Conference Paper

Requirements for Specific Practice Models to Help Young People who have Experienced Domestic and Family Violence

Natalia Gale
Yfoundations, Sydney
Policy Officer
natalia@yfoundations.org.au

&

Chris Stone
Yfoundations, Sydney
Senior Policy Officer
chris@yfoundations.org.au

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ABSTRACT: *Experiencing domestic and family violence (DFV) during the critical developmental times of adolescence and emerging adulthood has consequences that are distinct from those of experiencing DFV during prepubescent childhood or full adulthood. Young people's experience of DFV is a neglected area in both research literature and practice models to assist this group.*

This paper sets out the evidence on the prevalence of DFV for young people, especially disadvantaged young people, as well as indications that this evidence underestimates the true extent of the issue. The discussion includes detailed analysis of the results and methodological challenges of a survey of youth homelessness shelters on the prevalence of DFV. Indications are that the prevalence of DFV is much higher for this group than currently available data suggests, based largely on the self-reporting of DFV by young people.

The paper also looks at the research on the effects of trauma during adolescence and young adulthood and from this outlines what a specific practice model to help young people who have experienced DFV would need to include. Such a model would need to address the effects of DFV on developing belief systems, identity, coping mechanisms and resilience. It would also need to be supported by further research on this neglected area.

Introduction

It is not widely recognised that young people's experience of DFV is different to that of mature adults or pre-pubescent children. Too often the victims of DFV are described as "women and their children". Young people are not merely passive witnesses to trauma. Even as witnesses they may experience trauma, but too frequently they are themselves the target of violence. If raised at all, the prevalence and impact of DFV on 'young people' and 'children' is discussed synonymously, as though trauma during critical developmental phases will not have specific impacts.

This lack of recognition means that there is little data on the prevalence or characteristics of young people and experiencing DFV, and little understanding of the specific impacts. The consequences of this are that the prevalence of youth's experiences of DFV is often substantially underestimated, and that the significance and complexity of its impacts are

underrated. Not only are more young people affected than is generally acknowledged, the impacts of DFV during critical periods of development have substantial consequences that are not recognised. The combination of these errors obscures the critical need for a specific practice model for assisting young people who have survived/escaped DFV.

There is a need to outline what we do know about young people and DFV. This is attempted here along with results from a survey capturing some data about those young people in the homelessness services system who have experienced DFV. There is also a need to design a practice model for those, such as homelessness services workers, who assist these young people. At this stage further research is required to develop a full model, but the outline of a model is possible, and is presented here.

Prevalence and Characteristics

It is widely accepted that the data surrounding the prevalence of young people's experience of DFV is incomplete and unrepresentative of current trends. A number of barriers to assessing the extent of young people's exposure to DFV have been reported.

Many incidents of DFV, irrespective of the age of the victim, remain unreported. The NSW Bureau of Crime Statistics and Research interviewed victims of DFV and found that one half of the victims had reported their most recent incident of DFV to the police. Only 59% had reported at least one of their previous victimisation episodes to the police. Cited reasons for not reporting were fear of revenge or further violence by the perpetrator (14%), feelings of shame and embarrassment (12%) or a belief that the incident was too trivial or unimportant (12%). Ten victims stated that they had previously had a bad or disappointing experience with the police, while 8% thought the police would be unwilling to do anything about the violence (Birdsey & Snowball, 2013).

Further, socio-cultural differences in what is perceived and understood as DFV mean that it is not always reported or acknowledged as a social problem or indeed, one that requires attention. For example, the International Violence Against Women Survey (Mouzos & Makkai, 2004) found that stranger-perpetrated incidents were perceived as crimes more often than those perpetrated by known males (42% and 26%, respectively) but complaints to the police remained low regardless (27% and 10%, respectively). Further, women reported that they rarely sought assistance from specialised services or the police but opted to speak to

someone else instead.

The majority of data used to inform policy is often collected from specialist women's services. Therefore our understanding of DFV stems primarily from women's (or mother's) experiences, while those of children remain unreported. Yet, during additional analysis of the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) by Australia's National Research Organisation for Women's Safety (2015), it was observed that 54.2% of women who experienced violence by a current cohabiting partner had children in their care at the time of the violence. Of those, 57.8% of the children heard or saw the violence. For women who had since left their violent cohabiting partner, 77.5% reported that their children had seen or heard the violence.

The data that we do have on young people's exposure to DFV illustrates the need for better understanding of this issue as they face greater challenges to overcoming the abuse than a mature adult in an equivalent situation.

DFV and family/relationship breakdown is the main reason given for accessing specialist homelessness services (SHSs) by 45% of children and young people under 25 (AIHW, 2015). Yet this likely underestimates the importance of the issue. Young people may be guarded and reticent to share their experiences (Fox et al., 2012), and so it may take a considerable amount of time before a young person feels safe enough to share their experiences. DFV may destroy their ability to trust others, particularly adults, and the stigma and shame young people associate with their experiences have contributed to its underreporting to SHSs and other agencies collecting data. For those that have experienced DFV from a very young age, they may view DFV as 'part and parcel' of their day to day and not recognise it as a key factor or, indeed, a problem.

Analysis of the data from the Australian Institute of Health and Welfare (AIHW) (2015) SHS report 2014/15 indicates that the gendered nature of DFV varies with age. The prevalence of DFV for male and female children is similar up to age of 14. As children grow, the prevalence for young females becomes much higher than for young males. The ratio changes to approximately 2:1 for ages 15-17, and over 5:1 for ages 18-24.

Young women are at a higher risk of intimate partner violence than older women, with those aged 18 to 24 twice as likely to experience sexual assault, and those aged 15 to 19 four times

as likely. The PSS (ABS, 2012) identified that 13% of young women (aged 18 to 24) experienced at least one incidence of violence in the 12 months prior, a rate higher than for any other age group surveyed.

We also know that there are certain cohorts of young people who are at greater risk of DFV such as Lesbian Gay Bisexual Transgender Intersex Queer Asexual (LGBTIQA+), Culturally and Linguistically Diverse (CALD) and Indigenous Australians as a result of various factors such as language barriers, cultural differences, homophobia/transphobia and racism. In some cases, young people can belong to more than one of these groups, placing them at further risk (LGBTIQA+ and CALD communities, where there are issues surrounding family 'honour' (Constable et al., 2011)).

Current data collection methodologies provide limited information about a complex issue. There are a myriad of areas that we believe require rigorous and immediate investigation, such as:

- How are young people accessing and utilising DFV services. Where are the service gaps? Do they differ in rural and regional parts of Australia?
- What needs to change in the current system for minority groups (e.g. CALD) to access relevant and culturally appropriate support?
- What about boys who are excluded from accessing women's refuge services? Currently, very few refuges accept boys over 15 years old (Families Australia, 2014). Where do they go? How many families are not seeking support due to lack of services that accept both their male and female children?
- Investigations into why the gendered nature of DFV varies with age. Is it at least partly due to a lack of reporting by young male victims? Could a lack of reporting be driven by a lack of services they can access? Might reluctance to report be driven by a perception that, because the typical perpetrator is male, they might not be taken seriously as a victim?
- We need to know more about the perpetrators. Do adult abusers stop committing violence against young boys at a particular age and, if so, why?

In their research, Mullender et al. (2003) highlighted two issues crucial to children's ability to cope with DFV and its effects on them; the importance of being listened to and taken seriously as participants, and being actively involved in finding solutions and decision-making (CCYP, 2016). Given that we have known this for over a decade now, the absence of

any youth voice in tackling DFV is striking.

A Survey of Youth Homelessness Services

In an attempt to fill some of the above mentioned gaps in the data, a survey was conducted of thirty-five NSW services supporting young people experiencing homelessness, asking the following questions about the experience of DFV amongst the young people being assisted:

1. How many young people are accessing your service at present?
2. How many young people accessing your service (at present) have experienced domestic and family violence? (That you're aware of)
3. What is the average age of young people in your service who have experienced domestic and family violence? (Categories: [12-15] [16-17] [18-24])
4. How many of the young people who have experienced domestic and family violence had family members involved with domestic and family violence in the past?
5. In general who is the main perpetrator of violence in the majority of these young people's lives? (Categories: [Parent/guardian] [Other relative, e.g. sibling] [Intimate partner] [Non-family member e.g. housemate])
6. What do you need as a service provider to support young people experiencing domestic and family violence?
7. What is your relationship with your local DFV service(s)? (Categories: [No service present in my area] [No relationship] [No formal partnership but collaborate when required] [Partnership] [Partnership with Memorandum of Understanding])

The survey provided some key pieces of data in this under-researched area that are outlined below. However, given the need for further research in this area it is perhaps just as important to consider what data the survey failed to gather. A full discussion of the methodological challenges of this survey is included to help guide future research.

Key Findings

Prevalence: The most important finding of the survey was the indication that the prevalence of DFV amongst young people experiencing homelessness is much higher than previously estimated by data relying on self-reporting of DFV at initial contact. As stated above, AIHW (2015) data shows that 45% of children and young people under 25 accessing SHSs give DFV and family/relationship breakdown as the primary reason for needing assistance. Of the

thirty-two services in this survey that were able to state what proportion of their young people had experienced DFV, twenty-seven reported a proportion higher than the 45% in the data from AIHW (2015). Many services gave significantly higher numbers. Fourteen reported 80% or more, with half of those saying all of their young people had experienced DFV.

Intergenerational DFV: The high prevalence of young people experiencing intergenerational DFV was also an important finding. Of the twenty-three services that answered this question, thirteen reported that three-quarters or more of their young people who had experienced DFV had family members involved with DFV in the past. All but three services reported half or more with family members having experienced DFV.

Source of violence: Of the thirty-four services answering this question, twenty-six reported that parents or guardians were the primary source of violence for young people experiencing DFV.

Coordination with DFV services: Only around one third of services had a (formal or informal) partnership with a local DFV service. Most reported that the collaborated when required with their local DFV service.

Methodological Challenges

The survey was conducted by attempting to contact sixty-five services by phone. Unresponsive services were recontacted if possible. The survey was conducted across only two days to avoid the possibility of double counting young people moving between services. Thirty-five services responded. As well as common methodological challenges, such as the possibility of reporting bias, the following issues were encountered:

Varying accuracy: Although there was no question that assessed the accuracy of answers, the likelihood is that this varied widely. Speaking to survey respondents it was clear that in some cases they were giving exact figures from a client database. In other cases, particularly in the case of small services, workers simply knew all their current clients. It was also clear that some respondents were giving round-figure estimates.

Reporting prevalence data: The number of young people in each service ranged from 2 to 203, and there was a tendency for larger services to report lower proportions of young people

experiencing DFV. So, if the average proportion is weighted by the number of young people in the service, it is 59%. However, if a straightforward average of the answers of the services is taken, it is 68%. Noted accuracy was not assessed, but there did seem to be a tendency for larger services to be more likely to estimate, so the latter number is likely more accurate. However, given the likely extent of estimate answers, both numbers give a misleading sense of exactness. For this reason the key finding is reported as 'numbers of services reporting above certain proportions'.

Lack of intergenerational DFV knowledge: This item had the highest frequency of 'no data'. Eleven of the thirty-five services could not give an estimate. Many services simply do not collect this information.

Multiple sources of violence: The question on this asked respondents to nominate 'in general, the main perpetrator' of violence as: a parent or guardian, another relative, an intimate partner, or a non-family member of the household. Focusing on the most common source of violence can give a misleading impression that it is overwhelmingly the most common. Although the majority of services nominated parents and guardians as the most common source of violence, it was clear from conversations with respondents that intimate partner violence was usually a close second. The question was also not sufficiently nuanced since many services stated that it was specifically step-parents that were the most common source of violence. A question that allowed services to state proportions for a number of sources of violence might have garnered better data.

Impacts on Young People

As with our knowledge of the prevalence and characteristics of young people experiencing DFV, our understanding of the impacts of DFV on young people has significant gaps. However, a developing field of research that is beginning to fill the gaps in our knowledge of the impacts of DFV is that of focussing on complex trauma. Some of this research has focussed on child maltreatment. Child maltreatment only partially overlaps with youth DFV in that it includes behaviours, such as neglect, that are generally considered to fall outside the definition DFV. However, youth DFV is not a subcategory of child maltreatment because it encompasses sources of violence, such as intimate partner violence in young couples, which are not included in child maltreatment. Despite these distinctions, research on the effects of violent maltreatment of children is still relevant to our understanding of trauma experienced

during critical developmental phases and so is included here.

The relationship between wellbeing, stability and positive emotional health during adolescence (13-18) and emerging adulthood (19-25), together with satisfaction in later life, is well understood (Blakemore, 2012; Arnett, 2000; Emerson et al., 2015).

Trauma refers to an experience that creates a sense of fear, helplessness or horror, and overwhelms a person's resources for coping (Hopper et al., 2010). A traumatic experience can be a single event, a series of events and/or a chronic condition. It can immediately impact on an individual or it can have delayed onset.

Research has shown that types of abuse rarely occur in isolation. The majority of individuals with a history of maltreatment, report repeated (chronic) exposure to several sub-types of DFV (Arata et al., 2005). This is multi-type maltreatment. Other forms of victimisation such as bullying have been found to co-occur with child maltreatment (Finkelhor et al., 2007), known as poly-victimisation. Thus, complex trauma is the culmination of multiple, interrelated and coexisting stressors or patterns of harmful events occurring over critical developmental periods and within specific relationship contexts (Courtois, 2004).

Complex trauma requires and deserves a targeted and individualised response; exposure to DFV is not a homogenous one-dimensional phenomenon (Jouriles et al., 1998). Every young person's experience is unique – the outcomes may be debilitating for some, while positive for others (Lamont, 2010). There are a multitude of circumstances and factors that may impact on a child's vulnerability or resilience to DFV, and each should be taken into account. Factors that may make an individual vulnerable include socio-economic disadvantage, social isolation and living in dangerous neighbourhoods while high quality peer relationships, positive school environment and child attributes may strengthen an individual's resilience.

Further still, DFV is rarely an isolated event. It is something that potentially disrupts family functioning and may be one part of a broader 'adversity package' (Holt et al., 2008; Rossman, 2001). This may include a multitude of risk factors, e.g. parental substance abuse, mental health difficulties, unemployment, homelessness, social isolation and involvement in crime (Golding, 1999). It is important that all components of this adversity package are considered when supporting young people as "the presence of multiple stresses in a young person's life may both elevate the risk of negative outcomes and possibly render indistinct

the exact relationship between DFV and those negative outcomes" (Campo et al., 2014).

Practitioners supporting young victims of violence do not always fully understand the effect of cumulative harm on them. One explanation is that traditional mental health diagnoses, such as post-traumatic stress disorder (PTSD), often do not adequately capture the effects of chronic and/or multiple types of victimisation (Briere & Spinazzola, 2005). The DSM-IV Field Trial for PTSD supported the notion that trauma, particularly prolonged trauma, that first occurs at an early age and that is of an interpersonal nature, can have significant effects on psychological functioning above and beyond PTSD symptomatology (van der Kolk et al., 2005).

Complex trauma is not currently recognised by DSM-V, the international classification manual of mental disorders. A flaw of the current classification system is that, following trauma, it often reveals no diagnosis, inaccurate diagnosis or inadequate diagnosis (van der Kolk et al., 2009). Failure to officially acknowledge the reality of trauma and abuse in the lives of young people, and the long-term impact this can have on them as adults, is one of the significant clinical and moral deficits of current mental health approaches.

Without this, victims/survivors risk being stigmatised with a multitude of diagnoses (Cloitre et al., 2009). Parallel diagnoses do not fully acknowledge the interaction of symptoms and social factors that result in the problems experienced by sufferers (van der Kolk et al., 2005). However, care must be taken to ensure that classification does not hide the realities of complex trauma (Bremness & Polzin, 2014). Individual differences in how chronic abuse is perceived and experienced means that there must be flexibility for workers to adapt approaches to suit the needs of each individual.

It has been shown that chronic child maltreatment reports are a strong general indicator of future negative health and behavioural outcomes, including behavioural, neuropsychological, cognitive, emotional, interpersonal and psychobiological disorders (Becker-Weidman, 2009; Jonson-Reid et al., 2012).

Those adults who reported experiencing more than one sub-type of maltreatment, demonstrated significantly poorer wellbeing than adults reporting a single form, or those reporting none (Higgins & McCabe, 2001; Jonson-Reid et al., 2012).

Six domains of potential impairment related to complex trauma have been outlined: (a) affect regulation including anger-management and being self-destructive; (b) information processing including attention, concentration and learning difficulties; (c) self-concept including guilt and shame; (d) behavioural control including aggression and substance abuse; (e) interpersonal relationships including trust and intimacy; and (f) biological processes including delayed sensorimotor development (Margolin & Vickerman, 2007). The impacts of trauma characteristically persist long after the trauma has ended (Bateman et al., 2014).

At each stage of child development, children and adolescents have various age and stage salient tasks to achieve in order to become a fully functioning human being (Gimson & Trewhella, 2014). Adolescence and emerging adulthood are distinct stages of the life cycle, particularly in terms of identity exploring and role experimentation (Arnett, 2000; Munsey, 2006).

Adolescence is a physical, social, emotional, cognitive and behavioural growth period of life (American Psychological Association, 2002). It is a time when behaviours are established, many of which are sustained across the life span. Young people choose a career path, develop their skills and competencies, establish an identity and obtain greater responsibility and independence.

Increased experimentation in adolescence can be linked to the development of resilience and coping mechanisms. It is these attributes that can help in overcoming adversity in adulthood. The coping mechanisms developed by adolescent victims of DFV to manage anxiety and distress include suicidality, substance abuse and addiction, eating disorders, self-harm and dissociation (American Psychiatric Association, 1993; Jaffe et al., 2012).

Arnett (2000) coined the term ‘emerging adulthood’ after finding that many 18-29 year olds have a shared perception of feeling ‘in-between’, i.e. taking responsibility for their lives yet still feeling like an adolescent. Emerging adults are still pondering their identity, especially relating to love and their career path. It is viewed as an age of possibilities and self-focus but also of instability (Munsey, 2006). Exploration in love becomes more intimate and serious than during adolescence, and an emerging adult is developing important character qualities vital to moving towards being self-sufficient. Emerging adults who lack fundamental cognitive, emotional, familial, societal, and cultural supports are also at risk of suffering adverse effects from trauma exposure (Becker et al., 2004).

For young victims of DFV, this transition period can be even more challenging than for other adolescents and emerging adults.

A Practice Model

Our growing understanding of the effects of trauma on young people allows us to begin speculating on what a model would involve for assisting young people who have experienced DFV by looking to a trauma-informed model of care and practice.

Although there is no universally agreed definition of trauma-informed care and practice (TICP), Hopper at al. (2010) developed a consensus-based definition based on their review of the literature. It is a strengths-based framework that is grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

TICP requires practitioners to appreciate that an adolescent's responses and coping mechanisms have developed in the context of trauma. It recognises the impact of external, socially embedded causes of distress, trauma and disadvantage (McKenzie-Mohr et al., 2012). The focus is not on what is 'wrong with' the adolescent, but rather on what wrong was done to the adolescent.

Principles of TICP differ slightly from one researcher to the next, but there are five generally agreed upon core principles (Hopper et al., 2010; Hummer et al., 2010; Funston, undated):

1. Understanding trauma and its impact
2. Safety
3. Ensuring cultural competence
4. Control, choice and autonomy
5. Collaboration

Understanding trauma and its impact

In the previous section we touched briefly on an individual's unique disposition and personal experiences being key in determining whether or not it is traumatic. For example, a young

person who experiences one or two incidences of DFV may experience and interpret these events in the same way as a young person who has experienced chronic DFV.

Put simply, single traumas do not necessarily have a lesser psychological impact than repeated traumas. However, individuals who have encountered multiple and longer doses of trauma are at greater risk of developing complex trauma, especially when endured during the formative years of adolescence and emerging adulthood, interfering with their sense of safety, ability to self-regulate, sense of self, perception of control and self-efficacy, and interpersonal relationships. Typical maturation is disrupted as belief-systems and worldviews have developed both in the context of complex trauma and at a time when they are still developing and more sensitive. Their challenging behaviours and responses represent adaptive responses to past traumatic experiences (Bateman et al., 2014).

It is essential, therefore, that all services screen for trauma at first contact with the young person accessing their service. Currently, very few do. A study by Lewis et al. (2010) highlights the importance of identifying individual trauma histories. They found that a significant trauma-by-treatment-by-time interaction reveal that the different trauma groups responded differently to trauma.

Safety

Providing the young person with a physically and psychologically safe environment is the bedrock of TICP, primarily to protect against the risk of further traumatisation.

It is important to remember that incidences of DFV involve boundary violations and abuses of power, often by someone trusted. Young victims are likely to be mistrustful and to perceive services and their workers as a further threat rather than a helping hand. As a result, while their intentions are good, services and their workers may often – inadvertently – do more harm. Clinical set-ups may produce re-traumatising settings without being aware, such as, for example, using isolation or physical restraints, imposing policies and rules without exceptions or an opportunity for clients to question them, limiting participation in treatment plans, labelling behaviours and/or feelings, and disrupting counsellor-client relationships.

Practitioners should be aware of potential triggers. Re-traumatisation may occur when clients experience something that makes them feel as though they are undergoing another trauma.

This happens at an unconscious level and the individual may be left with unpleasant feelings that they cannot understand (Barton et al., 2012).

Trauma-sensitive environments need to be calming, predictable and reliable. To achieve this, it is not just practitioners who must adapt their way of thinking, but the organisation as a whole. Staff need to empathise with adolescents and be aware of how the impacts of violence and victimisation might have hindered a young person's development and coping mechanisms.

Practitioners should not assume that an adolescent in their care is out of harm's way. They should be informed of their rights and supported in obtaining police protection, where necessary.

Lastly, the safety and wellbeing of staff working with traumatised individuals mustn't be forgotten. Workers in this line of work are continually in an emotionally charged environment. Providing ongoing supervision and support for practitioners will help to mitigate the impacts of vicarious trauma, as many practitioners will have experienced trauma themselves which may be triggered by client responses and behaviours.

Ensuring cultural competence

This can be achieved through providing a culturally safe and gender-sensitive service. Culture might impact on how a young person experiences and perceives trauma and violence. Trauma may have different meanings in different cultures and traumatic stress may be expressed differently within different cultural frameworks. Practitioners must be aware of their cultural worldviews and histories and how they may influence engagement with young people (Elliot et al. 2005). They might consider doing this by, for example, asking the young person to educate them on their culture. It will be up to each organisation to provide adequate training on how to engage appropriately with young people and ensure such cultural competence.

Practitioners must be sensitive to other individual differences amongst clients and attuned to the prejudices they may have faced as a result, e.g. sexual orientation, religion, age, economic class, disability and ethnicity. All of these characteristics may interact to create more or less stigma associated with violence and trauma.

Control, choice and autonomy

"People with complex trauma will often respond better to treatment when they are empowered in ways that are unique to them, and [practitioners] should not underestimate their patient's ability to be useful and active in their own treatment" (Kezelman & Stavropoulos, 2012).

TICP should be tailored and individualised by adapting the therapy to the client rather than the other way round (Kezelman & Stavropoulos, 2012). The goal is to help young victims regain a sense of control over their lives and to build competencies that will strengthen their sense of autonomy (Bateman et al., 2014). Authoritarian or punitive treatment styles can cause re-traumatisation because patients re-live the experience of coercion and power used by the perpetrator.

An important characteristic of feeling empowered, is the ability to take charge of your life, to have conscious choice and control over your actions. Adolescents must be made aware that they have the right to refuse to answer a question, to refuse treatment and, within the limits of the organisation, to request different staff, modify their treatment plan and set limits. Adolescents should be involved in designing treatment services and be part of an ongoing evaluation of those services (Elliot et al., 2005).

Collaboration

TICP acknowledges the power imbalance in the patient-practitioner relationship and asks practitioners to do their best to flatten this hierarchy (Elliot et al., 2005). The trauma of a perpetrator having power over the adolescent is more effectively healed using a collaborative and empowering set up. While boundaries, which are a combination of warm and consistent, are important, these should be mutually negotiated and care should be taken to ensure that the client understands their significance and does not experience them as punitive (Bateman et al., 2014).

Practitioners and organisations need to ensure that communication is open and respectful. Trauma needs to be healed in a context in which the interpersonal relationships are the opposite of traumatizing. A RICH relationship is defined as one that offers respect, information, connection and hope (Saakvitne et al., 2000).

Conclusion

It should be clear from the above that young people experiencing DFV are likely to have distinct characteristics, and that the DFV is likely to have specific effects on young people. It should also be clear that not enough is known on both these subjects. Although challenging, as illustrated by the survey, further investigation is required. A better understanding is required to help young people, whose numbers are certainly higher than often estimated, escaping DFV. Further research towards a model, perhaps similar to the outline presented here, of assisting these young people is a clear necessity.

References

American Psychiatric Association (1993) 'Practice Guideline for Eating Disorders' *The American Journal of Psychiatry,* Vol. 150, No. 2: 212-228.

American Psychological Association (APA) (2002) *A Reference for Professionals: Developing Adolescents,* Washington: APA – available at https://www.apa.org/pi/families/resources/develop.pdf

Arata, C. M., Langhinrichsen-Rohling, J., Bowers, D. & O'Farrill-Swails, L. (2005) 'Single Versus Multi-Type Maltreatment: An Examination of the Long-Term Effects of Child Abuse' *Journal of Aggression, Maltreatment & Trauma*, Vol. 11, No. 4: 29-52.

Arnett, J. J. (2000) 'Emerging Adulthood: A Theory of Development from the Late Teens through the Twenties' *American Psychologist,* Vol. 55, No. 5: 469-480.

Australia's National Research Organisation for Women's Safety (ANROWS) to Reduce Violence against Women & their Children (2015) *Horizons Research Report. Violence against Women in Australia: Additional Analysis of the Australian Bureau of Statistics' Personal Safety Survey, 2012*, Sydney: ANROWS – available from http://media.aomx.com/anrows.org.au/s3fs-public/151022%20Horizons%201.1%20PSS.pdf

Australian Bureau of Statistics (ABS) (2012) *Personal Safety Survey, C*at. no. 4906.0, Canberra: ABS – available at http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4906.0Main%20Features12012?opendocument&tabname=Summary&prodno=4906.0&issue=2012&num=&view=

Australian Institute of Health and Welfare (AIHW) (2015) *Specialist Homelessness Services 2014-15*, Canberra: Specialist Homelessness Online Reporting – available at http://aihw.gov.au/homelessness/specialist-homelessness-services-2014-15/

Australian Institute of Health and Welfare (AIHW) (2013) *Specialist Homelessness Services: 2012-13*, Cat. no. HOU 273, Canberra: AIHW – available at http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545638

Australian Institute of Health and Welfare (AIHW) (2012) *Child Protection Australia 2010-*

11, Cat. no. CWS 41, Canberra: AIHW – available at http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421014

Barton, S., Gonzalez, R. &Tomlinson, P. (2012) *Therapeutic Residential Care for Children and Young People: An Attachment and Trauma-Informed Model for Practice,* London and Philadelphia: Jessica Kingsley Publishers.

Bateman, J., Henderson, C. & Kezelman, C. (2014) *Trauma Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia,* Sydney: Mental Health Coordinating Council – available at http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

Becker, D. F., Daley, M., Gadpaille, W. J., Green, M. R., Flahery, L. T. & Harper, G. (2004) 'Trauma and Adolescence 2: The Nature and Scope of Trauma' *Adolescent Psychiatry,* Vol. 27: 165-193.

Becker-Weidman, A. (2009) 'Effects of Early Maltreatment on Development: A Descriptive Study Using the Vineland Adaptive Behavior Scales-II' *Child Welfare,* Vol. 88, No. 2: 137-161.

Birdsey, E. & Snowball, L. (2013) *Reporting Violence to Police: A Survey of Victims Attending Domestic Violence Services,* Sydney: NSW Bureau of Crime Statistics and Research – available at http://www.bocsar.nsw.gov.au/Documents/BB/bb91.pdf

Blakemore, S. J. (2012) 'Imaging Brain Development: The Adolescent Brain' *NeuroImage*, Vol. 61, No. 2: 397-406.

Bremness, A. & Polzin, W. (2014) 'Commentary: Developmental Trauma Disorder: A Missed Opportunity in DSM V' *Journal of the Canadian Academy of Child and Adolescent Psychiatry,* Vol. 23, No. 2: 142-145.

Brière, J. & Spinazzola, J. (2005) 'Phenomenology and Psychological Assessment of Complex Traumatic States' *Journal of Traumatic Stress,* Vol. 18, No. 5: 401-412.

Campo, M., Kaspiew, R., Moore, S. & Tayton, S. (2014) *Children Affected by Domestic and Family Violence: A Review of Domestic and Family Violence Prevention, Early Intervention and Response Services*, Melbourne: Australian Institute of Family Studies – available from http://www.women.nsw.gov.au/__data/assets/file/0014/300623/PDF-6_Final_Report_Children_affected.pdf

Cloitre, M., Stolbach, B., Herman, J., van der Kolk, B., Pynoos, B., Wang, J. &Petkova, E. (2009) 'A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity' *Journal of Traumatic Stress*, Vol. 00, No. 0: 1-10.

Commissioner for Children and Young People in Tasmania (CCYP) (2016) *Children and Young People's Unique Experiences of Family Violence: Family Violence and Children and Young People in Tasmania*, Hobart: CCYP – available at http://www.childcomm.tas.gov.au/wp-content/uploads/2016/09/CCYP_FVR_Sept2016_web.pdf

Constable, A., De Castro, N., Knapman, R. & Baulch, M. (2011) *One Size Does Not Fit All: Gap Analysis of NSW Domestic Violence Support Services in Relation to Gay, Lesbian, Bisexual, Transgender and Intersex Communities' Needs. Executive Summary and Recommendations*, Sydney: ACON's Lesbian and Gay Anti-Violence Project – available at http://static1.1.sqspcdn.com/static/f/471667/11432104/1301276576180/Gap+Analysis_V4-a2.pdf?token=1O6KLlbTP0YoJQ8IfjabttUeMNo%3D

Courtois, C. A. (2004) 'Complex Trauma, Complex Reactions: Assessment and Treatment' *Psychotherapy: Theory, Research, Practice, Training,* Vol. 41, No. 4: 412-425.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S. & Reed, B. G. (2005) 'Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women' *Journal of Community Psychology,* Vol. 33, No. 4: 461-477.

Emerson, L., Fox, S. & Smith, C. (2015) *Good Beginnings: Getting it Right in the Early Years: Review of the Evidence on the Importance of a Healthy Start to Life and on Interventions to Promote Good Beginnings,* Melbourne: The Lowitja Institute – available at https://www.lowitja.org.au/sites/default/files/docs/Early-Childhood-web.pdf

Families Australia (2014) *Submission to the Senate Finance and Public Administration Committee Inquiry into Domestic Violence in Australia,* Canberra: Families Australia Inc.

Finkelhor, D., Ormrod, R. K. & Turner, H. A. (2007) 'Poly-Victimization: A Neglected Component in Child Victimization' *Child Abuse & Neglect,* Vol. 31, No. 1: 7-26.

Fox, C. M., Corr, M. L., Gadd, D. & Butler, I. (2012) From Boys to Men: Phase 1 Key Findings, Manchester: University of Manchester – available at http://www.boystomenproject.com/phase-1-research-findings/

Funston, L. (undated) *Trauma-Informed Practice,* Sydney: NSW Kids and Families – available at www.kidsfamilies.health.nsw.gov.au/media/225431/CRK_Section_34_Online.pdf

Gimson, K. & Trewhella, A. (2014) *Developing a Trauma-Informed Therapeutic Service in the Australian Capital Territory for Children and Young People Affected by Abuse and Neglect,* Canberra: ACT Government – available at http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiQgLX5z_nPAhXLKJQKHb23Cy0QFggbMAA&url=http%3A%2F%2Fwww.communityservices.act.gov.au%2F__data%2Fassets%2Fword_doc%2F0005%2F642830%2FDiscussion-Paper-Trauma-Recovery-Centre-September-2014.doc&usg=AFQjCNFUI3SNLIEf0K7CaQg4Hho1el17FQ&bvm=bv.136593572,d.dGo

Golding, J. M. (1999) 'Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta-Analysis' *Journal of Family Violence,* Vol. 14, No. 2: 99-132.

Higgins, D. J. & McCabe, M. P. (2001) 'Multiple Forms of Child Abuse and Neglect: Adult Retrospective Reports' *Aggression and Violent Behavior,* Vol. 6, No. 6: 547-578.

Holt, S., Buckley, H. & Whelan, S. (2008) 'The Impact of Exposure to Domestic Violence on

Children and Young People: A Review of the Literature' *Child Abuse & Neglect,* Vol. 32, No. 8: 797-810.

Hopper, E. K., Basuk, E. L. & Oliver, J. (2010) 'Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings' *The Open Health Services and Policy Journal,* Vol. 3, No. 2: 80-100.

Hummer, V. L., Dollard, N., Robst, J. & Armstrong, M. I (2010) 'Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A Curriculum for Organizational Change' *Child Welfare,* Vol. 89, No. 2: 79-95.

Jaffe, P. G., Wolfe, D. A. & Campbell, M. (2012) *Growing up with Domestic Violence,* Cambridge: Hogrefe Publishing.

Jonson-Reid, M., Kohl, P. L. & Drake, B. (2012) 'Child and Adult Outcomes of Chronic Maltreatment' *Pediatrics,* Vol. 129, No. 5: 839-845.

Jouriles, E. N., McDonals, R., Norwood, W. D., Shinn Ware, H., Collazos Spiller, L. & Swank, P. R. (1998) 'Knives, Guns and Interparent Violence: Relations with Child Behavior Problems' *Journal of Family Psychology,* Vol. 12, No. 2: 178-194.

Kezelman, C. & Stavropoulos, P. (2012) *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* Sydney: Adults Surviving Child Abuse – available at http://www.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

Lamont, A. (2010) *Effects of Child Abuse and Neglect for Children and Adolescents*, Melbourne: The Australian Institute of Family Studies – available at https://www.theactgroup.com.au/documents/EffectsofChildAbuseandNeglectforChildrenandAdolescents.pdf

Lewis, C. C., Simons, A. D., Nguyen, L. J., Murakami, J. L., Reid, M. W., Silva, S. G. & March, J. S. (2010) 'Impact of Childhood Trauma on Treatment Outcome in the Treatment of Adolescents with Depression Study (TADS)' *Journal of the American Academy of Child and Adolescent Psychiatry,* Vol. 49, No. 2: 132-140.

Margolin, G. & Vickerman, K. A. (2007) 'Post-Traumatic Stress in Children and Adolescents Exposed to Family Violence: I. Overview and Issues' *Professional Psychology: Research & Practice,* Vol. 38, No. 6: 613-619.

McKenzie-Mohr, S., Coates, J. & McLeod, H. (2012) 'Responding to the Needs of Youth who are Homeless: Calling for Politicized Trauma-Informed Intervention' *Children and Youth Services Review,* Vol. 34, No. 1: 136-143.

Mouzos, J. & Makkai, T. (2004) *Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence against Women Survey (IVAWS)*, Canberra: Australian Institute of Criminology – available at http://www.aic.gov.au/media_library/publications/rpp/56/rpp056.pdf

Mullender, A., Hague, G., Imam, U. F., Kelly, L., Malos, E. & Regan, L. (2003) *Children's Perspectives on Domestic Violence,* London: SAGE Publications Ltd.

Munsey, C. (2006) 'Emerging Adults: The In-Between Age' *Monitor on Psychology*, Vol. 37, No. 36: 68.

Rossiter, B., Mallett, S., Myers, P. M. & Rosenthal, D. A. (2003) 'Living Well? Homeless Young People in Melbourne' *Parity*, Vol. 16, No. 2: 13-14.

Rossman, B. B. R. (2001) 'Time Heals All: How Much and for Whom?' *Journal of Emotional Abuse,* Vol. 2, No. 1: 31-50.

Saakvitne, K. W., Gamble, S. J., Pearlman, L. A. & Lev, B. T. (2000) *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse,* Maryland: Sidran Institute Press.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S. & Spinazzola, J. (2005) 'Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma' *Journal of Traumatic Stress*, Vol. 18, No. 5: 389-399.

van der Kolk, B. A., Pynoos, R. S., Cichetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., Lieberman, A. F., Putnam, F. W., Saxe, G., Spinazzola, J., Stolbach, B. C. & Teicher, M. (2009) *Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSV-V* – available at http://www.traumacenter.org/announcements/DTD_papers_Oct_09.pdf