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Practice Commentary

Therapeutically Supporting Children to Recover from the Impact of Family Violence

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Family violence (also referred to as *Domestic Violence* and *Intimate Partner Violence*) describes violence that occurs within an intimate relationship, whether a current or former partner. Children can experience a range of abuses (emotional, physical, sexual and neglect) within the context of family violence, and harm is cumulative and may present as complex trauma. This paper is based on a practice presentation delivered at the *International Childhood Trauma Conference* in Melbourne (Australia) in June 2016. The purpose of this paper is to increase awareness of the impacts for children who have experienced family violence, to enhance understanding of the mechanisms that contribute to their trauma presentation, and to highlight the specific practice issues and considerations in providing therapeutic support to this client population, with the ultimate aim of improving diagnostic and treatment outcomes for children impacted by family violence. Sufficient safety and stability are required for children to experience therapeutic change, and if family violence is current, the initial response needs to be protective. Identification of family violence should prompt practitioners to use trauma-informed assessment and trauma-focused evidence-based treatments within a family therapy and systems framework. Family violence is complex and there are many barriers to treatment and practice considerations. Expansion of practitioner knowledge and skills in family violence trauma will enhance outcomes for children who have experienced family violence.

■ **Keywords:** Family violence, domestic violence, intimate partner violence, children, trauma

Introduction

Debate exists about terminology used to describe the experience of violence in the home and various terms are used throughout research, policy and practice (Campo, 2015). *Family Violence* is a broad term used to describe a range of interpersonal violence that might occur in the context of family relationships (e.g., elder abuse, sibling violence, etc.), however, contemporarily in mainstream Australia the term has increasingly been used to refer to *Domestic Violence*, also known as *Intimate Partner Violence*, to describe the violence that may occur within an intimate relationship, whether a current or former partner. The term *Family Violence* is favourable as it inherently acknowledges there are multiple victims within a family and is therefore more inclusive of children's experience of violence within their home. It also more accurately reflects this type of violence as a community issue with significant social and economic costs, rather than confined to impacts experienced within a domestic setting. Furthermore, the term *Family Violence* is commonly used in Aboriginal and Torres Strait Islander communities as it is considered a better representation of the extended family and kinship relationships of Indigenous Australians (Campo, 2015; Mitchell, 2015).

Family violence typically has a dynamic of power and control, where one person intentionally uses power in a pattern of coercive behaviours to control their partner (or ex-partner) through fear. Family violence can include a range of abusive behaviours that cause physical, sexual and psychological harm (World Health Organisation (WHO), 2016), and while legal definitions of family violence vary between jurisdictions within Australia, it can include physical and sexual violence, threats and intimidation, emotional, verbal, financial and spiritual abuse, and the abuse of children.

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Current data indicates family violence is gendered, predominately perpetrated by males against females (Australian Bureau of Statistics (ABS), 2006, 2012), and in 2013, the WHO identified violence against women and their children as a human rights issue (WHO, 2013). Latest reporting confirms family violence occurs in the presence of children (ABS, 2006, 2012), however, the prevalence of children exposed in Australia is hard to quantify due to the hidden nature and under-reporting of this form of violence. Data about children is not consistently recorded when family violence is reported, and children are considered the 'silent' victims of family violence (Mitchell, 2015).

Children are not Passive Witnesses–the Impact of Family Violence

Children do not need to directly witness violence to be hurt, and they can experience a range of abuses (emotional, physical, sexual and neglect) within the context of family violence. Family violence is a repetitive pattern of abusive behaviour and is child abuse; the harm caused to children is cumulative and directly impacts on outcomes in adulthood (Anda et al., 2006).

Family violence can change the way a child's brain develops (Perry, 2001). How a child's developmental trajectory is impacted depends, in part, on the age and developmental stage when exposure begins, as well as the length of exposure, and the severity of the family violence. The hierarchical nature of brain development means babies and young children are neurodevelopmentally more vulnerable to experience trauma (Perry, 2008). Children who grow up in family violence often present with *complex trauma*, also referred to as *developmental trauma* (van der Kolk, 2005). A protective factor is a child's experience of secure attachment with their primary care giver (van der Kolk, 2014), however, this attachment experience is less likely in family violence.

Why Attachment Matters

Attachment theory (Bowlby, 1958) suggests humans have innate survival strategies that drive babies to connect with their primary care giver so they survive and thrive. It has become evident during many years of clinical practice that in situations in which family violence occurs, a child does not experience their caregiving relationships as safe and protective, instead these relationships are the source of trauma with parents experienced as either 'frightening' (the perpetrator of family violence) or 'frightened' (the victim of family violence). Within the dynamic of power and control, the abusive parent will often directly attack the attachment bond between mother and child (e.g., Mum may be actively prevented from comforting or attending to the child's basic needs, children may be forced to participate in the abuse of mum, etc.), consequently this pattern of disrupted parental attunement and responsiveness to the child's needs impairs the quality of attachment (Bogat, Levendosky, von Eye, & Davidson, 2011; Buchanan, 2008).

A child who experiences distress in the context of secure attachment has access to repeated experiences of soothing comfort, e.g., eye-contact, touch, rocking, soothing noise, etc., co-regulation that strengthen neural pathways to develop capacity to emotionally self-regulate and calm physiological arousal. Alternatively, a frightened child who does not have a parent available to them – e.g., during incidents of family violence a mother struggles to manage her own safety and may separate from her child to ensure their safety – does not receive necessary co-regulation and is likely to develop neural pathways primed for threat without developing capacity to self-regulate and manage distress (Perry, 1997). Consequently, the child is left with a high level of fear, is unlikely to experience important relational repair with their care givers, or make meaning of and adaptively integrate the distressing experience. This early relational trauma can have a catastrophic impact on a child's worldview, their ability to emotionally self-regulate, and capacity to form healthy relationships into the future (Perry, 1999).

Family Violence Trauma–What Does it Look Like?

Children who have experienced family violence often present with symptoms of *Post-Traumatic Stress Disorder* (DSM-V; American Psychiatric Association, 2013). The intrusive re-experiencing symptoms are the triggered unresolved memories of the trauma. Using avoidance children try to reduce their experience of triggered distress. Alterations in arousal are common and reflect a child with a dysregulated system, who has a small *window of tolerance* for distress and limited capacity to self-regulate (Siegel, 1999). In the context of the danger experienced in family violence, a child's brain may operate on 'high alert' ready to protect against real or perceived threats. Focused on survival, a child may appear easily distracted with hyperactivity and sometimes aggression as their brain and body are literally at the ready to fight or run for their life. Dissociative symptoms are also common for children who have experienced family violence since infancy (Putnam, 1996). Babies are often in the arms of parents when family violence occurs and dissociation is a survival strategy, providing mental flight when physical escape is impossible, and to 'not know' the fear of parents who they rely on for survival. A child who has grown up in family violence may also experience a range of issues common in complex trauma presentations such as, attention and learning problems, developmental delays and regressions, poor sensory integration, somatic complaints and problematic self-soothing strategies (van der Kolk, 2014).

In our clinical experience, as a child adapts to their experience to survive, they develop family violence trauma-related negative core beliefs like 'I am unsafe', 'adults can't be trusted', 'I am un-loveable', etc. that influences their

thinking, feelings and behaviours, and lays the foundation for their understanding about self, others and the world into adulthood. A child who feels unsafe in the world may attempt to enhance their sense of safety through controlling behaviours, often misinterpreted as defiance and an inability to manage change. They are likely to have an unstable sense of self and poor self-worth that also impairs their capacity to initiate and maintain meaningful relationships. A child who has experienced family violence will often have poor relational templates and boundaries (rejecting or too familiar) and may perceive danger in any person, particularly adults.

Family Violence and Trauma-Informed Assessment: A Diagnostic Issue

All clients should be screened for family violence as it will not always be disclosed or evident at referral. Practitioners need to safely ask (i.e., see parents separately) about family violence (past and present), and need to be aware of and look for indicators. Referral for support may be a rare opportunity for a child to obtain help and safety.

Identifying family violence is not only a safety issue, but a diagnostic one. Case conceptualisation and diagnosis based on symptom presentation, without considering a background of family violence, risks pathologising children for what might be a dominant aspect of the family violence trauma symptom presentation (e.g., DSM-V diagnoses of ADHD, the anxiety, mood or behavioural disorders, etc.). Children respond to trauma in adaptive ways of survival that can present as 'negative' behaviours, which in the context of their experience are better understood as a means of self-protection. Using a trauma framework helps ask 'what happened to you'? rather than 'what is wrong with you'? to look beneath presenting behaviours to understand the ways a child is expressing their post-traumatic distress. It is also important to assess the 'good child' who may be overly-compliant and attempt to please people in an effort to stay connected, or may withdraw in an attempt to not be noticed as a means of maintaining safety. Children with this type of survival adaptation internalise their post-traumatic distress and can often be overlooked in service provision as they may otherwise appear unaffected by their experience. Identification of family violence during psychosocial assessment will inform decision making about appropriate trauma-focused psychometric assessment and the use of trauma-focused evidence-based treatments. The family violence is then clearly identified as the 'problem' rather than the child (Powell & Morrison, 2015).

Safety and Stability

Before providing a therapeutic response, an explicit assessment about whether a child has sufficient safety from the range of abuses that occur in family violence is paramount. Without physical and psychological safety therapeutic outcomes will be limited. Parental separation does not equate to a child's safety from further abuse, as family violence frequently escalates post-separation and children are at particular risk of further exposure at this time (Campo, 2015). Questions about safety include: Is family violence current? What is the pattern and history of family violence (predictor of future risk)? Are there legal protective orders? Is there a Family Law Court order, parenting agreement or informal contact arrangement? What is the impact of contact on the child? If current risk issues are identified a therapeutic response might not be indicated and the protective parent may require other types of support to enhance safety (e.g., legal, child protection, etc.). Post-separation family violence can go on for years and monitoring client safety is an ongoing assessment throughout therapy.

Safety and stability also needs to be assessed in the systems surrounding the child. This includes assessment of the protective parent who may have their own trauma impacts which makes stable parenting difficult, and they may require their own therapeutic support. Therapeutic parenting work focuses on strengthening the parent/child dyad (Wesselmann, Schweitzer, & Armstrong, 2014). Young people may choose to engage independently of their parent, and it is important to ensure they have adequate internal and external resources to support their trauma resolution work.

It is important to work with other systems (e.g., educational, medical, etc.) that support the child (Saxe, Eliis, & Kaplow, 2007) and to strengthen existing external resources and identify what additional resources are required for stabilisation and make appropriate referrals. Supporting these systems to understand and manage a child's trauma presentation will support inclusion for the child, and facilitate relational repair within these systems too (e.g., see *Making SPACE for Learning: Trauma Informed Practice in Schools.* Australian Childhood Foundation, 2010).

Recovery from Family Violence

Currently there is minimal published research on effective interventions for children specifically impacted by family violence (Bunston, Pavlidis, & Cartwright, 2016). In the absence of a rich evidence-base to inform therapeutic intervention, practitioners should consider using trauma-focused treatments (e.g., *Eye-Movement Desensitisation and Reprocessing* and *Trauma-Focused Cognitive-Behavioural Therapy* [Australian Psychological Society, 2013; Phoenix Australia Centre for Posttraumatic Mental Health, 2013; WHO, 2013]) drawing from the existing evidence-base in childhood trauma. Treatment that addresses the body as well as brain is essential to trauma recovery (Ogden, Minton, & Pain, 2006; van der Kolk, 2014). Treatment also needs to be individualised to meet the developmental and trauma needs of the child, and the use of play is important (Gomez, 2012).

Family therapy is indicated to work with the mother and child to heal the attachment often impaired by family violence (Bogat et al., 2011; Campo, 2015), to provide opportunities for repeated experiences of relational safety and

support any necessary relational repair. Family therapy does not involve the perpetrating parent, as the therapeutic space will not be experienced by the child as psychologically safe and may become another forum for the offending parent to exert power and control, therefore family therapy does not aim to 'treat' the family violence but focuses on trauma recovery for the child and repairing the relationship with their mother. If the offending parent is motivated to take responsibility for and change their behaviour, and wants to access therapeutic support, practitioners should direct them to a specialist family violence perpetrator program. The offending parent needs to engage with their own therapy separately from the mother and child, and demonstrate significant and sustained behaviour change – the violence and abuse needs to stop – before any consideration is given to inviting them into the therapy room to repair the relationship with their child.

Trauma recovery involves resourcing the child to increase emotional regulation, repair core beliefs, repair attachment and create healthy relational templates. It also involves trauma processing that enables a child to adaptively integrate their experiences into a coherent narrative, in a way that helps a child view their survival behaviours positively – as strengths and acts of resistance and not indicative of being 'broken' – to improve self-worth, and integrate a complete and stable sense of self (Lovett, 2015). For example, making new meaning about a child's aggressive behaviour can be re-told as the child's brain and body knowing something was wrong and fighting off danger to keep them-self safe. Viewing survival behaviour as adaptive at the time of the original trauma is empowering for the client, and helps reduce shame and address problematic behaviour in the context of current safety.

Practice Considerations

Family violence is complex and many barriers to treatment can be present. In our clinical experience, these can include, but are not limited to:

- Further exposure to family violence or other retraumatising experiences – will impact on therapeutic progress and outcomes.
- Protective parent functioning – may fluctuate depending on their experience of post-separation family violence, trauma presentation and recovery, housing issues, financial constraints, and ongoing legal proceedings regarding protective orders, assault charges, property settlement and child custody matters, that will all involve the perpetrator of family violence. Ensure the protective parent has adequate support networks to address practical and emotional support needs as required.
- Practitioner expertise – have they sufficient expertise in working with children/young people, complex trauma, and family violence? Ensure you develop your professional knowledge and skills, and consultation with a practitioner with expertise is essential. This is a complex field and the power and control dynamic can easily invade the therapeutic setting with an inexperienced practitioner.
- Service delivery context – is the practice context appropriate for the intervention required? e.g., session limits, ability to do family therapy, safety issues and any conflict of interests.

If a practitioner identifies family violence but cannot provide the extent of intervention required, it is important to acknowledge these limitations and refer to a practitioner who can provide a comprehensive specialist therapeutic response.

Stalking behaviours are common and practitioners need to consider client safety, put safety plans in place and provide a safe therapeutic space with adequate security and duress systems. Practitioner safety and well-being is also important, consider your safety and protect your personal life. Regular clinical supervision with a professional who has expertise in family violence and management of vicarious trauma is essential.

Conclusion

Family violence harms children, they can experience impairments in emotional regulation, development, and attachment, and may present with complex trauma. The harm caused to children is cumulative and directly impacts on outcomes in adulthood, so the early identification and appropriate treatment of family violence trauma is critical to promote positive outcomes for children, families and communities into the future. Sufficient safety and stability are required for children to experience therapeutic change, and if family violence is current the initial response needs to be protective. Identification of family violence should prompt practitioners to use trauma-informed assessment and trauma-focused evidence-based treatments within a family therapy and systems framework. Family violence is complex and there are many barriers to treatment and practice considerations. Clinical practitioners have an important role in helping children to recover from family violence trauma. Expansion of practitioner knowledge and skills in family violence trauma, and regular clinical supervision from a practitioner with expertise in the family violence sector will enhance outcomes for children who have experienced family violence.

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