the bigger picture and perspectives are lost.

ETHICS

I requested an evaluation of the study protocol from the Regional Committee for Medical and Health Research Ethics. They assessed their approval was redundant as the project's participants were from a non-clinical population (REK nr. 2014/301). In addition, a detailed account of the study was evaluated and accepted by a research committee at the University of Bergen (UoB). The participants received both written and oral information about the study and were invited to ask questions before they chose to participate. Also, they were informed that partaking was voluntary, and that they could withdraw at any time during the interview. If so, any given personal information would be deleted. The interviews were recorded without identifiable information about the participants and the Norwegian Centre for Research Data (NSD) authorized the study protocol. The audio files were transcribed, and the files were then deleted. Their executive leaders allowed them to be interviewed during work hours, but they received no payment or tokens for their participation. The leaders were promised a lecture on the study's findings upon completion of the project.

To protect the anonymity of the participants, no names or workplaces were transcribed from the interviews. Because the participants were asked to share stories from their work, they were specifically instructed not to name any children, adolescents or parents to protect the confidentiality and anonymity of all clients or patients.

There was a remote possibility that being interviewed could reactivate traumatic experiences from the participants' own life. Should this occur, we promised the participants a consultation with an external experienced psychologist specialized in clinical psychology within 24 hours.

BROADER ETHICAL CONSIDERATIONS

A standard definition of ethics is that ethics concerns doing good and avoiding harm (Beauchamp & Childress, 1989). In research contexts, ethics have largely been associated with the role of ethical principles and guidelines guiding the pursuit of knowledge (NESH,

the Helsinki declaration, ICMJE). However, a critical perspective of ethics is concerned with who gets to decide what is good and what is bad (Punch, 1994). Moreover, sound research ethics is associated with approvals from Research Ethics Boards (REBs) and evaluating the researchers' adherence to principles of autonomy, confidentiality, respect, beneficence, nonmaleficence, and justice (Mauthner & Birch, 2002). Guidelines and principles are set with a vision to protect participants and researchers, minimize harm, increase the sum of good, assure trust, ensure research integrity, satisfy organizational and professional demands, and cope with new and challenging problems from concern to conduct (Denzin & Gardina, 2007).

However, the guidelines and principles seem more adjusted to ethical regulation of quantitative research. This is because the static, formalized guidelines may disguise the inherent nature of tensions, fluidity and uncertainty of ethical issues arising from qualitative research (Denzin & Gardina, 2007; Lincoln & Canella, 2007). Ethical difficulties in qualitative research tend to be subtler and more complex than in quantitative research (Orb, Eisenhauer & Wynaden, 2001). Thus, ethical consideration in qualitative research require attention to the complexity of researching private lives and experiences in a fluid and exploratory manner as well as revealing these accounts in the public arena, that goes beyond application of a theoretical set of rules, principles and guidelines. Richards and Scwartz (2002) suggest that in health research, although the volume of qualitative studies published has increased and the interest for qualitative methods has amplified, the debate around ethical considerations for qualitative research have been lacking. Accounting for the shortcomings of ethical guidelines applied to qualitative research leaves us with ethical reflections based on judgments from philosophical first principles. The next section will discuss some ethical considerations in this study in accordance with different philosophical approaches to ethics.

The ethical issues most relevant for this thesis are to ensure the participants' self-determination and to protect them from harm. In this study, the potential harm in question is psychological and ensuring their self-determination entails to obtain the participants' free and informed consent.

Informed consent and self-determination

Informed consent and self-determination require an assessment and prediction of what harm the participants risk exposure to from the method, and the likelihood of the harm occurring (Orb et al., 2000; Richards & Schwartz, 2002).

Elliot and Guy (1993) found that female psychotherapists reported higher rates of physical abuse, sexual molestation, alcohol and psychiatric problems of parents, death of a family member, and greater family dysfunction in their families of origin than did other professionals. A large study (n=751) in North Carolina investigated the level of distress and impairment among social workers measured by the extent of drug use, depression, and burnout symptoms (Siebert, 2001). Estimated lifetime rates among the social workers were 60% for depression, 75 % for burnout, and 52% reported some professional impairment as a result of their distress. The same study found association between distress and impairment and trauma history. In a Canadian study (Maunder et al., 2010), 176 health care workers reported on experiences of violence, abuse and neglect. Results indicated a prevalence of 68% workers with one or more adverse childhood experiences and 33% of those had adverse experiences before the age of 13. The participants who had experienced childhood violence, abuse, and neglect were significantly more likely to respond to adverse events in adulthood with feelings of anxiety or fear, discouragement or hopelessness, and with feelings of being overwhelmed or helpless. These results are consistent with other research on adverse childhood experiences' correlation with adverse outcomes in adulthood, like the ACE study (Chapman, et al., 2004; Dube et al., 2001). In summation, professionals working with potentially abused children probably have a higher prevalence of self-experienced child abuse than the normal population, thereby increasing the likelihood of emotional reactions during interviews. Perhaps professionals' own trauma history may explain some of their failure to reveal child abuse.

Interview questions exploring challenges the participants experience meeting potentially abused children may cause them to revisit painful experiences from their own past. This may trigger anxiety and distress in the participants if they have trauma experiences not fully integrated and processed (Ford, 1999; Van der Kolk, 2002). Furthermore, when a process of trauma exposure is started, the effects could be irreversible, and persons wishing to return to their prior state of being inattentive to their past experiences may not be able to. Some could experience a psychological reaction that reduce their quality of life and daily function. If so, in addition to being harmed, the participants might also be less proficient in their work helping children than prior to their participation in the study.

In addition to the previously mentioned provision of swift psychological aid if needed, safeguarding ethical viability must also include informed consent from the participants. Hurd (1996) defines consent in terms of rights and obligations defining the boundaries of

permissible actions. The "moral magic of consent", is when researchers rely on the rights conferred to them by the consent without added reflection upon the power and responsibility of the researcher that accompanies this consent. In this project, informed consent may be too easily presumed from our educated participants from a non-clinical population and we risk allocating too much responsibility to the participants.

The NESH-guidelines declare that free and informed consent need to be obtained from the participants of a research project (2006). Informed consent entails understanding all aspects and risks pertaining to participation in the study. The NESH-guidelines states that the researcher shall *ensure that the information is actually understood by those being studied* (NESH p.13). The participants should also receive information about the purpose of the research, giving them the opportunity to rank the possible knowledge gains of the study over risks for personal discomfort in decision making.

A literal interpretation of the guidelines allows us to gain the participants' consent by having them sign a consent form after giving them oral and written information, as done in the present study. However, the issue of informed consent is more complex particularly in qualitative research that values the inductive and interactive nature of the research process, (Richards & Schwartz, 2002). The informed consent was given through a formalized interaction that contrasts with the setting for which it was utilized, and this discrepancy may diminish the validity of the consent. Moreover, as unexpected themes arise during the interviews and the analysis the participants could not be fully informed when consenting (Eisner, 1991).

To better incorporate the complexity of informed consent we could have treated consent as an on-going process throughout the project. However, there are some practical end ethical disadvantages to this that made us choose not to. Practically, it might be time-consuming for both researcher and participant. Ethically, such a dialogue-based approach presupposes ideals of egalitarianism and mutuality of interest that is unlikely (Lincoln, 1990). Also, the participants could be exposed to unwelcomed interpretations of the data material, or they could feel harassed by excessive contact.

A consent is valid when the information is understood by the participant and an informed consent thus permits research with a certain risk for harm or distress. Within the framework of complex trauma however, participants with adverse childhood experiences not fully integrated or processed may not be able to foresee their possible emotional reactions if

sensitive experiences were to surface during the interview. Can we then assume that their consent is informed? Answers to this question would depend on what psychological paradigm one adheres to. The more practical follow-up question is what precautionary measures should be taken. We could have given the participants detailed accounts of the worst-case scenario described earlier to fulfill the criteria of informed consent and disclose all potential risks. Such detailed information could induce expectations and guide the participants' thoughts, thus detracting from the study's results. Furthermore, the participant might not foresee their personal risk regardless of what information they receive. Balancing the consideration for the validity of the research results and for informing the participants of the risks, the participants were informed about risks in general terms.

We have no knowledge of any professionals refusing to partake in the study and no one withdrew their consent during or after the interview. However, most of the participants were asked to participate by their leaders, either in written form or orally. It is therefore reason to suspect that some of them felt obligated to participate in the study. This could limit their availability of a free and uninfluenced consent.

Scientific knowledge versus risk of harm to participants

An important ethical consideration in conducting research is to ensure the research benefits society and culture (NESH). The American Psychological Association (2010) expands on this: *Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society (p.3*), indicating that research on humans must contribute to both psychological knowledge and to human welfare. World Health Organization identify exposure to traumatic events to be one of today's most serious threats to public health. Generating knowledge intended to remedy this situation should thus be both important and beneficial to society and human welfare.

Decisions to perform research must rest on careful consideration of the balance between benefits from the study and potential harm to the participants (Orb et al., 2000; Kvale, 1997). This study was carried out on the premise that the benefits outweigh the potential harm, although that choice represents an ethical dilemma without correct answers or guidelines, and therefore warrants ethical and moral reflection. I will briefly outline this choice with reflections from three major philosophical approaches to ethics within the normative reign; utilitarian perspective, absolutist perspective and virtue ethics (Driver, 2007).

Utilitarianism, also termed a teleological position, accentuates the consequences of an action for the general good; for instance, increased happiness, health, or knowledge. In its extreme version it is a relativist stance where the end justifies the means (Kvale, 1997; Driver, 2007). Weighing the possible beneficial and harmful consequences of this study, the number of people that could benefit from this knowledge, outweigh the risk of harm to a few participants.

In an absolutist ethics of principles, a deontological position, morally good actions are those that live up to principles such as freedom, honesty, and respect without regard for the consequences. In this study the participants were treated with respect and attention by the researcher, they had the freedom to choose their participation and cessation in the project, and their privacy and anonymity was preserved. Perhaps extreme absolutism would disregard the risk of harm to the participants because the researcher adheres to the moral and ethical principles of research and would never intentionally inflict harm. Although one could argue that the researcher's moral responsibility to foresee and protect participants from all potential harm caused the study to not be ethically sound.

In virtue ethics the emphasis is solely on the internalized ethical values of the researcher and the researcher's wisdom and rational skills. Mature ethical behavior and context sensibility is obtained through experience. In this study, we thoughtfully reviewed all issues of research ethics and reflected on our subjective values and intentions to safeguard its ethical quality.

Findings

In paper I we reviewed international, empirical, qualitative research on professionals' experiences exploring child abuse. Papers II and III present findings from our interviews with child protection social workers and child mental health psychologists exploring their experiences of barriers and facilitators to address child abuse respectively.

Paper I

The first paper is titled "Walking children through a minefield: How professionals experience exploring adverse childhood experiences" and presents findings from our analysis of eight qualitative studies of professionals' lived experiences addressing child adversity. The article synthesizes the empirical findings from the selected studies to find overarching meaning and a coherent story from the presented participants' accounts. We developed the metaphor "walking children through a minefield" to convey the participants' struggles exploring abuse with a powerful and telling mental image. Three overarching themes support the metaphor: (1) *feeling inadequate,* (2) *fear of making it worse, and* (3) *facing evil*. The participants felt inadequate and unequipped to address child abuse due to lack of competence, inefficient and/or unsupportive organizational culture, and/or inadequate systemic resources. Metaphorically speaking, their mission was like maneuvering through a minefield without maps or knowledge on where to step safely, and without the ability or training to defuse mines. Moreover, the participants were afraid of leading a child into the minefield and risk stepping on a mine and hurt both the child and them. This refers to their accounts of how they found the unpredictability and lack of control over the outcomes of their efforts to help children highly stressful, and they were afraid of worsening children's situation. Facing the horrors of child abuse induced strong negative emotions in the participants comparable to having to walk through a minefield. Their emotional discomfort therefore generated various forms of avoidance patterns. In conclusion, findings indicate that the professionals' efficiency addressing abuse was contingent on their ability to handle emotional and moral distress, as well as complexity and unpredictability. The paper is published in *Qualitative Health Research.*

PAPER II

Paper II is titled "Plunging into a dark sea of emotions: Professionals' emotional experiences addressing child abuse in interviews with children" and describes the results from the 19 interviews with Norwegian professionals from CPS and CAMHS about their emotional experiences addressing child abuse. As the title indicates, all the participants described intense negative emotional reactions related to addressing abuse in interviews with children, much like plunging into a dark sea of emotions. When exploring the origin of this emotional discomfort, we identified five overarching themes: (1) *facing children's suffering caused by adults,* (2) *feeling mean,* (3) *doubting one's ability and skills,* (4) *feeling that one is betraying children*, and (5) *being obstructed by heavy workload and dysfunctional structure*. The participants empathized with the children and felt distressed when they listened to them share their encounters with abusive adults. Thus, striking a balance between self-protection from over-involvement and empathy with the child was a struggle for many participants. They also wrestled with disbelief and managing to integrate the commonality and brutality of child abuse into their world view. Addressing abuse could inflict pain and hardship upon children and made the participants feel guilty and mean. Their unsolicited questioning produced emotional strain for the child and could place the child in a loyalty conflict with its parents. Moreover, they felt uneasy about exploring abuse before establishing trust with the child, and they were concerned they would cause children new difficulties. Most participants doubted their own performance and ability addressing abuse. Their doubts about assessments and actions performed often instigated rumination combined with shame and guilt, as did intrusive doubt about their own competence. The participants felt they betrayed children when they were unable to protect them or keep their disclosure confidential. Additionally, the participants felt they let children down if they missed abuse and they felt responsible for children's fate. The restraints of their organizational setting were a major stressor for the participants as they felt obstructed by a heavy workload and pressured into work priorities they disagreed with. Even worse was the discouragement and frustration they felt from lacking influence over what happened to the child. In summation, profound emotional distress from facing child abuse and not feeling able help or rather feel obstructed from helping was evident in the participants' experiences. The paper is published in *Qualitative Health Research*.

Paper III

Paper III is titled: "Entering an emotional minefield: Professionals' experiences of facilitators to addressing abuse in child interviews" and presents the results from our interviews with 19 professionals from CPS and CAMHS on their accounts of facilitators for handling the challenges of asking children about abuse. We identified five key themes interpreting the participants' accounts: (1) *alleviate personal choice*, (2) *collective accountability*, (3) *sharing vulnerability*, (4) *finding your own way*, and (5) *doing it for the right reasons*. Most participants found routines, guidelines and assessment tools to facilitate addressing abuse as these could legitimize the inquiry to the child and because their instruction to ask everyone relieved them from assessing which children to ask. Moreover, routines helped them remember to explore abuse. On the downside, routines and assessment tools were not perceived to be important in revealing abuse and some participants even worried they could promote surface routine adherence at the expense of efficient clinical exploration. Discussing interpretations and decisions with other professionals eased the participants' fear of making erroneous calls and made them more confident in the quality of their work. They also found it reassuring that their leaders and co-workers supervised their work and thus shared responsibility for the outcomes. All participants found emotional support necessary to cope with their work with child abuse. They emphasized the importance of openness about personal vulnerability at the workplace and to have access to collegial support to handle difficult emotions when needed. In addition, the participants wanted their co-workers to recognize their worth as professionals and to monitor their well-being. The participants shared that finding their own way of addressing abuse took courage, practice and reflective experience. Their recipe for mastery was relentless effort and tailored improvement through self-analysis, reflection and feedback. All participants perceived their work as meaningful and they stressed the importance of believing they could make a difference for abused children. When they felt assured their actions were in sync with their moral and values it increased their stress-tolerance and strengthened their self-respect. The findings indicate that efforts to help professionals handle the challenges of addressing child abuse should apply reflective practice with performance feedback and endorse openness on personal vulnerability. Moreover, we should promote autonomy and compatibility with personal values as well as encourage development of individual style and volition. The paper is published in *BMC Health Services Research*.

DISCUSSION

WALKING CHILDREN THROUGH A MINEFIELD

In our metasynthesis of international research on professionals' experiences addressing abuse in child interviews, we developed the metaphor "walking children through a minefield" to promote an understanding of how the participants felt and emphasize the gravity, emotionality and unpredictability of their experiences (paper I). Our analysis of Norwegian professionals' perceived barriers and facilitators exploring child abuse supported and completed these findings (papers II and III). In the next section, all the findings from all three papers are merged and elaborated within the terminology of the metaphor.

All participants in papers I-III shared how they reacted with strong negative emotions when they encountered potential or revealed child abuse. To address child abuse induced emotional strain in the same manner as the idea of walking a child into a minefield. They were apprehensive about being hurt or risk the child becoming injured without being able to protect her. Subsequently the participants were prone to avoidance which could be detrimental to their work exploring abuse (paper I and II). To counteract their fear and avoidance, the participants shared that courage and practice could increase their skills and their ability to handle the emotional strain (paper III). In addition, recognizing that their goal was to help and protect children in need made walking through the minefield worth the risk (paper III).

Like walking a child through a minefield, all the participants (papers I-III) found addressing child abuse to be extremely difficult and they sometimes felt it surpassed their competence and resources. They shared feeling inadequate and that they often doubted themselves and their appraisals, decisions and actions in correspondence with previous research (Lines, Hutton & Grant, 2016; Uldum et al., 2017). In the Norwegian sample (paper II) it was evident that the participants often took these doubts home with them as rumination and haunting memories of children they had encountered at work, and these thoughts were accompanied by feelings of shame, guilt and sadness. They were questioning whether detonated mines could have been avoided, whether they had left a child alone in a minefield, or whether they had failed to lead a child in need to safety. When feelings of inadequacy and shame struck, it could be difficult for the participants to approach others for support due to perceived inferiority. To them, their colleagues may have seemed to be more in control and more

successful in guiding children through the minefield. To overcome, they found it helpful to share their vulnerability with others because then they realized how this was a familiar struggle and not just their own personal shortcoming (paper III). Venturing into the minefield became somewhat easier if they thought nobody were faultless or always confident in performing these tasks. Thus, our participants found sharing vulnerability and receiving emotional support from colleagues and partners helpful to relieve difficult emotions, and many of them requested more openness about difficult issues in their workplace (paper III). Moreover, they found it strengthened their confidence when colleagues recognized their worth as professionals and told them; "you *know* this". Discussions with colleagues could also help relieve the participants' constant doubts regarding their appraisals and decisions, a finding in accordance with other research stressing the importance of discussing suspicions with colleagues (Dahlbo et al., 2017; Saltmarsch & Wilson, 2016).

All the participants (paper I – III) cared for their small clients and felt responsible for walking them to safety across the minefield. Because of this involvement, the participants found it upsetting when they were unable to assist a child, or they felt they made matters worse. Similar to watching the child meet the minefield's perils alone, or to cause a mine to go off and injure the child. It seemed like the participants' ideal scenario would be to first build a trusting relationship with a child that encouraged the child to disclose abuse of their own volition, and thereafter stop the abuse and establish a safe home environment for the child. They wished to be there for the child and offer security and support throughout the whole process. This rarely or never happened. Most times the children were unwilling to disclose abuse and even asking about it could cause them distress and induce a loyalty conflict with their parents. This is in agreement with previous research on child abuse disclosure (Alaggia, Collins-Vezina & Lateef, 2019; McElvaney, 2015). In both our studies participants found it difficult to address abuse when they had insufficient time to build and continue a trusting relationship with the child. Other studies have revealed that children need relational support from adults to disclose abuse, thus supporting the participants' notion that they should build a trusting relationship with the child before addressing abuse (Flåm & Haugstvedt, 2013; LeMaigre et al., 2017). The participants (paper II) wanted the child to feel secure and willing to open up, and they felt like strangers intruding with unwanted questions when they lacked the child's trust. Many shared they felt untrustworthy and mean inflicting emotional strain and hardship upon children. The participants thought asking a child about abuse was an invitation to help, and if the child responded with disclosure, they felt obligated to improve

the child's situation. Failure to help children who had trusted them with their painful stories made the participants feel guilty and deceitful. They felt like the child had reached out its hand to them and asked for help maneuvering through the minefield and after starting the walk together they had to leave the child in a worse place than before. Other studies have revealed similar emotional strain occurring when a person is hindered from doing what feels morally appropriate and labelled it *moral distress* (Mänttäri-van der Kuip, 2016; Trotochaud, Coleman, Krawiecki & McCracken, 2015).

A major struggle for the participants was their fear of being left alone with a child in an exploding minefield (paper I-II). When they believed they lacked support from their leaders and their organization to prioritize addressing abuse, or even felt pressured to focus on lesser important tasks, abuse exploration became more stressful and difficult. Thus, the participants followed rules and guidelines they believed were inefficient and often unnecessary. Although they knew that no maps or methods existed to guide them safely through the minefield, they felt pressured to study both the assigned maps and adhere to the decided methods in fear of being left to fend for themselves in a crisis if they did not follow the collective brief. Discussing matters with co-workers, being supervised by their leader, following rules and guidelines, and keeping deadlines alleviated their fear and insecurity. The reason for this appeared to be that in case they should be caught amidst exploding mines their previous compliance increased their chances of being rescued by their leaders and colleagues.

PAINFUL TO FACE ADULTS' ATROCITIES TOWARDS CHILDREN

Concurrent findings from this thesis' studies reveal how distressing it is for professionals to relate to violence and abuse committed by adults towards children. There seems to be something profoundly anxiety evoking about facing actions where adults choose to harm innocent and defenseless children, especially when the adults are the ones who are supposed to protect them. This challenge emerged as a theme named "facing evil" in paper I and an equivalent challenge was revealed among our Norwegian participants and further developed into the theme called "facing children's suffering caused by adults" in paper II.

The emotional strain of facing adult's atrocities towards children could also be in effect among researchers. A surprising discovery in the literature search for paper I, was the minimal amount of qualitative research available regarding how professionals experience addressing or exploring child abuse. Initially, the plan was to include only studies researching the experiences of child psychologists and CPS-workers. Moreover, if possible, the search

could be further narrowed to only include studies on professionals' experienced individual challenges. However, the literature search yielded only one study of CPS-workers and no studies of child psychologists. Thus, we had to widen the inclusion criteria and embrace studies with participants who were both school nurses, counsellors, nurses and physicians, and include all types of challenges to reach an acceptable number of studies (that is eight). On a meta-level the apparent lack of research interest and activity on this subject mirror the avoidance and discomfort we found among the participants in our studies. Perhaps researching how professionals feel when they face potential child abuse is so uncomfortable that most researchers choose not to.

In Taylor's (1989) theory being forced to orient ourselves towards atrocities challenges our identity formation as we must weave good into our personal narratives to see ourselves as good and make sense of our lives. Being pressured to focus on atrocities instead of the good would therefore be stressful for professionals and challenge both their identity of being a good person and their perception of life as meaningful. The participants did share that exploring child abuse evoked emotional discomfort. However, most of them also reported that they found their work meaningful and worthwhile, thus making sense in their lives. Perhaps working with child abuse entail both dimensions; purposeful and affirming involvement as well as anxiety evoking and stressful involvement. This is exactly what Orlinsky and Rønnestad (2005) found in an international study of therapist development. They revealed that these positive and negative dimensions were largely independent of each other. Thus reinforcing our finding where the participants described facilitating aspects that helped them deal with stress and negative emotions, while they also described facilitators that helped them because they confirmed their work as meaningful and worthwhile.

Needing to belong – fear of exclusion

Our findings reveal how addressing abuse induces strong emotional discomfort in professionals. Looking into some of the themes elaborating this discomfort, an interesting feature is that many themes seem to revolve around individual aspects where the participants worry about falling short as a professional either due to self-perceived inadequacy or to an inability to predict and control outcomes. The origin of this emotional strain can be interpreted as fear of being excluded from the group or of becoming devalued as a professional. In the theme "feeling inadequate" from paper I the participants' expressed doubt about their competence, skills, and ability to make a positive change for the children. A

similar concern is addressed in the themes in paper II; “doubting one’s ability and skills” and “feeling mean”, where the participants feared their lack of proficiency would inflict hardship upon the children and reduce their efficiency in improving the children’s lives. Their feelings of inadequacy seemed to originate from a comparison between themselves and other factual or imagined professionals. Feeling less able than their colleagues and not finding themselves accomplishing what they believed was the right thing to do caused the participants to feel ashamed and guilty. Both shame and guilt are “social emotions” in that they are evoked by perceptions of not meeting the expectations and standards of the group (Tignor & Colvin, 2017). The participants could feel like outsiders when they thought they were below par, and fearful of being excluded should their inadequacies be revealed. In contrast, among the themes revealing what the participants found helpful to cope with emotional strain, many of these involved receiving support from others, either as emotional support, decision-making assistance, shared responsibility, or common guidelines for action. Thus, our participants seemed to seek belongingness to the group and acceptance from others to cope with emotional strain. In paper III the themes “collective accountability”, “alleviate personal choice” and “sharing vulnerability” describe different ways the participants pursued group support when they felt excluded or were afraid of being devalued. This is in concurrence with research on workplace belongingness where feeling valued at work seem to have a positive impact on professionals’ quality of life. Workplace belongingness has been shown to promote positive outcomes like a sense of achievement, joy in their job, and resilience, while also protecting health workers from burnout and reducing their distress levels (Shakespeare-Finch & Daley, 2017; Somoray, Shakespeare-Finch & Armstrong, 2017).

Exclusion is linked to a number of dysfunctional reactions including depression and anxiety, lowered self-esteem, self-defeating perceptions and behaviors, and withdrawal (Hutchison, Abrams & Christian, 2007). The more adaptive responses to exclusion include trying to engage with the majority group or conform more strongly to dominant norms. Feeling excluded and/or fearful of being exposed as incompetent may prevent participants from seeking help and support from their colleagues. When people feel excluded, they are more likely to feel depressed and have low self-esteem, and thereby lack the confidence and motivation to seek social relationships and inclusion. Their own perceived deficiencies can thus attribute to a self-perpetuating process of exclusion (Mendoza-Denton, Downey, Purdie, Davis & Pietrzak, 2002; Hortulanus, Machielse & Meeuwesen, 2006). This point to the importance of an open and supportive organizational culture that can alleviate professionals’

feelings of exclusion and inferiority. Moreover, experiences of inclusion have been shown to ameliorate the aversive consequences of exclusion even if the inclusion is provided by a different party than the exclusion (Tang & Richardson, 2013).

Is it all about recognition?

To develop a deeper understanding of the participants' experiences one could explore them within the philosophical framework of Axel Honneth (1995) who claims that as humans we can only become ourselves through being recognized by others. Thus, our social relationships are vital for developing and maintaining our identity and our sense of self-worth. Honneth describes identity as three modes of relating to oneself; self-confidence, self-respect and self-esteem, and contends that these attitudes towards oneself emerges from encountering others' reactions to oneself. I will discuss this thesis' findings in relation to Honneth's three types of recognition that correspond to the three modes of relating to oneself: *love* and self-confidence, *rights* and self-respect, and *solidarity* and self-esteem.

Recognition in the form of love and concern in close mutual relationships is fundamental for developing self-confidence. Honneth (1995) describes this self-confidence as an embodied fundamental faith in our environment comparable to Giddens' (1990) "ontological security", and he argues that the capacity to recognize and assert our needs is also a part of our self-confidence. Recognition as love is part of our existential needs and that makes threats to our fundamental faith highly stressful. Honneth believed disrespect in the form of physical abuse was the opposing force to love recognition and he thought it would cause *psychological death*. With this metaphor he demonstrated his point of view that severe disrespect can cause fragmentation of the identity and deterioration of the human mind to the extent that is comparable to being psychologically dead. When our participants struggled with emotionally relating to the existence of child abuse and child molesters, this can be explained as them being challenged on an existential level where they were at risk of losing basic self-confidence. Accepting the evils of their surroundings into their world view could mean altering a positive and fundamental faith in their social world. Recognition as love includes having mutual trusting relationships with others. The participants felt responsible for offering the children love and concern and build trusting relationships with them. However, when they felt untrustworthy, mean, and deceitful in their encounters with the children their self-confidence was shaken. All of the participants interviewed stressed the importance of receiving emotional support from people they were close to; most highlighted their

colleagues while a few stressed their life partners were vital sources of support. Our finding that the participants felt sharing their vulnerability with others was helpful seem interesting because Honneth defines the ability to recognize and assert our needs essential to our self-confidence. Most of the participants said they wished for more openness about difficult issues among their colleagues. That can be interpreted as a need for recognition as love and concern and as a need for assistance in recognizing and asserting their needs. This was also evident in the participants' desire for their co-workers' validation and in their request for colleagues who were attentive to their well-being.

Recognition as rights lead to self-respect and is formed both by being accorded recognition as an autonomous individual, and by being a morally responsible agent oneself. When we uphold our responsibility and accountability towards promoting the dignity of others, we achieve self-respect. Honneth (1995) believed the opposing disrespect to rights recognition was denigration with the consequence of social death, whereas a person loses the capacity to integrate into society. The participants felt uncomfortable suspecting adults of child abuse as they would then denigrate others and could subsequently feel morally inadequate themselves. When we fail to act morally responsible our self-respect is threatened. For instance, treating children as means rather than ends in themselves challenged the participants and was apparent in their frustration towards being pressured to make faulty priorities and to follow other objectives than the child's wishes. Schwartz (2011) connects being morally responsible to practical wisdom or competence in relational work. He argues that both moral will and moral skill, the components of practical wisdom, can never be reached through external regulations and he warns about the potential for demoralization of moral will and erosion of moral skill if professionals are forced to adhere to rules, guidelines and incentives. Uncertainty paired with responsibility was a challenge for the participants in our study and they reported feeling distressed when they risked worsening the child's situation. However, they could improve self-respect if they felt convinced that they were acting for the right reasons. That is, if the participants felt assured their actions were aimed at improving the child's situation, they could justify opposing the child's wishes. This assurance could also be helped along by discussing difficult calls with others.

Recognition as solidarity promotes self-esteem and Honneth (1995) explains self-esteem as a sense of being unique and that this uniqueness is positive and valuable to others. This entail that as members of society, we should use our individual abilities to contribute to the common good and have our contributions recognized in a way that affirms our self-

evaluation. Disrespect to solidarity recognition comes in the form of degradation and leaves victims with psycho-social scars. A protruding difficulty among the participants was their self-doubt and feelings of inadequacy. In accordance with Honneth's (1995) link between individuality and self-esteem, the participants were attentive towards individual differences in competence or talent among the professionals and when they felt they were not valuable, or they failed to contribute to the good of others they were filled with self-doubt. Many participants solicited feedback after their involvement in cases and some shared how positive outcomes became a driving force for them to continue their work. Moreover, the participants shared that it was necessary to find their own individual way of doing things through practice and feedback to master the challenges of addressing child abuse. This could be linked to studies of work authenticity, where people who perceive that their work is in concurrence with their values and needs report higher well-being at work, and workers who lack work-authenticity are more prone to negative states like burnout (Van den Bosch, Taris, Schaufaeli, Peeters & Reijseger, 2018). Finally, the belief that they could make a valuable contribution to children's lives increased the participants' willingness to endure emotional strain.

Implications for practice and research

In order to enable professionals to handle uncertainty and emotional strain we should tailor organizational contexts by adapting the organizational discourse and the allocation of resources, roles and responsibilities (Meyers, Durlak & Wandersman, 2012). This concur with our finding that the organizational discourse must be clearly goal-directed towards addressing and working with child abuse and organizations need to recognize challenging issues openly. Edmonson (2004) introduces the concept of psychological safety in organizations as a measure of how threatening or rewarding it is to take interpersonal risks at work. Psychological safety differs from *trust* in that people on the same team usually have the same perception of it. In accordance with our findings, psychological safety is promoted by role clarity, peer support, interdependence, learning orientation and positive leader relations (Frazier, Fainsmitdt, Klinger, Pezeshkan & Vracheva, 2017). The benefits of high psychological safety are improved performance, engagement, productive learning behaviors and job satisfaction (Frazier et al., 2017). Interestingly, Edmondson (1999) claimed that accountability for meeting demanding goals interact with psychological safety to determine performance outcome: Low psychological safety and low accountability for meeting demanding goals would induce apathy among professionals, mirroring the hopelessness and

disempowerment we revealed in our findings. Low psychological safety and high accountability for meeting demanding goals lead to an anxiety-prone culture, where people are afraid of doing something wrong and of asking colleagues for help. In our findings this version often seemed to be present in our participants' workplace. High psychological safety and low accountability causes a comfort zone with little effort or learning. In our findings we did not see any resemblance of this culture. High psychological safety paired with high accountability for meeting demanding goals is the ideal combination leading to collaboration, learning and high-performance outcomes (Frazier et al., 2017). This should be the aim for the services and teams working with abused children. In light of our findings, it appears that raising psychological safety remains the biggest challenge for these services.

Another significant finding from our Norwegian CPS-participants was how the services seemed to fail in optimizing their allocation of personnel resources. From our data we revealed that the cases involving exposed child abuse were referred to as the "heavy", "tough" or most "taxing" cases even if they were *not* the cases the participants thought induced the most emotional strain. This inaccurate labeling led them to assign the most resilient, competent and experienced professionals to these so-called "heavy" cases, whereas the unexposed cases that possibly implicated acute trauma intervention were given to less robust and less experienced professionals. Thus, the services did not assign the most resourceful professionals to the most challenging and uncertain cases. Perhaps this is a contributing factor to their inefficiency in revealing child abuse given the high level of dialogical sensitivity and trust-building skills required to help children disclose (Flåm & Haugstvedt, 2013; Lemaigre et al., 2017; McElvaney et al., 2014).

Our findings indicate that the participants' principal challenge with addressing abuse originates from the disproportionate and stressful relationship between their perceived responsibility for the well-being of the children they ask about abuse and their inability to control and predict the subsequent turn of events. Some of them explicitly said their inability to control or intervene in cases of suspected abuse was worse than relating to abused children. Consequently, the participants described feeling inadequate, mean, deceitful, treacherous, afraid of worsening matters for the child, powerless, and frustrated. Moreover, when they felt overwhelmed by doubt and dilemmas, it could lead to discouragement and even inaction. These findings are in accordance with Hood's (2014) study on how practitioners experience complexity in child protective work whereas their main issues were difficulties predicting cause and effect and lacking control over events. A complex system has many agents or

factors that interact with each other in a variety of ways and self-organize into patterns with low predictability (Snowden & Boone, 2007). This is also referred to as *causal complexity*. Hood (2014) argues that causal complexity is further complicated by *social* complexity because we have no direct access to the events in complex systems. Rather we interpret events, relations and other agents based on our preconceptions and our relations, or a "double hermeneutics" of interpreting other agents' interpretations (Danermark, 2002). Complex situations lack linear relationships between cause and effect and are therefore unfit to be handled with best practice or guidelines. However, Snowden (2002) argues that complex situations differ in degree of unpredictability and that they can appear chaotic when no patterns are detectable. Perhaps our participants experienced the uncertain cases of unexposed abuse as more taxing because they were more complex or maybe even chaotic in nature. Situations with revealed abuse were more governed by rules, guidelines and other services than cases with mere suspicion. Moreover, the participants' fear of worsening the child's situation lessened if they became convinced the child suffered in the home and was in need of help, as did the degree of chaos. So, even if the so-called heavy abuse cases were described as taxing because of lots of work and many involved parties, these cases may have caused the participants less emotional discomfort due to a conviction that they were doing the right thing.

A dissemination of the findings has already been presented, both as a popularized version of paper I in Norwegian published online, and through lectures and seminars with professionals. In addition, other lecturers have used these findings in their competence development efforts. Responses from professionals indicate that this research has been helpful and empowering for them because they feel their challenges are being openly stated, recognized, and understood. This contrasts with many other efforts to improve addressing, detection and reporting of child abuse, where the desired actions have been presented as simple and straight forward.

An interesting next step would be to research the prevalence of our findings in a larger sample in order to be able to generalize to a larger population. Moreover, translating the findings into a competence development program would be interesting both to implement and to follow with some form of evaluative research.

Strengths and limitations

Credibility can be discussed with reference to the philosophy of science stance guiding the research and researchers in contrast to the stance implicit to the research venue. An

interesting discovery in the metasynthesis was how the participants explained their struggles with the theme "feeling inadequate" referring to mostly instrumental and often organizational aspects, including guidelines, workload, role clarity, time, support measures, efficient CPS, but also competence and knowledge. Their suggested remedies for their hardship were mostly systemic external aspects like the ones mentioned above. However, the participants themselves did not verbalize the themes "facing evil" and "fear of making it worse" as causes of their difficulties, nor did they solicit help to regulate emotional distress or increase their ability to handle dilemmas and uncertainty. A similar discrepancy was apparent in the second article exploring participants' experiences of emotional strain addressing child abuse. They labelled the cases involving revealed abuse to be "tough" or "heavy" or most "taxing" due to the amounts of work accompanying these and the stress of listening to children's stories. While the participants shared that the unexposed cases filled with uncertainty were actually the ones causing them most emotional strain. In the third article about facilitators for addressing child abuse, most participants found assessment tools, routines and guidelines helpful and many solicited more and improved guidelines and tools. At the same time, many of them said they did not think assessment tools and guidelines were important in revealing abuse. Together, these findings could indicate that the participants were influenced by a positivist mindset when explaining the causes for their struggles and their requested solutions. Searching for standardized methods and best practice is closely linked to a positivist view that best practice exists and can be discovered. If the participants and their workplace surroundings are dominated by such a mindset, our hermeneutic phenomenological study could present a philosophy of science dilemma that also manifests as a methodological challenge. Can a hermeneutic phenomenological study of positivist settings be trustworthy and offer credibility? Professionals or leaders from CPS or CAMHS seem to seldom or never request qualitative research that can inform and improve their practice. Nevertheless, this fact may be better explained by their habitual practice on what research they usually utilize and commission than their lack of need for or the lack of usefulness of such research. Moreover, when we analyzed our participants' responses, they all recognized the complexity and unruliness of their work, thus in essence acknowledging the need for qualitative knowledge.

We have tried to ensure transferability by providing enough information about the research process and the participants for the readers to infer the findings' applicability to other settings. To allow readers to follow our process, we have shown how our themes were

generated by presenting quotations from our interviews for paper II and III, and from the original studies in paper I. The transparency of our data analysis invites the audience to judge for themselves the logic and coherence between our research process, our data material and our interpretations (Binder et al., 2012). Another strengthening element to the transferability of our findings is how our Norwegian results in paper II and III correspond with the results from international studies in paper I. We could perhaps have strengthened our findings further by conducting a second interview or a focus group interview with the participants from paper II and III to check how our findings resonate with their intended meaning.

In paper I, we synthesized international peer-reviewed qualitative studies with a meta-ethnographic approach. As we excluded articles of poor quality and dissertations, we ended up with eight studies. The fact that these studies originated from four different countries and involved participants with varied professions, roles, educational level, and experience strengthen the transferability of our findings. However, the rather small number of studies and the fact that we would have preferred some of the included articles to be of higher quality could be a limitation. A new metasynthesis including articles and/or dissertations from an updated literature search would perhaps lead to different insights.

Having our Norwegian participants vary on demographic variables and recruiting them from two different services allows for more transferable rigor. Within the two samples, we tried to maximize the range and variety of the participants' lived experiences addressing abuse by recruiting participants who varied in age and work experience, were from different geographical locations and worked in organizations of various sizes. Varying the gender distribution, however, was difficult. Our sample include only two male CPS workers and one male CAMHS worker. This reflects the traditional gender unbalance within health and social services, and the scarcity of men in the workplaces that we contacted (Johansen, 2014). Because a preliminary analysis revealed no apparent gender differences, we did not expand our recruitment to balance the gender distribution. However, other research indicates possible differences in role salience and work participation between men and women (Carr, 2002; Ghislieri, Gatti, Molino & Cortese, 2017), thus it could be interesting to investigate whether there are gender differences in how professionals experience abuse exploration.

The findings in paper II and III, are solely based on information from two groups of employees. We chose to include only workers from CAMHS and CPS, and in the sample from CAMHS we selected only psychologists. We made this decision although there is

reason to assume that the difficulties adults experience addressing abuse in child interviews are mostly universal. From our work experience in various types of services, all professionals seem to find abuse exploration challenging and they often claim it is due to their lack of education, knowledge, competence and training. As this is already familiar knowledge, we set out to reveal more about the challenges and facilitators professionals experience addressing abuse. Thus, in order to minimize the focus on lack of education, we opted for a sample of participants with education, training and experience in dealing with child abuse, in addition to knowledge about the prevalence and the harmful effects of child abuse. The fact that paper II and III studies the experiences of professionals qualified to address child abuse and the barriers they struggle with, makes it likely the results can be transferred to professionals less educated in child abuse. This because although professionals like schoolteachers and school nurses may be even more focused on their perceived lack of knowledge and qualifications for addressing child abuse than our sample, they probably share our sample's experienced additional barriers. However, had we chosen a different sample and included participants with less education, knowledge and experience on child abuse or included their leaders we could have revealed other challenges. Other potentially interesting sources of information on professionals' barriers and facilitators exploring child abuse include service users' perspective, ethnographic studies and participatory action research within the services, and comparing client self-report surveys of abuse disclosure with employee accounts.

To increase dependability and transparency we shared the search strategy and all the decisions made in the process of selecting the included articles in paper I, and we outlined the steps taken in the analysis. In paper II and III we explain in detail how the study was conducted for the readers to evaluate whether our conclusions seem reasonable given the context. Our interviews were audiotaped and transcribed verbatim to ensure the intended meaning was preserved, and all researchers read all transcripts in full to ensure the participants' voices were in the forefront of our analysis. Additionally, all decisions and interpretations during the study were discussed jointly among the researchers to safeguard quality and dependability.

All interviews for papers II and III were conducted at the participants' place of work except for one interview that was performed in the participant's private practice home office. The reason for this was to increase the response rate as participation at their workplace would require less time investment and no travel expenses for the participants as opposed to them travelling to my place of work. It is difficult to ascertain how and if this affected the

responses from the participants. All the CPS workers were interviewed in a meeting room at their service and most of them complained about their lack of rooms to meet with children and families as well as sharing their dissatisfaction with how the rooms were ill fitted to make children feel welcome and secure. The CAMHS participants all met in their office where they usually consulted with clients and they did not complain about spatial facilities or lack thereof. In all the interviews we talked uninterrupted and were not disturbed by any noise. Naturally, there is a chance that the participants would have been more open and carefree in their accounts had they not been at their workplace. Although, as all of them shared personal hardships and difficult emotional experiences with me and most participants also verbalized system and organizational critique their potential social desirability bias was not overpowering.

Although I had no relation to the participants, my employment at RVTS South and my research project could position me in an expert role from the participants' viewpoint, and the potential influence of that is worth considering. When interviewing the CPS-workers, they did not appear to feel threatened by any means, which could reasonably be explained by their experiences of seeking counseling and advice from other psychologists causing them to not see themselves in a unilateral position where they had to compete. Interviewing the CAMHS-workers was however somewhat different. These participants were employees with the highest level of education at their workplace and they had guidance and supervision responsibilities for co-workers with lower education, thus being local "experts" themselves. In some of these interviews I perceived some initial reluctance from the participants towards revealing their shortcomings and insecurities. Fortunately, this seemed to be a temporary effect as these participants revealed more vulnerability further into the interview. Still, there is a chance that valuable information was lost in some of these interviews regarding their insecurities, shortcomings and barriers. A surprising element, however, was the number of participants who thanked me for helping them gain new insight into themselves and their work through the interview. One of them even suggested to arrange interviews as an intervention to increase professionals' awareness and efficiency in exploring child abuse.

CONCLUSIONS

Our findings propose a need to change the way services for abused children are organized, both because the services seem to be unfit to fulfill the needs of exposed children and because professionals feel the system obstructs them from doing a good job. When services are

adapted to meet children's need for safety and stable relationships, we should endorse an open and supportive organizational culture. To aid professionals' relatedness and emotion regulation, our results suggest that shared vulnerability with colleagues will be helpful. Furthermore, there is reason to believe that to develop personal competence we should promote individual choice and volition, and decrease demands towards following rules and guidelines. We recommend promoting professionals' autonomy by highlighting the meaningfulness of their work and help professionals become aware of their work's compatibility with their personal values.

To improve professionals' skills when handling the challenges associated with exploring child abuse, we recommend goal-directed reflective practice combined with feedback on performance. Moreover, this study suggests that awareness of and training in handling complexity and chaos, as well as learning adaptive emotion regulation strategies would be beneficial. Interventions for improving professionals' relationship-building and communication skills may boost their confidence in addressing sensitive issues with children.

REFERENCES

Alaggia, R., Collin-Vezina, D., & Lateef, R. (2019). Facilitators and Barriers to Child Sexual Abuse (CSA) Disclosures: A Research Update (2000-2016). *Trauma Violence Abuse, 20*(2), 260-283. doi:10.1177/1524838017697312

Albaek, A. U., Binder, P. E., & Milde, A. M. (2019). Entering an emotional minefield: professionals' experiences with facilitators to address abuse in child interviews. *BMC Health Serv Res, 19*(1), 302. doi:10.1186/s12913-019-4128-8

Albaek, A. U., Binder, P.-E., & Milde, A. M. Plunging Into a Dark Sea of Emotions: Professionals' Emotional Experiences Addressing Child Abuse in Interviews With Children. *Qualitative Health Research, 0*(0), 1049732318825145. doi:10.1177/1049732318825145

Albaek, A. U., Kinn, L. G., & Milde, A. M. (2018). Walking children through a minefield: How professionals experience exploring adverse childhood experiences. *Qualitative Health Research, 28*(2), 231-244. doi:10.1177/1049732317734828

Al-Dabaan, R., Newton, J. T., & Asimakopoulou, K. (2014). Knowledge, attitudes, and experience of dentists living in Saudi Arabia toward child abuse and neglect. *Saudi Dent J, 26*(3), 79-87. doi:10.1016/j.sdentj.2014.03.008

Alvesson, M. S., K. (2009). *Reflexive Methodology. New Vistas for Qualitative Research*. London: Sage.

Andrews, T., Lindelov, B. & Gustavsen, A. (2015). *Interkommunalt samarbeid om barnevern i Norge*.

American Psychological Association., A.P.A (2010). *Ethical Principles of Psychologists and Code of Conduct*.

Beauchamp, T. L., & Childress, J. F. (1989). *Principles of biomedical ethics*. New York: Oxford University Press.

Berens, A. E., Jensen, S. K. G., & Nelson, C. A., 3rd. (2017). Biological embedding of childhood adversity: from physiological mechanisms to clinical implications. *BMC Med, 15*(1), 135. doi:10.1186/s12916-017-0895-4

Binder, P.-E., Holgersen, H., & Moltu, C. (2012). Staying close and reflexive: An explorative and reflexive approach to qualitative research on psychotherapy. *Nordic Psychology, 64*(2), 103-117. doi:10.1080/19012276.2012.726815

Blount, R. L., Simons, L. E., Devine, K. A., Jaaniste, T., Cohen, L. L., Chambers, C. T., & Hayutin, L. G. (2008). Evidence-based assessment of coping and stress in pediatric psychology. *J Pediatr Psychol, 33*(9), 1021-1045. doi:10.1093/jpepsy/jsm071

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research, 8*(1), 137-152. doi:10.1177/1468794107085301

Campbell, K. A., Olson, L. M., Keenan, H. T., & Morrow, S. L. (2017). What Happened Next: Interviews With Mothers After a Finding of Child Maltreatment in the Household. *Qual Health Res, 27*(2), 155-169. doi:10.1177/1049732315625197

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., . . . Donovan, J. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technol Assess, 15*(43), 1-164. doi:10.3310/hta15430

Carr, D. (2002). The Psychological Consequences of Work-Family Trade-Offs for Three Cohorts of Men and Women. *Social Psychology Quarterly, 65*(2), 103-124. doi:10.2307/3090096

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *J Affect Disord, 82*(2), 217-225. doi:10.1016/j.jad.2003.12.013

Collin-Vézina, D., De La Sablonnière-Griffin, M., Palmer, A. M., & Milne, L. (2015). A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse & Neglect, 43*, 123-134. doi:https://doi.org/10.1016/j.chiabu.2015.03.010

Creswell, J. W. (1998). *Qualitative Inquiry and Research Design*. CA: Sage.

Dahlbo, M., Jakobsson, L., & Lundqvist, P. (2017). Keeping the child in focus while supporting the family: Swedish child healthcare nurses experiences of encountering families where child maltreatment is present or suspected. *J Child Health Care, 21*(1), 103-111. doi:10.1177/1367493516686200

Danermark, B. (2002). *Explaining Society Critical Realism in the Social Sciences*.

De Bellis, M. D., & Zisk, A. (2014). The biological effects of childhood trauma. *Child Adolesc Psychiatr Clin N Am, 23*(2), 185-222, vii. doi:10.1016/j.chc.2014.01.002

Denzin, N. K. G., M. D. (2007). *Ethical Futures in Qualitative Research: Decolonizing the Politics of Knowledge*. New York: Left COast Press.

Driver, J. (2006). *Ethics: The Fundamentals*: Wiley-Blackwell.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *Jama, 286*(24), 3089-3096.

Edmondson, A. C. (2004). Psychological Safety, Trust, and Learning in Organizations: A Group-Level Lens *Trust and distrust in organizations: Dilemmas and approaches.* (pp. 239-272). New York, NY, US: Russell Sage Foundation.

Eisner, E. W. (1991). *The Enlightened Eye: Qualitative Inquiry and the Enhancement of Educational Practices*. Toronto: Pearson.

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice, 24*(1), 83-90. doi:10.1037/0735-7028.24.1.83

Felitti, V. J. (2002). The Relation Between Adverse Childhood Experiences and Adult Health: Turning Gold into Lead. *The Permanente journal, 6*(1), 44-47.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med, 14*(4), 245-258.

Finkelhor, D. (2018). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse Negl, 85*, 174-179. doi:10.1016/j.chiabu.2017.07.016

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2013). Improving the adverse childhood experiences study scale. *JAMA Pediatr, 167*(1), 70-75. doi:10.1001/jamapediatrics.2013.420

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2*(2), 209-230. doi:10.1177/146879410200200205

Finlay, L. (2006). 'Rigour', 'Ethical Integrity' or 'Artistry'? Reflexively Reviewing Criteria for Evaluating Qualitative Research. *British Journal of Occupational Therapy, 69*(7), 319-326. doi:10.1177/030802260606900704

Finlay, L. (2012). Debating Phenomenological Methods. In N. Friesen, C. Henriksson, & T. Saevi (Eds.), *Hermeneutic Phenomenology in Education: Method and Practice* (pp. 17-37). Rotterdam: SensePublishers.

Finlay, L. G., B. (2003). *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. Great Britain: Wiley-Blackwell.

Flåm, A. M., & Haugstvedt, E. (2013). Test balloons? Small signs of big events: A qualitative study on circumstances facilitating adults' awareness of children's first signs of sexual abuse. *Child Abuse & Neglect, 37*(9), 633-642. doi:https://doi.org/10.1016/j.chiabu.2013.06.007

Ford, J. D. (1999). Disorders of extreme stress following war-zone military trauma: associated features of posttraumatic stress disorder or comorbid but distinct syndromes? *J Consult Clin Psychol, 67*(1), 3-12.

Fosse, R. (2009). Ingen gener for psykiske lidelser. *Tidsskrift for Norsk psykologforening, 46*(6), 596-600.

Foster, R. H., Olson-Dorff, D., Reiland, H. M., & Budzak-Garza, A. (2017). Commitment, confidence, and concerns: Assessing health care professionals' child maltreatment reporting attitudes. *Child Abuse Negl, 67*, 54-63. doi:10.1016/j.chiabu.2017.01.024

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A. S., . . . Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical Research Methodology, 19*(1), 35. doi:10.1186/s12874-019-0670-7

Frazier, M. L., Fainshmidt, S., Klinger, R. L., Pezeshkan, A., & Vracheva, V. (2017). Psychological Safety: A Meta-Analytic Review and Extension. *Personnel Psychology, 70*(1), 113-165. doi:10.1111/peps.12183

Gadamer, H. G. (1960/2004). *Truth and method*. New York: Continuum International Publishing Group.

Gergen, K. J. (1999). *An invitation to social constructionism*. London: Sage.

Ghislieri, C., Gatti, P., Molino, M., & Cortese, C. G. (2017). Work–family conflict and enrichment in nurses: between job demands, perceived organisational support and work–family backlash. *Journal of Nursing Management, 25*(1), 65-75. doi:10.1111/jonm.12442

Giddens, A. (1990). *The Consequences of Modernity*. Stanford: Stanford University Press.

Gough, B. Deconstructing Reflexivity. In L. G. Finlay, B. (Ed.), *Reflexivity. A practical guide for researchers in health and social sciences.*: Blackwell science Ltd.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research *Handbook of qualitative research.* (pp. 105-117). Thousand Oaks, CA, US: Sage Publications, Inc.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?:An Experiment with Data Saturation and Variability. *Field Methods, 18*(1), 59-82. doi:10.1177/1525822x05279903

Heidegger, M. (1962). *Being and time*. San Francisco: Harper.

Heim, C. M., Entringer, S., & Buss, C. (2018). Translating basic research knowledge on the biological embedding of early-life stress into novel approaches for the developmental programming of lifelong health. *Psychoneuroendocrinology*. doi:10.1016/j.psyneuen.2018.12.011

Honneth, A. (1995). *The Struggle for Recognition. The Moral Grammar for Conflicts.* Great Britain: Polity Press.

Hood, R. (2015). How Professionals Experience Complexity: An Interpretative Phenomenological Analysis. *Child Abuse Review, 24*(2), 140-152. doi:10.1002/car.2359

Hortulanus, R., Machielse, A., Meeuwesen, L. (2006). *Social Isolation in Modern Society* (1st Edition ed.). London Imprint Routledge.
Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qual Health Res, 19*(9), 1284-1292. doi:10.1177/1049732309344612
Hurd, H. M. (2009). The Moral Magic of Consent. *Legal Theory, 2*(2), 121-146. doi:10.1017/S1352325200000434
Hutchinson, P., Abrams, D., Christian, J. (2007). The Social Psychology of Exclusion. In D. Abrams, Christian, J., Gordon D. (Ed.), *Multidisciplinary Handbook of Social Exclusion Research* (pp. 29-57): John Wiley & Sons Ltd.
Iris M. Steine, I. M. W., D.; Nordhus, I. H.; Milde, A. M.; Bjorvatn, B.; Grønli, J.; Pallesen, S. (2017). Hvorfor tar det så lang tid å fortelle om seksuelle overgrep? *Tidsskrift for Norsk psykologforening, 55*(2), 204-208.
Janson, S., Jernbro, C. & Långberg, B. (2011). Kroppslig besstraffning og annen krenkning - en nationell kartläggning. Retrieved from
Jernbro, C., Otterman, G., Lucas, S., Tindberg, Y., & Janson, S. (2017). Disclosure of Child Physical Abuse and Perceived Adult Support among Swedish Adolescents. *Child Abuse Review, 26*(6), 451-464. doi:10.1002/car.2443
Johansen, I. (2014). *Turnover in the municipal child protective services*. Oslo, Norway.
Kauffman, S. A. (2000). *Investigations* New York: Oxford University Press.
Kvale, S. (1996). *Interview Views: An Introduction to Qualitative Research Interviewing.* CA: Sage.
Kvale, S. Brinkman, S. (2015). *Interviews: Learning the Craft of Qualitative Research Interviewing. 3.ed*. CA: Sage.
La Greca, A. M., Silverman, W. K., & Lochman, J. E. (2009). Moving beyond efficacy and effectiveness in child and adolescent intervention research. *J Consult Clin Psychol, 77*(3), 373-382. doi:10.1037/a0015954
Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods, 2*(3), 21-35. doi:10.1177/160940690300200303
LeDoux, J. E., & Pine, D. S. (2016). Using Neuroscience to Help Understand Fear and Anxiety: A Two-System Framework. *Am J Psychiatry, 173*(11), 1083-1093. doi:10.1176/appi.ajp.2016.16030353
Leite, J. T., Beserra, M. A., Scatena, L., Silva, L. M., & Ferriani, M. (2016). Coping with domestic violence against children and adolescents from the perspective of primary care nurses. *Rev Gaucha Enferm, 37*(2), e55796. doi:10.1590/1983-1447.2016.02.55796
Lemaigre, C., Taylor, E. P., & Gittoes, C. (2017). Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. *Child Abuse Negl, 70*, 39-52. doi:10.1016/j.chiabu.2017.05.009
Lincoln, Y. S. (1990). Toward a categorical imperative for qualitative research. In E. W. Eisner, & Peshkin, A (Ed.), *Qualitative inquiry in education: The continuing debate.* New York: : Teachers College Press. .
Lincoln, Y. S., & Guba, C. S. (2009). Ethics and the Broader Rethinking/Reconceptualization of Research as Construct. *Cultural Studies ↔ Critical Methodologies, 9*(2), 273-285. doi:10.1177/1532708608322793
Lines, L. E., Hutton, A. E., & Grant, J. (2017). Integrative review: nurses' roles and experiences in keeping children safe. *J Adv Nurs, 73*(2), 302-322. doi:10.1111/jan.13101
London, K., Bruck, M., Wright, D. B., & Ceci, S. J. (2008). Review of the contemporary literature on how children report sexual abuse to others: findings, methodological issues, and implications for forensic interviewers. *Memory, 16*(1), 29-47. doi:10.1080/09658210701725732
Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *2010, 11*(3). doi:10.17169/fqs-11.3.1428
Maunder, R. G., Peladeau, N., Savage, D., & Lancee, W. J. (2010). The prevalence of childhood adversity among healthcare workers and its relationship to adult life events, distress and impairment. *Child Abuse Negl, 34*(2), 114-123. doi:10.1016/j.chiabu.2009.04.008
Mauthner, M. B., M.; Jessop, J. & Miller, T. (2002). *Ethics in Qualitative Research* (2 ed.). London: Sage.
McElvaney, R. (2015). Disclosure of Child Sexual Abuse: Delays, Non-disclosure and Partial Disclosure. What the Research Tells Us and Implications for Practice. *Child Abuse Review, 24*(3), 159-169. doi:10.1002/car.2280
McElvaney, R., Greene, S., & Hogan, D. (2014). To Tell or Not to Tell? Factors Influencing Young People's Informal Disclosures of Child Sexual Abuse. *Journal of Interpersonal Violence, 29*(5), 928-947. doi:10.1177/0886260513506281
Meinck, F., Cluver, L., Loening-Voysey, H., Bray, R., Doubt, J., Casale, M., & Sherr, L. (2017). Disclosure of physical, emotional and sexual child abuse, help-seeking and access to abuse response services in two South African Provinces. *Psychol Health Med, 22*(sup1), 94-106. doi:10.1080/13548506.2016.1271950
Mendoza-Denton, R., Downey, G., Purdie, V. J., Davis, A., & Pietrzak, J. (2002). Sensitivity to status-based rejection: implications for African American students' college experience. *J Pers Soc Psychol, 83*(4), 896-918.

Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: a synthesis of critical steps in the implementation process. *Am J Community Psychol, 50*(3-4), 462-480. doi:10.1007/s10464-012-9522-x

Morse, J. M., Bottorff, J. L., & Hutchinson, S. (1994). The phenomenology of comfort. *J Adv Nurs, 20*(1), 189-195. doi:10.1046/j.1365-2648.1994.20010189.x

Mänttäri-van der Kuip, M. (2016). Moral distress among social workers: The role of insufficient resources. *International Journal of Social Welfare, 25*(1), 86-97. doi:10.1111/ijsw.12163

Noblit, G. W. Hare, R. D. (1988). *Meta-Ethnography. Synthesizing Qualitative Studies*. CA: SAGE.

Ofsted. (2011). *The voice of the child: learning lessons from serious case review*. (Reference no: 100224). Manchester UK: Crown copyright.

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in Qualitative Research. *Journal of Nursing Scholarship, 33*(1), 93-96. doi:10.1111/j.1547-5069.2001.00093.x

Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC, US: American Psychological Association.

Padgett, D. K. (1998). *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, CA, US: Sage Publications, Inc.

Piltz, A., & Wachtel, T. (2009). Barriers that inhibit nurses reporting suspected cases of child abuse and neglect. *Australian Journal of Advanced Nursing, 26*(3), 93-100.

Punch, M. (1994). Politics and ethics in qualitative research. In N. K. L. Y. S. Denzin (Ed.), *Handbook of qualitative research* (pp. 83-95). CA: Sage Publications Thousand Oaks.

Purewal, S. K. B., M.; Wang, L. G.; Koita, K.; Marques, S. S.; Oh, D.; Harris, N. B. (2016). Screening for Adverse Childhood Experiences (ACEs) in an Integrated Pediatric Care Model. *Zero to Three, 36*(3), 10.

Reigstad, B., Jorgensen, K., & Wichstrom, L. (2006). Diagnosed and self-reported childhood abuse in national and regional samples of child and adolescent psychiatric patients: prevalences and correlates. *Nord J Psychiatry, 60*(1), 58-66. doi:10.1080/08039480500504933

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: are there special issues for health services research? *Fam Pract, 19*(2), 135-139. doi:10.1093/fampra/19.2.135

Saltmarsh, T., & Wilson, D. (2017). Dancing around families: neonatal nurses and their role in child protection. *J Clin Nurs, 26*(15-16), 2244-2255. doi:10.1111/jocn.13645

Sandelowski, M. (2012). Metasynthesis of qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 19-36). Washington, DC, US: American Psychological Association.

Schaeffer, P., Leventhal, J. M., & Asnes, A. G. (2011). Children's disclosures of sexual abuse: Learning from direct inquiry. *Child Abuse & Neglect, 35*(5), 343-352. doi:https://doi.org/10.1016/j.chiabu.2011.01.014

Schwartz, B. (2011). Practical wisdom and organizations. *Research in Organizational Behavior, 31*, 3-23. doi:https://doi.org/10.1016/j.riob.2011.09.001

Shakespeare-Finch, J., & Daley, E. (2017). Workplace belongingness, distress, and resilience in emergency service workers. *Psychol Trauma, 9*(1), 32-35. doi:10.1037/tra0000108

Shonkoff, J. P., & Garner, A. S. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232-246. doi:10.1542/peds.2011-2663

Siebert, D. C. (2006). Personal and Occupational Factors in Burnout Among Practicing Social Workers. *Journal of Social Service Research, 32*(2), 25-44. doi:10.1300/J079v32n02_02

Snowden, D. (2002). Complex acts of knowing: paradox and descriptive self-awareness. *Journal of Knowledge Management, 6*(2), 100-111. doi:doi:10.1108/13673270210424639

Snowden, D. J., & Boone, M. E. (2007). A leader's framework for decision making. A leader's framework for decision making. *Harv Bus Rev, 85*(11), 68-76, 149.

Somoray, K., Shakespeare-Finch, J., & Armstrong, D. (2017). The Impact of Personality and Workplace Belongingness on Mental Health Workers' Professional Quality of Life. *Australian Psychologist, 52*(1), 52-60. doi:10.1111/ap.12182

Steinberg, A. M., Pynoos, R. S., Briggs, E. C., Gerrity, E. T., Layne, C. M., Vivrette, R. L., . . . Fairbank, J. A. (2014). The National Child Traumatic Stress Network Core Data Set: Emerging findings, future directions, and implications for theory, research, practice, and policy. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(Suppl 1), S50-S57. doi:10.1037/a0037798

Stige, B., Malterud, K., & Midtgarden, T. (2009). Toward an Agenda for Evaluation of Qualitative Research. *Qualitative Health Research, 19*(10), 1504-1516. doi:10.1177/1049732309348501

Stoltenborgh, M., van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreat, 16*(2), 79-101. doi:10.1177/1077559511403920

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory, 2nd ed*. Thousand Oaks, CA, US: Sage Publications, Inc.

Tang, H. H., & Richardson, R. (2013). Reversing the negative psychological sequelae of exclusion: inclusion is ameliorative but not protective against the aversive consequences of exclusion. *Emotion, 13*(1), 139-150. doi:10.1037/a0029521

Taylor, C. (1989). *Sources of the self: The making of the modern identity*. Cambridge, MA, US: Harvard University Press.

Thomas, S. P., & Hall, J. M. (2008). Life Trajectories of Female Child Abuse Survivors Thriving in Adulthood. *Qualitative Health Research, 18*(2), 149-166. doi:10.1177/1049732307312201

Thoresen, S., Myhre, M., Wentzel-Larsen, T., Aakvaag, H. F., & Hjemdal, O. K. (2015). Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population. *Eur J Psychotraumatol, 6*, 26259. doi:10.3402/ejpt.v6.26259

Thorne, S. (2016). *Interpretive Description. Qualitative Research for Applied Practice*. New York: Routledge.

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The Analytic Challenge in Interpretive Description. *International Journal of Qualitative Methods, 3*(1), 1-11. doi:10.1177/160940690400300101

Tignor, S. M., & Colvin, C. R. (2017). The Interpersonal Adaptiveness of Dispositional Guilt and Shame: A Meta-Analytic Investigation. *J Pers, 85*(3), 341-363. doi:10.1111/jopy.12244

Uldum, B., Christensen, H. N., Welbury, R., & Haubek, D. (2017). How Danish dentists and dental hygienists handle their role in child abuse and neglect matters. *Acta Odontol Scand, 75*(5), 332-337. doi:10.1080/00016357.2017.1307448

Ussher, J. M. (1999). ECLECTICISM AND METHODOLOGICAL PLURALISM. *Psychology of Women Quarterly, 23*(1), 41-46. doi:10.1111/j.1471-6402.1999.tb00339.x

Van Beurden, E. K., Kia, A. M., Zask, A., Dietrich, U., & Rose, L. (2013). Making sense in a complex landscape: how the Cynefin Framework from Complex Adaptive Systems Theory can inform health promotion practice. *Health Promot Int, 28*(1), 73-83. doi:10.1093/heapro/dar089

van der Kolk, B. A. (2002). Posttraumatic therapy in the age of neuroscience. *Psychoanalytic Dialogues, 12*(3), 381-392. doi:10.1080/10481881209348674

Van Manen, M. (2014). *Phenomenology of Practice: Meaning-Giving Methods in Phenomenological Research and Writing*: Left Coast Press.

Van Niel, C., Pachter, L. M., Wade, R., Jr., Felitti, V. J., & Stein, M. T. Adverse events in children: Predictors of adult physical and mental conditions. [References]. (0196-206X). doi:http://dx.doi.org/10.1097/DBP.0000000000000102

Weiner, B. J., Belden, C. M., Bergmire, D. M., & Johnston, M. (2011). The meaning and measurement of implementation climate. *Implement Sci, 6*, 78. doi:10.1186/1748-5908-6-78

Wildeman, C., Emanuel, N., Leventhal, J. M., Putnam-Hornstein, E., Waldfogel, J., & Lee, H. (2014). The prevalence of confirmed maltreatment among US children, 2004 to 2011. *JAMA Pediatr, 168*(8), 706-713. doi:10.1001/jamapediatrics.2014.410

Zimmer, L. (2006). Qualitative meta-synthesis: a question of dialoguing with texts. *J Adv Nurs, 53*(3), 311-318. doi:10.1111/j.1365-2648.2006.03721.x

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Walking Children Through a Minefield: How Professionals Experience Exploring Adverse Childhood Experiences

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Abstract

Understanding the challenges of professionals in addressing child adversity is key to improving the detection, protection, and care of exposed children. We aimed to synthesize findings from qualitative studies of professionals' lived experience of addressing child adversity. Through a systematic search, we identified eight qualitative studies and synthesized them using metaethnography. We generated three themes, "feeling inadequate," "fear of making it worse," and "facing evil," and one overarching metaphor, "walking children through a minefield." The professionals felt that they lacked the means necessary to explore child adversity, that they were apprehensive of worsening the child's situation, and that their work with child adversity induced emotional discomfort. This metasynthesis indicated that the professionals' efficiency in exploring abuse relied upon their ability to manage emotional and moral distress and complexity. To support children at risk, we propose developing professionals' ability to build relationships, skills in emotion regulation, and proficiency in reflective practice.

Keywords

exploration, child abuse, health care professionals, child welfare workers, metasynthesis, trauma, professional education, screening health care, qualitative, Europe, USA

Introduction

Over the last two decades, a large body of multidisciplinary research has been conducted to document the prevalence and long-term effect of adverse childhood experiences (ACEs), including psychological, physical, or sexual abuse; violence against mothers; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned (Felitti et al., 1998). The findings have revealed that ACEs are a common pathway to social, cognitive, and emotional impairments, leading to an increased risk of unhealthy behaviors, violence, physical and psychological disease, disability, and premature mortality (Van Niel, Pachter, Wade, Felitti, & Stein, 2014). The prevalence of adverse and potentially traumatizing events in childhood appears to be high in Europe and the United States (Finkelhor, Turner, Shattuck, & Hamby, 2013; Janson, Jernbro, & Långberg, 2011; Thoresen, Myhre, Wentzel-Larsen, Aakvaag, & Hjemdal, 2015).

The early identification of ACEs and intervention with children may produce stronger effects than attempting to modify health-related behaviors or provide health care in adulthood (Anda, Butchart, Felitti, & Brown, 2010). Still, it appears that few of the children exposed to ACEs who have developed ongoing distress receive effective treatments (La Greca et al., 2009; Steinberg et al., 2014). Furthermore, we need to identify and address children's adversities to be able to reduce their exposure to stressors and/or to diminish the biological effects of stressors. Therefore, a major contributing factor to our failure in helping abused children may be that professional caregiving for these children rarely includes routine exploration of traumatic exposure (Blount et al., 2008; Cameron & Guterman, 2006; Reigstad, Jørgensen, & Wichstrøm, 2006).

Professionals' inadequacy in disclosing child adversity may be related both to the professional as an individual and to the norms and practices of institutions and

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Table 1. Search Strategy.

maltreatment OR abuse OR neglect OR violence OR “adverse childhood experience” OR “adverse experience” OR trauma* OR “early life stress” OR advers*	AND	investigat* OR identif* OR explor* OR disclos* OR assess* OR reveal* OR unveil* OR examin* OR uncover* OR interview* OR conversation* OR dialogue*
adj4—NEAR/3		adj5—NEAR/4
child* OR adolescen* OR teen* OR youth* OR young*		barrier* OR obstacle* OR hindrance* OR difficult* OR resistance* OR imped*

programs. Taylor, Daniel and Scott (2012) concludes in a review of quantitative research that there is sufficient evidence on the identification of, and response to, neglected children to guide practice. Despite this evidence, professionals’ willingness to explore and identify childhood adversity seems limited. This finding raises the question of what contributes to the reluctance of practitioners to explore psychological trauma with children. Plitz and Wachtels’s (2009) review of quantitative research found nurses’ identification and reporting of suspected child adversity to be dependent on individual factors such as knowledge, experience, fear of perceived consequences, lack of emotional support, and low opinion of child protective services (CPS). To recognize why today’s competence is inadequate and to enable future interventions to efficiently alter practice, we need to increase our comprehension of professionals’ experiential world. To our knowledge, no metasynthesis exists on this subject. Thus, we aimed to synthesize qualitative studies of professionals’ lived experience of addressing child adversity. Professionals’ lived experience includes screening, assessment, identification, and reporting behaviors, as well as intrapersonal (e.g., attitudes, values, beliefs, knowledge, and biases) and contextual factors. We anticipate that the findings will guide improvements in professional practice.

Method

Sandelowski (2012) defined qualitative metasynthesis as a form of scientific inquiry in which research findings in completed qualitative studies are summed up or integrated to make them more applicable to inform practice, policy, or future research. The main purpose is to compare, contrast, translate into each other, and synthesize empirical, qualitative findings from individual studies to gain new insight, overarching meaning, and a deeper understanding of a topic; this process avoids the possibility that these studies remain isolated pieces of a large puzzle (Zimmer, 2006). Noblit and Hare’s (1988) meta-ethnographic comparative method is the most frequently applied metasynthesis method in health care sciences, allowing us to interpret qualitative findings from diverse settings and cultures into higher order understanding. We applied this method and followed its seven recommended steps: isolate a research question to explore with qualitative data; identify relevant studies through literature review; read the studies thoroughly; find how the studies are interrelated; translate the studies into each other and extract overarching themes; synthesize translations; and communicate findings.

Search Strategy and Inclusion Criteria

We chose to include peer-reviewed, empirical, qualitative studies that examined professionals’ experiences addressing ACEs in interviews with children and adolescents published in English or Norwegian. Due to the sparse number of records available, we chose to include all established qualitative methods studying all groups of professionals who work with children and adolescents’ health and well-being. We developed a search strategy outlined in Table 1 with guidance from an expert academic librarian and searched the following databases through January 2015: PsychInfo, Medline, Embase, Web of Science, and ProQuest (11 databases, including ERIC).

The initial search resulted in 904 records after duplication removal in EndNote. We conducted a supplementary hand search, including a search in the Norwegian databases IDUNN and NORART, and in the reference list of relevant articles, resulting in seven potential articles. Finally, we found two more articles through contact with experts at the 9th Nordic Conference on Child Abuse and Neglect in Stockholm. To counteract the risks of researcher bias and of overlooking studies, we avoided having an a priori theoretical framework guiding our search and practiced reflexivity. Supplemental Figure 1 outlines the search process.

The screening process was carried out in four phases primarily performed by Albaek. An initial screening based on the title for concurrence with inclusion criteria reduced the records from 904 to 203. Next, reading the abstract reduced the number of possibly relevant records to 76. We then read the full text of the remaining 76 records, along with the seven records identified by the hand search and the two records identified by expert contact. In cases of doubt, all authors read the article and discussed its fit with the inclusion criteria. Finally, we

scrutinized the final cut of articles together to ensure agreement and ended up with eight studies.

Quality Assessment

We opted not to apply appraisal checklists to assess the quality of the articles partly due to the controversy regarding the use of rule-based judgments in qualitative research in general (Barbour & Barbour, 2003) and partly due to the vast amount of proposals for quality checklists that reveal several incompatible positions (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). Instead, we checked the relevance and proficiency of the articles with two screening questions suggested by Campbell et al. (2003): "Does the article report findings of qualitative research involving qualitative methods of data collection and analysis and are the results supported by the participants' quotes?" and "Is the focus of the article suited to the synthesis topic?" (p. 674). Through this process, we excluded four articles, although we kept two articles only partly compatible with the requirements (i.e., they lacked participants' quotes), as the findings were relevant and applicable. We discovered no major methodological or ethical flaws in the final sample of articles.

Sample

We have summarized the main attributes of the included studies in Table 2. Three studies were conducted in the United States; two, in the Netherlands; two, in Sweden (these were based on the same data material and informants); and one, in Great Britain. Six articles were published in medical or health journals, and two articles were published in thematic journals on abuse. The data collection methods used in these studies included in-depth and semistructured interviews (three studies), semistructured focus-group interviews (three studies), questionnaire with open-ended questions combined with in-depth interviews (one study), and small group seminars with open-ended questions and case discussions (one study). All studies covered responses from 172 professionals, including men and women, with varying work experience and different levels of education. Only some of the studies listed gender; hence, we could not quantify gender distribution. The professionals worked with children or adolescents in physical health care (four studies), school nursing (two studies), CPS (one study), and counseling (one study).

Researchers

Albaek is an organizational psychologist and is experienced in competence development for professionals in social and health services, with specialisation in psychological trauma. Kinn is an associate professor in occupational therapy and has published research on vocational rehabilitation for people with severe mental illness in international journals. Milde is an associate professor in biological and medical psychology and a specialist in clinical psychology. She has published research on stress and trauma in international and Scandinavian journals.

Analysis and Synthesis

Adhering to Noblit and Hare's (1988) method, Albaek summarized the results section of each study with metaphors and participants' quotes and distributed this information to Kinn and Milde. Thereafter, we grouped the findings into three categories: individual factors, factors related to the ACE, and organizational factors. Next, all authors of this study participated in a creative process in which we compiled a list of the concepts, themes, and key phrases from the individual studies. We juxtaposed the themes or ideas to understand how the studies could be interrelated and searched for findings confirming each other and findings that seemed to refute each other. Our list of findings appeared to concur with each other, although they addressed different aspects of our synthesis topic. In the next phase, we therefore chose to further our analysis through reciprocal translations of the findings by principles of thematic analysis and interpretative translation. We discovered several reoccurring themes, and we used key concepts from one study and translated them into findings of the other studies to deepen our understanding of the meaning behind the themes. Three overarching categories of themes emerged through these translations: external barriers, concern for the welfare of the child, and the participants' emotional discomfort. Finally, we conducted a line-of-argument synthesis to make inferences about the entire topic using meaningful metaphors or concepts. Through continued translation and synthesis, we developed three themes and a metaphor.

Results

We developed an overarching metaphor, "walking children through a minefield," to create a coherent comprehension of how our three themes were interrelated. We will outline this metaphor, along with the following three themes, below: (a) "feeling inadequate," (b) "fear of making it worse," and (c) "facing evil."

"Walking Children Through a Minefield"

The metaphor "walking children through a minefield" illustrates the participants' lived experiences of addressing ACEs. We chose this metaphor because the participants felt they lacked the competence and means

Table 2. Main Attributes of the Included Studies.

Citation and Location	Purpose	Design	Context	Findings—Overall Themes
Barter (1999) England and Wales, Great Britain	To enhance understanding of investigating allegations of institutional abuse	Qualitative design. Semistructured interviews, $n = 41$	Child protection practitioners and managers working for the National Society for the Protection of Cruelty to Children investigating allegations of institutional abuse	The study identified the theme *Independence* as important for the professionals, as closeness to the people they were investigating was difficult, and provision of *support* for the clients, for the alleged abuser, and for the other children was important, as well as lack of *postsubstantiation feedback* regarding the result of the investigation. The investigations were found challenging but important and rewarding
Engh Kraft, Rahm, and Eriksson (2016) Sweden	Explore how school nurses face child sexual abuse and their ability to detect and support sexually abused children	Qualitative design. Semistructured focus groups interviews ×2, $n = 23$	School nurses with adequate specialist training, minimum 2 years professional experience, and using a health tool in their health dialogues	The main overarching theme found was *avoidance*, and this permeated the other themes. *Arousal of strong emotions* included the subthemes *sensitive private sphere* and *creating distance through language. Ambivalence of the school nurse* encompassed *not seeing behind the symptoms* and *professional vulnerability*. The theme *disclosure process* had the subthemes *from blind-eye to eye-opener, children do actually tell* and *open up but not give up*
Kraft and Eriksson (2015) Sweden	Explore how school nurses detect maltreated children and initiate support measures	Qualitative design. Semistructured focus groups interviews ×2, $n = 23$	School nurses with adequate specialist training, minimum 2 years professional experience, and using a health tool in their health dialogues	The main theme was that school nurses find support for abused children is realized through a trust-creating process consisting of the following categories: (a) knowledge and experience (with the subcategories signs indicating suspected child abuse, instruments for detection, and intuition and experience), (b) Building relations (with subcategories general measures, and accessibility and treatment), (c) Talking about sensitive issues (subcategories the manner of asking, benefiting the child, and school nurse emotionally affected), and (d) preventive measures (with subcategories knowledge and information distribution, coordination of support, and guidance to other organizations)
Konijnendijk, Boere-Boonekamp, Fleuren, and Haasnoot-Smallegange (2014) Twente, The Netherlands	Identify factors that facilitate or impede adherence to CAP guidelines	Qualitative design, semistructured focus-group interviews, $n = 14$	Child health care professionals (doctors and nurses) in a regional preventive health care organization for children and adolescents	Facilitating factors adhering to CAP guidelines: personal advantage using guidelines, social support, confidence/self-efficacy, familiarity with the guidelines, positive affect, resources and services, a coordinator, and positive cooperation with other organizations. Impeding factors: unclear procedures, lack of cooperation from the client, lack of confidence/self-efficacy, unfamiliar with the guidelines, not integrated into daily practice, formal support from management (i.e., organizational policies), lack of resources, negative cooperation with other organizations

(continued)

Table 2. (continued)

Citation and Location	Purpose	Design	Context	Findings—Overall Themes
Louwers, Korfage, Affourtit, De Koning, and Moll (2012) South-Holland, The Netherlands	Define facilitators/ barriers to screening for child abuse and make recommendations to optimize screening	Qualitative design, semistructured interviews. First interviews with professionals (n = 27), then experts (n = 6) interviewed about results. n = 33	Hospital professionals (pediatricians, surgeons, ED-nurses, ED-managers, and hospital board members). Child-abuse experts and implementation expert	Barriers: lack of time and/or suitable location, fear of unjust suspicion, not primary responsibility, communication with parents, lack of support, unclear roles, screening tool, lack of knowledge and training, and prejudice. Facilitators: social support
O'Malley, Kelly, and Cheng (2013) Midwest, The United States	Identify the salient beliefs and attitudes related to routine assessment of family violence	Qualitative design, questionnaire with open-ended questions (24) and in-depth interviews (2). n = 26	Professionals at a pediatric-ED (physicians, nurses)	Main themes emerging were possibility of increasing risk to clients, and focus removed from medical condition. As well as social support, time, resources, and knowledge. Additional themes were acuity of the patient, lack of privacy, and painful issue for professionals. Disbelief in organizational approval of routine family assessment in half the subjects
Ramachandran, Covarrubias, Watson, and Decker (2013) Maryland, The United States	Investigate violence screening practices and factors that influence this process	Qualitative design, in-depth, semistructured interviews, n = 14	Health care providers (nurses, health educators, and medical office assistants) in three reproductive health clinics in Baltimore city	Inconsistent screening practices, and variation in referral and follow-up processes were the main themes regarding screening practices. Factors contributing to these variations were lack of shared vision on why to screen, role is not clarified, time constraints, and lack of confidence
Sikes, Walley, and Hays (2012) Southern United States	Identify professionals' knowledge, experiences, and concerns on ethical and legal issues pertaining to adolescent dating violence	Qualitative design, small group seminars with open-ended questions and case discussions, n = 21	Counselor trainees and practitioners working with adolescents	Six main themes were identified: knowledge of dating violence as an ethical and legal issue, client welfare, counseling interventions, informed consent and disclosure, barriers (legal and school), and counselor reactions

Note. CAP = child abuse prevention; ED = emergency department.

necessary to address child adversity, similar to maneuvering through a minefield without maps of safe routes or tools to defuse mines (i.e., feeling inadequate). Moreover, the participants feared their attempts to help could hurt the child, much like having to walk individuals into an unknown minefield and risk stepping on hidden mines (i.e., fear of making it worse). When the participants faced child adversity, they experienced emotional discomfort that induced avoidance patterns, parallel to how stepping into a minefield and risk injury would create fear and evasion (i.e., facing evil).

"Feeling Inadequate"

In all the included studies, the participants felt inadequate and unequipped to work with child adversity due to insufficient *competence*, *organizational culture*, and/or *system attributes*. The participants shared how they experienced a lack of agency over their practice and its outcome, which reduced their confidence in their ability to walk children through the minefield and their willingness to step into the minefield themselves. In addition, even if the participants chose to do so, they felt less optimistic about the likelihood of positive outcomes for the child.

In most studies, the participants identified sufficient *competence* (e.g., "knowledge," "training," "self-efficacy," and "confidence") as key to working efficiently with ACEs. The participants in two studies (Engh Kraft, Rahm, & Eriksson, 2016; Kraft & Eriksson, 2015) underlined their calls for satisfactory competence *addressing* child adversity; in four studies (Engh Kraft et al., 2016; Konijnendijk, Boere-Boonekamp, Haasnoot-Smallegange, & Need, 2014; Kraft & Eriksson, 2015; Louwers, Korfage, Affourtit, De Koning, & Moll, 2012), for *identifying* ACEs; and in six studies (Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Louwers et al., 2012; O'Malley, Kelly, & Cheng, 2013; Ramachandran, Covarrubias, Watson, & Decker, 2013), for *responding* to ACEs. As a participant claimed, "You can't just go and ask these questions without having some sort of previous knowledge. . . Otherwise it can go really wrong" (Engh Kraft et al., 2016, p. 5). This quote illustrates that many participants found it difficult to know how and when to ask children about ACEs. They believed that professionals had to possess the knowledge and specific skills to *address* adversity in a way that would benefit the child, and they doubted whether professionals with insufficient competence should ask about ACEs (Engh Kraft et al., 2016; Kraft & Eriksson, 2015). However, the included articles reported mixed messages about this issue. Ramachandran et al. (2013) described that some participants always asked about adversity without ruminating on how or when to ask: "Every time I see a patient, regardless of what the visit is for . . . I ask them if he or she is nice to them, and if they hit or kick or punch them, and if they feel safe" (p. 858). Differing opinions of tasks and responsibilities may explain this discrepancy. The participants in Ramachandran et al's study (2013) perceived their job to entail screening and registering ACEs and not a responsibility for improving the child's overall situation. As this participant said when asked how he or she followed-up on positive screens, "I don't, unless it's a patient that follows up with me" (Ramachandran et al., 2013, p. 858).

The participants in four studies (Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Louwers et al., 2012) found it difficult to *identify* child adversity, as they had to interpret the child's signs with ingenuity. One participant explained, "It is not easy to see. You have to develop spectacles to see. Extremely hard" (Engh Kraft et al., 2016, p. 5). The participants underscored how intuition and relational skills were essential to recognizing ACEs. Although experience could refine these skills, the participants believed that the professional's intentions and ethics were the ultimate origin of proficiency in recognizing child adversity. As said by one participant, "What we say is part of our profession. How we should act comes from within us" (Kraft & Eriksson, 2015, p. 356). This quote shows how the participants felt that their actions defined them and their worth as professionals and fellowmen. Therefore, these participants invested more into identifying adversity and helping children than the participants who limited their duties to asking about ACEs.

The participants in six studies (Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Louwers et al., 2012; O'Malley et al., 2013; Ramachandran et al., 2013) felt inadequate and insecure, as they did not know how to *respond* to a child's disclosure. As expressed by one participant, ". . . But then someone says yes and then you're like, oh no, because now I really have no idea what to do with them" (Ramachandran et al., 2013, p. 860). These participants felt insecure about how to act in the interview setting and how to respond with supportive measures, both of which made the participants question whether a walk into the minefield would be worthwhile. One participant described not knowing how to respond after losing their on-site social worker: "When I do see a patient, we're supposed to ask them, have they experienced any violence, or so and so . . . but no one has said yes, so I haven't been forced to figure out what we're going to do" (Ramachandran et al., 2013, p. 858). As shown in this quote, the participant felt ambiguous toward screening with no plan for a positive response, and the ambiguity conveyed may account for the lack of disclosure from patients.

In all studies, the participants felt frustrated and inadequate due to *system* failure, as shown in this participant's complaint: "On many, many occasions, the child's

anxiety landed in our lap" (Kraft & Eriksson, 2015, p. 357). After a child's disclosure, the participant felt as if she were left alone with a scared and hurt child without any support measures to offer. Such incidents tended to discourage the participants from reporting ACEs and sometimes from even screening: "Naturally, I should have reported my concern to the CPS but the question is what they would have achieved" (Engh Kraft et al., 2016, p. 6). Deficient cooperation with the legal system and/or CPS made the participants feel incapable and upset to see children treated unfairly:

> . . . It doesn't seem that the law—this is the legal side—it doesn't seem like they do much about it. But you have to report it a number of times, before they step in. And I don't think that's fair. (Sikes, Walley, & Hays, 2012, p. 1483)

In five studies (Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Louwers et al., 2012; O'Malley et al., 2013; Ramachandran et al., 2013), the participants thought *organizational culture* influenced their ACE exploration in the form of insufficient guidelines, unclear roles and responsibilities, lack of social support, and disagreement about the screening tool. The participants in all studies requested clearer guidelines and better assessment tools to handle their uncertainty in working with child adversity. Although, in one study, the participants handled doubt with experience-based intuition: "My years of service and experience mean that I am not so scared anymore but I feel that I can rely on my gut feeling" (Engh Kraft et al., 2016, p. 6).

In three studies (Louwers et al., 2012; O'Malley et al., 2013; Ramachandran et al., 2013), the participants did not think it was their primary objective or responsibility to screen for ACEs, as exemplified by this quote: "We're too busy with STDs (sexually transmitted diseases)" (Ramachandran et al., 2013, p. 857). Similarly, two studies reported that the participants perceived unclear roles and division of labor, which hindered their exploration of ACEs (Louwers et al., 2012; Ramachandran et al., 2013). Quotes from two participant colleagues may be illustrative: "I would say that clinicians would be able to identify it a little bit better. . . " and "[screening] is a social work issue" (Ramachandran et al., 2013, p. 859). Due to their feelings of inadequacy, the participants seemed to think that other professions were more skilled to detect ACEs.

In all studies, the participants felt challenged by insufficient *system attributes* important for their practice and its outcomes, such as time, resources, workload, support measures for the child, and cooperation with CPS and legal authorities. Moreover, in five studies (Engh Kraft et al., 2016; Kraft & Eriksson, 2015; Louwers et al., 2012; O'Malley et al., 2013; Ramachandran et al., 2013), the participants experienced a heavy workload and/or a lack of *time*, which impeded ACE screening. One participant shared how addressing ACEs required difficult priorities:

> I hate opening up a door to someone and then being like I am not going to deal with it… unfortunately, when you're really busy, knowing that, you know, a certain conversation could make this an hour long visit, and you have three more people on your door. . . (Ramachandran et al., 2013, p. 860)

This quote exemplifies that the participants could choose not to enquire if they felt unable to respond properly to disclosure. Otherwise, exploring ACEs would come at the expense of other clients. With a lack of time requiring harsh prioritization, the participants felt inadequate, powerless, and guilty: ". . . we just can't save everyone. You can't get involved in any case" (Engh Kraft et al., 2016, p. 6).

"Fear of Making It Worse"

This theme captures the participants' fear of taking a child into the minefield where they could trigger a mine and hurt the child. As the participants felt unable to predict the consequences of their actions, they felt anxious that their attempts to help would make the child's situation worse (Engh Kraft et al., 2016; Kraft & Eriksson, 2015; O'Malley et al., 2013; Sikes et al., 2012).

The participants were afraid of making it worse for several reasons. First, they were scared of inflicting harm upon the child by causing fear, as illustrated in this quote: "The pupil had been so scared and said 'I don't know where I am going after school, whether I can go home or not'. . . Threats are so awful. . . " (Kraft & Eriksson, 2015, p. 357). The participants were also afraid of exposing the child to added abuse, as explained by this participant: "You could inadvertently trigger violence if the abuser finds out about the disclosure" (O'Malley et al., 2013, p. 276). Second, the participants expressed worry that interviewing a child about ACEs could introduce new hardships into the child's life. These hardships included ruptured relationships within the child's family (O'Malley et al., 2013), unjustified suspicions posed to parents or legal authorities (Louwers et al., 2012), or the parents could deny the child further contact with the professional (Engh Kraft et al., 2016). Third, the participants in all studies doubted they had sufficient resources to help the child: "If we ask about abuse but then are not able to do much when the answer is yes, things could get much worse at home" (O'Malley et al., 2013, p. 276). Implicitly, the participants' stories embedded their fears of entering an unchartered minefield, in which they could never trust that their actions would be beneficial or at least not harmful.

In three studies (Engh Kraft et al., 2016; Kraft & Eriksson, 2015; Sikes et al., 2012), the participants described how revealing ACEs could catch them in a dilemma between different ethical and legal standards. An example from Kraft and Eriksson's study (2015) is the contradiction between upholding client confidentiality and their legal obligation to

report uncovered ACEs. Given no correct answer, any action would breach one set of ethics. Moreover, when the participants could not help a child after reporting ACEs, they felt they had deceived the child and given false hope, as revealed by one professional:

> . . . if someone came and they were in a relationship of violence or something, and they trusted us to do something about it . . . in a way they might feel you are betraying their trust because you have to report it. So you do that, and then it's like, if nothing happens, you've just betrayed their trust and nothing happened. (Sikes et al., 2012, p. 1481)

The next quote shows how unpredictability caused the participants to feel caught in a "catch-22" situation: "This is something you always bear in mind when you start something. How will it benefit the child? However, there is no other way. . . All the same, you look at the pros and cons" (Kraft & Eriksson, 2015, p. 357). If the participants chose not to explore ACEs, they could not initiate any support measures. In contrast, if the participants addressed and reported ACEs and could not protect the child, the participants risked losing the child's trust and exposing the child to more danger.

In five studies, participants doubted if they should lead the child into the minefield if they were unsure they could walk the child to safety (Barter, 1999; Engh Kraft et al., 2016; O'Malley et al., 2013; Ramachandran et al., 2013; Sikes et al., 2012). One professional explained the situation as follows: "You can't just give child abuse or domestic violence a prescription and make it better; you can't scan it away, radiate away, so they won't ask" (O'Malley et al., 2013, p. 277).

Interestingly, in one study, the participants claimed that they always explored what they interpreted as "obvious signs of child abuse" (Kraft & Eriksson, 2015, p. 357). Another study reported that participants had low self-efficacy when they based their suspicion of ACEs on vague and ambiguous signals (Konijnendijk et al., 2014). It seems that the participants were more willing to walk the child through the minefield if they felt certain that a child was a victim.

The participants in all studies searched for ways to increase the predictability of their actions and reduce their fear of making it worse. In addition to improved competence, the participants requested follow-up information after reporting to CPS in three studies (Barter , 1999; Konijnendijk et al., 2014; Kraft & Eriksson, 2015). Information about outcomes of their actions could help the participants maneuver through a similar minefield in the future. Moreover, the participants in three studies (Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015) believed that accumulating experience with ACEs would help them overcome self-doubt and fear. As one professional explained, ". . . then you will become increasingly skillful and tend to experience less fear of making poor decisions" (Konijnendijk et al., 2014, p. 421).

"Facing Evil"

In all included studies, the participants described how facing potential child adversity (facing evil) induced emotional discomfort, such as frustration, despair, anger, guilt, and shame. The participants' reactions to the emotional distress of facing evil evoked several types of avoidance patterns on varying levels of cognitive awareness: *suppression*, *avoidance of talking about it, disbelief*, and *fear of negative reactions*.

The participants displayed the effects of facing evil with their emotional reactions to the horrors of child adversity, as illustrated in this quote: "It is such a taboo area. It is so awful if it is true" (Engh Kraft et al., 2016, p. 4). In two studies (Engh Kraft et al., 2016; Kraft & Eriksson, 2015), the participants shared how these reactions also made it challenging to suspect someone of child abuse: "Thinking of someone in these terms is very harsh" (Engh Kraft et al., 2016, p. 4).

In Engh-Kraft et al.'s study (2016), the participants initially *suppressed* their recall of their experiences with sexual-abuse cases: "I had completely forgotten about it. I have even been to the district court as a witness" (p. 5). As this quote shows, the participants kept painful experiences of facing evil away from their everyday awareness. Another participant explained it in this way: "We who are right on the edge push it (child abuse) to the back of our minds because it is unpleasant" (p. 6).

The participants in four studies (Barter, 1999; Engh Kraft et al., 2016; Kraft & Eriksson, 2015; Louwers et al., 2012) expressed how talking about ACEs was emotionally challenging, as described by one participant: "It is extremely difficult to ask about abuse. It really is" (Engh Kraft et al., 2016, p. 4). They tended to *avoid talking about abuse*, and if they did, they created distance through language (Engh Kraft et al., 2016). For instance, they would use vague terms and periphrases, as exemplified by this quote: "It wasn't consummated then, but in another way. I don't want to. Ugh, it's tough talking about what had happened in detail. But it was then, you know" (Engh Kraft et al., 2016, p. 4). Markedly, in four studies (Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Ramachandran et al., 2013), the participants referred to a child's ACEs in several ways, including "it," "the case," "their situation," "that," and "awful thing." Moreover, the participants used circumlocutions despite their belief that children need and want direct questions. Utility of distant language could be a

method for the participants to protect themselves from facing evil through objectifying adversity and detaching it from human suffering. If they failed to do so, the participants could lose control over their emotional involvement, as this participant said, "A warning sign for the counsellor may be that—you are extremely upset. Something happened to her—you're going to have to distance yourself. Kind of transference" (Sikes et al., 2012, p. 1483).

The participants in two studies (Engh Kraft et al., 2016; Kraft & Eriksson, 2015) described how their *disbelief* or oblivion toward the presence of evil in their daily practice disrupted their ability to identify ACEs. This phenomenon was described by one professional as follows: "You find what you want to see, you don't look for what this might stand for, do you? Many times, seeing it is tough, although you don't realize you are resisting" (Engh Kraft et al., 2016, p. 6). As this quote shows, the participants had to intentionally search for ACEs and become aware of implicit personal issues preventing them from reading signs of adversity. Six studies (Barter, 1999; Engh Kraft et al., 2016; Kraft & Eriksson, 2015; O'Malley et al., 2013; Ramachandran et al., 2013; Sikes et al., 2012) mentioned such issues including preconceptions, defensive attitudes, identification with parents, avoidance, denial, and personal experiences, as exemplified in the following quote: "I think this counselor may be able to resolve their own experiences from the past, before they take on this individual" (Sikes et al., 2012, p. 1483).

The participants in six of the studies expressed fear that facing evil would expose them to *negative reactions* and cause emotional discomfort (Barter, 1999; Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Louwers et al., 2012; Sikes et al., 2012), as expressed by this participant: "This mother has an aggressive boyfriend . . . When I am at the mother's house, I hope that her boyfriend will not show up. When I mention the word CPS, they will burst with anger" (Konijnendijk et al., 2014, p. 421). In addition to dreading negative reactions from caregivers, the participants also worried about critiques from their colleagues and from the legal system, as illustrated by this quote: "You are in a stronger position when you have discussed the case with professional colleagues, and this will also give you greater legal protection if your decisions are challenged" (Konijnendijk et al., 2014, p. 421).

Even with a general perception that addressing ACEs was challenging, six studies had participants who said they often screened for abuse (Barter, 1999; Engh Kraft et al., 2016; Konijnendijk et al., 2014; Kraft & Eriksson, 2015; Ramachandran et al., 2013; Sikes et al., 2012). Some of the participants reasoned that they addressed adversity because of their commitment to help exposed children, as said by one participant: "doing what's best for the client" (Sikes et al., 2012, p. 1480). To overcome their self-protection from emotional discomfort and choose the child's best interest, the participants had to exert drive and courage. They believed that although screening was tough, it was necessary for helping the child, as illustrated in this quote: ". . . even when the answer is awful, you have shown you can take it" (Kraft & Eriksson, 2015, p. 357). The participants who perceived their actions to be beneficial and efficient found it meaningful and worthwhile to address adversity. Barter (1999) explained it in the following way:

> Despite the fact that many participants felt these investigations were particularly challenging, they also spoke about how rewarding and important they were. For many, their involvement in these investigations was seen as a substantial contribution to the safety and protection of children. (p. 401)

Discussion

We aimed to synthesize findings from qualitative studies of professionals' lived experiences of addressing child adversity and revealed that professionals experience emotional discomfort, fear of doing something wrong, and feelings of inadequacy when they address ACEs. In our analysis, we found an interesting discrepancy between *how professionals experienced* addressing ACEs and what professionals *described as causes* for difficulties in exploration, as well as their suggested *interventions/improvements*. The professionals' *experiences* of exploring ACEs were categorized into the themes "facing evil" and "fear of making it worse," referring to personal and emotional issues, whereas the professionals' *descriptions of causes* for hardships in addressing adversity and *requested amendments* were categorized into the theme "feeling inadequate," referring to instrumental, often organizational, issues. The professionals' stories of work with ACEs were often emotional and personal, revolving around intrapsychic conditions and relationships with children. Still, the professionals did not ask for interventions to help them regulate emotional discomfort or strategies for handling dilemmas and uncertainty. Rather, the professionals requested guidance, knowledge, guidelines, and enhancement of external factors, such as time, workload, facilities, and role clarity. The professionals solicited knowledge about ACEs, how to ask about adversity, and the actions to perform if they revealed ACEs. With the narratives being so emotionally loaded and personal, the professionals' expressions of causes and desired interventions seem like externalizations. Our finding is similar to Killén's (1996) findings, in which CPS workers protected themselves from the emotional distress of

working with abusive families using the mechanisms of problem displacement and simplification. In *problem displacement*, professionals fixated on one aspect of the situation, such as a child's developmental delay, instead of the ongoing abuse. In our study, we found problem displacement exemplified by the professionals' focus on inadequate external factors. In *simplification*, professionals protected themselves using simplified methods that were inadequate to encompass the complexity of the task. A method was more popular the more it created distance between the professionals and the emotional pain of families. We found simplification in the professionals' desire for standardizations in form of guidelines and assessment tools, although they would be unable to capture the complexity of exploring ACEs.

The professionals described ethical and moral challenges addressing child adversity in our themes "feeling inadequate" and "fear of making it worse" and felt incapable of helping children either due to *moral distress* or *moral dilemma*. Our findings in "feeling inadequate" concur with findings from other studies showing *moral distress* in pediatric health care providers (Trotochaud, Coleman, Krawiecki, & McCracken, 2015), nurses (Burston & Tuckett, 2013), and social workers (Mänttäri-van der Kuip, 2016). Moral distress occurs when constraints hinder a person from performing actions he or she considers morally appropriate (Jameton, 1984). Constraints can be both individual (i.e., knowledge, skills, and confidence) and site specific (i.e., resources, workload, organizational culture, and interagency cooperation). These ideas are in line with our findings that professionals felt distressed because of unsatisfactory competence, organizational culture, and system attributes. Burston and Tuckett (2013) revealed that moral distress made nurses feel powerless and prone to inaction. Similarly, in our study, constraints made the professionals feel discouraged, and they became less inclined to address or report ACEs. In the "fear of making it worse" theme, professionals experienced *moral dilemma*, defined as a choice between options with differing values without a correct answer. As in the case of moral distress, we found that the professionals facing moral dilemmas experienced doubt and found it difficult to act. Both moral distress and moral dilemma have cognitive, emotional, and behavioral aspects, but the central aim and desired outcome of addressing these issues is to enable professionals to engage in moral action. The professionals in our metasynthesis requested knowledge, coaching, and improved organizational resources to facilitate their work with ACEs. Burston and Tuckett (2013) concur and suggest education and coaching to facilitate moral action, and add the need for communication practices to increase ethical awareness and relieve moral distress. Tiedje (2000) proposed that professionals need awareness of moral distress and need empowerment to believe they can make a difference to improve quality of care.

We found a discrepancy between studies in terms of findings and work role. Four studies presented more findings included in the theme "feeling inadequate," in which the authors interviewed professionals in health polyclinics performing physical examinations (Konijnendijk et al., 2014; Louwers et al., 2012; O'Malley et al., 2013; Ramachandran et al., 2013). The other four studies included more findings encompassed in the themes "fear of making it worse" and "facing evil" and included professionals working in CPS or in counseling (Barter et al., 1999; Engh Kraft et al., 2016; Kraft & Eriksson, 2015; Sikes et al., 2012). This discrepancy could reflect a divergent primary focus in their work. Work aimed at improving children's psychological health over time may evoke deeper emotional involvement from professionals compared with short-term work with physical examinations.

Our themes "facing evil" and "fear of making it worse" incorporate the strong negative emotions professionals experienced when working with potential child abuse, and "walking children through a minefield" illustrates the professionals' anxiety-evoking journey. Similarly, Diamond and Allcorn (1985) outlined how events perceived as unpredictable caused anxiety in professionals. This anxiety threatened the professionals' existence and identity and motivated them for anxiety-reducing actions, either attempting to control the environment or to control feelings. The professionals in this metasynthesis handled anxiety by trying to control environmental factors while repressing their feelings.

Diamond (2008) introduced the concept "unthought known," defined as "unconscious thoughts and feelings as known, but not thought or communicated to oneself or others in any meaningful form" (p. 351). "Unthought known" could explain the contradiction we revealed between the professionals' emotional accounts of addressing child abuse, and their external attribution of causes and suggested remedies. The professionals were aware of their emotional reactions, but because they suppressed their emotions, they became masked to both themselves and others. Thus, their emotional reactions were absent from their daily work discourse. An example of unthought known is the situation in which professionals suppressed recollection of their experiences with sexual-abuse cases.

Our theme "facing evil" incorporates the negative emotions evoked in professionals when working with ACEs. However, we infer that "facing evil" also includes existential challenges because recognizing people's potential for evil-doing disturbed the professionals' view of people as essentially good. To be able to reveal abuse, the professionals had to accept that malevolent acts exist and that the people they met could commit them. The professionals in our study felt discomfort thinking of parents

as potential perpetrators. Similarly, Killén (1996) found that professionals' overidentification with parents made them look for alternate explanations for potential abuse and minimize or ignore negative aspects of parents. Looking further into the existential dimension of "facing evil" for professionals, May (1982) proposed that seeing evil in others challenges our basic narcissism and self-worth if we lack an integrated view of human nature as both good and evil. Thus, the professionals in our study could feel like "facing evil" threatened their basic self-worth and explain the emotional distress and avoidance they exhibited. Zimbardo (2007) agreed we must accept human nature as prone to evil as most people are capable of inflicting serious harm upon others under compelling circumstances. More importantly, Zimbardo stressed that *awareness* of human's potential for evil and our *individual choice* to engage in harmful or heroic acts are the keys to fighting evil. Self-protection from the emotional distress of facing people's potential for cruelty may have left us with professionals who struggle to accept evil as an inherent part of their work.

Implications for Practice

The professionals in this metasynthesis requested experience, counseling, knowledge, training, and guidelines to work efficiently with ACEs. Warner-Rogers, Hansen, and Spieth (1996) challenged the notion that *experience* with ACEs facilitates exploration of abuse and found no significant difference in abuse identification between medical students and experienced practicing physicians. Likewise, Chow et al. (2015) found that therapists' number of years of experience was unrelated to positive client-reported outcome. The benefit of experience appears to be dependent on conditions such as the quality of experience and professionals' learning outcomes. For instance, the professionals presented here who thought their actions had worsened a child's situation were less inclined to repeat these actions. Ericsson, Krampe, and Tesch-Romer (1993) claimed that effortful activities (deliberate practice) and coaching lead to expert performance, and Chow et al.'s (2015) findings, where therapists with the best client outcomes spent the most time on deliberate practice, support this claim. In addition, Joyce and Showers's (2002) review found that ongoing on-site coaching was crucial to alter job performance. In this study, many professionals believed that work experience facilitates exploration. Thus, the beneficial effect of experience could depend on deliberate practice and coaching to ensure that professionals learn from experience. Ericsson, Nandagopal, and Roring (2009) highlighted the need for immediate objective feedback on performance and outcomes at work to achieve deliberate practice, and argued such feedback often is difficult to obtain for professionals in health care and CPS. This is congruent with our finding that the professionals requested feedback on the child's situation after their involvement and felt that lack of follow-up information was a barrier for exploration.

The professionals in this metasynthesis wanted more and improved *guidelines*. Koijnendijk, Boere-Boonekamp, Fleuren, Haasnoot, and Need (2016) found that child health care workers' adherence to guidelines was low even when they viewed them positively, indicating that guidelines may not improve professionals' screening for ACEs. This supports our conclusion that efforts to improve efficiency in ACE exploration need to address the professionals' emotional distress and the complexity of abuse cases rather than offer simplified solutions such as guidelines and assessment tools.

We were unable to find empirical studies of interventions that increase professionals' efficiency in exploring ACEs. Conventionally, professionals acquire theoretical knowledge on ACEs, methods/tools for exploring adversity, and guidelines for a systemic chain of action. Our findings lead us to suspect these interventions cannot resolve challenges such as emotional discomfort and complexity-induced fear of making it worse.

In this study, the professionals thought that *organizational support* would facilitate addressing ACEs, in the form of both social support and role clarity. Implementation studies concur with these findings, showing that to improve competence, we need enabling organizational contexts (Meyers, Durlak, & Wandersman, 2012), which entails adaptive leadership and purposeful retailoring of organizational culture, roles, structures, and functions (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Diamond (2008) claimed that denial and repression can be part of organizational culture, where members share resistance toward unwanted realities, thus preserving the status quo. A requirement for change is therefore to acknowledge difficult issues openly, which fits with our finding that talking to colleagues about difficult issues was helpful for professionals.

This metasynthesis focused mainly on professionals' experiences rather than organizational attributes. However, Stevens and Hassett (2007) revealed that when anxiety-evoking events occur, organizations tend to seek simplified solutions, much as professionals do. Our findings support the need to counteract anxiety-based responses from both professionals and organizations. Hence, we must move past simple linear thinking and connect factors in complex causal relations to find interventions that can improve professionals' efficiency in addressing ACEs.

Methodological Reflections

The heterogeneity of the included studies covered diverse organizational settings and different countries, and the

studies' participants varied in professions, roles, educational level, and experience. However, the three themes and overarching metaphor of our metasynthesis emerged with little evidence of data that would refute the essence of that interpretation. We therefore believe that this diversity is a strength in terms of the transferability of results.

In qualitative analysis and synthesis, researchers engage in a creative and intuitive process of meaning-making and interpretation (Kinn, Holgersen, Ekeland, & Davidson, 2013). Naturally, these exploring and synthesizing developments are susceptible to researcher bias. Albaek and Kinn have focused on organizational and work environment in their career, and Albaek and Milde have specialized in psychological trauma. Consequently, the authors could be sensitized to reveal contextual influences and individual emotional reactions. In the analysis, we therefore took care to be as open-minded as possible and to expand our interpretations beyond our preconceptions, for instance by exploring existential challenges, relational aspects, and case complexity. In addition, we used verbatim quotations for validation, and Albaek safeguarded the intersubjectivity of interpretation by feeding the second- and third-order results back to the coauthors who confirmed the congruence with their interpretations.

Suggestions for Future Research

Based on our findings, we propose searching for effective interventions improving professionals' emotion-regulation skills and self-awareness to advance efficiency in handling emotional discomfort. In addition, interventions improving professionals' relationship-building and communication skills may boost their self-efficacy in addressing sensitive issues with children. Finally, we recommend exploring interventions to increase professionals' capacity to accept and tolerate complexity and dilemmas, as well as interventions to improve their reflection skills in complex situations.

Authors' Note

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Supplementary Material

Supplementary Figure is available for this article online.

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References

Anda, R. F., Butchart, A., Felitti, V. J., & Brown, D. W. (2010). Building a framework for global surveillance of the public health implications of adverse childhood experiences. *American Journal of Preventive Medicine*, *39*, 93–98. doi:10.1016/j.amepre.2010.03.015

Barbour, R. S., & Barbour, M. (2003). Evaluating and synthesizing qualitative research: The need to develop a distinctive approach. *Journal of Evaluation in Clinical Practice*, *9*, 179–186. doi:10.1046/j.1365-2753.2003.00371.x

Barter, C. (1999). Practitioners' experiences and perceptions of investigating allegations of institutional abuse. *Child Abuse Review*, *8*, 392–404. doi:10.1002/(SICI)1099-0852(199911/12)8:6<392::AID-CAR571>3.0.CO;2-T

Blount, R. L., Simons, L. E., Devine, K. A., Jaaniste, T., Cohen, L. L., Chambers, C. T., & Hayutin, L. G. (2008). Evidence-based assessment of coping and stress in pediatric psychology. *Journal of Pediatric Psychology*, *33*, 1021–1045. doi:10.1093/jpepsy/jsm071

Burston, A. S., & Tuckett, A. G. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions. *Nursing Ethics*, *20*, 312–324. doi:10.1177/0969733012462049

Cameron, M., Elkins, J., & Guterman, N. (2006). Assessment of trauma in children and youth. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare*. New York: Guilford Press, 53–66.

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, *56*, 671–684.

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, *52*, 337–345. doi:10.1037/pst0000015

Diamond, M. A. (2008). Telling them what they know. *The Journal of Applied Behavioral Science*, *44*, 348–364. doi:10.1177/0021886308317403

Diamond, M. A., & Allcorn, S. (1985). Psychological dimensions of role use in bureaucratic organizations. *Organizational Dynamics*, *14*, 35–40. doi:10.1016/0090-2616(85)90042-7

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *Quality and Safety in Health Care*, *13*, 223–225. doi:10.1136/qshc.2003.008714

Engh Kraft, L., Rahm, G., & Eriksson, U. B. (2016). School nurses avoid addressing child sexual abuse. *The Journal of School Nursing*, *33*, 133–142. doi:10.1177/1059840516633729

Ericsson, K. A., Krampe, R. T., & Tesch-Romer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review*, *100*, 363–406.

Ericsson, K. A., Nandagopal, K., & Roring, R. W. (2009). Toward a science of exceptional achievement: Attaining superior performance through deliberate practice. In W. C.

Bushell, E. L. Olivio, & N. D. Theise (Eds.), *Longevity, regeneration, and optimal health: Integrating Eastern and Western perspectives* (pp. 199 -217). Hoboken, NJ: Wiley-Blackwell. doi:10.1196/annals.1393.001

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*, 245–258. doi:10.1016/S0749-3797(98)00017-8

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics*, *167*, 614–621. doi:10.1001/jamapediatrics.2013.42

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Jameton, A. (1984). Nursing practice, the ethical issues. *International Journal of Nursing Studies*, *22*, Article 343. doi:10.1016/0020-7489(85)90057-4

Janson, S., Jernbro, C., & Långberg, B. (2011). *Kroppslig bestraffning ock annan kränkning av barn i Sverige [Corporal punishment and other violations of children in Sweden]*. Stiftelsen Allmänna Barnhuset [The Foundation of Communal Children's House] Sweden: University of Karlstad.

Joyce, B., & Showers, B. (2002). *Student Achievement through Staff Development* (3rd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.

Killén, K. (1996). How far have we come in dealing with the emotional challenge of abuse and neglect? *Child Abuse & Neglect*, *20*, 791–795. doi:10.1016/0145-2134(96)00066-X

Kinn, L. G., Holgersen, H., Ekeland, T.-J., & Davidson, L. (2013). Metasynthesis and bricolage. *Qualitative Health Research*, *23*, 1285–1292. doi:10.1177/1049732313502127

Konijnendijk, A., Boere-Boonekamp, M. M., Fleuren, M. A. H., Haasnoot, M. E., & Need, A. (2016). What factors increase Dutch child health care professionals' adherence to a national guideline on preventing child abuse and neglect? *Child Abuse & Neglect*, *53*, 118–127. doi:10.1016/j.chiabu.2015.11.006

Konijnendijk, A., Boere-Boonekamp, M. M., Haasnoot-Smallegange, R. M. E., & Need, A. (2014). A qualitative exploration of factors that facilitate and impede adherence to child abuse prevention guidelines in Dutch preventive child health care. *Journal of Evaluation in Clinical Practice*, *20*, 417–424. doi:10.1111/jep.12155

Kraft, L. E., & Eriksson, U. B. (2015). The school nurse's ability to detect and support abused children: A trust-creating process. *The Journal School of Nursing*, *31*, 353–362. doi:10.1177/1059840514550483

La Greca, A. M., Boyd, B. A., Jaycox, L. H., Kassam-Adams, N., Mannarino, A. P., Silverman, W. K., . . . Wong, M. (2009). *Children and trauma: APA presidential task force on posttraumatic stress disorder and trauma in children & adolescents*. Washington, DC: American Psychological Association.

Louwers, E. C. F. M., Korfage, I. J., Affourtit, M. J., De Koning, H. J., & Moll, H. A. (2012). Facilitators and barriers to screening for child abuse in the emergency department. *BMC Pediatrics*, *12*, Article 167. doi:10.1186/1471-2431-12-167

Mänttäri-van der Kuip, M. (2016). Moral distress among social workers: The role of insufficient resources. *International Journal of Social Welfare*, *25*, 86–97. doi:10.1111/ijsw.12163

May, R. (1982). The problem of evil: An open letter to Carl Rogers. *Journal of Humanistic Psychology*, *22*, 10–21. doi:10.1177/0022167882223003

Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: A synthesis of critical steps in the implementation process. *American Journal of Community Psychology*, *50*, 462–480. doi:10.1007/s10464-012-9522-x

Noblit, G. W., & Hare, D. R. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). London, England: Sage.

O'Malley, D. M., Kelly, P. J., & Cheng, A. L. (2013). Family violence assessment practices of pediatric ED nurses and physicians. *Journal of Emergency Nursing*, *39*, 273–279. doi:10.1016/j.jen.2012.05.028

Piltz, A., & Wachtel, T. (2009). Barriers that inhibit nurses reporting suspected cases of child abuse and neglect. *Australian Journal of Advanced Nursing*, *26*, 93–100. Retrieved from http://hdl.handle.net/2328/32995

Ramachandran, D. V., Covarrubias, L., Watson, C., & Decker, M. R. (2013). How you screen is as important as whether you screen: A qualitative analysis of violence screening practices in reproductive health clinics. *Journal of Community Health*, *38*, 856–863. doi:10.1007/s10900-013-9690-0

Reigstad, B., Jørgensen, K., & Wichstrøm, L. (2006). Diagnosed and self-reported childhood abuse in national and regional samples of child and adolescent psychiatric patients: Prevalences and correlates. *Nordic Journal of Psychiatry*, *60*, 58–66. doi:10.1080/08039480500504933

Sandelowski, M. (2012). Metasynthesis of qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 19–36). Washington, DC: American Psychological Association.

Sikes, A., Walley, C., & Hays, D. G. (2012). A qualitative examination of ethical and legal considerations regarding dating violence. *Journal of Interpersonal Violence*, *27*, 1474–1488. doi:10.1177/0886260511425791

Steinberg, A., Robert, S., Briggs, E. C., Gerrity, E. T., Layne, C. M., Vivrette, R. L., . . . Fairbank, J. (2014). The national child traumatic stress network core data set: Emerging findings, future directions, and implications for theory,

research, practice, and policy. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(Suppl. 1), 50–57. doi:10.1037/a0037798

Stevens, I., & Hassett, P. (2007). Applying complexity theory to risk in child protection practice. *Childhood*, *14*, 128–144. doi:10.1177/0907568207072535

Taylor, J., Daniel, B., & Scott, J. (2012). Noticing and helping the neglected child: Towards an international research agenda. *Child & Family Social Work*, *17*, 416–426. doi:10.1111/j.1365-2206.2011.00795.x

Thoresen, S., Myhre, M., Wentzel-Larsen, T., Aakvaag, H. F., & Hjemdal, O. K. (2015). Violence against children, later victimisation, and mental health: A cross-sectional study of the general Norwegian population. *European Journal of Psychotraumatology*, *6*, Article 26259. doi:10.3402/ejpt.v6.26259

Tiedje, L. B. (2000). Moral distress in perinatal nursing. *Journal of Perinatal & Neonatal Nursing*, *14*, 36–43. doi:10.1177/0969733012462049

Trotochaud, K., Coleman, J. R., Krawiecki, N., & McCracken, C. (2015). Moral distress in pediatric healthcare providers. *Journal of Pediatric Nursing*, *30*, 908–914. doi:10.1016/j.pedn.2015.03.001

Van Niel, C., Pachter, L. M., Wade, R., Jr Felitti, V. J., Jr, & Stein, M. T. (2014). Adverse events in children: Predictors of adult physical and mental conditions. *Journal of Developmental & Behavioral Pediatrics*, *35*, 549–551.

Warner-Rogers, J. E., Hansen, D. J., & Spieth, L. E. (1996). The influence of case and professional variables on identification and reporting of physical abuse: A study with medical students. *Child Abuse & Neglect*, *20*, 851–864. doi:10.1016/0145-2134(96)00073-7

Zimbardo, P. (2007). *The lucifer effect: Understanding how good people turn evil*. New York: Random House.

Zimmer, L. (2006). Qualitative meta-synthesis: A question of dialoguing with texts. *Journal of Advanced Nursing*, *53*, 311–318. doi:10.1111/j.1365-2648.2006.03721.x

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III

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Entering an emotional minefield: professionals' experiences with facilitators to address abuse in child interviews

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Abstract

Background: Extensive research documents that child abuse is widespread and that it has detrimental effects on victims' physical, psychological and social well-being. Efforts to help abused children by removing stressors and administering restorative care can reverse these negative effects, but the evidence suggests that professionals often fail to expose child abuse. This study aims to generate insight into professionals' experiences with facilitators in handling the challenges of addressing abuse in child interviews. We expect that this knowledge can improve interventions that qualify professionals in the identification, protection and care of abused children.

Methods: Within the qualitative approach and an Interpretive Description framework, we performed in-depth interviews with nineteen participants from southern Norway, specifically ten social workers from child protective services and nine psychologists from child mental health services. Then, Interpretive Description analysis was performed by using constant comparison, reflexive and critical examinations, and contextualized theoretical interpretations.

Results: The participants' accounts revealed that various facilitators relative to the stages of the skill development and intrinsic motivation of the practitioner enhance the explorative work of the professional. We identified the following five main themes: (a) *alleviating personal choice*; (b) *collective accountability*; (c) *sharing vulnerability*; (d) *finding your own way*; and (e) *doing it for the right reasons*.

Conclusions: To facilitate explorative work, our findings suggest that competence development should apply goal-directed reflective practice combined with positive feedback on performance. Furthermore, our results indicate that developing personal competence is contingent on supporting individual choice and volition while decreasing demands towards following rules and guidelines. To promote the relatedness and the emotion regulation of professionals, we suggest endorsing shared vulnerability with colleagues and promoting an organizational culture that supports openness and allows professionals to discuss their emotions when addressing difficult and complex issues. It is also advisable to promote autonomy by helping professionals to find meaning in their work that is compatible with their personal values.

Keywords: Exploration, Child abuse, Health care professionals, Social workers, Facilitators

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Background

Reports indicate that professionals often feel that they lack the necessary resources to explore child abuse when conducting child interviews. Professionals are also afraid that they may make matters worse for the child, given that exploring abuse induces such strong negative emotions [1, 2]. Akin to walking a child into a minefield, professionals fear the unpredictability and potential harmful effects to both themselves and the child when broaching the subject of child abuse [1]. Although traditional training and education include theoretical knowledge of child abuse, the methods and assessment tools for addressing child maltreatment, action guidelines, and standardized procedures seem to be unable to resolve the complex challenges with which professionals struggle when interviewing children [1, 2]. Moreover, evidence from studies indicates that professionals in child protective services (CPS) and child and adolescent mental health services (CAMHS) are often unsuccessful in uncovering children's adversities [3–5].

Numerous studies from several disciplines document the detrimental and long-term effects of child abuse, including psychological, physical and sexual abuse and neglect [6–9]. Moreover, maltreatment can impede a child's neurobiological development and cause cognitive, emotional, and relational deficiencies followed by an increased probability for physical and psychological disease, disability, and mortality in adulthood [10]. Studies also indicate a high frequency of child abuse in both Europe and the US [11–13]. Therefore, we must ensure that children are protected from abuse, and we must swiftly offer restorative care to children exposed to such abuse to minimize both the short- and long-term negative consequences. Nevertheless, few abused children who exhibit symptoms that warrant clinical attention receive effective treatment [14, 15]. Therefore, we must assess children's adversities correctly and systematically to diminish further exposure to stressors and reduce their harmful effects. Consequently, the inadequate exploration of abuse within child services may be a key issue that prevents efficient assistance to child victims [3, 16–18]. For instance, research reveals that many victims of child abuse do not disclose their experiences during childhood [5], despite their contact with CPS or CAMHS professionals [3, 18]. Piltz and Wachtel's [19] review of quantitative research reveals that nurses' suspicions of child abuse depended on the individual practitioner's personal characteristics, such as their knowledge, experience, fear of perceived consequences, and lack of emotional support. In a meta-synthesis of qualitative research [1], professionals struggled to address abuse in child interviews because of their emotional discomfort, the complexity and unpredictability of broaching the subject, and the belief that they lack sufficient knowledge and skills to address the issue. Research regarding the origins of professionals' emotional strain when exploring child abuse emphasizes their perceived lack of resources and ability to effectively aid abused children and their concern about their personal empathic involvement [2]. The lack of empirical studies on how professionals overcome their challenges when addressing maltreatment during child interviews indicates a substantial knowledge gap. Accordingly, the aim of the present study is to address the following research question: based on the experiences of professionals, what are the facilitators that allow them to handle the challenges associated with exploring abuse in child interviews?

Method

We used Interpretive Description (ID) methodology [20, 21] to investigate the clinical phenomenon of addressing child abuse while also ontologically and epistemologically applying hermeneutic phenomenological methodology. ID methodology is an applied qualitative approach to address complex experiential questions in health disciplines and uncover subjective and experiential knowledge that can inform clinical practice. Heidegger's [22] phenomenology inspired our approach of the contextual investigation of the participants' lived experiences aimed towards interactively constructing meaning patterns. Heidegger advocated that a person's lived experience is an interpretive process that occurs intersubjectively through communicative signs and language. Our goal to understand the participants' lived experiences with facilitators when addressing child abuse led us to be inspired by Heidegger's concept of the hermeneutic circle, whereas research entails a continuous movement between questions and answers and between implicit preunderstandings and explicit understandings. Similarly, Gadamer's [23] dialogical hermeneutics, which emphasized how all interpretation is a result of the fusion between the horizons of the interpreter and the interpret, also influenced our research. Moreover, Gadamer argued that we must explore a phenomenon from different angles to understand its various aspects. Consequently, when researching the participants' experiences with aspects that facilitated explorative work, we tailored our interviews and our analysis; thus, we could view the phenomenon from different angles. Consistent with both Heidegger's phenomenology and Gadamer's hermeneutics, we have an epistemological perception of research such that it is a product of the complex interplay among the informants, the research process, the context, and the actions of the researchers [24, 25]. Because of this perception, we practiced reflexivity during all parts of the project to identify our preconceptions and how they influenced our interpretations [26, 27]. ID methodology contributed to the achievement of our study goal because the methodology is

constructed to identify themes and patterns from participants' subjective perceptions while acknowledging the researchers' clinical foreknowledge and expertise as influential and beneficial to the research process [20]. We collected data through informed questioning, reflexive critical examination, and contextualized interpretations consistent with ID methodology [21]. Most importantly, ID methodology seeks to generate findings not only in the form of isolated themes but findings that form a coherent professional narrative that experts in the field perceive to be convincing. Thus, the research product should expand clinical understanding and propose practical applications [21].

Recruitment

The first author telephoned seven leaders of CPSs and CAMHSs to introduce the project and ask for permission to interview their employees. All leaders accepted and were subsequently sent an e-mail that delineated the study. Some leaders selected participants and arranged interviews, other leaders forwarded the e-mail and invited interested employees to contact the first author, and one leader shared the employees' contact information with us and allowed us to make direct contact with the employees. We have no knowledge of any employees who declined participation.

Participants

We interviewed 19 participants, namely, 10 social workers (two males) from CPS and nine clinical psychologists (one male) from CAMHS. Because our aim was to investigate professionals' experiences with facilitating aspects to address abuse in child interviews, participants with specialized competence and work experience in the field of child abuse were included. The Norwegian CPS is responsible for upholding children's right to protection from abuse and neglect. They uphold this right by counselling parents, investigating suspected maltreatment, presenting legal claims for child removal, reporting suspected parental legal violations to the police, and providing alternative care. When someone is concerned that a child may be experiencing abuse, they usually report it to CPS. The CPS participants in this study were assigned to investigate suspicions of child abuse and worked in three separate CPS offices that varied in size, geographic location, organization, and demographic area (urban, suburban and rural). The inclusion criteria were a degree in social work and work experience that involved suspected child abuse cases. The participants' work experience ranged from one to 35 years (median 14), and they worked with different client age groups, i.e., preschool and elementary school children and adolescents. The Norwegian CAMHS provides services to children with mental health challenges through individual, group, and family therapy, which means that CAMHS workers meet with many troubled and potentially traumatized children. The inclusion criteria for the CAMHS workers were a degree in clinical child psychology and clinical experience with children exposed to abuse. The CAMHS participants worked in four CAMHS offices that varied in size, geographical location, and organization. These participants had between 10 and 35 years of work experience (median 20), and all CAHMS participants supervised colleagues with lower levels of education.

Data collection method

The first author conducted singular, semistructured, in-depth interviews with all participants. As geographic dispersion created a travel distance, we chose to interview the participants at their workplace to increase the response rate. We developed an interview guide to ensure that key areas of interest were covered, and we supplemented these questions with exploratory spontaneous questions to maximize the collected data [28]. Our interview guide included the following: the participants' successful and challenging experiences with respect to abuse exploration; their thoughts regarding the impact of individual differences; their personal experiences, work experiences and relationships; their perceptions of facilitators, barriers, and improvement strategies; and their suggestions for interventions to improve abuse exploration (see the translated interview guide as an Additional file 1). The mean duration of the interviews was 68 min, the range was 44 to 97 min and the median was 74 min. We transcribed four interviews verbatim, and a professional firm transcribed the remaining interviews by using the same transcription template. All coding and further analyses of the transcripts were performed by the authors. We checked all transcripts for inaccuracies. The 19 transcribed interviews constitute the data for this study.

Researchers

The first author is an organizational psychologist experienced in competence development for professionals and leaders within health and social services. During the data collection, she worked at a regional center for psychological trauma. The second author is a professor in clinical psychology who studies psychotherapy and change processes and is also an experienced psychotherapist. The third author is an experienced clinical therapist and an associate professor in biological psychology who conducts experimental and clinical research on stress and psychological trauma. Our motivation for this study was based on a joint desire to help abused children. However, we were also influenced by research that indicates that many abused children remain undetected, despite contact with various agencies and aid services. Based on

our professional experiences as clinicians and as educators of professionals, we all had a presumptive understanding that addressing child abuse is difficult. Moreover, we also believed that the challenges associated with exploring child abuse are not well-understood and are not often discussed.

Data analysis

Adhering to the general principles of ID methodology, our analytical progression was inductive and entailed constant comparative analysis to extract commonalities and discrepancies between and among the participants with respect to the research question. ID methodology favors coding with a focus on a broad overall picture rather than a line-by-line focus, which is advocated in content analysis. Therefore, we identified codes through reading and constant comparisons and assigned broad and descriptive titles to our emerging codes to capitalize on their potential and expand the analysis with the assistance of Nvivo 8 software [21]. Next, we identified initial meaning units endorsed by intriguing quotations. Evolving in our analytic process, we immersed ourselves in the initial meaning units and explored the data set as a whole to develop and expand our thematic insights. Finally, we searched for conceptual relationships and explored remarkable and divergent meaning units and quotes in relation to the research question. We chose to work as a team with critical reflexive discussions that were enhanced and contested by our diverse experiential and professional backgrounds. In several stages, we described proposed themes with representative quotes, discussed these themes, and then replaced them with improved themes until we developed an organizational structure that we agreed conceptualized the most meaningful set of findings [20].

Results

Our analysis of the participants' accounts of the aspects that facilitated their management of the emotional strain associated with addressing abuse in child interviews produced the following five main themes: (1) *alleviating personal choice* describes how the participants perceived routines and tools to facilitate exploration and alleviate their individual responsibility; (2) *collective accountability* delineates how the participants allayed their doubts through consultations with other professionals; (3) *sharing vulnerability* incorporates openness and emotional support as ways to assist the participants in coping with the challenges associated with addressing abuse; (4) *finding your own way* involves the participants' agreement that overcoming the challenges of explorative work requires courage, reflective experience and practice; and (5) *doing it for the right reasons* means that the participants found it easier to endure stress when they believed that they could make a difference in the lives of abused children. All of these themes were expressed by both the CPS and CAMHS participants with only minor intergroup variances. In the following presentation, "all" participants equals all 19, "most" is equal to 12 to 18 participants, "some" means 5 to 12 participants, and "a few" refers to less than 5 participants.

Alleviating personal choice

Most participants found routines, guidelines and assessment tools to be beneficial in initiating abuse exploration during child interviews. Routines supported them in overcoming inner resistance to asking children about abuse, and they also alleviated their personal responsibilities for making decisions. On the downside, some participants thought that routines and forms were inefficient and served ulterior motives.

Most participants reported that asking about maltreatment caused them to feel mean, and they then feared that they would lose the children's trust. However, an obligation to routinely explore abuse helped many participants to overcome these obstacles, as they could then legitimize their inquiry of the child.

> …But I try to sugar-coat it a bit, that it's something I ask everybody. We've decided that we have to ask everybody, so that's what I do. When I put it like that, it's less uncomfortable to ask. [...] I think it's helpful to use a form as a starting point (#10).

To tell children that they asked everyone these questions made it easier for the participants to raise the subject. Some participants emphasized that explicit routines provided safety for both the professionals and the children. "Even though there'll always be things that'll be difficult, the clearer the guidelines and routines, the more secure the framework will be for us, and it'll be safer for the child" (#3). The participants' understanding of children's safety referred to fair, high-quality services that allowed children to disclose abuse. Some participants also stated that by telling children that the reason they asked everyone is because abuse is common, the children would feel more normal. Similarly, the safety of the participants involved relief from solely depending on their own interpretations and suspicions. One participant explained, "Previously, I acted on my gut feeling that there was something like that through observing the interplay – my impression that this child is hiding something. But now we must ask about it anyhow" (#17).

When the participants had direct orders to always ask about abuse, they found it easier to ask about abuse. "Of course, when it comes to interviews with children, and it's written that we must investigate, you go more into it than if it didn't say that it was mandatory" (#19).

Another advantage to routinely addressing maltreatment was that it became easier to remember to address maltreatment. “The explicit procedure saying that we always have to ask about psychological trauma creates a benchmark for us. It makes it easier. Then, it’s like we can tick the box – we’ve done it. It turns into a kind of checklist” (#14).

Because most participants found it difficult to determine how and when to ask about abuse, some believed that routines and assessment tools helped. “What makes it easier is that there are clear procedures or guidelines on *how* we should do it and maybe *when* we should do it. [...] I’m very fond of using those forms, and I think it’s great that we have them” (#14). Some participants said that they followed routines without thinking about adhering to them. These participants regarded this as testimony to the routines’ efficiency. “There’s a lot we have routines for where I don’t think about it being routine. And I believe that’s a good routine because you don’t think, ‘Oh right, I must follow that routine,’ you just do it” (#6).

Even if most participants said that they used routines and assessment tools, they agreed that these played a miniscule part in the disclosures by children. One participant laughingly summed up the limitations of the assessment tools. “The dream would be to have a tool that told us exactly what questions to ask to get a correct answer” (#6). Another claimed that routinely asking everyone about abuse during a first or second session only elicited disclosure from the children who had already decided to tell. “Those [children] who aren’t ready or can’t do it don’t tell right away no matter what. A superficial investigation is not enough to achieve disclosure” (#16).

Some participants were critical of the extensive use of routines and forms because they believed that some routines were used to limit liability or to document task completion rather than promoting and ensuring the best interest of the children. In fact, some participants perceived that routines could be obstructive.

> Routines are important, but I have a pet peeve. I believe in routines, but sometimes, I think you have them just to look good. You shouldn’t create a routine just because it’s a routine but because it’s something that works. Having a routine that doesn’t work is much worse than having no routines. And I’ve experienced that here, we have a routine just because there must be a routine (#6).

Many participants were afraid that their appraisals and decisions would be challenged by outside parties, and they used guidelines to safeguard themselves from critique. “If we have doubts about something, then we have to check, and then, we’ve covered our backs because at least we’ve checked the guidelines” (#8). Thus, guidelines could induce a false sense of accomplishment for adhering to them while suspending professional judgement.

Collective accountability

Most participants expressed that they felt more confident after discussing difficult calls with colleagues, counselors and leaders. When they were unsure of how to interpret children’s responses and how to act, these discussions allowed them to share accountability for their interpretations and decisions with other people, which therefore eased their fear of critique or of making errors. Additionally, asking other people for their opinions made them feel more confident in the quality of their work.

> If it’s been discussed in the group and with the second caseworker, it’s not just my point of view that led to this conclusion. Then, if there’s still doubt, we have a forum we can confer with to get a broader deliberation. That makes it easier. Court cases are even less stressful since *we* don’t make the final decision (#7).

Many participants thought that routine group discussions functioned as a quality assurance measure.

> All of our cases are discussed after 3 months or 6 months. We check if a diagnosis is set or if we need help. It’s a system to ensure all cases are regularly discussed by a multidisciplinary team. And that’s a [...] quality assurance for us. Because if you’ve forgotten to ask about it, then at least someone will mention it at the evaluation (#14).

This routine made the participants collectively accountable for the case work, including any errors committed. Correspondingly, having their leaders review their work reassured some participants. “I think it’s important that someone does a quality check of important documents and appraisals that we make. It shouldn’t be *one* person making all the decisions that we do. We need supervision. It’s imperative that someone oversees us” (#19). Many participants emphasized the importance of having a colleague with whom to collaborate when appraising a child interview and deciding what to do. One participant stated that “To reassure the workers that they’re not alone [...] because being the only one thinking about it can be a lot. [...] We need someone to turn to and not be left alone in appraising these cases” (#8).

A few participants with short work experience felt reassured when working with experienced colleagues.

> If you're working with someone with extensive work experience, then you have such reassurance [...] to confirm that the approach is good and that we'll do it this way. It creates lots of security right away, and you get a sense of confidence in what you do. [...] I'm on a team that feels good to be on, especially for me as a newcomer, because I have many experienced social workers around me (#3).

In organizational cultures that emphasized abuse-disclosure, many participants found exploration easier. "I think in our culture, everybody agrees that you should ask about it. And that probably makes you more alert to it" (#10). Likewise, many participants highlighted the importance of their leaders' explicit instructions to address abuse. "What's so reassuring is that we know that our leaders' attitudes concur with our own, and then it becomes so much easier to work with it [...] The leaders are very, very important" (#4).

Interestingly, one participant shared that when her heavy workload reduced the quality of her work, she handled her frustration by allocating the responsibility for this to her leader. "I've become more outspoken over the years, like 'okay, I'll take that family too if my leader decides that, but then you have to know that the quality will be so and so.' It does weaken the quality. But if everyone acknowledges that and finds it acceptable, then it's fine by me" (#5). Therefore, attributing the reduced quality of her work to reasons beyond her control allowed her to maintain her self-efficacy.

Sharing vulnerability

All participants described their work with potentially abused children to be so challenging that they needed emotional support to cope. The participants valued comfort from colleagues, a culture for sharing vulnerability in the workplace, and recognition of their worth as a professional.

Most participants emphasized the importance of comfort from colleagues when they felt overwhelmed by difficult emotions. They explained their needs in different ways. "To get counselling to work on myself so I can feel secure that I can handle the information I get" (#17). "Of course, it's vital to be able to talk to colleagues if you've heard things that are difficult to relate to" (#10). Trusting that their colleagues would take time to understand and comfort them made the emotional turmoil more tolerable. As one participant stated, "To be allowed to *disturb* others, your colleagues, because they know that it's not always easy" (#19).

The participants agreed that an open, supportive culture was crucial for efficient collaboration. "Working in a team requires a great deal of security and openness… you know each other and dare to say things, because it's mostly about that" (#9). A key element to this openness was admitting personal vulnerability, shortcomings and insecurities.

> That I can say things such as 'You know what, I find this uncomfortable' and be certain that they won't think that I'm dense or 'you should get it together.' It's never anything like that. And we can talk about everything (#6).

"To have good colleagues…and places where you can discuss things and dare to ask stupid questions" (#5) was identified as vital for collaboration. For example, expressing doubt about their own ability to cope could have the paradoxical effect of increased mastery. "Recognizing your own insecurity is also a qualification, and then, you have places to go and people to ask" (#13). Although many participants had colleagues to whom they could turn, they actually solicited more the collective sharing of vulnerability and emotional reactions. "To have an open dialogue on how [discussions of abuse] can affect you psychologically and what it does to you to have these interviews, I'm sure that would have helped" (#1).

The participants' own self-doubt and emotional distress resulted in insecurities about their worth as professionals. Many shared a wish for other people to recognize their personal value and competence, such as "Not just the case work but also security, personal security that I'm doing a good enough job" (#14). "[You want] To receive some support that the way you acted was good and that it's tough to listen to, and for someone to support my decisions [...] We do need help from the ones we're working with to have faith in ourselves, at least I need that. I need someone to give me a 'thumbs up' now and again" (#19). "To become self-assured, you need feedback and someone that can see that you do good things, too" (#5). When asked what advice she would give other therapists, one participant said "You *know* this. Us devoted therapists have lots of competence and there are no magic tricks or exact solutions, rather it's about using your general competence combined with openness and access to support from colleagues" (#13). One participant explained how feeling significant promoted coping.

> All these things are very important. It's about yourself feeling supported, feeling seen and through that, maybe feeling significant? This makes you want to go to work even if it's a difficult job. "So, it's important because I know from experience that if you start to struggle and become more and more invisible and no one catches you, it's not long before you're in that spiral, and it becomes too hard to do your job" (#7).

Thus, handling difficult emotions became easier when the participants shared their endeavors and their situations with their colleagues. Although most participants expressed gratitude for their colleagues' emotional support and recognition, many wished for greater shared vulnerability and openness about difficult emotional reactions.

Finding your own way: practice, practice, practice

All participants agreed that handling the challenges of exploring abuse depended on reflective experience and practice. They each had to develop their own way of performing their professional role through bravery, experience, practice beforehand, episodes of mastery, and an analysis of their performances and feedback.

Because addressing abuse evoked strong emotions, most participants believed that it required courage and willpower. "It's about daring to ask and not be afraid of missing the mark or making a fool of yourself" (#16). "You must dare to be honest and direct. Dare to ask the difficult questions" (#18). Some participants found that risking to explore abuse taught them that the discomfort was manageable. "I don't know if it'll feel less stressful, but what I'll say is, 'Dare to talk about it.' What I've learned over time is that it's not so dangerous to talk about it, to dare to put into words what it's really about" (#7).

Most participants found that practicing beforehand reduced their discomfort and insecurities. Some talked about practicing with colleagues. "To practice your interviewing technique is key. It's important to become comfortable interviewing and keeping a person on track. It varies with the degree of taboo linked to the questions, but I think it's about training, experience, and being prepared" (#17). "If I think something might be uncomfortable, I do it anyway, but first I talk to someone about it. I get counseling, role play, or reflect on it. [...] To practice talking about it with each other is how you learn that it isn't that scary after all" (#4). One participant recommended practicing alone. "Use the mirror, find sentences that are yours and repeat them. Rehearse your tone of voice. Notice how you may signal that now I'm asking something that I don't really want an answer to, notice your gaze, your voice… Get to know yourself" (#17).

Experiences of mastery increased most participants' level of confidence. "When you have a fair share of experiences of mastery where you contributed…the more of these positive experiences you have, the more self-assured you become that I *can* do this" (#19). "It's about my experience when I have these interviews often and I feel they went okay, and I get feedback from the child that it was fine, or I reveal things and move forward. It strengthens me…" (#8). Some also said confirmation that their past actions were warranted made the tough decisions easier. "Then, at least we're reassured afterwards that we had the right gut-feeling and responded correctly [...] And then you become more confident in your own decisions [...] You gain confidence that makes it easier to take children seriously next time". (#1).

Many participants said that they worked hard to improve by analyzing themselves, their practice, and the feedback from other people. "You need to make an effort to perform well and find out what works and what doesn't. You must invest in it to become good at it" (#6). For some participants, regretful experiences instigated scrutiny from which they learned and then modified their approach. "It's one of those situations I've analyzed… How you meet a child and convey, '[it's] great that you can tell, but you should tell it to someone else.' This was because I didn't think. It was done with the best intentions, but I was supposed to be able to take it" (#5). Many participants said that they needed to work on themselves to improve their approach: "To go in depth because we must work extensively on challenging ourselves to learn […] because we must rehearse it to be able to do it" (#19). They realized that becoming aware of their shortcomings was difficult but necessary. "Then, there's the question of where my blind spots are, and those are more difficult to become aware of. The challenge is the immediate things, the ones I don't see" (#13). "This disbelief that I have, that's important to have an ordered relationship to, because it can get in the way of seeing" (#12).

Most participants believed that accumulated experiences facilitated the exploration of abuse in children. "So I think you need volume training to gain the self-assurance necessary for the child to feel it's okay to tell" (#1). "I think it works pretty well most of the time, but maybe that's because I've done it so many times and feel more self-assured talking about it and to stand to hear what they say" (#2). "For me, it took a few years before everything was comfortable [...], or it can [still] be uncomfortable, but at least you feel that you can take it" (#14).

Training, reflection and experience increased most participants' understanding of their strengths and weaknesses and helped them to develop a personal work style. "Some need a long time while others learn fast, but it's about finding your own [way] and being assured in your own role and not conveying to children that you're insecure and uncomfortable" (#13). "I think it becomes easier and easier the longer I've worked. I'm feeling secure enough to create my own standard sentences" (#14). Another participant emphasized that quality depends on authenticity. "Be yourself. Don't try to be something you're not. Follow the child in the interview,

be present and show that you care" (#7). Some participants explained that being genuine was scary and felt unprofessional although it was crucial for effective interactions. "Maybe just daring to use yourself more. That it's okay to do so" (#8). Some participants explained that they had developed a certain basic knowledge that guided their practice. "I always ask children, 'What's the worst you have experienced in your life,' and then I assess how the child looks when [he/she] tells me" (#17). Developing a personal style when exploring abuse requires courage and diligent effort through practice, experience and self-reflection. However, when the participants were successful, finding their own ways to address abuse improved their confidence, emotion regulation, and self-assessed performance.

Doing it for the right reasons – values and intentions matter

All participants described their work helping abused children as meaningful, and many stated that believing that they could make a difference helped them to tolerate and cope with job-related stress. Moreover, for most participants, the conviction that they were doing it for the right reasons mitigated their fears and insecurities, and acting according to their morals and values created and strengthened their self-respect.

To believe their efforts could create positive changes for children was important to most participants: "To believe that it can change. [...] and to later on learn about subsequent improvements in the home makes the work worthwhile. There are some success stories" (#7). "It's rewarding to work with, and at the same time challenging. It's worthwhile […] I have very good examples that demonstrate it's important work and that you can make a difference" (#13). Some participants also said that the ability to do a good job depended on each professional believing that they could make a difference. "You must have a desire to help and believe that your help works […] You must want to change things and have faith that it can happen" (#6). A few participants said that their knowledge of the harmful effects of abuse increased their motivation to help and strengthened their faith in the meaningfulness of their work. "Understanding how extensive it can be to live with violence and abuse...that it affects basic functioning and that it's beyond just a 'difficult experience'" (#16). Other participants, however, found these challenges to be intriguing. "At the same time, it's an extremely exciting job, too. So, it's full of contrasts really" (#7).

Many participants found it easier to endure the associated discomfort because of their commitment to improving the lives of the children. One participant explained that "When you have a plan in those cases where they've begun to talk about violence, I think it's okay to talk about it. As long as we're moving in the right direction" (#5). Feeling convinced of the child's need for intervention and support also made it easier to address abuse during the interview. "It's easier to ask when the violence is known, because then, it's on the table, and everybody knows" (#9). Sometimes, the participants shared with the child their reasons for asking about abuse. "I notice that it helps a little for me, too, if I explain our responsibility to help to the child and that the reason we ask is that we want to ensure their well-being" (#3). Although most of the participants found their limited ability to control events in the children's lives stressful, reminding themselves of their mission helped. "I can't make things perfect, but to manage to see that you still can make a difference and find some mastery in that helps" (#5). Interestingly, although all participants experienced emotional strain when listening to the children's stories of abuse, a few participants maintained that being in a position to help made it easier to listen. "It can be difficult to hear about violence. I can't watch violence in movies, but it's easier to listen to people telling me about it because then you can contribute, hopefully, and be more than a passive witness to violence as entertainment or news" (#10).

Many participants expressed pride in their work. One participant described her CPS' mentality by stating that "I find that there's a pride in what we do and in our profession" (#3). Other participants expressed their pride differently. "Unfortunately, it's not that often, but it feels meaningful when you can do good and give the child the help [he/she] needs. Then, you think you've accomplished something" (#6). "For me, it's thinking I can make a difference in that child's life" (#4). Even when the participants became unpopular due to their unwelcomed interference, their self-respect and pride in their work helped them to endure. "I think that if I can commit to what I say, and we have a good rationale that's in the child's best interest, and it's a well-founded argument, they can just go on disliking me. I can stand by my choices regardless, because I've done the right thing. And then, it's fine" (#6). Having their work and intentions align with their core values enhanced the participants' self-respect and helped them to manage the hardships and challenges associated with their work.

Discussion

In our study, the participants shared what they perceived to be facilitators for handling challenges and increasing their proficiency when exploring abuse in child interviews. All participants agreed that routines and assessment tools could aid in overcoming inner resistance and in safeguarding decisions, which thus eases the pressure on the child, although some of them worried that routines could diminish professional responsibility and clinical judgement. Discussing their interpretations and

decisions with other professionals relieved the participants' doubts, and they became less fearful of making mistakes. Additionally, by offering comfort, understanding and encouragement, the participants' colleagues and leaders were deemed to be important in facilitating the participants' regulation of difficult emotions to promote their self-worth. All participants agreed that practice was crucial to reducing emotional strain and increasing their competence with respect to exploring abuse. Furthermore, they also agreed that exploration required courage, willpower, repeated reflective practice, and the finding of one's individual work style. Knowing that they did meaningful work that aligned with their core values allowed the participants to tolerate emotionally taxing situations while maintaining their self-respect and believing that they could make a difference.

Our findings indicate that professionals' facilitators for addressing abuse in child interviews are two-dimensional; some facilitators alleviate the participants' emotional strain and doubt, while other facilitators promote the participants' job satisfaction. To help professionals manage difficult emotions and doubt we should offer them emotional support as well as frequent case discussions and joint responsibility for complex decisions and appraisals. Meanwhile in order to increase professionals' job satisfaction we should provide them with practice time and tailored feedback on their performance as well as promote an awareness of their personal values and put focus on the humanitarian goals of this work.

Joining children in the minefield: is it all about motivation?

Given that the facilitators for performing emotionally difficult work are closely related to motivators, we discuss our findings with motivation theory. Ryan and Deci's self-determination continuum [29] can explain the experienced participants' identified facilitators when handling the challenges associated with addressing child abuse, including negative emotions and self-doubt. Our themes fit within their model while detailing the different degrees of extrinsic motivation into various regulatory styles. As depicted in Fig. 1, behavioral regulation and the perceived locus of causality are allocated on a continuum from extrinsic to intrinsic motivation. Our theme, alleviating personal choice, corresponds with externally regulated behavior either by compliance or by response to external rewards and punishments. With respect to introjected regulation, behaviors serve to avoid guilt and fear or to enhance pride and uphold contingent self-esteem, both of which concur with our theme of collective accountability. Our theme, sharing vulnerability, equates to identified regulation given that reflecting goals and actions are valued as individually important. Integrated regulation occurs when developing a professional identity as actions and goals become more congruent and begin to synthesize with the self, although they may still be motivated by extrinsic reasons. Finally, intrinsic regulation occurs when actions and goals are inherently gratifying, as in our theme, doing it for the right reasons.

These dissimilar types of motivation are located on a continuum of relative autonomy or self-determination [30]. As increasing levels of autonomy or internalized motivation amplify work engagement and stress-tolerance [31], they may also improve both achievement effort and performance [32]. Furthermore, relatedness and competence facilitate the internalization of goals and behaviors [29], which explains how feeling connected to and cared for by colleagues and how experiencing efficacious performance increased our participants' mastery of challenges.

To promote autonomous professionals

Given the benefits of autonomous behavioral regulation, such as effectiveness, persistence, well-being and group cohesion, Ryan and Deci [29] suggest engineering the social environment to facilitate the integration of extrinsic motivation. Such autonomy-supportive contexts must relinquish undue pressure towards acting or thinking in a certain way and instead promote freedom of choice and volition while also guiding professionals to find meaning that they can synthesize with their personal values and goals. Focusing on interpersonal involvement and emotional support in the work environment can enhance professionals' relatedness. Providing structure in the work-place for goal-directed endeavors, including positive feed-back regarding performance, can increase perceived competence and intensify intrinsic motivation.

Initially, professionals may strive towards preventing discomfort and achieving self-control, but because this leads to only limited self-awareness and self-development, we anticipate that practice and increased emotion regulation skills will shift their focus towards promotion and growth.

Schwartz [33] argues that any work that involves human interaction requires practical wisdom. Practical wisdom entails goodness in conduct and action, both in the form of the moral will to do good and in the ability to discern the right thing to do in any situation. Consequently, practical wisdom can never be attained through external regulation, such as rules, guidelines, or incentives. In contrast, Schwartz contends that extreme dependence on guidelines prevents professionals from developing moral skills and that unwarranted dependence on incentives weakens their moral will. Moreover, because rules and incentives demoralize professionals and erode practical wisdom, it is crucial to encourage professionals to handle their challenges without relying

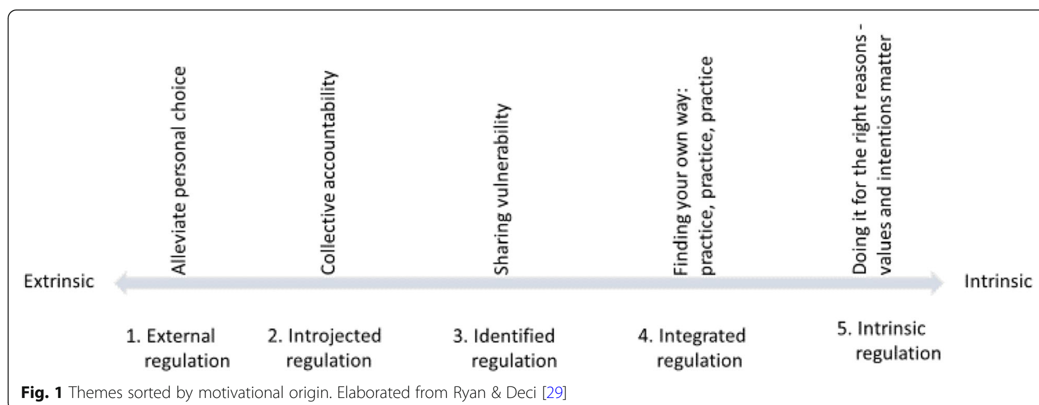

Fig. 1 Themes sorted by motivational origin. Elaborated from Ryan & Deci [29]

on rules and incentives and to guide them towards intrinsic behavioral regulation.

Reflexivity

During the data gathering process, the participants may have been reluctant to reveal their insecurities if they perceived the interviewer as an expert on child abuse due to the interviewer's cited workplace. Accordingly, emphasis was placed on promoting a safe atmosphere and posing open and nondirective questions. The interviewer's experience providing competence development in CPS and CAMHS may have influenced the probing and directionality of the interviews. Similarly, the fact that the interviewer knew the system and was open to critical viewpoints and opinions may also have influenced the way that the participants responded. Interestingly, many participants said that the interview had expanded their reflections and insights regarding themselves and their work.

When analyzing the data, we strived towards a reflexive awareness of our preconceptions, and we continuously discussed how these reflections might affect our interpretation and condensation into themes. The authors have diverse experiences and fields of expertise within the discipline of psychology, which thus added credibility to our findings. However, researchers from different disciplines, such as sociology or anthropology, may have interpreted the data differently according to their educational background.

Scope and limitations

We attempted to maximize the range and variety of the participants' lived experiences in exploring abuse by recruiting participants who varied in age and work experience, were from different geographical locations and worked in organizations of various sizes. Varying the gender distribution, however, was difficult. Our sample include only two male CPS workers and one male CAMHS worker. This reflects the scarcity of men in the workplaces that we contacted and the general gender distribution in these services [34]. As a preliminary analysis revealed no apparent gender differences, we did not expand our recruitment to balance the gender distribution.

Conclusions

Several important points from these findings should guide future interventions that serve to improve professionals' skills when handling the challenges associated with exploring child abuse. We recommend promoting the autonomy of professionals by emphasizing the meaningfulness of their work that is compatible with their personal values. Furthermore, the findings indicate that developing personal competence depends on encouraging individual choice and volition while decreasing the demands towards following rules and guidelines. To facilitate the relatedness and the emotion regulation of professionals, our results suggest endorsing shared vulnerability with colleagues and promoting an organizational culture that supports openness and allows practitioners to discuss their emotions when addressing difficult and complex issues. Finally, we recommend competence development in the area of goal-directed reflective practice combined with positive feedback on performance.

Additional file

Additional file 1: Interview guide. How professionals experience addressing child abuse. Interview guide translated from Norwegian to English. (DOCX 17 kb)

Abbreviations

CAMHS: Child and Adolescent Mental Health Services; CPS: Child Protective Services; ID: Interpretive Description

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Availability of data and materials
The data used in this study are not publicly available due to the potential for identifying the participants from the context and the transcripts if the data were shared. The participants were promised that the raw data would remain confidential.

Authors' contributions
AUA collected the data and was responsible for the application for ethical approval. AUA developed the first version of codes, categories and themes. AUA, PEB and AMM discussed the preliminary categories and themes through several rounds until consensus was reached. AUA wrote the first draft of this manuscript. PEB and AMM contributed with comments to all versions of the manuscript. All authors read and approved the final manuscript.

Ethics approval and consent to participate
This study was conducted in accordance with the International Declaration of Helsinki [35]. The Regional Committee for Medical and Health Research Ethics in southern Norway (REK) assessed that their approval was redundant because the project's informants were from a nonclinical population (REK nr. 2014/301). The Norwegian Center for Research Data (NSD) authorized the study protocol, and all participants were informed both verbally and through written information of their right to withdraw from the study at any time. All participants gave their written consent to participate in the study.

Consent for publication
The participants gave their written consent to publish research from their interviews.

Competing interests
The authors declare that they have no competing interests.

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References

1. Albaek AU, Kinn LG, Milde AM. Walking children through a minefield: how professionals experience exploring adverse childhood experiences. Qual Health Res. 2018;28(2):231–44.
2. Albaek AU, Binder PE, Milde AM. Plunging into a dark sea of emotions: professionals' emotional experiences addressing child abuse in interviews with children. Qual Health Res. 2019. https://doi.org/10.1177/1049732318825145.
3. Ofsted. The voice of the child: learning lessons from serious case reviews. In: The Office for Standards in Education CsSaS, editor. UK: crown; 2011. p. 25.
4. Priebe G, Svedin CG. Child sexual abuse is largely hidden from the adult society. An epidemiological study of adolescents' disclosures. Child Abuse Negl. 2008;32(12):1095–108.
5. Steine IM, Winje D, Nordhus IH, Milde AM, Bjorvatn B, Grønli J, Pallesen S. Delayed disclosure of sexual abuse: predictors and correlates among adult survivors of childhood sexual abuse. Norwegian Journal of Psychology. 2016;53(11):889–99.
6. Berens AE, Jensen SKG, Nelson CA, 3rd. Biological embedding of childhood adversity: from physiological mechanisms to clinical implications. BMC Med 2017;15(1):135.
7. De Bellis MD, Zisk A. The biological effects of childhood trauma. Child Adolesc Psychiatr Clin N Am. 2014;23(2):185–222 vii.
8. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14(4):245–58.
9. LeDoux JE, Pine DS. Using neuroscience to help understand fear and anxiety: A two-system framework. Am J Psychiatry. 2016;173(11):1083–93.
10. Van Niel C, Pachter LM, Wade R Jr, Felitti VJ, Stein MT. Adverse events in children: predictors of adult physical and mental conditions. J Dev Behav Pediatr. 2014;35(8):549–51.
11. Finkelhor D, Turner HA, Shattuck A, Hamby SL. Violence, crime, and abuse exposure in a national sample of children and youth: an update. JAMA Pediatr. 2013;167(7):614–21.
12. Jernbro CJ, S. A national survey. Violence against children in Sweden. The children's welfare foundation. 2016.
13. Thoresen S, Myhre M, Wentzel-Larsen T, Aakvaag HF, Hjemdal OK. Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population. Eur J Psychotraumatol. 2015;6: 26259.
14. La Greca AMB, B. A.; Jaycox, L. H.; Kassam-Adams, N.; Mannarino, A. P.; Silverman, W. K.; Tuma, F.; Wong, M. Children and trauma. APA presidential task force on posttraumatic stress disorder and trauma in Children & Adolescents. American Psychological Association. 2009.
15. Steinberg AMP, Robert S, Briggs EC, Gerrity ET, Layne CM, Vivrette RL, Beyerlein B, Fairbank JA. The National Child Traumatic Stress Network Core Data set: emerging findings, future directions, and implications for theory, research, practice, and policy. Psychol Trauma Theory Res Pract Policy. 2014; 6(Suppl 1):50–7.
16. Blount RL, Simons LE, Devine KA, Jaaniste T, Cohen LL, Chambers CT, et al. Evidence-based assessment of coping and stress in pediatric psychology. J Pediatr Psychol. 2008;33(9):1021–45.
17. Cameron M, Elkins J, and Guterman N. Assessment of trauma in children and youth. In N. B. Webb (Ed.), Working with traumatized youth in child welfare NY. Guilford Press; 2006.
18. Reigstad B, Jørgensen K, Wichstrøm L. Diagnosed and self-reported childhood abuse in national and regional samples of child and adolescent psychiatric patients: Prevalences and correlates. Nordic Journal of Psychiatry. 2006;60(1):58–66.
19. Piltz A, Wachtel T. Barriers that inhibit nurses reporting suspected cases of child abuse and neglect. Aust J Adv Nurs. 2009;26(3):93–100.
20. Thorne S, Kirkham SR, O'Flynn-Magee K. The analytic challenge in interpretive description. Int J Qual Methods. 2004;3(1):1–11.
21. Thorne S. In: Morse J, editor. Interpretive description. Qualitative research for applied practice. 2nd ed. New York: Routledge. Taylor & Francis Group; 2016. p. 336.
22. Heidegger M. Being and Time. Oxford: Blackwell Publishing; 1962.
23. Gadamer HG. Truth and method: continuum international publishing group; 1975. p. 593.
24. Binder P-E, Holgersen H, Moltu C. Staying close and reflexive: an explorative and reflexive approach to qualitative research on psychotherapy. Nordic Psychology. 2012;64(2):103–17.
25. Laverty SM. Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. Int J Qual Methods. 2003;2(3):21–35.
26. Alvesson MS, K. Reflexive Methodology: New vistas for qualitative research: SAGE; 2009.
27. Finlay LG, Reflexivity B. A practical guide for researchers in health and social science. Oxford: Blackwell Publishing; 2003. p. 250.
28. Kvale SB, Interviews S. Learning the craft of qualitative research interviewing. Los Angeles: SAGE; 2009.
29. Ryan RM, Deci EL. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. Am Psychol. 2000;55(1):68–78.
30. Ryan RM, Connell JP. Perceived locus of causality and internalization: examining reasons for acting in two domains. J Pers Soc Psychol. 1989; 57(5):749–61.

31. Parker SL, Jimmieson NL, Amiot CE. Self-determination as a moderator of demands and control: implications for employee strain and engagement. J Vocat Behav. 2010;76(1):52–67.
32. Vansteenkiste M, Soenens B, Lens W. Intrinsic versus extrinsic goal promotion in exercise and sport: understanding the differential impacts on performance and persistence. Intrinsic motivation and self-determination in exercise and sport. Champaign, IL: Human Kinetics; 2007. p. 167–80. 337-40
33. Schwartz B. Practical wisdom and organizations. Res Organ Behav. 2011;31:3–23.
34. Johansen I. Turnover in the municipal child protective services. In: Statistics Cbo, ed. Norway: Department of Children, equality, and inclusion; 2014. p. 35.
35. World Medical Association. World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects. Bulletin of the World Health Organization. 2001;79(4):373–74.

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How professionals experience addressing child abuse

Interview guide translated from Norwegian to English

1. Will you please tell me about your experiences asking children and youth if they have been exposed to various types of child abuse?
    a. Can you describe in detail a situation where you felt it was okay to ask?
    b. Can you describe in detail a situation where you felt it was challenging to ask?
    c. What do you think was the reasons for this?
2. Do you have experiences where you either have revealed a child's exposure to child abuse or cases where you have had a strong suspicion of child abuse?
    a. Will you tell me more about your experience related to this/those cases?
    b. What did you learn from this/those experiences?
3. What, in your opinion, is influential when asking children and youth about adverse experiences?
    a. If relevant, what do you think may have contributed to making you insecure in the situation?
    b. How do you think personal experiences contribute? If you find them influential, would you elaborate on what type of experiences matter?
    c. Could you say some more about how this is interrelated?
4. How do you experience characteristics of your work environment affect how challenging you find it to ask?
    a. How do you feel your relationships with your colleagues influence your asking?
    b. The manner of leadership on your work place, how do you feel that influences how easy or challenging it is to ask?
    c. How do you experience routines and guidelines affect asking the children?
    d. How do you feel the culture at your work place influences you? Are there any unwritten rules that you think affect if it is easy to ask or not?
    e. Are there other factors in the system you work in that you believe can influence how you feel about asking children about adverse events? Do you think the cooperation with other organizations somehow influence how easy it is to ask?
5. How are your experiences of taking care of the child while inquiring about child abuse?
6. Will you please describe as much as possible of things you feel influences your experience of how easy or difficult it is to ask children whether they have been exposed to adverse experiences?
7. What advice would you give to other professionals for them to feel less challenged asking children.
8. What advice Would you give to leaders to make it easier for professionals to ask to children about negative experiences?
9. What advice would you offer to agents providing competence development regarding exploration of child abuse in children and youth? What do you think would make a difference?

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	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999 V	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.

	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.
H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.
	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000 V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001 V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.

	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002 V	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.
	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.
	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003 V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.

	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004 V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.
	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.
	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
2004 H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005 V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
2005 H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.

	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
2006 V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.
	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.
	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consiousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
2006 H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children’s psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects

	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
2007 V	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson’s disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr.psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints
	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work
	Thuen, Elin Marie, Dr.philos.	Learning environment, students’ coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
2007 H	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
2008 V	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.

	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
2008 H	Brønnick, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.
	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
2009 V	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Konwledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners

2009 H	Skorpen, Aina Øye, Christine	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes
	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour
	Wageningen, Heidi Karin van	The role of glutamate on brain function
	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
2010 V	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevold	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools

H	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
	Bjørkelo, Brita	Whistleblowing at work: Antecedents and consequences
	Reme, Silje Endresen	Common Complaints – Common Cure? Psychiatric comorbidity and predictors of treatment outcome in low back pain and irritable bowel syndrome
	Helland, Wenche Andersen	Communication difficulties in children identified with psychiatric problems
	Beneventi, Harald	Neuronal correlates of working memory in dyslexia
	Thygesen, Elin	Subjective health and coping in care-dependent old persons living at home
	Aanes, Mette Marthinussen	Poor social relationships as a threat to belongingness needs. Interpersonal stress and subjective health complaints: Mediating and moderating factors.
	Anker, Morten Gustav	Client directed outcome informed couple therapy
	Bull, Torill	Combining employment and child care: The subjective well-being of single women in Scandinavia and in Southern Europe
	Viig, Nina Grieg	Tilrettelegging for læreres deltakelse i helsefremmende arbeid. En kvalitativ og kvantitativ analyse av sammenhengen mellom organisatoriske forhold og læreres deltakelse i utvikling og implementering av Europeisk Nettverk av Helsefremmende Skoler i Norge
	Wolff, Katharina	To know or not to know? Attitudes towards receiving genetic information among patients and the general public.
	Ogden, Terje, dr.philos.	Familiebasert behandling av alvorlige atferdsproblemer blant barn og ungdom. Evaluering og implementering av evidensbaserte behandlingsprogrammer i Norge.
	Solberg, Mona Elin	Self-reported bullying and victimisation at school: Prevalence, overlap and psychosocial adjustment.
2011 V	Bye, Hege Høivik	Self-presentation in job interviews. Individual and cultural differences in applicant self-presentation during job interviews and hiring managers' evaluation
	Notelaers, Guy	Workplace bullying. A risk control perspective.
	Moltu, Christian	Being a therapist in difficult therapeutic impasses. A hermeneutic phenomenological analysis of skilled psychotherapists' experiences, needs, and strategies in difficult therapies ending well.
	Myrseth, Helga	Pathological Gambling - Treatment and Personality Factors

	Schanche, Elisabeth	From self-criticism to self-compassion. An empirical investigation of hypothesized change prosesses in the Affect Phobia Treatment Model of short-term dynamic psychotherapy for patients with Cluster C personality disorders.
	Våpenstad, Eystein Victor, dr.philos.	Det tempererte nærvær. En teoretisk undersøkelse av psykoterapautens subjektivitet i psykoanalyse og psykoanalytisk psykoterapi.
	Haukebø, Kristin	Cognitive, behavioral and neural correlates of dental and intra-oral injection phobia. Results from one treatment and one fMRI study of randomized, controlled design.
	Harris, Anette	Adaptation and health in extreme and isolated environments. From 78°N to 75°S.
	Bjørknes, Ragnhild	Parent Management Training-Oregon Model: intervention effects on maternal practice and child behavior in ethnic minority families
	Mamen, Asgeir	Aspects of using physical training in patients with substance dependence and additional mental distress
	Espevik, Roar	Expert teams: Do shared mental models of team members make a difference
	Haara, Frode Olav	Unveiling teachers' reasons for choosing practical activities in mathematics teaching
2011 H	Hauge, Hans Abraham	How can employee empowerment be made conducive to both employee health and organisation performance? An empirical investigation of a tailor-made approach to organisation learning in a municipal public service organisation.
	Melkevik, Ole Rogstad	Screen-based sedentary behaviours: pastimes for the poor, inactive and overweight? A cross-national survey of children and adolescents in 39 countries.
	Vøllestad, Jon	Mindfulness-based treatment for anxiety disorders. A quantitative review of the evidence, results from a randomized controlled trial, and a qualitative exploration of patient experiences.
	Tolo, Astrid	Hvordan blir lærerkompetanse konstruert? En kvalitativ studie av PPU-studenters kunnskapsutvikling.
	Saus, Evelyn-Rose	Training effectiveness: Situation awareness training in simulators
	Nordgreen, Tine	Internet-based self-help for social anxiety disorder and panic disorder. Factors associated with effect and use of self-help.
	Munkvold, Linda Helen	Oppositional Defiant Disorder: Informant discrepancies, gender differences, co-occuring mental health problems and neurocognitive function.
	Christiansen, Øivin	Når barn plasseres utenfor hjemmet: beslutninger, forløp og relasjoner. Under barnevernets (ved)tak.

	Brunborg, Geir Scott	Conditionability and Reinforcement Sensitivity in Gambling Behaviour
	Hystad, Sigurd William	Measuring Psychological Resiliency: Validation of an Adapted Norwegian Hardiness Scale
2012 V	Roness, Dag	Hvorfor bli lærer? Motivasjon for utdanning og utøving.
	Fjermestad, Krister Westlye	The therapeutic alliance in cognitive behavioural therapy for youth anxiety disorders
	Jenssen, Eirik Sørnes	Tilpasset opplæring i norsk skole: politikeres, skoleledederes og læreres handlingsvalg
	Saksvik-Lehouillier, Ingvild	Shift work tolerance and adaptation to shift work among offshore workers and nurses
	Johansen, Venke Frederike	Når det intime blir offentlig. Om kvinners åpenhet om brystkreft og om markedsføring av brystkreftsaken.
	Herheim, Rune	Pupils collaborating in pairs at a computer in mathematics learning: investigating verbal communication patterns and qualities
	Vie, Tina Løkke	Cognitive appraisal, emotions and subjective health complaints among victims of workplace bullying: A stress-theoretical approach
	Jones, Lise Øen	Effects of reading skills, spelling skills and accompanying efficacy beliefs on participation in education. A study in Norwegian prisons.
2012 H	Danielsen, Yngvild Sørebø	Childhood obesity – characteristics and treatment. Psychological perspectives.
	Horverak, Jøri Gytre	Sense or sensibility in hiring processes. Interviewee and interviewer characteristics as antecedents of immigrant applicants' employment probabilities. An experimental approach.
	Jøsendal, Ola	Development and evaluation of BE smokeFREE, a school-based smoking prevention program
	Osnes, Berge	Temporal and Posterior Frontal Involvement in Auditory Speech Perception
	Drageset, Sigrunn	Psychological distress, coping and social support in the diagnostic and preoperative phase of breast cancer
	Aasland, Merethe Schanke	Destructive leadership: Conceptualization, measurement, prevalence and outcomes
	Bakibinga, Pauline	The experience of job engagement and self-care among Ugandan nurses and midwives
	Skogen, Jens Christoffer	Foetal and early origins of old age health. Linkage between birth records and the old age cohort of the Hordaland Health Study (HUSK)

	Leversen, Ingrid	Adolescents' leisure activity participation and their life satisfaction: The role of demographic characteristics and psychological processes
	Hanss, Daniel	Explaining sustainable consumption: Findings from cross-sectional and intervention approaches
	Rød, Per Arne	Barn i klem mellom foreldrekonflikter og samfunnsmessig beskyttelse
2013 V	Mentzoni, Rune Aune	Structural Characteristics in Gambling
	Knudsen, Ann Kristin	Long-term sickness absence and disability pension award as consequences of common mental disorders. Epidemiological studies using a population-based health survey and official ill health benefit registries.
	Strand, Mari	Emotional information processing in recurrent MDD
	Veseth, Marius	Recovery in bipolar disorder. A reflexive-collaborative exploration of the lived experiences of healing and growth when battling a severe mental illness
	Mæland, Silje	Sick leave for patients with severe subjective health complaints. Challenges in general practice.
	Mjaaland, Thera	At the frontiers of change? Women and girls' pursuit of education in north-western Tigray, Ethiopia
	Odéen, Magnus	Coping at work. The role of knowledge and coping expectancies in health and sick leave.
	Hynninen, Kia Minna Johanna	Anxiety, depression and sleep disturbance in chronic obstructive pulmonary disease (COPD). Associations, prevalence and effect of psychological treatment.
	Flo, Elisabeth	Sleep and health in shift working nurses
	Aasen, Elin Margrethe	From paternalism to patient participation? The older patients undergoing hemodialysis, their next of kin and the nurses: a discursive perspective on perception of patient participation in dialysis units
	Ekornås, Belinda	Emotional and Behavioural Problems in Children: Self-perception, peer relationships, and motor abilities
	Corbin, J. Hope	North-South Partnerships for Health: Key Factors for Partnership Success from the Perspective of the KIWAKKUKI
	Birkeland, Marianne Skogbrott	Development of global self-esteem: The transition from adolescence to adulthood
2013 H	Gianella-Malca, Camila	Challenges in Implementing the Colombian Constitutional Court's Health-Care System Ruling of 2008
	Hovland, Anders	Panic disorder – Treatment outcomes and psychophysiological concomitants
	Mortensen, Øystein	The transition to parenthood – Couple relationships put to the test

	Årdal, Guro	Major Depressive Disorder – a Ten Year Follow-up Study. Inhibition, Information Processing and Health Related Quality of Life
	Johansen, Rino Bandlitz	The impact of military identity on performance in the Norwegian armed forces
	Bøe, Tormod	Socioeconomic Status and Mental Health in Children and Adolescents
2014 V	Nordmo, Ivar	Gjennom nåløyet – studenters læringserfaringer i psykologutdanningen
	Dovran, Anders	Childhood Trauma and Mental Health Problems in Adult Life
	Hegelstad, Wenche ten Velden	Early Detection and Intervention in Psychosis: A Long-Term Perspective
	Urheim, Ragnar	Forståelse av pasientaggresjon og forklaringer på nedgang i voldsrate ved Regional sikkerhetsavdeling, Sandviken sykehus
	Kinn, Liv Grethe	Round-Trips to Work. Qualitative studies of how persons with severe mental illness experience work integration.
	Rød, Anne Marie Kinn	Consequences of social defeat stress for behaviour and sleep. Short-term and long-term assessments in rats.
	Nygård, Merethe	Schizophrenia – Cognitive Function, Brain Abnormalities, and Cannabis Use
	Tjora, Tore	Smoking from adolescence through adulthood: the role of family, friends, depression and socioeconomic status. Predictors of smoking from age 13 to 30 in the “The Norwegian Longitudinal Health Behaviour Study” (NLHB)
	Vangsnes, Vigdis	The Dramaturgy and Didactics of Computer Gaming. A Study of a Medium in the Educational Context of Kindergartens.
	Nordahl, Kristin Berg	Early Father-Child Interaction in a Father-Friendly Context: Gender Differences, Child Outcomes, and Protective Factors related to Fathers’ Parenting Behaviors with One-year-olds
2014 H	Sandvik, Asle Makoto	Psychopathy – the heterogenety of the construct
	Skotheim, Siv	Maternal emotional distress and early mother-infant interaction: Psychological, social and nutritional contributions
	Halleland, Helene Barone	Executive Functioning in adult Attention Deficit Hyperactivity Disorder (ADHD). From basic mechanisms to functional outcome.
	Halvorsen, Kirsti Vindal	Partnerskap i lærerutdanning, sett fra et økologisk perspektiv

	Solbue, Vibeke	Dialogen som visker ut kategorier. En studie av hvilke erfaringer innvandrerungdommer og norskfødte med innvandrerforeldre har med videregående skole. Hva forteller ungdommenes erfaringer om videregående skoles håndtering av etniske ulikheter?
	Kvalevaag, Anne Lise	Fathers' mental health and child development. The predictive value of fathers' psychological distress during pregnancy for the social, emotional and behavioural development of their children
	Sandal, Ann Karin	Ungdom og utdanningsval. Om elevar sine opplevingar av val og overgangsprosessar.
	Haug, Thomas	Predictors and moderators of treatment outcome from high- and low-intensity cognitive behavioral therapy for anxiety disorders. Association between patient and process factors, and the outcome from guided self-help, stepped care, and face-to-face cognitive behavioral therapy.
	Sjølie, Hege	Experiences of Members of a Crisis Resolution Home Treatment Team. Personal history, professional role and emotional support in a CRHT team.
	Falkenberg, Liv Eggset	Neuronal underpinnings of healthy and dysfunctional cognitive control
	Mrdalj, Jelena	The early life condition. Importance for sleep, circadian rhythmicity, behaviour and response to later life challenges
	Hesjedal, Elisabeth	Tverrprofesjonelt samarbeid mellom skule og barnevern: Kva kan støtte utsette barn og unge?
2015 V	Hauken, May Aasebø	«*The cancer treatment was only half the work!*» A Mixed-Method Study of Rehabilitation among Young Adult Cancer Survivors
	Ryland, Hilde Katrin	Social functioning and mental health in children: the influence of chronic illness and intellectual function
	Rønsen, Anne Kristin	Vurdering som profesjonskompetanse. Refleksjonsbasert utvikling av læreres kompetanse i formativ vurdering
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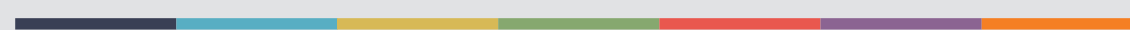

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