Infancy and domestic violence

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The case that was presented to the symposium highlighted the impact of witnessing domestic violence on the health and development of an infant. For privacy reasons the full paper cannot be published. An outline of the presentation is summarised and some of the literature relevant to the particular case presented.

The case presented at the symposium concerned an 11-month-old infant, admitted to hospital because her weight and height were below the 3rd percentile. She had not gained weight for six months. Although well hydrated she showed signs of muscle wasting and on admission was diagnosed with Failure to Thrive and Rickets. She was breast fed, vomited formula and was eating only small amounts of solid food.

The case study described the baby's initial presentation and then progress in hospital with medical treatment alone, prior to a referral to the Infant Mental Health Team and disclosure of domestic violence. The assessment of the infant's emotional state and relationship with each parent, as well as the assessment of each parent's emotional state and the family dynamics, was presented. The impact of the hospital's early medical management (before disclosure of domestic violence) on the family power relationships and consequently the infant and mother's emotional state was explored.

The presentation also discussed how domestic violence might impact on an infant, resulting in feeding difficulties and failure to gain weight.

The aetiology of failure to thrive may be organic, psychological, or a mixture of the two. Chatoor classifies eating or feeding disorders of infancy linking their onset to the emotional tasks of particular developmental phases (Chatoor, 1997).

0-2 months	Disorders of homeostasis
2-6 months	Disorders of attachment
6-36 months	Disorders of separation and individuation

Chatoor proposes an added Post Traumatic Feeding Disorder – which is pervasive food refusal secondary to traumatic oral experiences related to medical procedures (naso-gastric tubes, gagging and choking on food). Although this infant had not had any of these experiences, her feeding refusal can be understood as a post traumatic feeding disorder.

Winnicott, a British paediatrician and psychoanalyst, wrote that the first mirror that the baby looks into is its mother's face – as the baby looks into her mother's face she see reflected back what the mother sees as she looks at the baby (Winnicott, 1971). Thus what the baby sees in her mother's face while drinking can have a powerful impact on the feeding interaction. If what is 'dished up' with the milk is too frightening, or too intense, the baby might avert her gaze, be on and off the breast, clamp her mouth shut and completely refuse, or vomit what she does take in.

In the case presented, violence occurred during breast feeding. Thus one can imagine that this baby could approach subsequent feeds in a hypervigilant state, and that for her and her mother feeding could evoke memory of the trauma. This baby accepted the breast but did not take much in. In the second six months of life (and particularly after teeth appear) feeding involves coming to terms with aggressive impulses and being confident that the mother can survive these. This can be a near impossible step for a baby whose mother is physically and emotionally bruised.

Attachment behaviours promote the infant's close proximity to parent and also evoke parental anxiety to keep the parent close to their infant. The infant is continually and simultaneously appraising potential danger or stress in the environment and the whereabouts and accessibility of their attachment figure. Bowlby described how attachment behaviour is complementary to exploration – when attachment behaviour is activated, eg, by fear, then exploration is shut down, and when attachment (proximity, security) is achieved, attachment behaviours shut down and exploration can occur (Bowlby, 1959). When the infant's attachment figure (and secure base) is under threat, the infant is not free to explore the environment. Thus an infant may be less likely to wean from the breast or accept solid food if their relationship with their mother is not secure, or if the environment is threatening and impinging.

There is a body of knowledge developing about infants who have witnessed violence – infants growing up in communities of violence as well as those living with family violence. Infants and toddlers exposed to overwhelming traumatic events experience similar symptoms to adults and older children with their symptoms having a developmentally determined expression.

Very young infants use primitive defences to cope with extreme anxiety and thus infants in situations which cause extreme anxiety have difficulty regulating effects. They may present as hypervigilant or extremely withdrawn. Withdrawal responses and avoidance, including avoidance of feeding, exploration and interpersonal interaction, may be evident (Drell, Siegal & Gaensbauer,1993).

In older infants post traumatic response includes:

- Re-experiencing the traumatic event (traumatic play, re-enactment play, dissociative response, eg, dazed expression, stereotypical behaviour, extreme withdrawal, periodic unresponsiveness);
- Numbing of responsiveness (emotionally subdued, socially withdrawn, restricted play);
- Hyperarousal (irritability, emotional lability, temper tantrums, hypervigilance or signs of fear and aggression, eg, head banging, scratching own face).
(Zeanah & Scheeringa, 1996)

Factors that are considered to lead to severe responses include:

- Intensity of traumatic event;
- Child's proximity;
- Witnessing versus hearing about the event;
- Familiarity/identification with perpetrator, victim or both.
(Osofsky, 1996)

In domestic violence all of the factors that increase the severity of the post traumatic response apply. Usually in traumatic circumstances the immediate support and emotional availability of caregivers mitigates adverse effects. However, the obverse may happen when the trauma is perpetrated in the family – the presence of the violent parent is a cause for alarm for the child. The parents' capacity to deal with the trauma themselves is an important influence in how successfully they can provide their child with the emotional resources to deal with trauma. Parents exposed to violence are likely to have difficulty being emotionally available, sensitive and responsive to their children (they are in survival mode, they may be dissociating or suffering from other PTSD symptoms themselves, ie, they may be traumatised by their own exposure to violence) (Osofsky, 2000).

The literature emphasises that reinstitution of a safe, stable and nurturing environment is crucial for recovery from trauma. In the case presented the intervention included:

- A structured ward program that enhanced the infant's autonomy and pleasure in feeding, provided developmentally appropriate play therapy and interaction experiences, and minimised impingement and anxiety for the infant;
- A referral to statutory protective services to ensure safety for the mother and infant. This included seeking a court order with conditions that supported the mother-infant relationship as the primary nurturing relationship;
- Allocation of a primary nurse as an adjunct attachment figure and a primary nursing team while the infant was an in-patient; and
- Mother-infant psychotherapy.

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