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ORIGINAL ARTICLE

Using Trauma Informed Treatment Models with Child-to-Parent Violence

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Abstract In recent years, there has been an increase in the reporting of youth as perpetrators of family violence. However, despite the relatively high prevalence of child-to-parent violence, little is known about this pervasive family problem and the effectiveness of intervention strategies. The purpose of this article is to highlight the effectiveness of the current interventions used to treat child-to-parent violence and recommend the inclusion of trauma-informed assessment and intervention strategies. When working with child-to-parent violence, interventions should be informed by the correlates of such violence rather than the notion that the parent–child dynamic mirrors that of the adult intimate relationship. Effective treatments must address the multiple determinants of child-to-parent violence and offer broad level, complex interventions that consider childhood traumatic experiences and the role they play in child-to-parent violence.

Keywords Child-to-parent violence · Youth perpetrated family violence · Childhood trauma · Trauma informed treatment

Traditionally, children have been viewed as victims of family violence, either as a victim of abuse/neglect, or witness to intimate partner violence. In recent years, there has been an increase in the reporting of child-to-parent violence. Estimates of youth-perpetrated violence against a parent range from 5 to 13 % (Kennedy et al. 2010; Walsh & Krienert 2007), and these numbers are growing as this newly identified phenomenon is gaining more public attention. However, despite the relatively high prevalence of youth-perpetrated violence against a parent, little is known about this pervasive family problem and the effectiveness of intervention strategies. The purpose of this article is to highlight current interventions used to treat child-to-parent violence, their usefulness, and to recommend the inclusion of trauma-informed assessment and intervention strategies to end the cycle of violence.

Child-to-parent violence (CPV) is defined as any harmful act (physical, psychological, or financial) by an adolescent against a parent (Coogan 2011). Research has documented characteristics of youth who perpetrate violence against a parent and found youth to be white males (Kennedy et al. 2010; Paulson et al. 1990; Walsh & Krienert, 2007) between the ages of 15 and 17 (Cornell and Gelles 1982; Kennedy et al. 2010; Paulson et al. 1990), and single mothers were often the targets of violence (Cornell and Gelles 1982; Nowakowski & Mattern 2014; Ulman and Straus 2003). The psychological characteristics of CPV youth were described as unhappy, having low self-esteem, and low self-worth (Harbin and Madden 1979; Kennedy et al. 2010; Paulson et al. 1990). Additionally, substance abuse has been found to be a significant predictor of CPV (Calvete et al. 2011; Nowakowski & Mattern 2014), as well as having a mental illness (Charles 1986; Evans and Warren-Sohlberg 1988; Fernandez et al. 2011).

Numerous studies have found relationships between witnessing violence in the home and child-to-parent violence (Boxer et al. 2009; Kennedy et al. 2010; Nowakowski & Mattern 2014). Parental characteristics also contribute to child-to-parent violence:; specifically, when a parent or caregiver used drugs or alcohol, the likelihood of parent–child conflict increased (Pelletier and Coutu 1992; Way and Urbaniak 2008) and parental incarceration has also

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demonstrated an association with child to parent violence (Geller et al. 2009). Finally, ineffective parenting, either too controlling (Brezina 1999; Cottrell & Monk 2004) or too permissive (Calvete et al. 2011, 2014) has been linked with child-to-parent violence.

Current Interventions

The effects of child-to-parent violence have caused attention to shift from *why* youth perpetrate violence towards *how* to treat youth through effective intervention programs. There is a considerable lack of evidence-based interventions to use with youth who perpetrate violence against a parent. Many jurisdictions do not have diversionary programs in place for these adolescents and their families, but those that do often refer youth into traditional anger management group counseling and family therapy.

Anger Management

Anger management is currently the most popular model that is used with youth who perpetrate violence against a parent. Anger management uses a cognitive behavioral group approach that seeks to explain how stimuli may cause anger through a series of information processing biases: the core components of this approach include increasing self-awareness, developing coping strategies, and relaxation training (Walker & Bright 2009). This approach stems from the idea that violence is a learned behavior and can be unlearned through cognitive behavioral therapy. Despite the pervasiveness of this treatment model, there are several criticisms for using this modality with any population, let alone youth perpetrators of family violence.

Anger management is one of the few cognitive behavioral treatment interventions with published studies that do not show benefit of treatment (Sharry and Owens 2000; Watt and Howells 1999). Researchers have also suggested that anger management might not be adequate when trying to avoid or control dangerous situations in which emotion overcomes capacity to think; it's in these moments that "the 'parts' not reached by anger management may be those causing the most dangerous violent acts" (Walker & Bright, 2009, p. 178).

In reviewing the literature on the effectiveness of cognitive behavioral group programing to treat youth who perpetrate violence against a family member,, Routt and Anderson (2011) Step UP program was offered as a treatment model. This model was based on the treatment of adult domestic violence, but it is adapted to the needs and circumstances of a parent–child relationship. The program is a 20 weeks group program in which youth learn respectful communication, conflict resolution, anger management, and behavioral and emotional awareness techniques in order to prevent violence and abusive behavior; it includes a youth group, a parent group, and a youth-parent group. Routt and Anderson (2011) identified the program as a 'promising program'; but the evaluation of the program fails to provide any evidence of success beyond identifying risk factors for youth offenders and characteristics of victimized parents and families. Nowakowski and Mattern (2014) looked at characteristics that impacted the completion of a family violence diversion program and found that youth with a history of violent arrests, who used substances, and skipped school, were less likely to complete the program than youth without such characteristics. In this study, the anger management group and family counseling were not enough to ensure retention and successful completion of diversion programming among youth with multiple delinquency characteristics.

The Duluth model of anger management is a feminist psychoeducational approach (Pence and Paymar 1993) that focuses on 'power and control' as the primary etiological factor in intimate partner violence. When using the Duluth Model, men are asked to examine how they control their partners and how society sanctions this control in order to create strategies that eliminate violent behavior (Stuart, Temple, & Moore, 2007). Babcock et al. (2004) conducted a meta-analysis of 22 studies evaluating treatment efficacy for domestically violent males and found that effects due to treatment were in the small range, meaning that the current interventions have a minimal impact on reducing recidivism beyond the effect of being arrested.

Anger management groups for youth who perpetrate violence against a parent use a modified version of the Duluth Model. This may be appropriate, given the hypothesis that child to parent violence is an abuse of power by the youth through which he or she attempts to dominate, coerce, and control others in the family (Coogan 2011; Harbin and Madden 1979); however, this explanation has yet to be fully supported by research. Of the few published studies that examine child-to-parent violence, most explore characteristics of the perpetrator (Boxer et al. 2009; Calvete et al. 2013; Kennedy et al. 2010; Nowakowski & Mattern 2014; Walsh & Krienert 2007). Justification for using a power and control intervention model with this population is not yet available. Uekert et al. (2006) argued that there is a lack of reliable data on the effectiveness of adult battering intervention programs, yet adult battering intervention programs continue to be the model that is used to create adolescent programs. Additionally, regardless of their circumstance, all youth are grouped together to receive the same 12 weeks program. Not all batterers are alike, yet in this approach most receive the same treatment programs. Batterer intervention programs that have been developed for adult batterers are often plagued by the one-size fits all assumption, in which batterers are presumed to suffer from the same malady, thus requiring the same

treatment (Uekert et al. 2006). This might obtain because the literature on batterer intervention is dominated by very few treatment models, most commonly the Duluth model (Price & Rosenbaum 2009).

Family Counseling

In addition to anger management groups, youth who perpetrate violence against a parent are often referred for family counseling. Family counseling typically is comprised of hour-long sessions with the youth perpetrator and family members. In many cases, the victim participates as well. Research supports the inclusion of the family in treating youth who perpetrate violence against a parent (Calvete et al. 2014; Micucci 1995); however, family counseling that fails to attend to the underlying causes of the violence is unsuccessful. Additionally, in family counseling, often the youth is viewed as the problem and the one who needs to be "fixed". Micucci (1995) argued that, in family counseling, when the youth is identified as the symptomatic member and locus of the problem, family members are less apt to attend to the role that the family interactions may play in maintaining the violence.

Rationale for a Different Type of Treatment

Treatment options seem limited for youth who are violent in the family. These programs are not context-specific, are not altered to accommodate individual needs, and usually focus on one type of aggression. Tate et al. (1995) proposed that many treatments in relation to aggression fail because they focus on only one specific type of aggression or use only one mini-theoretical approach to treatment. Walker and Bright (2009) pointed out that individuals should only be referred for anger management if anger is identified as a significant problem. So, if anger is not the driving force behind a youth's aggressive behavior towards a parent, what might be involved? One hypothesis is that untreated childhood trauma is the driving force behind a youth's violent behavior within the family, at least when the traditional definition of trauma is expanded to include adverse childhood experiences. Ford et al. (2012) argued that assessing and treating undetected trauma provides an alternative approach to remediating complicated and severe behavior problems in justice-involved youth. The unique development and causes of a problem are central to deciding the best course of treatment. With violence, there are a vast number of possible causative, exacerbating, and ameliorating factors that may act differently in combination, so that the most effective treatment will depend on which of these factors are involved (Bush 1995).

Trauma

Research has shown that traumatic childhood experiences are common and have a profound impact on development (Ford 2005, 2010; Turner et al. 2006). The American Psychiatric Association [APA] (2013) presents its criteria of posttraumatic stress disorder (PTSD) in the DSM-5, and defines a traumatic event as exposure to actual or threatened death, serious injury, or sexual violence for which one must directly experience the traumatic event, witness the traumatic event in person, learn that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental), or experience first-hand repeated or extreme exposure to aversive details of the traumatic event. More recent research has argued that the definition and what qualifies as traumatic has been problematic (McDonald et al. 2014), suggesting that the definition of traumatic events should be expanded to include adverse childhood experiences that are not typically considered traumatic according to the DSM-5 PTSD criteria. Felitti and colleagues (1998) conducted the Adverse Childhood Experiences study, which looked at the impact of child abuse and household dysfunction; it included conditions such as parental drug abuse, spousal violence, and criminal activity in the household on adult health and well-being. Felitti et al. (1998) recognized that without measuring household factors, as well as child abuse, long-term influence might be wrongly attributed solely to single types of abuse and also the cumulative influence of multiple categories of adverse childhood experiences would not be assessed. Cumulative adversity suggests that especially intense and long-lasting effects occur when problems aggregate, particularly in childhood (Dong et al. 2004). Traumatic stress theory—the dominant framework for understanding the impact of victimization—has evolved toward the notion that, for some children, victimization is not a single overwhelming event but a condition (Finkelhor et al. 2007).

Children who have histories of multiple forms of traumatic stress and with repeated victimization may be at greater risk for experiencing complex trauma. van der Kolk and Courtois (2005) describes complex trauma as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events that are most often of an interpersonal nature and early life onset" (p.17). Ford et al. (2012) continued that complex trauma is multifaceted (i.e., several forms of traumatic stressors) and cumulative (i.e., involving repeated victimization). Multiple studies have documented the additive effect of adverse childhood experiences leading to more symptoms later in life (Dube et al. 2003; Felitti et al. 1998; McElroy and Hevey 2014). When children experience a range of adverse childhood experiences compared to children who experience repeated episodes of the same kind of victimization (Finkelhor et al. 2007), this cumulative stress can result in a multi-symptom clinical presentation, including posttraumatic stress

(Kerig and Becker 2010; Tatar et al. 2012), anxiety (Courtois and Ford 2009; Tatar et al. 2012), depression (Allwood et al. 2011), aggression (Ford 2010; Ford et al. 2012), and substance abuse (Ford et al. 2008; Kilpatrick et al. 2003).

Based on the above definition, untreated trauma is a pervasive and growing problem, and it has been identified as the United States' single most important public health challenge (D'Andrea et al. 2012). Childhood exposure to trauma varies based on its definition. In a sample of 2,453 university females, Briere et al. (2008) found 28 % of the sample had experienced at least one childhood traumatic event and an additional 28 % had experienced more than one traumatic event. A sample of 305 children aged 2–5 recruited from a public pediatric clinic showed that 52.5 % of the children had experienced at least one severe traumatic stressor in their lifetime; 20.9 % had experienced the loss of a loved adult; 16 % had been hospitalized; 9.9 % had been in a motor vehicle accident, 9.5 % had a serious fall, and 7.9 % had been burned (Lieberman et al. 2011). In their study of more than 64,000 juvenile offenders in Florida, Baglivio et al. (2014) found a high cumulative traumatic exposure of justice-involved youth, whereby family violence was the number one reported adverse childhood experience. In 2010, 16.4 million children were poor in the United States, and 7.4 million of those children lived in extreme poverty (Children's Defense Fund, 2012). The 2007 National Survey on Drug Use and Health reported that 8.3 million children live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year. In a survey of 1,245 American adolescents, 23 % were victims of physical or sexual assault, as well as witnesses of violence (Office on Child Abuse and Neglect, Children's Bureau, 2009).

Linking Trauma History and CPV

The link between childhood trauma and aggression is well established, but what is less known is the reasons *why* youth perpetrate violence against a parent. In the absence of a well-established explanation of child-to-parent violence, the cycle of violence is the most accepted theoretical model for explaining child-to-parent violence. Children with a history of maltreatment exhibit higher levels of aggression towards parents (Browne and Hamilton 1998; Pratchett and Yehuda 2011; Ulman and Straus 2003). Other studies have confirmed that witnessing interparental violence in the home poses a risk for teenagers to aggress toward their parents (Boxer et al. 2009; Brezina 1999). In this context, violence is accepted as a normal part of a familial relationship that is directly or indirectly reinforced when children replicate the behavior of their parent or caregiver. However, Baker (2012) has argued that the cycle of violence model for explaining child-to-parent violence needs further work and the limits to its generalization needs specification.

It has been suggested in the literature that youth who perpetrate violence against a parent have features common to those who perpetrate intimate partner violence for power and control (Calvete et al. 2014; Coogan 2014; Hunter et al. 2010; Routt and Anderson 2011). Calvete et al. (2013) found a correlation between proactive violence and child to parent violence; however, the authors admitted that the link may be better understood within the context of parental permissibility rather than one of power and control. Hunter et al. (2010) acknowledged there is a more complex set of dynamics at issue in relation to child to parent abuse and that 'the two forms of violence' are not synonymous.

Others have suggested a connection between complex trauma and aggression rooted in early patterns of attachment (Ford et al. 2012; Tatar et al. 2012; Van der Kolk et al. 2009). Traumatized children reset their normal level of arousal so that even when no external threats exist, they are in a constant state of alarm (Perry 2006). Children who have experienced trauma come to view adults as potential sources of threat rather than comfort and support. Van der Kolk et al. (2009) explained that when trauma occurs in the home, children become overwhelmed and are unable to regulate internal states, which may lead to a feeling of helplessness. It is this feeling of helplessness that drives children to go immediately from (fearful) stimulus to (fight/flight/freeze) response without being able to learn from the experience. Unless caregivers understand the nature of such re-enactments they are liable to label the child as "oppositional", 'rebellious", "unmotivated", and "antisocial" (van der Kolk et al. 2009, p. 5).

Worthington (2012) found that trauma exposure can cause a person to use preemptive aggression to manage fear. Porter (1996) introduced the concept of secondary psychopathy, in which youth "turn-off" their emotions in order to cope with trauma, leading to the emotional blunting associated with psychopathy. Adverse childhood experiences are a key environmental factor in the development of secondary psychopathy. Environmental factors, including traumatic exposure (e.g., adverse childhood experiences, abuse, and neglect), have been empirically linked to child and adolescent psychopathy (Farrington et al. 2010). Another hypothesis suggests that youth-perpetrated family violence is reactive aggression, by which youth aggress as a means to cope or protect oneself based on past complex trauma (Ford et al. 2006). Ford et al. continued:

> When exposed to coercion, cruelty, violence, neglect, or rejection, a child may cope by resorting to indifference, defiance of rules or authority, or aggression as self-protective counter-reactions. The child may feel so terrified, alone, and powerless, in the face of victimization that the best way she or he can find to cope may take the form of anger, defiance, callousness, or aggression. In these cases, risk taking breaking rules, fighting back,

> and hurting others reflect a shift from survival coping to victim coping. Such reactive and defensive attempts to overcome or resist helplessness and isolation caused by victimization are motivated by a desire to regain the ability to feel safe and in control. (2006, p. 17)

Currently, there are no known studies that have tested the above hypotheses why a child perpetrates violence against a parent; However, the few studies that have examined child-to-parent violence do include perpetrator characteristics among which are emotional and behavioral outcomes of untreated trauma–e.g., depressive symptoms (Calvete et al. 2013); low self-esteem (Kennedy et al. 2010); substance abuse (Calvete et al. 2013; Nowakowski & Mattern 2014); and juvenile delinquency (Kennedy et al. 2010; Nowakowski & Mattern 2014).

Trauma begets trauma (Kerig and Alexander 2012), and when working with youth who perpetrate violence against a parent, interventions should be informed by the correlates of child-to-parent violence rather than the notion that the parent–child dynamic mirrors that of the adult intimate relationship. The aggressive behavior of a youth who is reacting to past traumatic experiences may be no less dangerous or problematic than that of a youth who means to inflict harm on a family member; however, diversion programs have a responsibility to include, as it plans its interventions, a full understanding of the role that trauma and victimization can play in youths' actions and in their reform (Ford et al. 2006).

Trauma Informed Treatment for Child–Parent Violence

Research has consistently shown that children who experience trauma are at a greater risk of reactive aggression (Ford et al. 2012), and child–parent-violence may be one example of such reactive aggression. To effectively respond to trauma-related histories, it is necessary to have advanced therapeutic skills that promote healing and connection. This can be done within the context of a trauma-informed approach to recovery. This approach focuses on improving wellness rather than treating a mental illness. Trauma Informed Care (TIC) offers a safe and client-centered environment in which service providers understand and respond to maladaptive behavior in the context of traumatic experiences by helping clients to develop the self-observation skills necessary to build self-regulatory capacity (Levenson 2014). Van der Kolk and Courtois (2005) identified three critical elements of delivering trauma informed care: the development of safety, the promotion of healing relationships, and the teaching of self-management and coping skills. Bath (2008) identified three therapeutic tasks:

> The first task is to create a safe emotional and physical space for children. Because traumatized children view adults as potential sources of threat, the next task is for providers to help children develop positive emotional responses with adults and can learn to accurately distinguish between those who threaten harm and those that do not. The final task is to teach and support children to learn new ways of effectively managing their emotions and impulses. (p.19–20)

Trauma specific treatment includes evidence based programs that have been proven to facilitate recovery from trauma and must address the multiple determinants of child-to-parent violence. Therefore, an effective treatment is one that provides broad-level, complex interventions that consider childhood traumas and the role they play on child-to-parent violence. Currently, few trauma-focused treatments are used in juvenile justice settings due to lack of resources, under-identification of trauma symptomatology, and a stronger focus on behavioral management issues (Mahoney et al. 2004). One promising program is the Trauma Affect Regulation-Guide for Education and Therapy (TARGET) program. TARGET teaches youth to better manage their emotions, thoughts, and behavior by enhancing and building upon strengths in functioning and relationships. Ford and Hawke (2012), in a sample of 394 juvenile detention youth, found that participating in TARGET groups was associated with a reduction in disciplinary incidents and in punitive sanctions in juvenile detention facilities. Additionally, TARGET has been adapted to be delivered with entire families in community-based and home-based interventions.

Juvenile justice involved youth have a higher prevalence of trauma than the general population (Dierkhising et al. 2013) and perhaps the most important component for justice systems is the implementation of trauma screening and assessment for all youth entering the system, as well as the provision of evidence-based, trauma-informed treatment and interventions for youth identified (Ford et al. 2006). Juvenile justice systems should implement and reinforce trauma-informed training for all staff who have contact with juveniles in order to help them understand traumatic and posttraumatic reactions (Griffin et al. 2012), as well as to help them make appropriate referrals to clinically trained mental health professionals (Dierkhising et al. 2013).

Child-to-parent violence merges the notion of perpetrator with victim and requires a paradigm shift in how to work with juveniles who have been arrested for domestic battery. Diversion programming should include services that address emotional dysregulation and survivor-based information processing; these both can help children recover from their experiences with trauma while reducing the likelihood of recidivism or continued delinquency (Ford et al. 2006). Parent involvement is critical to the success of youth trauma treatment

(Kerig and Alexander 2012) and parents must contend with being both the victim of their child's violence and advocate for their child's well-being.

Conclusion

Child-to-parent violence is a growing social problem with implications for research, policy, and practice. The connection between trauma and aggression is well supported in the literature, yet the connection between trauma and child-to-parent violence is hypothesized, but unknown. Future research should explore the relationship between childhood trauma and child-to-parent violence, specifically looking at mediating influences between childhood trauma and child-to-parent violence. By understanding the multiple pathways connecting childhood trauma and child-to-parent violence, intervention efforts can be tailored to meet the needs of families who are impacted by child-to-parent violence. If untreated trauma is associated with child-to-parent violence, the legal and justice systems must shift from using a punitive model to a rehabilitative model when working with youth and their families. Policymakers should be concerned with child-to-parent violence and be aware of successful diversionary efforts as a way to prevent the transmission of violence. Clinicians working with these youth should consider a trauma assessment and incorporate trauma work into their treatment plans. Finally, family involvement constitutes best practice for these youth. Intervention programs that detect and treat childhood and adolescent trauma have the potential to stop child-to-parent violence.

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