The Effects of Childhood Exposure to Family Violence

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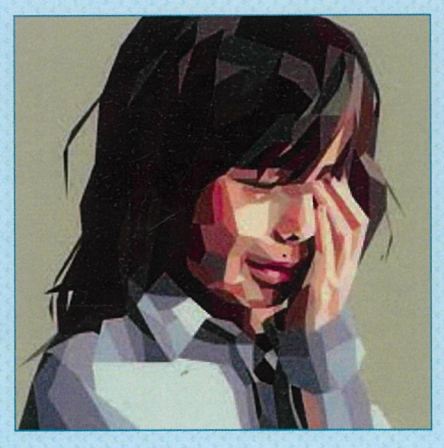
Clinical Setting/Practice Issue

In the clinical context of youth, child and family community mental health services the referrals are discussed in MDT's. Immediately noticeable is the number of referrals containing a history of family violence.

Although New Zealand has particularly high rates of family and intimate partner violence (Families Commission, 2009), children and youth from such families seem to be over-represented in the referrals.



Why is it an Issue?

In New Zealand 25% of our children live in risk-homes, 1 in 3 girls and 1 in 6 boys will experience sexual abuse and there were 55,494 notifications with further action and 13 child homicides in one year.

Family violence requires our attention. As health care professionals it is important to recognise and respond to family violence appropriately (Ministry of Social Development, 2012).

Research Question

Using the PECOT critical appraisal tool (Jackson, 2010) in reverse to engineer a formal research question we reveal a *P*opulation of survivors, an *E*xposure to violent experience, a *C*ontrol in those unexposed, an *O*utcome of affected mental health and a *T*imeframe of childhood and adolescence. This provides the question:

How does Exposure or Experience of Family or Partner Violence in Childhood or Adolescence Affect the Mental Health and Wellbeing of Survivors?

Literature Review Summary

Whether the child is a witness to intimate partner violence or personally experiences family violence, the situation is considered abusive. The violence may take the form of physical, sexual, verbal, emotional, psychological, threatening or intimidating, fiscally controlling, entitled or neglectful behaviours. Psychological, emotional and neglectful violence can be much harder to define and recognise, both at the time and in retrospect (Briere, 1992).

Problems may arise in any arena of the child's functioning. Some of the signs and symptoms include emotional withdrawal, impulsivity or aggressiveness, apprehension or fear, helplessness, anger, anxiety or hyper-vigilance and disturbance of eating or sleeping patterns (Lien Bragg, 2003).

Longer-term effects are often less observable, potentially because retrospective reports of childhood abuse often underestimate the actual occurrence. Childhood abuse can lead to various significant negative mental health outcomes, as demonstrated by an increased risk for alcohol and drug abuse directly proportional to the frequency of exposure (Dube *et al.*, 2002).

Another negative outcome can be post-traumatic stress disorder (PTSD). Children reported being troubled by distressing thoughts and dreams, conscious avoidance, hyper-vigilance and sleeping difficulties, even 20 months after leaving a violent home. Both PTSD and family violence are linked to other mental health concerns, including depression, phobias, anxieties, oppositional disorder (McCloskey & Walker, 2000). Predictably, behavioural disturbances can also become concerning. These often relate to anger, problem solving difficulties, poor social skills, delinquent behaviours and distorted gender-role beliefs (Briere, 1992; Lichter & McCloskey, 2004).

Implications for Practice

- Screening for violence is an important tool to initiate care. All interactions with health care provide an opportunity to intervene.
- Collaborative multi-disciplinary practice alongside full utilisation of identified community resources will be most effective (Ferguson II, 2010).
- Due to the potential for continued contact there is a need for ongoing parental support to ensure child safety and development (Appleyard & Osofsky, 2003).
- Whatever the context we need to protect the cultural safety of the client (Nursing Council of New Zealand, 2007). This will equip our practice to supply appropriate care including preventative child and family support services (Paterson, Carter, Gao, Cowley-Malcolm & Iustini, 2008).

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