USING A 'WOMEN'S AID' SUPPORT NEEDS ASSESSMENT (SNA) TO INVESTIGATE THE MENTAL HEALTH OF CHILDREN IN DOMESTIC ABUSE REFUGES

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How does Domestic Abuse harm children?

Through:

- abuse in pregnancy leading to adverse outcomes.
- the sequelae of poor maternal mental health
- witnessing violent episodes
    - 75% directly witnessed violence; 10% witnessed sexual assault of their mother; 20-70% physically abused
- the social and educational disruption in consequence of fleeing violence.
- the association of domestic abuse and child abuse

What is the nature of that harm?

- **Physical health**.
  - •Low birth weight; poor immunisation and surveillance rates; children with chronic conditions without access to specialist services; increase health risking behaviours in adolescent girls; abuse and neglect; death.
- **•Cognitive development and educational achievement.**
  - •developmental delay; 8-point reduction in IQ ; school problems (bullying, educational failure and school exclusion.)
- **•Mental health**

Mental health

- 2 meta analyses : living with domestic abuse causes increased emotional and behavioural problems in children
- Witnessing physical aggression has a greater effect then witnessing just verbal aggression
- boys' & girls' experiences within violent families are different
  - husbands' aggression to wives correlate positively to parents' aggression towards sons
  - boys report higher levels of mother-to-child aggression than girls
  - boys more likely to engage in domestic violence as adults
  - females more likely to become victims.
- Study of **refuge population** showed over 50% scoring above threshold for CAHMS assessment using Rutter behavioural screening questionnaire

Aims & Objectives

1. Evaluate the usefulness of a Cardiff Women's Aid* Support Needs Assessment (SNA) to investigate the mental health of children coming into refuge.

2. Provide a preliminary description of the mental health of this population to inform service need.

3. Provide recommendations to enhance the SNA in order to screen more effectively for at risk children and target interventions more effectively

* an NGO providing refuge to women victims of domestic abuse

Setting

- Cardiff. Population = 320,000
  - c75,000 are aged <17
  - in one year 3,924 reports of domestic abuse received by Cardiff Police
  - 2,152 involved children aged <17
- Subjects:
  - Children staying at any one of the 5 Cardiff Women's Aid refuges in a specified year and receiving care from SafeAs (included 6 individuals aged 18 -21)

Method (5 medical students doing SSCs)

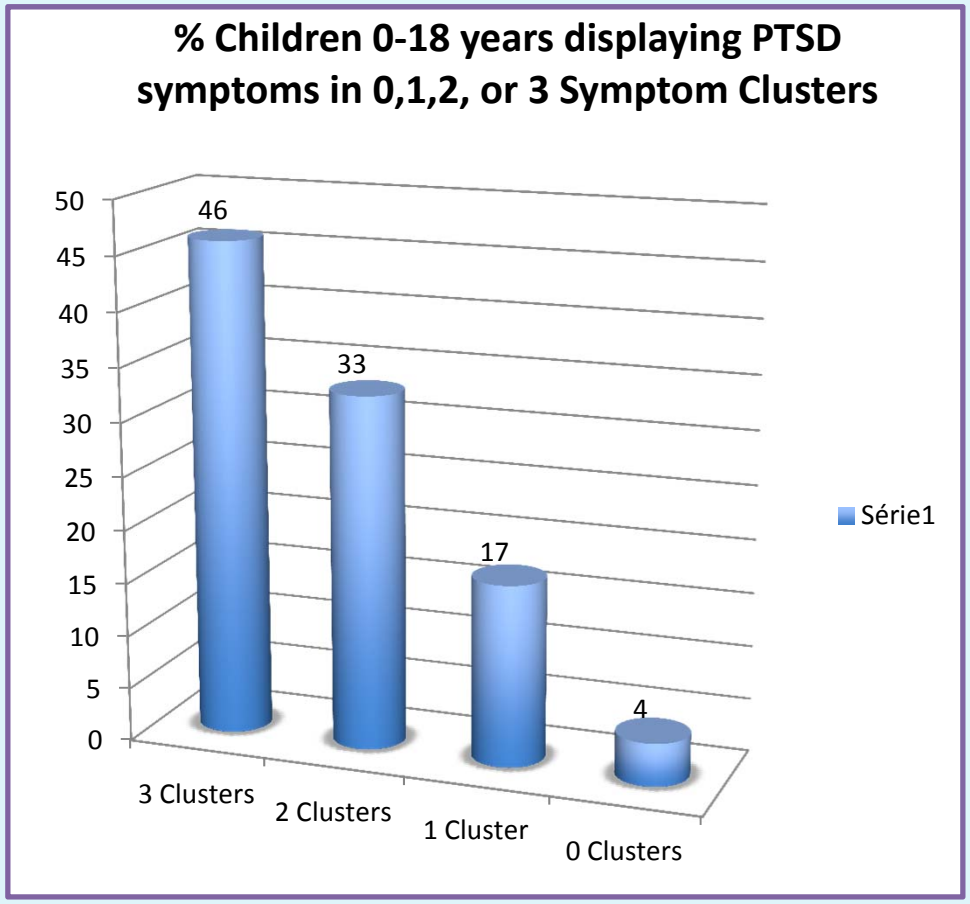
- Mapping of questions from the SNA to
  - PTSD symptoms based on ICD10 and DSM IV (only children in the first 6 months of the study)
  - externalising and internalising behaviours based on the literature (including abusive behaviours and aggression)
  - minimisation
- Retrospective audit of SafeAs database against PTSD symptom clusters and behaviours relating to emotional and behavioural difficulties
- Observation of interviews to appreciate context

PTSD Symptoms

There is no "gold standard" assessment to diagnose PTSD symptoms in children and adolescents.

PTSD Symptom Clusters according to ICD-10	DSM-IV Child Specific Amendments	PTSD related symptomatology in Child Support Need Assessment
Cluster B: Re-experiencing Intrusive flashbacks, vivid memories, recurring dreams.	Repetitive play, trauma specific behavioural re-enactment (physical, emotional, abusive).	**Nightmares Re-enactment Abusive behaviour**
Cluster C: Avoidance Of circumstances resembling/associated with stressor.		**Avoidance Minimising**
Cluster D: Hyperarousal Inability to recall, difficulty sleeping, angry outbursts, difficulty concentrating, hypervigilance.	Aggression, oppositional behaviour, regression in developmental skills, separation anxiety, new fears.	**Memory loss, Hypervigilance, Difficulties sleeping, Angry outbursts, Hyperactivity, Bed wetting, Attachment difficulties.**

PTSD: Of 98 children 79 had data collected related to PTSD:
36/79 (46%) had symptoms in all 3 of the clusters for PTSD (18m and 18f)
PTSD was more common in older children



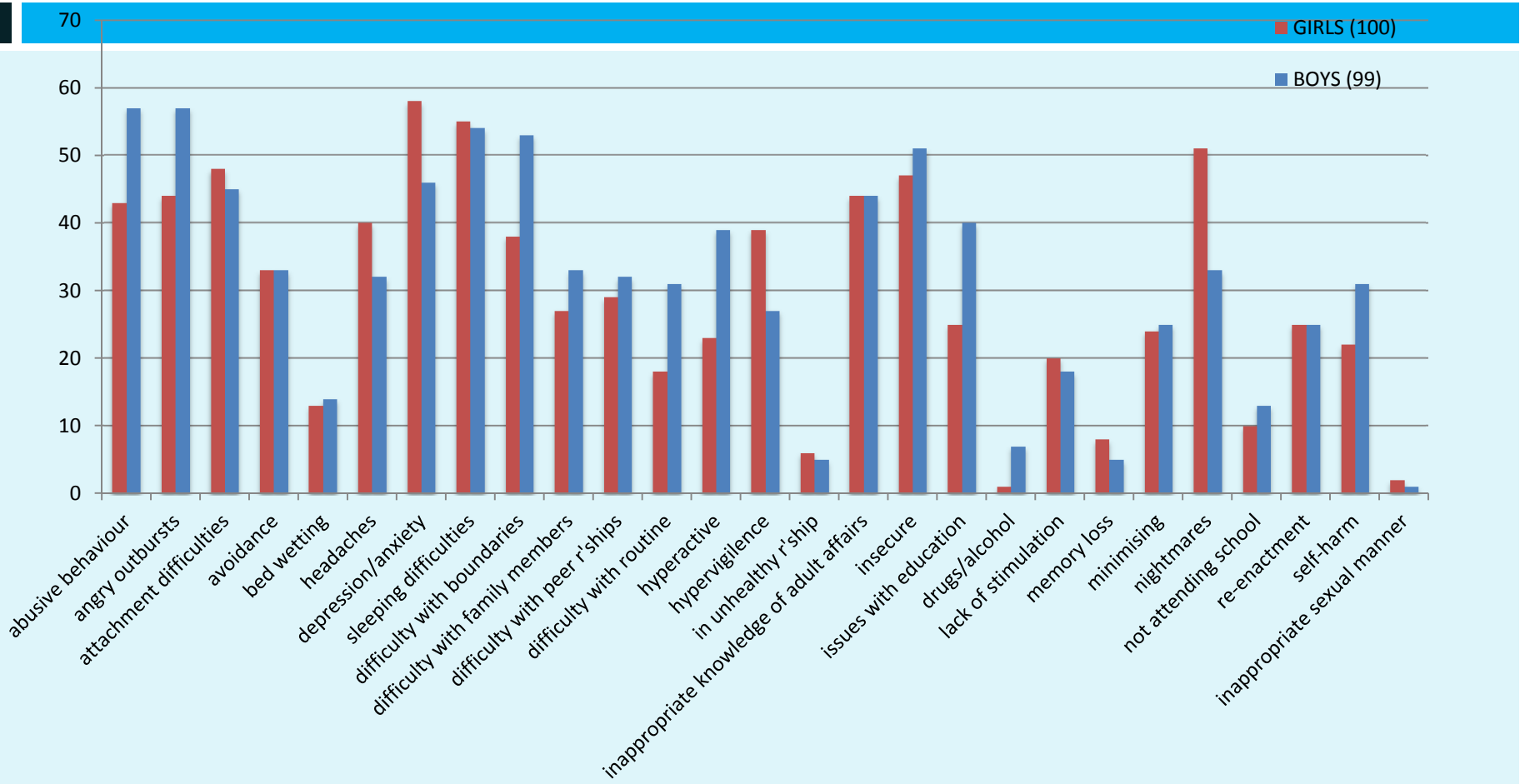
Cluster B: Re-experiencing
Intrusive flashbacks, vivid memories, recurring dreams.

Cluster C: Avoidance
Of circumstances resembling/associated with stressor.

Cluster D: Hyperarousal
Inability to recall, difficulty sleeping, angry outbursts, difficulty concentrating, hypervigilance.

Externalising	Internalising
Abusive behaviour	Attachment Difficulties
Angry outbursts	Avoidance (of contact, engagement with workers)
Difficulty with boundaries	Bed wetting
Difficulty with family members	Headaches
Difficulty with peer relationships	Depression/Anxiety
Difficulty with routine	Sleeping difficulties
Hyperactive	Insecure
Hyper-vigilance	Lack of stimulation/socialisation
Re-enactment	Memory loss
Inappropriate sexual manner	Nightmares
	Drugs/Alcohol
	In an unhealthy relationship
	Inappropriate knowledge of adult affairs
	Self harm
	Issues around school /nursery
	Not attending school

Numbers of children displaying internalising and externalising symptoms



Externalising behaviours by gender

Externalising SNA symptoms	GIRLS (%)	BOYS (%)
Abusive behaviour	43 (43)	57 (58)
Angry outbursts	44 (44)	57 (58)
Difficulty with boundaries	38 (38)	53 (54)
Difficulty with family members	27 (27)	33 (33)
Difficulty with peer relationships	29 (29)	32 (32)
Difficulty with routine	18 (18)	31 (31)
Hyperactive	23 (23)	39 (39)
Hyper-vigilance	39 (39)	27 (27)
Re-enactment	25 (25)	25 (25)
Inappropriate sexual manner	2 (2)	1 (1)

Internalising behaviours by gender

SNA	GIRLS (%)	BOYS (%)	SNA	GIRLS (%)	BOYS (%)
Sleeping difficulties	55 (55)	54 (55)	**Other issues education**	25 (25)	40 (40)
Insecure	47 (47)	51 (52)	**Drugs/Alcohol**	1 (1)	7 (7)
Lack of stimulation	20 (20)	18 (18)	**Self-harm**	22 (22)	31 (31)
Bed wetting	13 (13)	14 (14)	**Nightmares**	51 (51)	33 (33)
Memory loss	8 (8)	5 (5)	**Headaches**	40 (40)	32 (32)
Not at school	10 (10)	13 (13)	**Depression/Anxiety**	58 (58)	46 (46)
Attachment Difficulties	48 (48)	45 (46)	**In an unhealthy relationship**	6 (6)	5 (5)
Avoidance	33 (33)	33 (33)	**Inappropriate knowledge**	44 (44)	44 (44)

Abusive behaviour:

Of 199 children 182 had data collected related to abusive behaviours.

	Aged < 4 (%)	4-8 (%)	9-12 (%)	13-18 (%)	Male (%)	Female (%)	Total
Abusive	11 (48)	37 (49)	34 (63)	18 (65)	**57 (63)**	**43 (47)**	**100**
Non-Abusive	12 (52)	39 (51)	20 (37)	10 (35)	33 (37)	49 (53)	**99**
Total	**23**	**76**	**54**	**28**	**90**	**92**	**182**

Common across all groups, but appears more likely in males and older children.

'*He hits his mother and sister regularly. Mum thinks he is copying his father'*

Minimisation

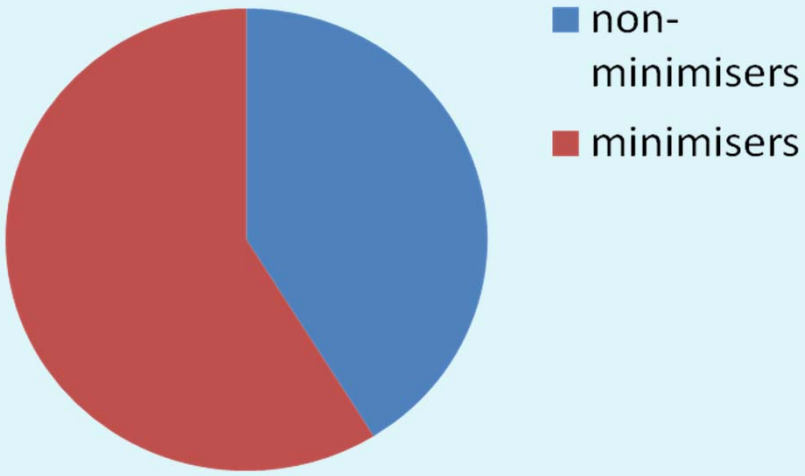
Of 199 children 177 had data collected related to minimisation

- Normalisation of violence
- Not a symptom but a **coping strategy**
- More common in older children

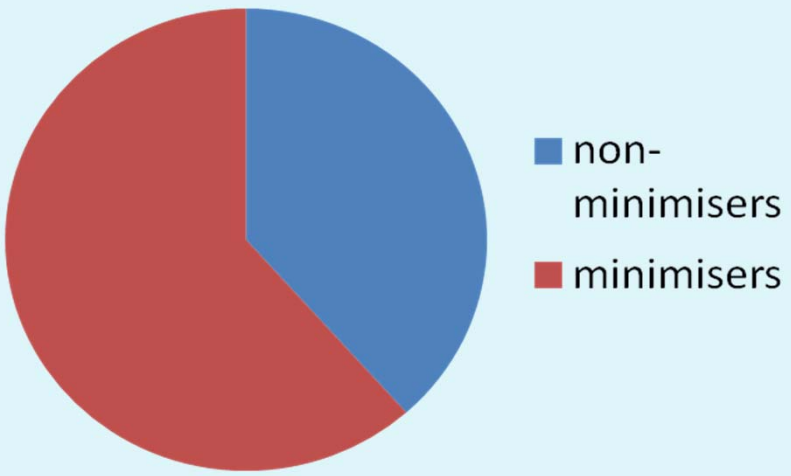
Gender	Minimisers 49	Non-minimisers 128
Male	25/86 (29%)	61/86 (71%)
Female	24/91 (26%)	67/91 (74%)
Age		
0-6	**10/65 (15%)**	55/65 (85%)
7-11	**22/72 (31%)**	50/72 (69%)
12-18	**17/37 (46%)**	20/37 (54%)

minimisation and behaviours

internalising behaviours



externalising behaviours



Minimisers appear to show more behavioural problems of all types

Limitations

- Opportunistic study
  - Support Needs Assessment not specifically designed to screen for PTSD and other behavioural symptoms.
- (Mainly) Maternal reports of children's symptoms
- Variation in questioning style between assessors
- Missing data

Conclusions: - the SNA

- Needs refinement to better match accepted symptom clusters
- The assessment needs repeating after a period in refuge
- Refuge workers need training to ensure consistency

Conclusions & Suggestions - Mental health

- Many children have symptoms of PTSD and emotional and behavioural problems
- 25% show minimisation as a coping strategy; this seems to be associated with more emotional and behavioural difficulties and is thus a **maladaptive strategy**
- There is a gender difference in response to domestic abuse.
- Many boys (and quite a lot of girls) exhibit “difficult behaviour” and are stereotyped as BAD or diagnosed with “ADHD”. **It is important that children’s behaviours are recognised as a *consequence* of domestic violence and not the *cause* of family conflict** (or an indication for medication).
- Refuge staff need formal support from Child Mental Health Services to help them provide a therapeutic environment for these children

Thank you

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Key References

1. Edleson J. Children's Witnessing of Adult Domestic Violence. *Journal of Interpersonal Violence* 1999; 14(839):839-870. www.sagepub.com/content/14/8/839 (accessed 20 November 2012)
2. Webb E, Shankleman J, Evans M, Brooks R. The health of children in refuges for women victims of domestic violence: cross sectional descriptive survey. BMJ 2001; 323: 210-213. www.bmj.com/cgi/content/full/323/7306/210 (accessed 20 November 2012)
3. Hughes M, Jones L. *Women, Domestic Violence, and Posttraumatic Stress Disorder (PTSD).* Department of Health and Human Services. Report Number 1. 2000
4. Kaminer D, Seedat S, Stein D. Post-traumatic stress disorder in children. World Psychiatry 2005; 4(2): 121-125. (accessed 20 November 2012)
5. Wolfe, D.A., et al., *The effects of children's exposure to domestic violence: A meta-analysis and critique.* Clinical Child and Family Psychology Review, 2003. **6**(3): p. 171-187.
6. Kitzmann K, G.N., Holt A, Kenny E, *Child Witnesses to Domestic Violence: A Meta- Analytic Review.* Journal of Consulting and Clinical Psychology, 2003. **71**(2): p. 339-352.
7. Brooks R & Webb E. *Helping Families Who Are Victims of Domestic Abuse. In* Mental Health Interventions and Services for Vulnerable Children and Young People*. Ed. Panos Vostanis.* London 2007. Jessica Kingsley Publishers

□Hofstra, M.B., Van Der Ende, J. and Verhulst, F.C. Adolescents' Self-reported Problems as Predictors of Psychopathology in Adulthood: 10-year follow up study. *British Journal of Psychiatry*. 2001;179:203-209.
□Chan, Y., Dennis, M.L. and Funk, R.R. Prevalence and Co-morbidity of Major Internalizing and Externalising Problems among Adolescents and Adults presenting to Substance Abuse Treatment. *Journal of Substance Abuse Treatment*. 2008;34(1):14-24.
□Lochman, J.E., Powell, N.R., Clanton, N. and McElroy, H.K. Anger and Aggression. In G. Bear and K. Minke (Eds.) *Children's needs III*. Bethesda, MD: National Association of School Psychologists; 2006.
□Cebulla, A. and Tomaszewski, W. *Risky Behaviour and Social Activities*. London:National Centre for Social Research; 2009.
□Milich, R., and Landau, S. The Role of Social Status Variables in Differentiating Subgroups of Hyperactive Children. In L. M. Bloomingdale and J. M. Swanson (Eds.) *Attention deficit disorder*. Oxford, England: Pergamon Press; 1989.
□Lewinsohn, P. M., Rohde, P., Seeley, J. R., Klein, D. N., and Gotlib, I. H. Psychosocial Functioning of Young Adults who have Experienced and Recovered from Major Depressive Disorder during Adolescence. *Journal of Abnormal Psychology* 2003;112(3): 353-363
□Lewinsohn, P. M., Rohde, P., and Seeley, J. R. Psychosocial Risk Factors for Future Adolescent Suicide Attempts. *Journal of Consulting and Clinical Psychology* 1994;62(2):297- 305
□Bayer, J.K., Hastings, P.D., Sanson, A.V., Ukoumunne, O.C. and Rubin, K.H. Predicting Mid-Childhood Internalising Symptoms: A Longitudinal Community Study. *International Journal of Mental Health Promotion* 2010;12(1): 5-17
□Hodas, G.R. Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care. *Pennsylvania Office of Mental Health and Substance Abuse Services*; 2006
□Cristensen, L., Marchant, M. and Caldarella, P. Effective Positive Behaviour Interventions for Students with Internalizing Behaviour Problems. In: Positive Behaviour Support Initiative, *4th International Conference on Positive Behaviour Support*. Boston,MA; 2007.
□Gundersen, K.K. Reducing Behaviour Problems in Young People through Social Competence Programmes. *The International Journal of Emotional Education* 2010;2(2):48-62.
□Finkelhor, D. & Browne, A. Initial and Long-Term Effects: A Conceptual Framework. In D. Finkelhor (ed.) *A Sourcebook on Child Sexual Abuse*. Beverly Hills: Sage Publications; 1986.
□Plumb, J.C. and Orsillo, S.M. and Luterek, J.A. A Preliminary Test of the Role of Experential Avoidance in Post-event Functioning. *Journal of Behaviour Therapy and Experimental Psychiatry* 2004;35(3):245-257.
□Rapport, M.D., Denney, C.B., Chung, K-M, and Hustace K. Internalizing Behaviour Problems and Scholastic Achievement in Children: Cognitive and Behavioural Pathways as Mediators of Outcome. *Journal of Clinical Child Psychology* 2001;30(4):536-551.
□El-Sheikh, M. *Sleep and Development: Familial and Socio-cultural Considerations*. New York: Oxford University Press; 2011.
□Campbell, S. B. Behavior Problems in Preschool Children: A Review of Recent Research. *Journal of Child Psychology and Psychiatry*. 1995;36(1): 113–149.
□Boucher, M. An Exploration of Experiences Teachers' Relationships with Traumatized Students [PhD]. California: California Institute of Integral Studies; 2012.
□Stanley, N., Miller, P., Foster, H.R. and Thomson, G. *Children and Families Experiencing Domestic Violence: Police and Children's Social Services' Responses*. London: NSPCC; 2010.
□Jordan, S.S. Further Validation of the Child Routines Inventory (CRI): Relationship to Parenting Practices, Maternal Distress and Child Externalizing Behaviour [PhD]. Louisiana: Louisiana State University; 2003.