VisAble
Enabling Safer Lives and Communites

Child to parent violence and abuse: New Zealand’s invisible family violence.

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www.visable.co.nz

“Instead of running, I would stand there and silently will her to stab me, just so it would all be over once and for all.”

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Who we are

VisAble is a disabled person led organisation. People employed work in the areas of disability rights, safeguarding, adult safeguarding, and the prevention of violence against disabled people. We are dedicated to ending violence towards tāngata and whānau whaikaha Māori, tagata sa'ilimalo and their āiga-tele, d/Deaf, disabled people, Adults at Risk (across the lifespan) and their families. Together we have extensive experience and expertise in working with the disability communities, government, police, health, disability and the family violence and sexual violence sectors. Our goal is to create safety and wellbeing and improve outcomes for people who are experiencing violence, abuse and neglect.

> When we say people in this report we mean tāngata and whānau whaikaha Māori, tagata sa'ilimalo and their āiga-tele, d/Deaf, neurodivergent, disabled people, Adults at Risk (across the lifespan) and their families.

Everyone in Aotearoa New Zealand has the right to live their good life free from violence and abuse.

Nothing about us without us

Disabled people experience higher rates of violence than non-disabled people and our experiences are not often recognised or considered in conversations about preventing violence. We believe that an inclusive approach that meets the needs of all New Zealanders can only occur when there is recognition and acknowledgement of the marginalisation and exclusion of people in the current system, and when people have the power to lead solutions that meet our needs and aspirations.

Our Vision

For all tāngata whaikaha Māori, tagata sa'ilimalo, d/Deaf, neurodivergent and disabled people to achieve their aspirations to live their good lives, including to be respected, included and welcomed into their communities and wider society, free from harm, violence and abuse.

Our Mission

VisAble encompasses the concepts of **visible** and **enable** and sums up in a single word our mission of making violence against people and Adults at Risk visible while enabling a more disability responsive family violence and sexual violence system.

What We Do

VisAble works to equip and enable individuals and organisations, working with, or who come into contact with, people who are impacted by violence, to make their services more inclusive and accessible. We provide a range of tailored services and programmes to assist organisations to implement Te Tiriti o Waitangi and rights-based twin-track response (that is based on the Enabling Good Lives (EGL) principles and approach) in the prevention, identification and response to violence, abuse and neglect against people.

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Introduction

Child to Parent Violence and Abuse (CPVA) encompasses a broad range of behaviours that children under the age of 18 display towards their parents/caregivers. The violence can also continue into adulthood. When responding to CPVA all forms of (non CPVA) family violence must first be screened for. If (non CPVA) family violence is eliminated as a reason, other avenues can then be explored. The material in this report is predicated on the idea that (non CPVA) family violence is not the cause of the child's distress and discusses the many other issues that can be causative.

The first part of this report explores research on CPVA and discusses the assumptions, beliefs and discourses that exist. A lack of awareness, knowledge and support means that if parents seek help, they are often blamed and the violence in their homes minimised. Despite the high prevalence rate of CPVA, this form of family violence remains invisible in policy and service provision in New Zealand. Contemporary research is indicating that there is an overrepresentation of CPVA within the neurodivergent community.

CPVA is a safeguarding issue. Currently there is no guidance on recognising who is at risk depending on which professional lens is used to view behaviour. The risk to adults and siblings and the child/adult displaying the violence is ignored. This form of family violence needs to be urgently addressed through policy, research, and support.

The second part of this report examines what programmes and resources are being used to respond to CPVA internationally and explores whether these would be a good fit for families living with neurodiversity. Included is information on some influential peer support groups which have emerged as a response to unmet need in the community. Finally, this report looks at what general support and services are available to families in New Zealand, as currently there are no specific New Zealand programmes to address CPVA. If any support is to be developed, it must be done using Te Tiriti o Waitangi principles, which foster equitable outcomes for all New Zealanders while respecting Māori rights and interests.

Terms and words used in this document

ACE: Adverse Childhood Experience.

ADHD: Attention Deficit Hyperactivity Disorder – a neurodevelopmental disorder that impacts the part of our brain that helps us to plan, control impulses and execute tasks.

Adaptive functioning: Ability to perform everyday tasks and effectively manage social interactions. Impairment can make it difficult for a person to be independent.

Autism Spectrum Disorder: A neurodevelopmental condition which covers a wide spectrum of how people see and interact in the world**.**

CPVA: Child to Parent Violence and Abuse.

Executive functioning: Responsible for working memory, flexible thinking, and self-control. Impairment can make it difficult to follow instructions, focus and handle emotions amongst other things.

FASD: Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe the neurodevelopmental impacts on the brain and body of individuals prenatally exposed to alcohol.

Language of violence: The terms *family violence, intimate partner violence* and *domestic violence* are used in New Zealand to refer to violence and abuse that happens within a family or domestic relationship.

Family violence is, in New Zealand, defined by the Family Violence Act 2018 and is abuse between people in a family domestic relationship.   For the purposes of this Act, a person is in a family relationship with another person if they are a spouse or partner, a family member, or ordinarily share a household or are in a close personal relationship, including a recipient of care-carer relationship. It incorporates elder abuse, child abuse, dating violence, sibling abuse, abuse by in-laws and other relations, and intimate partner abuse. There does not have to be a sexual relationship between these people.

Intimate partner violence (IPV) is violence between people in an intimate relationship; this can be dating violence, or violence between de facto or married partners.

Sexual violence is also commonly called rape, sexual abuse and sexual assault and is inclusive of a range of offences and abuses.

Neurodivergent and Neuro-disability: Both are used interchangeably in research to describe brains that think, learn and process information differently. The terms encompass many neurological differences including but not limited to FASD, Autism, ADHD, TBI, PDA.

Parent/caregiver: The term includes grandparents, kin and non-kin who have assumed the parental role.

PDA: Pathological Demand Avoidance – a person will exhibit an extreme avoidance of demands which is more intense than observed in other autism spectrum disorders.

Safeguarding: The term safeguarding is broader than child and adult protection. It relates to the actions taken to promote, enhance and protect a person’s, rights, decision making, choice and control, culture, safety and wellbeing, citizenship and quality of life. Safeguarding is a continuum from promoting wellbeing to protecting people from harm. It includes preventative measures such as building a person’s capacity and capability to safeguard themselves from harm, to, on the other end of the spectrum, a coordinated interagency safeguarding adults’ response (SAFA) to a situation of harm, abuse or neglect (includes family violence and sexual violence), or the risk of it. It is about communities, organisations and government working together to enable disabled people to live the lives they want and to prevent violence occurring and respond constructively when it does. This includes ensuring that every person’s views, wishes and preferences are respected so that the person remains in control of the decision-making about their life and support.

Safeguarding Adults. Safeguarding Adults is the process of protecting Adults at Risk. An Adult at Risk is any adult 18+ who has needs for care and/or support (whether they are receiving services or not) and is in an unsafe abusive or neglected situation and cannot remove themselves from that unsafe situation because of their needs for care and/or support.

Safeguarding Adults from Abuse (SAFA) multi-agency response
SAFA is a multi-agency response to prevent and respond in situations of abuse of Adults at Risk, across the lifespan (includes family violence and sexual violence), while supporting people to remain in control of decision making about their supports and maintain control of their lives. It is also about people, organisations and communities working together to prevent and respond to abuse. SAFA provides a strengths-based, person-led, and whānau-focused human rights-based approach

Somatics:
Refers to integrating mind-body practices aimed at increasing awareness of bodily sensations, promoting emotional regulation, and releasing physical tension.

TBI: Traumatic Brain Injury, usually caused by a blow or traumatic injury to the head.

What is CPVA?

"Unless people have directly experienced the constant pressures of raising a child with complex behavioural needs together with coercive control, it is hard to relate to how devastating and traumatic this is for the parents/caregivers as well as the child. Loss of hope, shame, blame, isolation, suicide ideation and failure are in the mix alongside deep love and despair".

There is no internationally accepted terminology for child to parent violence. Some of the descriptions in the literature include:

- CPV – Child to Parent Violence
- CPVA – Child to Parent Violence and Abuse
- CAPVA - Child/Adolescent to Parent Violence and Abuse
- APVA – Adolescence to Parent Violence and Abuse
- AFCCA – Aggression towards Family/Caregivers in Childhood and Adolescence
- VCB – Violent Challenging Behaviour
- VCB – Violent Childhood Behaviour
- AVITH – Adolescent violence in the home

In this report we use the term Child to Parent Violence and Abuse (CPVA) as it best describes a child of any age (including adult children) and encompasses the wide range of violence and abuse that can be targeted towards parents and caregivers.

Definition

The word ‘child’ in the context of CPVA refers to the relationship between a child and parent. Therefore, the violence a child uses towards their parents can occur at any age including adulthood. There is no universally-accepted definition. CPVA has been defined as:

> *A pattern of behaviour which involves using verbal, financial, physical and/or emotional means to practice power and exert control over a parent...such that a parent unhealthily adapts his/her own behaviour to accommodate the child. Commonly reported abusive behaviours include name-calling, threats to harm self or others, attempts at humiliation, damage to property, theft, and physical violence* (Holt, 2016).

> *If others in the family feel threatened, intimidated, or controlled by it and they have to adjust their behaviour to accommodate threats* (Paterson, Luntz, Perlesz and Cotton, 2002).

> *Any harmful act by a child, whether physical, psychological, or financial which is intended to gain power and control over a parent or carer* (Thorley, Coates and Huges, 2020).

Holt, (2022) argues that the use of the word *‘intent’* is ambiguous. Who determines whether it was intentional or not? Was the act deliberate and planned? Was it reactive behaviour, trauma related, or anxiety induced and is the child able to understand the consequences of such an action? Our understanding of how functioning can impact on a child’s behaviour will inform how we respond to this form of family violence and what interventions are used.

What CPVA may look like:

“Suddenly without warning she started to call me a fucking bitch and tell me that she was going to smack my face in”.

The child will use a broad range of violence to exert power and control over parents. This list is not exhaustive but can include:

- **Physical** – hitting, biting, pinching, strangling, kicking, slapping, restraining, punching, using weapons, lighting fires
- **Verbal** – insults, threats, humiliating, intimidating, demeaning, frightening, screaming, yelling, threatening to use weapons or self-harm, making false allegations
- **Coercion** – controlling and bullying to gain power in a relationship, gaslighting
- **Financial** – stealing, pressurizing, or manipulating to get money
- **Property damage** – holes in walls and doors, smashed windows and furniture, trashing houses
- **Hurting pets** – strangling, kicking, hitting, throwing, neglecting, torturing
- **Sexual** – any unwanted sexual action including sexualised behaviour
- **Self-harming** – cutting in front of people, sending photos of injuries, threatening to harm themselves to get demands met
- **Digital** – sending threatening messages or photos, online bullying.

How prevalent is CPVA?

There is no consensus on the prevalence and patterns of behaviour. Empirical research is limited and shows wide discrepancies. Each methodology will have limitations, as results are determined by the focus of the research and this has led to findings being contradictory.

- Was it one incident versus looking at patterns of behaviour?
- Did the study look at specific ages?
- Did it just look at those in the criminal justice system or at CPVA incidents within the home?
- Was it just measuring physical violence, or did it include other forms of violence and frequency?
  (Holt, 2022).

In addition, studies have tended to be from certain sample groups which can be influenced by bias. Coogan (2018) gives an example, explaining that women in poor socio-economic communities are more studied in family violence situations than women who are from affluent areas, giving a false assumption that prevalence rates are higher in poorer communities. Despite these limitations CPVA has been found to be an emerging problem in many countries and across cultures. There is international consensus that qualitative longitudinal studies need to be carried out to try and understand this form of family violence.

Holt, (2022) discussed how data analysed from the Crime Survey for England and Wales (CSEW) over a nine-year period (2011/12 – 2019/20) found the prevalence of CPVA at 1.2% but highlighted that 43% of CPVA is not reported to the police. This is despite Brennan et al., (2022) reporting the worrying concern by a survey of practitioners working with families across London who had shared that most of their caseloads were families living with CPVA. In 2019 the United Kingdom government allocated funding to establish a violence reduction unit in Merseyside. The aim of the unit was to embed into practice a public health approach in prevention and responding to violence across the county, which also included CPVA. In their evaluation report Bates, Smith, Porcellato, Booth, McCoy, McManus and Quigg

(2023) discussed how data across four local authorities identified that 64-67% of family violence cases reported to police were committed by someone under the age of 18.

Studies in Spain by Calvete, Orue and Gamez-Guadix (2013) showed a dramatic increase in the number of CPVA cases reported to the State Public Prosecutors Office. The numbers rose from 1627 incidents in 2006 to 5377 in 2011. As a result of this, legislation was introduced so restraining orders could be made on adolescents who were violent to their parents. The study by Calvete et al., (2013) found higher prevalence rates for one-off incidents, but for more frequent occurrences the rate was 3% for physical violence and 14% for emotional abuse. When exploring prevalence rates Kuay, Othman and Tiffin, (2023) mentioned further studies in Spain which found wide variation rates of between 5% - 21% for physical violence and up to 35% for verbal and emotional abuse (Calvete, Orue and Sampedro, 2011; Ibabe and Bentler, 2016.)

A longitudinal study carried out by Pagani, Tremblay, Nagin, Zoccolillo and McDuff (2009) on CPVA from kindergarten to mid-adolescence aged children towards fathers found that that the violence was 12.3% from sons and 9.5% from daughters. This study also linked aggression displayed at school as a factor which led to CPVA in the home. In Australia, Campbell, Richter, Howard, and Cockburn (2020) reported data which showed around 10% of family violence call outs in Victoria were for CPVA. This is a significant issue as it is recognised that most CPVA remains under reported. The University of Sunderland discussion paper on CPVA by Thorley and Coates (2017) reported further discrepancies/ambiguities on prevalence with research findings ranging from Stevenson (2016) suggesting it is around 10%, Bonnick (2016) advising that professionals place it at 3%, but Selwyn and Meakins (2015) pointing to variations of between 3% to 27%.

As the research findings have never been consistent, there is accepted consensus within the community that most CPVA is unreported and therefore hidden. Holt, (2022) found reasons included:

- Similarities to intimate partner violence where not all parents understand what is occurring and will often normalise the behaviour towards them
- Fear of their child being criminalised especially if they have a neuro-disability
- Shame for disclosing what is happening to anyone outside the home
- Fear that if they disclose it may increase the violence
- Fear that services may remove their child or other siblings as it may be viewed as a child protection issue
- Being blamed by others who do not understand
- Not being believed

“Most of us minimize it and keep it hidden, like a sordid secret. We have been so conditioned by society that if we have violent children it is our fault as the violence must have been role modelled, or it is due to our poor parenting”.

Selwyn, Magnum and Mitchel, (2018) looked at findings in a project undertaken by the University of Bristol which found that severe violence towards other family members was the main reason that adoptions disrupted, with 27% of adoptive parents reporting their child had threatened them with a knife during incidents. Due to the early adversity adopted children have experienced, many will have complex additional needs which are communicated through behaviour (Thorley & Coates, 2017).

Gibbs’ (2024) research has identified high prevalence rates of CPVA in the FASD community here in New Zealand. During interviews 57% of caregivers disclosed that they had experienced worrying levels of physical violence and frequent emotional abuse from their children. Gibbs cites a study by Joseph, Mela and Pej (2022) which undertook a systemic review of the violent behaviour displayed by some children with FASD towards their caregivers. They found that the child's brain injury was a contributing factor towards the violence as the child had impaired adaptive and executive functioning, poor social and communication skills, reduced reasoning capacity, and impulsivity.

Another New Zealand study was carried out by Murphy-Edwards (2012) who wrote her thesis *Not just another hole in the wall - investigation into child and youth perpetrated domestic property violence* to shine a light on CPVA. As a result of her work as a clinical psychologist Murphy-Edwards was concerned by the number of CPVA cases she found were occurring in her clients' homes and the lack of knowledge, awareness, and support in the community to address this properly. She hoped that her research would highlight the complexities and impacts of CPVA and recommended that a quantitative study be established to ascertain the behavioural patterns and prevalence of CPVA. Twelve years on, there is still no national response to this form of family violence and it remains invisible in all policy, with no public awareness.

As research in New Zealand on CPVA is limited, we are relying on international findings that ignore our unique social settings and cultural obligations for bi-cultural practice under Te Tiriti o Waitangi. The wide discrepancies within the research highlight the urgent need for New Zealand to commit to a large-scale quantitative study so we can learn why CPVA is occurring and how we address this in all service provision, so families living with this form of family violence are supported.

Age

“When Indie was old enough to walk, she started to hit me.

I was hit for the next 16 years”.

There is no consensus on the age when CPVA starts. Usually, it has been present for a long time before parents have sought help or it is disclosed outside of the family. When parents do seek help, it is because the violence has become extreme and there are safety concerns. Some researchers have suggested that CPVA starts at puberty, whilst others have found it starts at an earlier age but escalates at puberty. Defining when puberty begins can be problematic. According to the World Health Organisation (2024) puberty begins at 10 years of age. The age of criminal responsibility in New Zealand is also 10. However, society tends to accept that puberty occurs around the age of 13 to 14 years of age. Using age as a marker for CPVA is not helpful to determine risk. There are expectations that a person’s chronological age matches their developmental age. This assumption ignores those who are neurodivergent and whose developmental age is variable. As well as cognitive functioning, adaptive and executive assessments give us a more accurate picture of functioning than relying on chronological age.

Thorley et al., (2020) presented a report *Policing Childhood Challenging Violent or Aggressive Behaviour: Responding to Vulnerable Families* on data collected by Northumbria police over a nine-month period on CPVA incidents. As this was a study into how the police identified and responded to CPVA they acknowledged that a lot of violence might have been occurring for years, with the family finally resorting to calling the police to keep them safe. Prior to police involvement families will sometimes seek support via their local mental health provider, others may view their child’s behaviour as temper tantrums or understand that the behaviour may be caused by a brain-based disability such as FASD.

The report cites a study by Breman and McRea (2017) that found 5 years of age was the highest age group for CPVA to start, and another by Ulman and Strauss (2003) which found the early years were the most common period for CPVA to begin. Of the latter study, one third of the survey group involved 3- to 5-year-olds who were violent, compared to 1 in 10 for ages 14 to 17. The research identified peak periods as 6 years of age, before declining at age 7. The second peak period was 9 years of age, before declining at age 10. Thorley et al., (2020) cited a longitudinal study by Giradi, Tremblay, Nagin and Cotes (2019) that challenged traditional research findings on CPVA. They found that rather than CPVA starting during adolescence CPVA declines with age, as the development of the child means that they have a better understanding of social cues and communication skills.

ParentLine Plus, (Thorley et al., 2020) found that CPVA escalated over childhood. Analysing data from the calls made to their helpline during the study period found that:

- 13% of parents identified that CPVA had been present from birth,
- 27% reported it started during toddlerhood,
- 10% said it commenced at school,
- 21% in middle childhood and
- 29% in adolescence.

26% of the calls to ParentLine were concerning violence from children under the age of 9. Thorley et al., (2020) highlighted similar research findings, citing studies by Trembley, Vitaro and Cote (2018) and Vitaro, Brendgen and Barker (2006) which found that physical aggression can start as early as infancy when the ability to harm others through biting and kicking has begun. Kuay et al., (2023) reported that, though prevalence peaked around mid-adolescence, the child had often first started to display aggressive behaviour at around 5 years old. Parents had only sought help when the violence had become unmanageable.

Family Lives (2022) undertook a data review into calls for help that they had received from families in the United Kingdom. Following this they produced a report *Feeling Under Siege* (2020/22) which found that CPVA occurred across all stages of childhood. They reported that the peak age of concern was 13 to 15 years old. However, they had received calls from parents concerned about children as young as one displaying aggression. 40% of calls were for children under 10. Of concern was that they had seen an escalation in calls from family members relating to the levels of violence from children towards them. The research clearly demonstrates that CPVA is a type of family violence that needs to be taken seriously.

As a response to parents being victims of CPVA and a subsequent lack of awareness and appropriate responses in the community, a social enterprise initiative was started in the United Kingdom by a parent. It is called Parental Education Growth Support (PEGS) (2024). They provide free peer support, virtual drop-ins, bespoke workshops, and empowerment programmes for those living with CPVA. Each year they undertake a survey to ascertain the demographics and household make up of those affected by CPVA. Their 2022 report *The impact of Child to Parent Abuse: Who does it affect and how?* shows that a quarter of children were five or under when the abuse began, making up the largest cohort of emerging behaviour.

In conclusion, though there is no consensus on the age CPVA starts, research has shown that it often starts in early childhood and escalates as the child grows, only coming to the attention of services when there are significant safety risks within the home.

Is CPVA gender based?

"I sat down at the dining table and started to read the TV guide. Suddenly a knife was thrust into the magazine and Indie started to repeatedly stab at it, stating it would be me next. She was 8".

The gender prevalence rate varies with data sources. Thorley et al., (2020) identified that percentages can be impacted by the methodology used: some areas may have higher male to female populations, and societal views will impact reporting, as males are traditionally seen as more threatening than females. Coogan, (2018) reported that in their Spanish study Calvete et al., (2013) found that there was no differentiation between genders, though males tended to use more physical aggression and females more psychological and verbal aggression. However, Kuay et al., (2023) found in their research that males were more likely to be perpetrators of abuse towards their parents. PEGS, in their 2022 study also found a higher percentage of males were violent towards their parents, with reporting rates of CPVA at 61% boys, 35% girls and 4% for people identified as non-binary or transgender.

The report *Feeling under siege 2020/2022* by Family Matters in the United Kingdom found that, whilst boys were reported more for CPVA, the difference was not as significant as assumed. During this period, they collated data from calls to their helpline and found that the children of concern were 57% boys, 41% girls, 1% other gender and 1% gender unknown.

In their research Brennan et al., (2022) found that a high proportion of perpetrators were male, at 71%. They recognised that these findings could be influenced by social ‘norms’ where males were more likely to be reported to police, and more likely to be arrested. Research conducted by Armstrong, Muftic and Bouffard, (2021) found that daughters were far less likely to disclose violence towards their parents. Anecdotally, practitioners have reported girls are more likely to engage in psychological and verbal abuse, and boys are more likely to engage in physical violence (O’Toole, 2022; Holt and Lewis 2021). What should be of significant concern is that, as already mentioned (Holt, 2022), 43% of CPVA is not reported to police despite parents being subjected to multiple forms of abuse. This report will further explore the barriers to disclosing this type of family violence.

Gender based victims?

"All I had wanted the last few years was to be a mum with my own family".

The research has found that victims of CPVA are gender based, with women mainly the targets. Australian research by Burck, Walsh and Lynch, (2019); Lyons, Bell, Frechette, and Romano, (2015) highlighted how studies have consistently found that mothers are disproportionately targeted by their children compared to other family members, citing studies by Downey, (1997); Robinson, Davidson and Drebor, (2004); Ulman and Straus, (2003). Baker and Bonnick (2021) cited Gallagher (2008) who found that when physical violence was severe the ratio was 80% towards mothers and 20% towards fathers. Mothers generally spend more time with their children than fathers and this can be seen as a contributing factor as to why they are targeted. Thorley et al., (2020) also identified mothers as victims with higher rates of CPVA in single and adopted families. Though research has identified mothers as the main victims, it would be erroneous to assume that CPVA does not happen to fathers.

Burck et al., (2019) cited a study by Peek, Fischer, and Kidwell (1985) that contradicted these findings. This study found that male students targeted their fathers more often than their mothers. Coogan, (2018) also shared similar concerns on the accepted consensus amongst professionals and researchers that women are the main targets though it is mothers and grandmothers who are predominately seeking help. He cites Condry and Miles (2014) who believed that violence perpetrated by the child towards the father is less likely to be reported due to the shame and stigma attached. Societal expectations on gender and masculinity would be hard to overcome for many.

Whatever the gender of the target Burck et al., (2020) have identified that these victims' voices are largely ignored in all the research on CPVA. This should be of primary concern. Is bias another barrier to understanding what is really occurring in homes impacted by CPVA? Discussing CPVA through a professional lens cannot convey the traumatic impact that parents experience living in a violent home. Despite this, they are revictimised through the often-damaging discourses and theories about their parenting.

Common myths that surround CPVA

“Not only are we victims of violence but we’re also blamed for our parenting as our child must have learnt this behaviour somewhere”.

Due to the invisibility of CPVA, parents will often join online peer support groups to connect with other parents living in similar circumstances. This provides a rich source of data to ascertain directly what is occurring at the coal face for those experiencing CPVA. The PEGS survey (2022) found that 89% of parents had only one child in the family who was abusive towards them. If poor parenting was the cause of the violence, surely other children in the home would be showing similar patterns of behaviour towards them? Through education, PEGS aim to dispel the myths that that surround CPVA. These are:

- **Myth 1:** Only children who have witnessed domestic abuse or violence in the home will go on to abuse a parent or carer
- **Myth 2**: Only a certain type of family is impacted
- **Myth 3:** It is caused by bad parenting
- **Myth 4:** CPVA only happens where a child has an additional need or mental health condition
- **Myth 5:** There is a simple solution

(PEGS, 2022)

Breaking down the myths: why does CPVA occur?

Myth 1:

Only children who have witnessed domestic abuse in the home or violence in the home will go on to abuse a parent or caregiver.

To ensure safety for all the family it is important to initially screen for all forms of (non CPVA) family violence and, if these are eliminated, to explore other avenues as to why CPVA may be occurring. There are many theories and assumptions that are used to conceptualise CPVA. This includes cognitive-behaviour theories such as social learning, which postulates that the child has grown up witnessing family violence. The methodology used and the groups studied will influence percentages. Baker & Bonnick (2021) found some clinical samples have estimated that between 50-80% of the children had witnessed violence in the home. PEGS (2022) reported that 55% of families they work with have not experienced any previous violence in the home. Other research has found a relatively small correlation between witnessing violence in the home and CPVA. The *'Feeling under Siege'* report by Family Lives (2022) stated that only 4% of reported cases were from homes where there was domestic abuse in the family. Coogan (2018) cites a study by Gallagher (2016) who completed a review of the literature and concluded that growing up with violence in the home was not a contributing factor towards CPVA.

Myth 2:

CPVA only impacts certain types of families

Coogan (2018) believes that there is no one typical family where CPVA takes place. His research has highlighted two main themes of CPVA: a pattern of escalation over time and the parents' own sense of shame and self-blame. These findings are consistent in much of the contemporary research, with studies pointing out the double stigma parents find themselves in. They are victims of ongoing violence towards them and then are re-stigmatised by societal responses to this problem. Coogan (2018) refers to conflicting studies, with one finding that CPVA is more likely to occur in low socio-economic families (Cottrell and Monday, 2004) and another reporting that it occurs more in families who are middle class and well educated where the child had developed a sense of self entitlement (Gallagher, 2008). Holt (2016) believes that CPVA can occur in any family irrespective of socio-economic status, education, religion, ethnicity, single parent, two parent, or same sex parents. CPVA crosses all social, racial, and cultural contexts.

Myth 3:

It is caused by bad parenting

One concerning argument threaded throughout the literature (Burck et al., 2019; Lyons, Bell, Frenchette and Romano, 2015; Margolin and Baucom, 2014) is that CPVA is caused and then reinforced by permissive parenting. This type of parenting style is viewed by professionals as parents who cannot keep boundaries and will give in to their child's demands to avoid violent incidents, therefore reinforcing and rewarding violent behaviour. This discourse is harmful and lacks a comprehensive understanding of the complexities of CPVA. Thorley and Coates, (2017) stated that that '*CPVA is not just found in problem families but for many families CPVA is the problem.'*

Myth 4:

CPVA only happens where a child has an additional need or mental health condition

This myth is complex to unravel and will be explored in this report. Being neurodivergent or having a mental health condition does not mean that CPVA will occur, but it may occur as a co-morbid behaviour. It is important to remember that CPVA also occurs in families raising neuro-typical children. Kuay et al., (2023) found that children who had at least one mental health or developmental diagnosis were more at risk of being aggressive towards their family. This can be due to struggles related to regulating their emotions and trouble controlling their impulses. Coogan (2018) cited research by Ibabe, Arnoso, and Elgoriagga (2014) that found adolescents who were violent to their parents were more likely to have emotional and behavioural problems, including difficulties at school, and suggested that a diagnosis could help to understand what is needed to support the young person.

Myth 5.

There is a simple solution

Responding to CPVA is complex. Each family is unique, requiring a tailored response. This myth will be unpacked in the report. We also provide information for professionals working with families experiencing this form of family violence. At the end of the report, information on international and New Zealand resources is provided.

Other possible contributing factors:

Substance misuse

Australian research by Burck et al., (2019) cited Galvani (2016) found a strong correlation between CPVA and substance abuse. Aggression did not just occur when children were under the influence of substances but could be due to withdrawal effects, or trying to get parents to give them money so they could use. Coogan (2018) found that young people who use substances are more likely to experience a deterioration in their mental health and have poor impulse control. This can be upsetting for parents to witness and lead to an escalation of arguments in the home as the parents try and control the substance use by imposing sanctions. However, Holt (2022) pointed out the limited research that has been carried out on the link between CPVA and substances. Baker (2021) gives another perspective on substance use, as her research found young people often used cannabis to de-escalate conflict.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS)

According to the PANDAS Network (2024) PANDAS affects an estimated 1 in 200 children and can occur after a strep throat infection. It can lead to a sudden change in behaviour and the child may experience a wide range of symptoms. A few of these include aggression, mood changes, screaming, developmental regression, anxiety, tics, and sensory sensitivities related to the infection. PANDAS is not routinely recognised in New Zealand so for more information and research on this condition (including symptoms) refer to the PANDAS website https://pandasnetwork.org/

ACES

The impact of trauma and adverse childhood experiences (ACES) cannot be overlooked. Thorley et al., (2020) reported how ACES considerably increased the risk of mental health and behavioural difficulties. Children will internalise their anxiety/depression and externalise behaviour such as violence and aggression as a way of communicating how they are feeling. Brain patterning and the memory of experiences start to develop prenatally, and, in the first few months of life, adverse experiences will influence how the child thinks and behaves. The research by Thorley et al., into children who had been through the care system found significantly higher levels of aggression in adopted children compared with their peers. If children have also been prenatally exposed to drugs or alcohol this will have impacted the developing brain and will be an additional trauma.

One of the key findings from the PIPA project (2020) in Australia was the link between childhood trauma and CPVA. The project highlighted concerns that childhood trauma is not often documented in legal files. If more information about the child’s trauma were to be recorded, it would be beneficial to generate a greater understanding of the person’s capacity and needs over their lifespan. Nowakowski-Sims (2019) found that 78% of children in their study had five or more ACES. Researchers Cruz, Lichten, Berg and George, (2022) also linked ACES to negative outcomes for the child including suicidal behaviour, and higher rates of cognitive difficulties such as learning, attention and information processing. Childhood trauma can also mean that a child will often struggle with their ability to self-regulate, as their central nervous system is on high alert, and they easily slip into fight or flight as a protective mechanism. This is often displayed as angry outbursts which can sometimes be violent. Despite the above reasons being given as possible indicators for an increased risk of CPVA, there is still no consensus in the research on the overarching reason why CPVA occurs in families.

Neurodiversity/Neuro-disabilities and CPVA

"Society from cradle to the grave, views behaviour as something a person can control. Why do we believe this simplistic view of how a brain functions without taking into account brain-based differences which are unique to each individual?"

There is a paucity of research into disability and CPVA. What is available has identified that many families with a neurodivergent child, including traumatic brain injuries, seek help for their child's challenging behaviour. Thorley et al., (2020) found that 30% of CPVA reports to the police were about children who had been identified as having *'special education needs and disabilities'* (p. 34). They also identified an increased risk of CPVA in cohorts who had attachment disorders, PTSD, complex trauma, global development delay and those who were adopted. Anderson's research (2011) also highlighted the high prevalence of CPVA in the neurodivergent community. It found that 56% of autistic children in their study displayed CPVA and this was a major issue for caregivers. When autistic individuals had a co-morbid diagnosis, CPVA rose by another 13%.

The prevalence rate was also high in the *Feeling Under Siege* (Family Lives, 2022) report which highlighted that neurodivergent children, 5 to 12 years old, made up 58% of calls received to their helpline The figure for 13- to 19-year-olds was 42%. Family Lives (2022) point out that neurodivergence and CPVA have been marginalised in policy, practice, and research. The focus has been on the neurotypical community, meaning that interventions would probably not be appropriate to meet the needs of neurodivergent children and their families, who may also be neurodivergent.

Thorley et al., (2020) identified distinct types of aggression. These are proactive and reactive. They describe proactive as calculating and predatory. It can be linked to gang association, substance misuse and anti-social behaviour. This type of aggression is goal driven, where the person has learnt to be aggressive to get what they want. Reactive aggression occurs as a reaction to a perceived threat resulting in anger and retaliation. The person who displays reactive aggression has poor emotional regulation, self-control, and impulsivity. Peck et al., (2021) and Contreras and Cano, (2015) discussed that children with neuro-disabilities are more likely to be involved in CPVA. Burck et al., (2019) concur with these findings, stating that the permissive parenting and social learning theory has failed to consider neuro-disability. They refer to research conducted by Monash University in Victoria by Fitz-Gibbon, Elliott & Maher, (2018) that found parents were reporting high prevalence rates of neuro-disabilities in their children who engaged in CPVA. Contreras and Cano's (2015) research also found that that most of the children in their study displaying CPVA were diagnosed with ADHD and autism. They believed that a contributing factor for the violence was the child's continued heightened stress response caused by their restricted communication abilities and repetitive patterns of behaviour, which made it more difficult for them to manage social cues leading to aggressive outbursts. The violence was unintentional though others were often injured, including the child.

Holt, (2023); Humphrey and Hebron, (2015) and Maiano, Normand, Salvas, (2016) found that stigma and bullying were particularly high for neurodivergent children, who experience disproportionate levels of trauma and therefore childhood ACES compared to their neurotypical peers. Masking and trying to fit in can have a significant impact on mental health and lead to burnout. Research by Blanchard et al., (2021) identified increased rates of self-harm and suicide ideation within this cohort. The lack of accommodation and support for neurodivergent children and their families can be seen as a contributing factor to CPVA. Rather than seeing this as a neurodivergent 'problem,' the problem can be seen as the way society has been set up to reward neurotypical functioning, thereby excluding those who interpret the world in an equally valid way but have diverse means of understanding, sensing, and communicating.

Other leading advocates in the CPVA field include Yvonne Newbold, who set up Newbold Hope (2024) in the United Kingdom as a parent-led organisation to support parents/caregivers experiencing CPVA from their children with neurodevelopmental disabilities. Newbold states on her website that CPVA is common amongst this cohort where around 25% of individuals with a diagnosis of autism, learning disability, ADHD or PDA exhibited harmful behaviours towards their parents. She is clear that this is not due to poor parenting, but is a result of having a neuro-developmental disability with the child trying to communicate their anxiety and frustration. Rather than intentional behaviour, the child will often target their safe person which is their mother.

CPVA and education settings

In their evaluation report on the Violence Reduction Unit, Merseyside, United Kingdom, Bates et al., (2023) identified that a contributing factor for CPVA in the home was the lack of support given to neurodivergent children in mainstream school. The report also identified that children who used CPVA were more likely to be disruptive at school. This made them at risk of being excluded. The chronic lack of support for neurodivergent children means that they can experience high anxiety levels throughout the day, leading to behaviour related issues at home. This is often mistaken by others as a parenting issue rather than a child who has masked all day and then feels safe enough to let go with their safe person which is often the mother (Newbold, 2024). In her book *Not fit for purpose – Disability rights abuse of children living with FASD in New Zealand,* King (2023) writes about how she would cry each day on her way to collect her daughter from school as she knew she was going to be hit. As her daughter masked, the school maintained that the problem was in the home environment and refused to put any learning support into place despite her daughter having FASD, an intellectual disability and severe speech and language disorder. Eventually, due to extreme anxiety the violence tipped over into the school and her daughter was excluded when she assaulted another pupil.

FASD and CPVA

"Ok so with FASD it is very individual and can cause anger by triggers for example someone eating loud or someone talking and tryna help u but u don't like what there saying…It can also be sensory thing aka someone saying come on please fold your washing or plz tidy your room and your not in a good regulation matter for that time so FASD is a brain based disorder"

Indie.

As already discussed, Gibbs (2024) found CPVA in the FASD community is high, with 57% of caregivers reporting living in violent homes. Though our (New Zealand) government recognises it as a disability, there is no disability funding available. This lack of response often leads to poor outcomes for families in New Zealand. The booklet *'Fetal Alcohol Spectrum Disorder. A Handbook for parents, caregivers and their whānau families'* (FASD-CAN, 2022) discusses how behavioural difficulties can emerge due to unrealistic expectations placed on the child who has FASD. They advocate using Diane Malbins' (2002) Neuro-Behavioural approach which sees behaviour as brain based and requires those around the person who has FASD to make accommodations to support the child's individual needs. This is difficult to achieve if there is no funding available to support the child at school and in the community. This can lead to escalating violent and aggressive behaviour in their safe place, which is the home environment. Parents will often acknowledge that the violence towards them is caused by their child's unmet needs rather than being an intentional behaviour. Discourses that view parents' responses as permissive are demeaning as they fail to acknowledge that the violence is often brain based, and that raising a child with high and complex unmet needs is a huge burden on already exhausted caregivers.

Neurodiversity and the youth justice system

The PIPA project (2020) found that a considerable number of adolescents before the court for CPVA had diagnoses that were psychosocial or for a cognitive disability. This should be a red flag to the disability sector where there needs to be an increased awareness of CPVA. Most of the time the violence in the home only comes to the attention of the police when the child hits adolescence and the parents fear for their safety. If parents were able to have open conversations about CPVA, with no blame or shame responses, early intervention could be put into place and the crisis before the courts might be adverted. Criminalisation of those living with neuro-disabilities and other complex needs should not be happening.

Tailored response

Neurodivergent families experiencing CPVA require a tailored, multi-agency response. Sometimes, through no fault of the individual or their family, due to brain based impairment, CPVA support may need to be ongoing across the lifespan. Holt, (2022) highlights that there is growing awareness that ‘one size fits all’ responses to CPVA might not always meet the direct needs of the family, and that some families will need specialist input to meet the unique needs of “*adoptive parents, foster carers, kinship cares, neurodivergent children and children with disabilities”* (p. 11). In addition, this cohort is more likely to have experienced ACES and may experience higher rates of violence towards them in the community than non-disabled people, adding layers of complexity to the response.

Is CPVA like other forms of family violence?

"Knowing that I have a suicide plan gives me comfort that there is a way out if I need it. This reassures me more than any professional ever has".

Coogan (2018) believes that there are many parallels between CPVA and other types of family violence, as it includes abusive, controlling, and violent behaviours which occur within the confines of the family unit. There are also differences. Compared to other forms of family violence, CPVA is far less likely to be reported due to the shame and blame culture that has arisen from the belief that it is because of poor parenting. It is different to other forms of family violence as the parents cannot abdicate their legal responsibilities, which means they cannot just walk out of a violent home. Worryingly, Bonnick (2019) reports that parents have sometimes been arrested when they have rung the police. King (2023) spoke of a comparable situation when her husband pushed his daughter away to protect himself when she was attacking him - the police who he had called to help ended up cautioning him for assaulting his daughter. Selwyn, Magnus and Mitchell (2018) refer to the *Responding to Child to Parent Violence International ESRC Funded Study* which found that '*child to parent violence is the most hidden, misunderstood and stigmatized form of family violence*'. p.1.

The lack of awareness means that CPVA is absent from New Zealand policy, with Gibbs (2024) finding that it is only briefly mentioned in our national strategy to eliminate family violence. There appears to be no plan to fund responses to this form of family violence. The strategy does recognise that disabled people experience more violence towards them than non-disabled people but does not recognise that children can be the victims and perpetrators of violence within their family. This is of concern to those families living in a desperate cycle of fear and isolation.

What is the impact on the family?

Living with CPVA has a significant impact upon the parents' health and wellbeing. D'Andrea, Sharma, Zelechoski and Spinazzola (2011) found that exposure to trauma disrupts the body's ability to function optimally. Negative impacts on health include:

- cardiovascular system: strokes, heart attacks, high blood pressure
- decreased immunity
- endocrine: menstrual pain, endometriosis
- gastrointestinal system: digestion, irritable bowel disorder
- inflammatory diseases: migraines, arthritis, increased risk of becoming insulin resistant.

Chronic trauma also disrupts brain functioning which increases risk of anxiety, depression and PTSD. Furthermore, D'Andrea et al., (2011) found suppressing trauma can increase the risk of these negative impacts upon health. For parents experiencing CPVA, this is not good news as they will have to continually suppress their own responses and emotions to what is occurring to avoid triggering their child. In addition, the invisibility of this form of family violence means that they cannot express the devastating effects the violence has on their lives outside the home, for fear either of not being believed or of being blamed. They are locked into a bubble of ongoing trauma and invisibility.

The PEGS (2022) survey found that:

- More than 50% of parents were attacked each week
- 19% were attacked each day
- 17% of them were dealing with sexualised behaviours
- 72% were verbally abused each day
- 24% had a long-term illness or disability
- 27% had a mental or emotional health issue
- 73% had lost or reduced contact with other family members
- 97% reported that they had to change the way they lived
- 36% of children had hurt a pet with 1% killing an animal.

The impact of this was:

- 4 out of 5 reported that their health was suffering and 90% said it had affected their wellbeing
- 40% felt unable to keep themselves or their family safe.
- 92% felt isolated
- 89% felt helpless
- 83% were frustrated
- 89% were worried
- 80% felt blamed
- 78% were frightened in their home
- 73% felt ashamed and humiliated
- 71% felt guilty
- 74% had to leave work or reduce their hours.

  PEGS (2022)

Mothers experiences

Rutter's (2020) study on mothers experiencing CPVA found that all the participants reported physical symptoms related to their mental health. These were significantly worse after a violent incident. The symptoms reported included fatigue, pain, sensory challenges, and the fear that their health would be impacted further after another violent episode. This affected how the mothers interacted with their child as they avoided certain activities as they did not want to re-trigger them and be subjected to more abuse. Baker and Bonnick (2021) found that mothers avoided mixing with others to avoid judgement. This made them socially isolated and more at risk within the home, especially as Holt (2023) identified that mothers of neurodivergent children spend 50% more time with their child compared to mothers of neurotypical children. Tunali and Power (2002) found that much of this time was spent modifying the environment, providing structure, routine, and teaching daily living skills.

This adds to the stress levels of mothers who have less downtime than mothers of neurotypical children and who are also hypervigilant to avoid potential triggers that may escalate into violence. Extra challenges are caused by lack of support rather than parenting. In addition to a poorer quality of life, mothers of neurodivergent children are often blamed for their child's differences. Holt (2023) identified the extra layer of stigma that mothers of neurodivergent children experience, writing that part of this is caused by

> *The cultural legacy of theories about how neurodivergent conditions such as autism and ADHD are caused by inadequate mothering* (p.2).

Examining how mothers made sense of the CPVA they experienced from their neurodivergent child, Holt (2023) used her research to help us understand the complexities of the issue and the deep distress experienced by both mother and child. During a violent incident, some children expressed suicide ideation with some attempting suicide on more than one occasion. This left the mothers feeling anxious about how to respond as, if they attempted to intervene, they did not know if the violence would be re-directed towards them, and they might be hurt. After an incident where they had been harmed, mothers then pushed aside their own needs even if they had been injured, to support their child with what had just occurred. Often a child would hug their parent and state "*I did not mean to*." The mother then had to re-establish her connection to her child as she recognised that the violent episode was due to her child feeling overwhelmed. Rather than being caused by permissive parenting, Holt (2023) described a range of triggers which were often unavoidable, including distressing sensory stimulus. This could include, but was not limited to, loud noises, difficulty regulating body temperature and bright lighting, leading the child to become anxious and stressed. All mothers in the study reported being targeted by their child but knew that they were seen by the child as a safe person who would support them through these intense emotions.

In their study Sutherland, Rangi, King, Llewellyn, Kavanagh, and Vaughan (2022), found that mothers often made themselves the direct target of their child's aggression to protect siblings and other family members who were under threat. Baker and Bonnick (2021) spoke of the inner turmoil and the dilemma that parents of neurodivergent children live with. Many recognise that their child is feeling overwhelmed and view the behaviour as a symptom of their child's disability. This means that they are more likely to tolerate violence towards them. In the disability community, CPVA is rarely discussed. King, (2023) noticed that whenever CPVA was brought up in an online peer support group there was a lack of response from other parents, meaning that families shut down from sharing their experiences as they did not feel supported and accepted that the violence was a normalised part of their family life. Being a parent to a neurodivergent child, however, should not be an excuse for continuing to live in a family violence situation with no support.

When mothers reached out for help, agencies minimised what was occurring (Holt, 2023). Professionals often misconstrued violent behaviour and viewed it as part and parcel of the child's disability, normalising the violence and therefore reinforcing to parents that they should put up with what was occurring. Trying to access services is another layer of exhaustion for already exhausted parents who are battling the myth of inadequate parenting and are often socially isolated. King (2023) describes how she was told that if she wanted professionals to believe her, she had to call 111 each time a violent incident occurred, so a paper trail confirming the abuse could be established before any intervention was offered. King wrote "*No one would help us. I wanted it all to end. When Indie threatened me with a knife instead of running, I would stand there and silently will her to stab me, just so it would all be over once and for all." p.*76.

The family

Thorley et al., (2020) found that despite the significant trauma families were living with, most would not discuss the violence in their home. This was because when they had shared their concerns with professionals, they were often seen as overly anxious parents or blamed for their permissive parenting. Socially accepted ‘norms’ mean that society struggles with the notion that children are in charge rather than parents having control. Parents would only seek outside help as a last resort. This was usually the police when they were unable to de-escalate the situation and were in fear of their safety. Often the police will record CPVA as criminal behaviour.

In their 2022 survey PEGS found that the reasons that parents were reluctant to call professionals were:

- 30% were worried their other children would be removed
- 20% did not know who to call for help
- 68% had not received the support they needed when they spoke to a professional
- 91% had been threatened with eviction or needed to move house due to CPVA
- 28% had been told that there was a possibility they could be prosecuted for neglect or abandonment
- 61% did not want their child to be prosecuted or have a criminal record
- 53% found that services had not been helpful in the past.

PEGS (2022)

Child development theory has influenced how parents experiencing abuse by their children are perceived by society. Cortina and Holt (2024) analysed responses on social media from the public when discussing CPVA. They found that the assumptions often were that the child had either learnt this behaviour by growing up in a violent home, or the child was lashing out to protect themselves from their abusive parent. Other people who responded, blamed the parents for their permissive parenting and failing to put boundaries in place. Some even advocated punitive methods of corporal punishment to get their child back into line. Others simply blamed the child as being evil or mad. The researchers recommend public awareness campaigns and education initiatives to raise the profile of CPVA in our communities. Until this is done CPVA will remain hidden, buried beneath the stigma and shame that accompanies this form of family violence.

Living with CPVA means that all family members must adapt their own behaviour and responses to manage the violence (Holt, 2023). King (2023) shared how her child's behaviour could switch in an instant. This made her hypervigilant as she never knew when the violence would start and had to always be aware of where her other child and pets were and whether her safety exit was clear. King (2023) describes how exhausting it was to always be in this hyper state of arousal. Living this way impacts all relationships both inside and outside the home environment. Parents cannot be the parent or partner they would choose to be and the invisibility of CPVA means that they are socially isolated, unable to share what is happening to them. In addition to the violence, PEGS (2022) found that housing tenancy can become unstable if there are constant family violence incidents, and the house is smashed up. This places families at risk of eviction if multiple calls about disruptive behaviour have been made against them.   If they have not personally experienced the violence, family and friends do not understand the challenges and minimise what is occurring. Often, they will urge the parent to be stricter and push traditional parenting strategies onto them.

Gibbs (2024) found that the impact of CPVA on the caregivers she interviewed created a host of problems in addition to the CPVA they were experiencing. Some of the violence included repeated property damage comprising holes in the walls, broken windows, doors and items smashed. The damage needed to be repaired, putting a financial strain on families who were already often limited in their capacity to work due to the needs of their child. This impacted further on their mental health. A study by Holt and Birchall (2022) on grandparents living with CPVA found high rates of suicidal ideation, depression, and anxiety amongst this cohort. The cost of inaction by service providers can lead to dire consequences for the family unit.

Bonnick (2021) cited Australian findings by McKenna (2006) that 29% of parents had suicidal ideation, and 2% of this cohort had made attempts to end their life due to CPVA.

King, (2023) found that there is a reluctance within the disability community to openly talk about CPVA. This was due to the violence being minimised as part of the disability by both professionals and parents, and the stigma attached to CPVA. King (2023) advocates for more honesty in acknowledging that accommodating the child's needs will not always stop the violence, as it can be brain-based behaviour. The focus is on the child and accommodating their needs, often to the detriment of the parents' wellbeing. This buries the parent in silence within their own community, as they try hard to use recommended strategies which fail to stop the violence. Families like Kings need therapeutic support to enable the family unit to survive.

The Australian PIPA project (2020) found that there is little support available. Socially accepted 'norms' of 'good' parenting meant that parents were reluctant to report their child until incidents had become severe, resulting in their child entering the judicial system. Some of these youth ended up in care, which cost the state financially, as many needed specialised placements. This money would have been better invested in early intervention to support the family unit. PIPA (2020) believes that it is imperative to build long term trust and support. They stated that CPVA cannot be fixed in six to twelve weeks, which is what many programmes, due to funding limitations, offer. Bates et al., (2023) found that parents within the neurodivergent community reported that agency support had been ineffective. This was because the focus had been on mainstream responses with the use of consequences imposed on the neurodivergent child, which did not work due to brain-based differences.

In New Zealand, King (2023) described how throughout her daughter's childhood she tried to seek help from services but found significant barriers due to lack of knowledge and awareness of both FASD and CPVA. Eventually the family collapsed, and her daughter went into care. Oranga Tamariki was not skilled or equipped to deal with the range of complex behaviours her daughter presented with, leading to both King and her daughter submitting statements to *The Abuse in Care Royal Commission of Inquiry*. King's book highlights the urgent need for a multi-agency approach to upskill the workforce in both FASD and CPVA awareness and evidence-based responses. The trauma that a child and their whole family experiences from their child going into care cannot be measured. Bonnick (2019) found that children who ended up in care due to the CPVA were still viewed as much loved family members by their parents who lived in hope of the situation resolving itself. The parents still wanted to be involved in their child's life, albeit at a safe distance. Sadly, this is often interpreted by services as meddling rather than as advocating for the best possible outcome for their child in care and they are shut out. This can be seen as a human rights abuse by statutory agencies who have failed to comprehend the complexities of CPVA.

The impact on siblings

"He was just over the violence and told me that, as he was walking up the driveway, he would be scared to enter the house because he thought that he might find me dead on the floor. Killed by Indie who wouldn't have meant to kill me but would have done it by accident when she was in a rage".

The risk to siblings is significant, as they are growing up in a violent home. There are no studies on the sibling voice and how growing up with a violent brother or sister has affected them (Bonnick & Baker, 20201). Though it is an under-researched area, it is of prime concern to parents who are juggling the different needs of each child. Holt (2023) explains this dilemma further, as in her study she found that mothers living with CPVA have conflicting concerns as the needs of one child are incompatible with the child displaying CPVA needs. The whole family walks on eggshells to reduce potential triggers and there is little choice but to try and meet the needs of the most challenging child first and foremost, to avoid violence and to try and protect the sibling. The PEGS (2022) survey found that 13% of siblings living in CPVA homes have been strangled or suffocated by the child with violent behaviour. As teenagers, to avoid confrontation, they will prefer to stay out of the home environment or withdraw to their bedroom. As well as receiving less attention, siblings will experience significant trauma witnessing their parents being physically assaulted and verbally abused. Some may try and intervene to protect the parent and either get hurt or hurt their sibling in retaliation. It is concerning that, rather than intervening and addressing the core issues of the CPVA, the PIPA project (2020) identified that siblings were being removed by social services, causing further trauma to the sibling and the family unit. As siblings spend their childhood trying to avoid conflict and putting the needs of the violent sibling first, it can be difficult for them as adults to assert themselves, as they have walked on eggshells their entire childhood.

Impact on the child

The impact on the child who is violent cannot be underestimated, though there is a lack of research on this. In addition to some ending up in the care system, Baker and Bonnick (2021) described it as common for them to sustain injuries themselves during violent episodes. They also suffer psychological harm, have low self-esteem, and poor relationships with their family members who are less likely to want to engage with them. As they mature into adolescence the ongoing violence towards the family means that they are more likely to enter the youth justice system. The child may only be violent in the family home towards the parents, or it may occur in other settings in the community. Holt (2023) cites a study by Baker (2021) that found CPVA is also linked to substance abuse, delinquency, and anti-social behaviour in adulthood. Furthermore, Holt (2023) wrote that CPVA has been linked to becoming a perpetrator of intimate partner violence in adulthood (Ibabe et al., 2020).

Just as it is misguided to blame the parents, it is also misguided to apportion blame to a child for their violent behaviour, as it fails to consider the complexities of each individual situation.

Hard to engage parents?

Parents are often seen as difficult to engage with. Bonnick (2019) challenges this assumption and asks practitioners to put themselves in the shoes of the parents who, as well as living in highly stressful, unsafe situations, are often advocating for services that do not exist, are not being believed or are blamed instead. Bonnick (2023) asks if it is difficult parents, or if it is difficult professionals and difficult services who, through lack of knowledge, are applying harmful practice to abused parents? Bonnick (2019) points out that, as parents are the ones with the lived experience of CPVA, they are the experts on what is occurring. It is no wonder parents are often frustrated. They love their children and want the best for the family unit, just like any other parent.

Currently, parents are generally seen as the problem and put on generic parenting courses. The focus is on modifying the behaviour, not what causes the behaviour. Thorley et al., (2017) found that parents live with CPVA daily or 2-3 times a week. The PEGS (2022) survey of parents showed that 19% of respondents experienced physical abuse daily, 50% experienced it weekly, and 72% experienced daily verbal abuse. If the child has a diagnosis the risk is overlooked, as it is seen as a symptom of their disability. Bonnick & Baker (2021) cited studies by Ibabe, Arnoso & Elgorriaga (2020); and Simmons, McEwan and Purcell (2020) that showed the violence continues into adulthood and parents are still the victims.

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CPVA is a safeguarding issue

“On paper it looked like we had a lot of agencies supporting us but none of them were actually doing anything practical to support us”.

CPVA is a safeguarding issue. Currently there is no guidance on recognising who is at risk as it depends on which professional lens is used to view behaviour. Parents have often revealed that they are frightened that they may be killed by their child. Holt (2017) investigated parricide and found that, though it does occur, it is relatively rare. 90% of the perpetrators were sons. Fathers were more likely to be killed by teenage sons and mothers were more likely to be the victims later in life.   Most attacks occurred in the family home where their child had used blunt or sharp weapons to kill them. 9% of parricide in the United Kingdom was committed by children aged between 10 to 17 years of age. Current discourses focus on the mental health of the person, including their extreme anti-social traits and living or growing up with abusive parents.   As demonstrated in this document, CPVA is far more nuanced than society’s current understanding of CPVA. The *Police Statistics on Homicide Victims in New Zealand 2007-2020* (New Zealand Police, 2023) found that 3% of murders between 2003-2020 were parents who had been killed by their child. More research is needed to understand predictors of parricide and why it occurs.

Coogan (2018) believes that living with CPVA is an infringement of the human rights of parents and children. He cites the Universal Declaration of Human Rights (1948) which states that:

> *“Everyone has the right to life, liberty and security of person (article 3) and that no one should be subject to torture or to cruel inhuman or degrading treatment for punishment (article 5)*”. p. 27.

A universally accepted consensus within all the research is that there is an urgent need for CPVA to be recognised by Governments and policy developed by the state that provides clear guidelines on CPVA which can be implemented across all services. This should include policy on how to support families with children who are neurodivergent, as their needs will require a different approach. All practice must be grounded in the safety of the child and their family unit.

A devastating outcome which can occur when CPVA remains ignored is the breakdown of the family, with the child bring removed from the family home to live in state care. This is not a failure of the parents or child but rather of society, which has failed to support the family and address the presence of CPVA. State care is not geared up to support children with high and complex needs. King (2023) discussed how her daughter's human rights were breached as interventions ignored her disability and were punitive and punishment based rather than therapeutic. Nothing was done to address the CPVA. Despite being their child's best advocate, parents must fight to remain involved; even though they are legal guardians they will often be bypassed over legal decisions. Bonnick (2019) writes

> *"It may come as a surprise to hear that for many families, while trust and safety have broken down, the bond of love continues as strongly as ever, with a continuing hope and expectation of involvement in a young person's life, and, if possible, their eventual return home".* P. 215.

It is imperative that if a child does have to be looked after outside the family home, everything is done to continue to support the family unit, acknowledging that for safety sometimes parents must parent at a distance.

Recommendations for a national approach to safeguarding

In New Zealand CPVA remains invisible in all social policy. Those at ground level will be working with CPVA families but the lack of policy and framework around this means that there is little guidance about how to deal with this complex form of family violence. As there is no legal definition of CPVA there is also no way to record what is occurring. To implement safeguarding, system wide changes need to happen. These include:

- CPVA needs to be included in the Te Aorerekura strategy and action plan
- Te Tiriti o Waitangi principles need to be incorporated into policy development that fosters equitable outcomes for all New Zealanders while respecting Māori rights and interests
- There should be open dialogue with policy makers to ensure that guidance is clear and consistent. The parent and disability voice must be included in the consultation to ensure policy is fit for purpose
- A legal definition of CPVA should be agreed upon so everyone is on the same page when responding to and understanding what CPVA is
- Screening for CPVA needs to be incorporated into all family violence assessments
- A longitudinal study should be funded to develop an understanding of the implications and costs to society of CPVA in New Zealand
- A national database needs to be established, with all services having access to record data and share information. This will have multiple benefits as it will identify families at risk, inform responses and help to ascertain prevalence rates, patterns of behaviour, and other important factors such as gender, age, ethnicity, neurodivergent, disability, adoptive, kinship care, family structure, siblings, mental health, substance misuse, and family dynamics

- The national database should be analysed each year to disaggregate the data so funding can be targeted towards early intervention and families at high risk
- Nationally agreed safeguarding tools should be developed to understand what safeguarding may look like for CPVA
- There should be national guidance for professionals on where to locate specialist providers on CPVA
- A comprehensive workforce development programme should build knowledge and skills amongst professionals
- Research on CPVA needs to include both the parent, child's and siblings' voice as their perspectives will be different
- A national helpline and CPVA specific website on CPVA should be developed for families. A national helpline will also be a rich source of data collection direct from the coalface
- There should be a government-led public awareness campaign to destigmatise CPVA and break the cycle of shame that stops families from coming forward
- Funding for specialist programmes is required. CPVA impacts the whole family, therefore a whole family centered approach is needed when developing programmes. Each family's needs will be different, and responses will need to be tailored. A neuro-diverse family will require a different response from mainstream programmes
- Recognise that it is not a quick-fix solution, and time-limited programmes may be of limited value within many communities
- Fund early intervention before behaviour has become ingrained
- Early identification of neurodevelopmental or mental health concerns and fast track pathways to a diagnosis which will help to identify what support should look like for the family
- Funded peer support groups to reduce parents' isolation and enable them to connect and share information

Professionals responding to CPVA

"Dealing with services often leads to secondary trauma as the way they treat the child and family are in our experience, inhumane".

This document acknowledges how challenging and frustrating it can be for professionals when they encounter CPVA, as it is a complex form of family violence. As there is no national guidance, education or resources, it can be difficult for practitioners to know how to support the families that they work with safely and effectively. Despite the lack of resources, professionals still have the capacity to have a positive impact on the family just by listening and being there. All forms of (non CPVA) family violence must initially be screened for. If they are eliminated as a reason for CPVA, other avenues can be explored. Most families will not disclose their experiences, or the true extent of what is going on, for fear of being judged, threatened with having their child removed, an escalation in the violence, or their child being criminalised. Gaining parents' trust and believing without minimising what they are saying, helps to remove barriers to disclosing. Asking parents what they need, what they have already tried, and what outcome they want, shifts control back to them. Parents are often realistic in their expectations and already know that this is not a quick or easy fix. If they identify that a programme or intervention will not work, believe them - as they are the experts on their child. Be aware of the imbalance of power in the professional/client relationship and that ingrained perceptions on CPVA can affect bias.

An excellent resource for Professionals is *Child to Parent Violence and Abuse: A Practitioner's Guide to Working with Families* by Helen Bonnick (2019). Many of the recommendations she made have been included in this section:

- Non CPVA violence in the wider family unit must initially be screened for
- Until risk has been assessed the child should not be told that the parents have disclosed abuse as this could escalate the violence in the home
- Recognise that a whole family response is needed as everybody in the family will be impacted, requiring a multi-agency response and referrals
- Early intervention is imperative to avoid a crisis. Children often do not 'grow out of it'
- Collaborate with the family to develop a safety plan
- Early referral if neuro-disabilities are suspected. If a diagnosis cannot be given, still accommodate potential disability into any intervention
- Ability to recognise ACES and use trauma informed approaches in any intervention. The parents will need support as they also have trauma from what is occurring
- Be solution focused. The parents, or the child are not the problem. The problem is the CPVA. Tell the parents that the abuse is not their fault
- Recognise that counselling may be helpful but will not stop the violence which needs specialist input (Baker & Bonnick, 2021)
- Generic parenting courses will not work and are a waste of everybody's time
- Consult with schools. The school environment may be a trigger for the CPVA at home. Accommodation may need to be made during the school day to support the child, so they do not have to take their pent-up frustrations out on their safe people - the parents - at the end of the school day
- Be explicit in your questioning to avoid confusion

- Recognise that the parents are not difficult, they are traumatised, scared, sad and want the best for their child just like any other parent
- Liaise with the police to ensure the family are logged onto the system with an alert should they receive a 111 call
- If the child no longer lives at home but keeps returning, a trespass notice may need to be served. The child may need ongoing education and support on what this means
- Self-care and supervision for the professional so vicarious trauma and burn-out do not occur.

Safety plans

Safety plans are helpful for parents to follow when an incident occurs as they provide guidance on the steps to follow. Plans should be worked on collaboratively with the parents and include each family member - including pets; identify the associated risks, including where and when the violence is likely to occur; and set out what happens when an incident occurs and to whom. Be guided by the family as to whether neighbours can be included in the safety plan, as they are able to alert the police if needed, or casually knock on the door for a cup of sugar which may de-escalate things. Parents may need to install locks on some internal doors and have cameras and panic alarms on the property. They may also need to install a safe for their valuables. Safety plans should be reviewed regularly to check whether they meet the needs of the family or require tweaking.

Consideration of when to call police

Parents often feel conflicted on whether to call the police, as they do not want their child criminalised or may feel that they are wasting police time. A plan made with professionals as to when to call police can reduce this anxiety. Plans should include where family members can go during an incident to keep themselves safe, who needs to be made aware of the situation other than the police - such as siblings or other professionals working alongside the family. Sometimes it can be dangerous for family members to directly call the police if under threat, as it can escalate the situation more. Identifying and sharing a codeword that can be used when situations are unsafe means that others know to contact 111 immediately.

Multi agency response

A one size fits all approach will not work as each case will be different. Bates et al., (2023) found that applying a multi-agency approach to CPVA led to better outcomes for families. Some families reported a decrease in violence if basic needs were met such as housing, financial assistance, and employment, as this led to a reduction in stress levels. Holt (2022) also advocated for a multi-agency approach, highlighting that the complexities mean that social services, schools, police, disability, and mental health providers may need to become involved. Services should not just target the child but encompass the whole family unit. This means that adult services may also need to be involved to support the parents or siblings. Often young people will refuse to engage with services. If this is the case, professionals can still work with the parents. Bonnick (2019) believes if we seek to only work with the young person and not the parents this reinforces the belief that the young person is the problem.

International programmes and resources

This section describes a range of programmes which may be suitable for use in New Zealand. Any programme will need to be adapted to ensure they reflect our cultural needs and obligations under Te Tiriti o Waitangi. Some of the programmes included can be tailored to accommodate neurodiversity.

Who's in Charge?

Who's In Charge - Working with Child to Parent Violence & Abuse

This is an Australian and United Kingdom based 9-week programme for parents experiencing CPVA, spread over 8 sessions with a follow up review.   The first part of the programme addresses the shame, guilt and blame that parents experience, different parenting styles, and CPVA itself, including the myths. Part 2 explores the use of consequences that are meaningful to that child. The programme stresses this is not behaviour modification but more about the parents taking back control and being more assertive to create change. Part 3 supports parents in making these changes, helps them to explore their own triggers and builds upon their confidence to implement the consequences.

The programme is delivered in a group setting, enabling participants to connect with others in similar situations and reduce the shame and isolation.   It can also be delivered online to reach a wider audience. Feedback from parents has been positive with 65% reporting a decrease in violence. The service also offers training so practitioners can work within their own agencies to deliver the programme. Following on from the training there are quarterly peer support groups for the facilitators so they can share knowledge. Practitioners felt that to stop the increasing prevalence of CPVA further research and funding resources were needed so best practice could be developed further.

One of the goals of the programme is to debunk the belief of parents that the behaviour is part of a neuro-disability response. This programme would not be a good fit for the neurodivergent community as it appears to be a one size fits all approach with no accommodations for brain-based differences.

Break4Change

Break4Change | Centre for Justice Innovation

Break4Change is a United Kingdom programme, established in 2009, that runs for 10 weeks for youth between the ages of 11-17. The programme works collaboratively alongside other agencies using modalities of non-violent resistance, restorative justice, cycle of change and active engagement models. The aim is to reduce parents' feelings of isolation and the child's feelings of entitlement. As well as exploring behaviour, the programme establishes engagement by running a youth music project. The parents engage in a parallel programme to help them maintain boundaries and feel less isolated. In-house evaluation, following completion of the programme, found that parents felt more empowered, that they had a range of strategies they could use and the violence in the home had decreased. Young people reported that they were happier at home, with many re-engaging with school. In addition to the programme, Break4Change holds conferences and workshops to raise awareness of CPVA so when professionals encounter this form of family violence they can respond appropriately.

Having looked through each session offered through the Break4 Change programme, it would not be a good fit for the neuro-diverse community as there are no accommodations made for neurodiversity. The parents are told to stop making excuses for their child's behaviour and balance out the perceived entitlement of the child by giving them responsibilities. This may be counterproductive for the neurodivergent community, as unrealistic expectations could lead to heightened stress responses.

Step Up

Step-Up Program - King County, Washington

This is an American restorative and skills-based programme that uses restorative approaches to resolve conflict. It has been adapted for use across the United Kingdom and Australia. Sessions are carried out with the parent and adolescent working both together and individually in either a youth or parent group. Originally a 21-week programme, a 12-week programme is also available. The programme does not appear to accommodate neurodiversity.

Keeping Families Safe Program (KFS)

Keeping Families Safe Program - Peninsula Health

Keeping Families Safe is a Victoria (Australia) State funded programme available to families living with violence from their 12 to 18-year-olds. The focus is on the safety and needs of the family. The programme works with youth to help them learn how to resolve conflict respectfully and develop skills in managing emotions. It also supports the parents to look at alternative ways of parenting to promote wellbeing and better relationships within the home. Sessions run for 8 to 10 weeks. The programme can link families into other community-based services. The programme does not appear to accommodate neurodiversity.

Respect Young Peoples Programme (RYPP)

RYPP | Respect

Developed in the United Kingdom in 2016 and endorsed by the Youth Justice Board Effective Practice Unit, RYPP (Respect Young People's Programme) supports children between the ages of 8 to 18 and their families. It is run over a 3-month period, or longer if there are barriers to engagement. Sessions are carried out with the family unit, and individually with the young person and the parents. Using a cognitive behavioural approach and the theory of change model, the sessions help the family to learn strategies for conflict resolution and effective communication to improve family dynamics.   The programme can be adapted to accommodate neurodiversity.

Outcomes showed that the young person developed an increased understanding of their triggers and were able to use the strategies that they had learnt to manage conflict better. This led to improved communication and less violence by the young person towards their family.   In addition, the young person was more likely to remain engaged at school and less likely to become involved in the youth justice system. RYPP has been externally evaluated with a specific focus on the mental health outcomes for the youth. These were shown to have improved. Parents also reported that they felt more empowered in their parenting role.

The Respect programme recommends using Urie Bronfenbrenner’s nested ecological theory to build an understanding of the interactions within the different systems of the model, including individual, family, community, culture, and policy. The online booklet *Understanding CPV* by Baker and Bonnick (2021) provides detailed information on using the ecological theory in CPVA work. Neurodiversity is not mentioned in the programme information.

CAPA First Response

Families - Capa First Response

Offering a bespoke service to families and delivered as an online first response for families and professionals, the CAPA First Response is available throughout the United Kingdom. It was established as a response to the gap in service provision for CPVA information and awareness.

CAPA works with children up to the age of 18 (or 25 or if they are neurodivergent) and their families, including siblings. They aim to build a strong collaborative relationship with families, tailoring support to each family’s individual needs. During the first session they aim to identify the key drivers of CPVA, which informs their subsequent work. Part of CAPA's mission is to build a network of support through the United Kingdom and they offer free consultations, training and supervision to professionals.

SafeSpace

Amity iCAN and SAFESPACE (weareamity.co.uk)

This is United Kingdom based training for professionals working with CPVA. The training programme is delivered over a day and provides tools for professionals to then deliver a six-session programme to families they work with who have a child under the age of 15. Neurodiversity can be accommodated within the programme.

Non-Violent Resistance (NVR)

ABOUT | Non Violent Resistance UK

Developed in Israel by psychologist Haim Omer, NVR is based on the principles of non-violence resistance that were used in the civil rights movement. It is an evidence-based programme working with the parents individually or in group settings to provide psychoeducation and therapeutic support. An NVR trained practitioner will coach the parents over a few sessions to:

- Commit to engage with their child using non-violence and resistance to specific behaviours that are not acceptable
- Increase their parental presence using an authoritative parenting style
- Learn de-escalation skills including self-management and self-calming skills to change patterns and escalation of behaviour
- Develop a network to support the parents
- Make an announcement to all members of the family that violence at home will no longer be tolerated

- Acts of reconciliation by the parents to the child, such as spontaneous unearned treats and kind gestures
- Refuse orders from their child and do things such as watching what they want to on TV
- Hold a sit-in protest to demonstrate a commitment to non-violent resistance and break bad habits.

Coogan, (2018) p. 173.

In the United Kingdom NVR is gaining popularity and is used in a variety of contexts including adoption, special education needs, the disability field, schools and with parents. It may be a good fit for some New Zealand families experiencing CPVA.

Uniting Communities for Children - Adolescent Family Violence and (cyber) Bullying Prevention Project.

Uniting's Communities for Children launches Adolescent Family Violence and (Cyber)bullying Prevention Project. | Uniting Vic.Tas (unitingvictas.org.au)

An Australian initiative launched in October 2023. It partners with La Trobe University and VICSEG New Futures through the Communities for Children (CDC) Hume Program. The project focuses on children aged 10 to 12 years of age, their parents, and teachers. It provides specialist knowledge in child psychology, family violence, disability LGBTIQA+ communities, and cultural awareness of Aboriginal and Torres Strait Islanders. There is no information yet on what the programme includes so the writer is unsure if it is more focused towards cyber bullying as a form of adolescent violence.

International Resources and Peer Support Groups for Parents and Professionals

Bates et al., (2023) found that peer support has been identified by parents as the most positive type of intervention available as it enables them to connect to others sharing similar experiences. This reduces feelings of isolation. The internet has made access to peer support groups easier, and parents are able to share knowledge and practical strategies. Networks have provided national and international platforms for raising awareness of issues such as CPVA and subsequent advocacy for change as seen in the groups listed below.

PEGS

Support for Parents & Guardians | Pegs Support (pegsupport.co.uk)

PEGS was set up in the United Kingdom due to a lack of awareness and response to CPVA. Their aims are to support parents, train professionals, influence regional and national policy, and raise awareness. They do not work directly with the child displaying CPVA but are able to direct parents to services that are able to assist. They run virtual drop ins where parents can share what is going on for them, closed online peer support groups, online EPIC sessions 'Empowering Parents in Crisis' and one on one support, which includes advocacy. There is a range of professional training available including CPVA awareness and training, understanding CPVA, risk assessment training called PRAM to help identify CPVA, and bespoke training around an organisation's needs.

Newbold Hope

Home - Newbold Hope

This is a parent led organisation based in the United Kingdom set up by Yvonne Newbold to support and educate parents and professionals on how to reduce anxiety and aggressive behaviour in children with additional needs or disability. Yvonne believes that the three main trigger points for a young person are sensory processing differences, changes/transitions, and communication barriers. There is an online community of 14000 families and over 2000 children have been supported to successfully reduce their violent behaviour. The website offers free written and video resources covering different topics of CPVA and premium resources where a fee is required to gain access. There is a parents' online learning platform with a monthly subscription fee of 15 pounds. A professionals' toolbox section offers further information via written articles, videos, and TED talks. All training is designed to facilitate awareness of how to offer support to a child in a way that reduces their undesired behaviour, so they are calmer and happier.

Holes in the Wall

HOLES IN THE WALL | documenting parent abuse

Helen Bonnick is a social worker in the United Kingdom. She is a specialist in the CPVA field and has authored a book *Child to Parent Violence and Abuse. A Practitioner's Guide to Working with Families.* She created this website as a one stop shop for research and links to relevant material including audio and visual resources and training and events.

NICE – National Institute for Health and Care Excellence

Recommendations | Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges | Guidance | NICE

Provides information on challenging behaviours and learning disabilities, prevention, and interventions for people with learning disabilities. Advice is geared more towards schools or children in residential settings rather than their home environment, but is a useful resource to refer to.

Revelations in Education

Templates and Lessons – REVELATIONS IN EDUCATION

Revelations in Education is a website Dr Lori Desautels created for educators and clinicians working with children who have experienced trauma and adversity. It provides information and practical resources on regulating the nervous system and being aware of triggers.

New Zealand resources

To the writer's knowledge there are no specific programmes that work with families living with CPVA. The services listed can provide support for specific neuro-disabilities and how to deal with challenging behaviour by making accommodations to the environment. Parents have often instinctively done this, but it also requires external environments that the child operates in such as at school and in the community to make these accommodations as well. This rarely happens due to lack of funding.

Explore Wellbeing Services

About - Explore Wellbeing

Explore is part of the New Zealand Health group and is funded by Whaikaha Ministry of Disabled People to offer a nationwide range of services for the disability community, families and supporters. These include drug and alcohol support, psychology and wellbeing, community mental health, autism support and specialist behaviour support.

FASD-CAN Aotearoa New Zealand

Fetal Alcohol Spectrum Disorder - Care Action Network (fasd-can.org.nz)

This is a one stop shop for FASD whose aim is to *unite caregivers, support whānau and individuals, strengthen communities and educate about FASD across Aotearoa.* The resource section offers access to fact sheets, learning support tools for educators, downloadable flyers and cards, a healthy outcomes framework, webinars and hui recordings. The parents/caregiver section offers information on a broad range of subjects including which DHBs offer a diagnosis, and behaviour support strategies including CPVA. Practical help is offered through training and peer support groups both online and in person. There are two navigators, one in Auckland and the other in Northland, who offer whānau support and advocacy as well as education on FASD in the wider community. In addition to information for professionals, there is a networking group for educators and one for social workers and support workers. Each year a workshop provides information on both international and national developments. Membership is free and caregivers receive a handbook which is a useful resource as they will need to adapt their parenting using the neuro-behavioural approach, as traditional parenting can cause an escalation in behaviour. If professionals wish to purchase the handbook, they are charged a nominal fee. it. FASD-CAN also supports individuals living with FASD by linking them with access to resources and an online peer support group. They are running a development project for individuals living with FASD so they can become advocates/leaders in their communities.

Altogether Autism

Altogether Autism - Trusted Autism Information and Advice

This is an information hub for Autism in New Zealand. It provides education resources for the individual, their families, and professionals. It hosts a wide range of workshops which can be tailored to meet specific needs, including bespoke workshops by autistic people for autistic people. Professional development training relevant to organisational needs is offered.

Autism NZ

Home - Autism NZ

This site offers information on autism educational resources, diagnosis, transition services, and online peer support groups. An outreach service is available across the country with coordinators offering a range of support, education, and information services from 16 nationwide branches. It is available to autistic people, families and their support networks, including professionals. There is also a range of training options for autistic adults, their families, and professionals.

ADHD New Zealand

What is ADHD | ADHD NZ - ADHD NZ

ADHD New Zealand provides information and education on ADHD, including a directory of ADHD experienced professionals. Online webinars and access to peer support groups both online and face to face.

Brain Injury New Zealand

Home - Brain Injury New Zealand (brain-injury.nz)

Brain Injury New Zealand offers support and resources to individuals and their families through Liaison Officers who work from 14 regional hubs. In addition to providing information, peer to peer support groups are available.

www.visable.co.nz

Interventions and support that may help New Zealand families living with CPVA

Neuro-disability/Neurodiversity

Living with a neuro-disability does not mean that there will be violence in the family. However, research is indicating that there are higher prevalence rates amongst this cohort. If a neuro-disability is suspected, a referral and diagnosis are ideal. Realistically, due to lack of capacity in our health system, this is often not possible, with the only option for many being via the private sector which is cost prohibitive for most families. This does not mean that interventions cannot still be tailored to meet the family's needs. Most parents will know if something will work or not, so be led by them and their knowledge as they are the experts on their child.

Sensory profile

Some children have sensory processing issues which impact upon their brain's ability to receive, organise and respond to sensory input. This can sometimes lead to extreme behaviours occurring when the child becomes overwhelmed by their environment. If this is suspected, a referral to an occupational therapist is recommended so an evaluation can be carried out and a 'sensory diet' can be put in place that is customised for their individual needs. If this is successful and accommodations are made, it could lead to a reduction in undesired behaviour.

Speech and language disorders

It is not always clear whether a child has a speech and language disorder, though it often coexists with some disabilities such as FASD. Having a speech and language disorder can lead to behavioural issues as it has a big impact on how the child engages with the world. They child will often be unable to process what is being said, follow the television or radio, follow instructions at school, or communicate effectively, leading to intense frustration. A diagnosis may therefore help them and those around them (including schools) to put into place appropriate accommodations to support the child better.

Sleep

Poor sleep quality has been linked to increased aggression, as it impacts cognitive functioning and the ability to regulate emotions (Maaike et .al., 2021). There is a high prevalence of sleep problems in children with neurodiversity. One study found that 85% of people affected by FASD had sleep problems (Chen et al., 2012). The Ministry of Health provides information on healthy sleeping at
Sleeping (info.health.nz)

Medication

Medication may help to reduce or eliminate some of the stress and anxiety a young person may be feeling. To aid effectiveness and reduce over-prescribing a psychotropic medication algorithm has been developed to guide clinicians about what medications to give to people with FASD. FASD-CAN reports that it is one of the most popular downloadable resources, with members reporting successful outcomes in reducing aggression. Information about this can be found at

Medication Algorithm - CanFASD

Te Whare o Oro

Te whare o Oro : a mātauranga Māori framework for understanding the roro / Andre McLachlan, Tahlia Kingi, Waikaremoana Waitoki, Matariki Cribb-Fox & Whatahoro Cribb-Fox. (natlib.govt.nz)

Te Whare o Oro is based on te ao Māori concepts of understanding how the brain develops and functions. This framework incorporates Bruch Perry's neuro-sequential model of neurodevelopment, Te Whare Tapu Whā and Ngā Pou o te Wharenui. This publication is part of a research programme to examine different ways of understanding how a child's brain is impacted during pre-birth, birth and early development. The next part of the research aims to develop an interactive learning model to build on neurodevelopment from a Māori perspective. The model itself uses Te Whare Tapa Whā to represent the 4 corner pou within Te Whare o Oro which represent taha hinengaro, taha tinana, taha whānau and taha wairua. Additional pou include pou tuarongo (the brainstem), pou tāhū (diencephalon and cerebellum), pou tokomanawa (limbic system), pou kaiāwhā (cerebral cortex),

The framework introduces Polyvagal Theory which emphasises the role of the autonomic nervous system (vagus nerve) which is responsible for regulating our health and behaviour. It also draws on the Neurosequential Model of Therapeutics (NMT) which asserts that adversity during early childhood is likely to impact functioning within various parts of the brain that are developing. Children who have impaired functioning from alcohol, drugs or adversity/trauma can benefit from rhythmic and repetitive activities to help organise the brain stem and aid regulation of the central nervous system through vagus nerve exercises.

This could be a good fit in helping to understand our community. Professional training on implementing Te Whare o Oro would need to be provided to ensure it is understood fully and is applied in a culturally appropriate way.

Neurosequential model

The Neurosequential Network | neurodevelopment

Developed by Dr Bruce Perry, the Neurosequential model is a neuroscience informed approach to understanding how early adverse experiences (ACES), including prenatally, shape brain development and functioning. Early trauma affects the brain stem (also known as the primitive part of the brain) which is responsible for the fight/flight response. If stuck in this response, the higher parts of the developing brain do not get the right messages, which makes learning difficult. Assessment by a trained clinician can help to determine where the child’s brain domains are underdeveloped or dysfunctional. Once this has been determined, appropriate strategies such as repetitive sensory input and movement are used to facilitate development and healing. Everyone involved in the child’s life needs to work collaboratively together using the same approach. A good video to explain the Neurosequential model is *The Repair of Early Trauma: A Bottom Up Approach.* The Repair of Early Trauma: A Bottom Up Approach – YouTube

SomaPsych

http://www.somapsych.org/ amanda@somapsych.org

Amanda Hana (2024) has written about Somatic Psychology for this report and how this modality may benefit the whole family.

Overview

Somatic movement (somatics) refers to integrating mind-body practices aimed at increasing awareness of bodily sensations, promoting emotional regulation, and releasing physical tension. Down-regulation strategies involve techniques that calm the nervous system, reducing heightened states of arousal and stress. These approaches acknowledge the interconnectedness of bodily experiences and emotional states, recognising the role that dysregulated emotions and decreased ability to self-regulate play in violent experiences (Hetherington and Gentile, 2022).

Somatic psychology, nervous system regulation, and vagus nerve support can play crucial roles in addressing child-to-parent violence (CPVA) by offering holistic approaches that address the underlying emotional and physiological factors contributing to violent behaviours and dynamics.

Somatic Psychology recognises the intricate connection between the body and mind. It emphasises the importance of integrating bodily sensations, emotions, and cognitive processes in therapeutic interventions. In the context of CPVA, somatic psychology can help individuals explore and understand the physical sensations and emotions associated with violent behaviours. By fostering greater body awareness and emotional regulation skills, somatic approaches enable individuals to express themselves more effectively and manage conflict in healthier ways.

By combining somatics and psychology and weaving in nervous system support through polyvagal exercises, we can work toward a more regulated and stabilised autonomic and central nervous system. Understanding and implementing somatic practices can gradually help whaiora and caregivers to recalibrate their dysregulated nervous system responses to become more internally aware and increase their capacity to self-regulate (Punkanen and Buckley, 2021). Integrating somatic psychology, nervous system regulation, and vagus nerve support into interventions for CPVA acknowledges the multifaceted nature of violent behaviours and addresses the underlying emotional, physiological, and relational dynamics at play. By empowering individuals with tools for self-regulation, emotional expression, and interpersonal connection, these approaches promote healthier patterns of interaction within the family system and support long-term healing and transformation.

Key Elements

Nervous System Regulation: The autonomic nervous system (ANS) plays a central role in regulating physiological responses to stress and threats. Individuals who engage in CPVA may experience dysregulation of their ANS, leading to heightened states of arousal, anxiety, and aggression. Techniques aimed at regulating the nervous system, such as deep breathing exercises, progressive muscle relaxation, and mindfulness practices can help individuals modulate their physiological responses and restore a sense of calmness and equilibrium. By promoting nervous system regulation, interventions can mitigate the triggers and escalations that contribute to CPVA episodes.

Vagus Nerve Support: The vagus nerve, a key component of the parasympathetic nervous system, plays a critical role in regulating emotional and physiological states. It helps modulate the heart rate, breathing, digestion, and stress responses, exerting a calming influence on the body and mind. Support for vagal tone and activation can enhance emotional resilience and promote adaptive coping strategies in individuals experiencing CPVA. Practices such as diaphragmatic breathing, gentle movement exercises, and social engagement activities stimulate the vagus nerve, fostering a sense of safety, connection, and emotional well-being.

Polyvagal-Informed Therapy for Complex Trauma: Polyvagal theory, developed by Dr. Stephen Porges, provides a neurobiological framework for understanding how the autonomic nervous system responds to threat and safety cues. Polyvagal-informed therapy integrates principles of nervous system regulation and vagus nerve support into trauma treatment approaches, emphasising the importance of creating a sense of safety and connection in therapeutic relationships. Therapists trained in polyvagal theory use interventions such as voice prosody, rhythmic breathing, and sensory regulation techniques to help clients regulate their nervous systems and co-regulate with others. By promoting neurobiological safety, polyvagal-informed therapy can help individuals who have experienced complex trauma, including CPVA, to restore a sense of equilibrium and resilience.

SomaPsych's training incorporates short, quick and highly effective practices for down-regulation that can be taught verbally and non-verbally. These tools can be incorporated into personal and professional practices for overall nervous system support, vagal toning for down-regulation, and physiological recalibration for increased emotional regulation.

Summary

Integrating somatic psychology, nervous system regulation, and vagus nerve support into interventions for CPVA acknowledges the multifaceted nature of violent behaviours and addresses the underlying emotional, physiological, and relational dynamics at play. By empowering individuals with tools for self-regulation, emotional expression, and interpersonal connection, these approaches promote healthier patterns of interaction within the family system and support long-term healing and transformation.

Polyvagal theory, developed by Dr. Stephen Porges, provides a neurobiological framework for understanding how the autonomic nervous system responds to threat and safety cues. Polyvagal-informed therapy integrates principles of nervous system regulation and vagus nerve support into trauma treatment approaches, emphasising the importance of creating a sense of safety and connection in therapeutic relationships. Therapists trained in polyvagal theory use interventions such as voice prosody, rhythmic breathing, and sensory regulation techniques to help clients regulate their nervous systems and co-regulate with others. By promoting neurobiological safety, polyvagal-informed therapy can help individuals who have experienced complex trauma, including CPVA, restore a sense of equilibrium and resilience.

The vagus nerve plays a critical role in regulating emotional and physiological states. It helps modulate the heart rate, breathing, digestion, and stress responses, exerting a calming influence on the body and mind (Werbalowksy, 2019). Support for vagal tone and activation can enhance emotional resilience and promote adaptive coping strategies in individuals experiencing CPVA. Practices such as diaphragmatic breathing, gentle movement exercises, and social engagement activities stimulate the vagus nerve, fostering a sense of safety, connection, and emotional well-being.

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