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Responding to child-to-parent violence: the experiences of family support group providers.

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ABSTRACT

Support groups for families negatively affected by a relative's substance use provide a vital community service for people who otherwise have little formal or informal support. While global mutual aid networks exist, including organisations such as Al-Anon and SMART recovery, many smaller independent support groups in the UK are marginalised and minimally funded. Consequently, they do not have the access to resources of the larger networks to advance their knowledge and skills. This small UK study set out to explore the experiences of people who ran such groups. In particular, it focussed on how they identified and responded to domestic abuse and what their training and resource needs were. Twelve semi-structured telephone interviews were conducted with family support group providers around the UK. Despite a focus on domestic abuse, what emerged from the interviews was a high level of abuse of parents from intoxicated children of all ages. The findings suggest the need for greater support for family support group providers who require information on child-to-parent violence, its relationship to substance use, and how to overcome barriers to disclosure.

Key words: alcohol, drugs, child-to-parent violence, family support groups

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BACKGROUND

The impact of a family member's problematic substance use on their family and friends can be devastating. The stress and strain placed on families when living with someone with a substance problem has been well documented (Orford et al. 2010). Evidence shows that all members of the family can be negatively affected including siblings, parents, partners and wider family and friendship groups (Barnard 2005, Copello et al. 2000a). Problematic substance use can create tensions in family relationships as they struggle to work out the best way of responding to the person's changeable mood and behaviour. High levels of conflict are common among families affected by a relative's substance use and these can often escalate to domestic violence and abuse. Current figures show that between 44-58% of men in substance use treatment have perpetrated adult domestic abuse and between 60-80% of women receiving support for an alcohol or drug problem have been victims of adult domestic abuse (see *author's own* 2012 for review). Until now, there has been almost no recognition that some of those adults in treatment may be either victims of child-to-parent violence or perpetrators of violence towards their own parents in their youth and/or their adulthood. Evidence to date has largely identified the co-existence of substance use as a factor in adolescent-to-parent violence only (Condry and Miles 2014; Walsh and Krienert 2007).

The negative impact a relative's problematic substance use can have on family members has led to the development of models for supporting families in their own right, for example, Copello's et al. (2000a) '5 step model' and the global mutual aid fellowships of Al-Anon and Al-Ateen (Al-Anon 2014). The evidence shows that such family support can improve the health and well-being of family members even without any change in the substance using behaviour of their relative (Copello et al. 2000b, Orford et al. 2007). However, concerns have been raised about the extent to which family or network focussed approaches safely, and adequately, identify and address domestic violence and abuse within their practice models; particularly how service providers and mutual support providers understand, and work with, the connection between experiencing or perpetrating violence and abuse and the individual's substance use (*author's own* 2007, *author's own* 2009, 2010).

At a time when commissioned substance use services in England are declining in size and number as a result of Government spending cuts, support through mutual aid is a potentially cost effective alternative. The growth of mutual aid groups has been large and fast (Phillips 2015), hastened by a Government policy discourse on commissioning for 'recovery' (National Treatment Agency 2010). However, to support people safely, facilitators of mutual aid must be adequately equipped to respond appropriately. The risk is that, in looking for a cheaper way of delivering services, the policy makers and commissioners have not given adequate consideration to the training and support needs of mutual aid facilitators.

Much has been written about the need for substance use professionals to consider domestic abuse in their interventions and treatment models given the high prevalence of men and women in substance use services that have either suffered and/or perpetrated intimate partner violence (Bennett and O'Brien, 2007; Osman and Delargy, 2009; Stella Project, 2007). However, the extent to which peer led support groups have been able to access and apply this guidance is unknown and more recent evidence suggests that even among those who have policy and practice support, it is not always embedded within practice models and can quickly fall off the practice agenda (Templeton and Galvani, 2011).

According to Adfam, the UK's leading charity set up to support friends and family of people with problematic substance use, there are approximately 500 family support services in the UK offering a range of group and individual services (Adfam, 2015). Many are associated with statutory treatment services or those provided by large substance service provider services. Some are mutual aid groups and run by group members, others are smaller, independent support groups or individual support led by facilitators who have similar personal experience.

The research on which this paper is based was a small study in England that explored the perspectives of two groups of family members on the relationship between substance use and domestic abuse; i) children and young people and ii) adult family members who ran support groups. This paper focusses on the perspectives of adult family members who ran support groups for others affected by a relative's substance use. These groups were often run by volunteers and were based out of people's homes, small community centres and, occasionally, a more specialist substance use service. Adfam, a UK wide charity supporting the families of people with alcohol and other drug problems, identified this group as one that was easily overlooked in terms of training and information given that they sat outwith any formal mutual aid or volunteer organisation.

METHODOLOGY

This study formed part of a collaborative project between AVA (Against Violence and Abuse), a national second tier organisation in England working to end domestic and sexual violence against women, Adfam, and the University of [author's own].

Aims and objectives

The research had three aims:

1. To explore the views and perspectives of affected family members of substance users on the relationship between alcohol, drugs and domestic abuse.
2. To develop practice and policy recommendations based on these findings and the wider literature.
3. To establish what support and resources affected family members need on these issues.

Sample selection

A purposive approach to sampling was used to ensure the research was able to gather data from those with relevant experience (Davies and Hughes 2014). One of the partner organisations, Adfam, maintained a database of family support groups and services across the UK with details of the support they offered and a named contact. This database was used as the sampling frame and three criteria were used to select participants. Participants had to:

1. Have a family member, now or in the past, with alcohol and/or other drug problems
2. Be running family support groups for family members affected by their relation's substance use
3. Be volunteer support group providers or be working for independent local support groups.

Data collection and analysis

The nature of the project was to explore the experiences and views of family members and therefore a qualitative research design was adopted. Semi-structured interviews were conducted by phone to keep costs to a minimum. Semi-structured interviews allow for in-depth discussion while ensuring that the focus of the interview remains on track (Flick 1998).

The interview schedule collected brief demographic information, background about the participant's experience of providing family support services, information about any training they received in domestic violence or substance use and information about their own support mechanisms. This was followed by 20 questions relating to their experiences of discussing family conflict or domestic abuse within the family support services either individually or within group support. Examples included "To what extent do you think people feel able to talk openly about domestic abuse in your work with them?" and "How would you normally respond if people talk to you about family conflict or domestic abuse?"

The interviews took one hour on average and were audio recorded with permission from the participants. They were fully transcribed and manually coded once the data collection was completed. The analytic approach adopted was thematic in nature and allowed us to pay close attention to the words of the participants both as individual accounts but also in relation to others' accounts. The process is one of coding individual data but noting similarities and differences as the analytic process progresses. This allows for prospective themes to emerge from the data, while the cross-checking of the emerging themes to the individual accounts ensures the thematic domains remain true to the original data (Flick 1998)..

Ethics

Given the sensitive nature of the two topics of substance use and violent and abusive behaviour, ethical approval processes need to be rigorous. Two research governance processes were adhered to within the [*author's employing university*]; the first was an ethics committee at Research Institute level, the other at University level. Written individual consent from participants was collected following verbal and written information about the research and what would be done with the findings. Where appropriate or necessary, written approval by employing organisations was collected prior to any interviews taking place.

RESULTS: SAMPLE PROFILE AND CONTEXT

Fifteen family support services around the UK were identified following application of the selection criteria and 12 family member support providers (FMSPs) participated in the interviews. These 12 participants ran 12 different support groups in different areas of the UK. All participants were over 45 years of age with half (n=6) aged 55-64 years. Ten of the 12 participants were women and all but one identified as White British. One participant had a partner with a substance problem, the others had children with substance problems. Most had been running family support services for adult family members for some years; six for more than 10 years, five for 5-9 years, and one for two years. The number of people they saw each week varied from five to 40 depending on the size of the service.

The staff composition of the services varied: four were staffed by volunteers only, three of these ran out of people's homes; three had more volunteers than paid staff, and five had both volunteers and paid staff. Three agencies were based in the south of England, three were based in the north Midlands and five in north east and north west England. One of the participants spoke about the importance of having a dual identity as a family member and provider of support services. She felt this enabled her to have credibility with both family members and with other professionals in the field.

While three of the FMSPs offered support to people in their own homes, the majority said they preferred not to do home visits or just did not do them. They offered a range of family support including individual work (telephone and face to face) and group work with the majority of family members attending being women and mothers. Men attended only occasionally. The facilitation role the FMSPs played was generally 'light touch' allowing the group or individual to determine the focus of the discussion.

RESULTS: THEMATIC ANALYSIS

From the analytic process, nine thematic groups emerged. Most were directly related to the questions posed, i.e. definitions of domestic abuse, responses to domestic abuse, types of violence and abuse, conflict or domestic abuse, frequency of conflict vs domestic abuse, and the relationship between substance use and domestic abuse. Three emerged from the data in a much more iterative way, i.e. child-to-parent violence

and abuse, tolerance of domestic abuse, and barriers to disclosure (including a lack of trust and shame, guilt and fear).

Due to word limitations, five of these themes that are most pertinent to reflective practice and service development have been selected for discussion below.

Child-to-parent violence and abuse

While the interview questions focussed primarily on domestic abuse, the FMSPs reported a far higher number of family members reporting experiences of child-to-parent violence. Children in this context could be adult children as well as younger children and adolescents. This was surprising given only one interview question mentioned child-to-parent violence, as an example of the types of possible abusive relationships the FMSPs may hear about.

Well in my work it tends to be child-to-parent, far more often, although we have had it between partners too.

There are quite a few children to parents, children abusing parents. For example, a 16 year old lad using drugs or alcohol and a single parent, they would be subject to a lot of abuse.

With [this] project I would actually say it's most often with child-parent relationship; the intimidation stuff around money, but also the smashing up when that person's been drinking.

As in the first quotation above, adult partner violence was mentioned occasionally in passing but there was no sense of it being a frequent topic for discussion in the support groups. It was very clear that child-to-parent violence was by far the main type of home-based abuse experienced by the families who sought support.

Relationship between substance use and abusive behaviour

All the FMSPs reported a belief in a detrimental relationship between substance use and perpetrating abuse. Some felt there were particular types of substances or combinations of substances that were associated with particular types of abuse. For example, financial abuse of parents was associated with illicit drug use whereas physical violence was more related to alcohol:

I think there's quite a large relationship between alcohol and domestic abuse. From the drugs side, it's usually because they're after money. They're not being given it. That's when the aggression comes in usually.

Well there is a strong relationship. Especially with alcohol, where it's more the physical or verbally abusive side. With drugs, it tends to be related to needing money or keeping a certain lifestyle, it's more financial and emotional abuse, but it's still there.

Blaming the substance rather than their relative for their abusive behaviour under the influence of a substance was not common. Only a minority of FMSPs appeared to blame the substance rather than the relative for their actions.

It makes people behave in ways that they wouldn't normally, and it makes people do terrible things to the people they are supposed to love.

I think there's a big relationship between the lot. I think it certainly fuels it. It fuels people to go on and commit [domestic abuse]... it's a big part of it.

Having a clear and accurate understanding of the relationship between substance use and domestic abuse is important for FMSPs. It will help to ensure they are conveying the right message through their support service which, in turn, will maximise the parent's, and child's, safety and well-being.

Parental tolerance of abuse

The FMSPs spoke of the tolerance their family members/parents displayed for the violence and abuse they were subjected to. Some presented it as resignation or, alternately, as the parent's sense of hope that the situation would just improve:

They would rather put up with what's happening. Especially when it's the emotional abuse or the financial abuse, they are resigned to it.

A lot of our clients have spent a great deal of time walking on eggshells, trying to avoid any kind of confrontation, in the hope that it will make things better, but often it doesn't.

Some of the FMSPs appeared frustrated by this and voiced their concerns about the impact it had on the parent and other family members and the way the violence had become normalised:

Sometimes they just take it that that's what's happening, and they don't actually understand that it's not acceptable behaviour for them, or their children, or their family members to see them in this position.

This sense of frustration was evident in the responses disclosed by some participants and contains echoes of the some of the wider criticism of other 'helping' professionals' responses to date. This is discussed further below.

Shame, guilt and fear: barriers to disclosure

Reasons for not disclosing child-to-parent violence (CPV) largely centred around issues of trust, shame, guilt and fear. As with existing knowledge about the barriers to

disclosure of adult violence and abuse, the FMSPs reported the parents as being scared of their child and also wanting to avoid stigma and embarrassment if people found out.

It's the same as with having a drug or alcohol user in the family. ... there's the double stigma of admitting you're being abused as well. ... The other thing is that they are scared of what the person who's abusing them would do if they found out.

As I've said, because it's the shame of it, as though they've instigated it or it's something they've done wrong. And they feel that this child, that they've brought up to being 35 or whatever, they are behaving in this abominable way towards their parents.

Concerns about disclosing CPV were similar to those expressed by victims of partner abuse. These family members had the added embarrassment of knowing it was the child they raised who was behaving abusively towards them. The complex dynamic of this parent-child relationship requires an informed, sensitive yet direct exploration and response.

Responding to domestic abuse

The high rate of CPV reported by these participants raised questions about how the FMSPs were responding and what informed their response. Questions for this study focussed on how people responded to the disclosure of family conflict or domestic abuse rather than CPV specifically. However, the quality of FMSPs practice in response to conflict and abuse, and their sensitivity to domestic abuse, is likely to be indicative of their responses to the newer issue of CPV. As might be anticipated, there was a range of responses including some examples of good practice as follows:

So it's about trying to get them into a safe place to have a 1-1 session. If they're not happy to do that, it's about giving them helpline numbers, out of hours numbers as well, telling them about police procedures.

Well, the most important thing is to try to react in a non-judgmental way and to listen to what is happening to the family member and how it is making them feel. Also to help them to understand, if they are being abused, that it is not their fault. And then, depending on the type of abuse, how serious it is, and if there is anything they feel they want to do about it, we can help them explore their options.

Some responses that raised concern included overly directive FMSPs telling people what they 'must' do, couples counselling (without first establishing the presence of domestic abuse or not), guaranteeing confidentiality without the required caveats relating to reporting any significant risks of harm to self and others. Finally, there were questions that implied, however inadvertently, that the victim of CPV was responsible for not stopping the violence with questions including, 'what had they done to try to stop it'.

DISCUSSION

CPV has been described as a form of domestic abuse and defined as "any act of a child that is intended to cause physical, psychological or financial damage in order to gain control over a parent" (Cottrell 2001:3). It is a new area of research, policy and practice development in the UK. There is relatively little information known about its prevalence and incidence, as well as a lack of guidance for parents and practitioners on how to respond. There are consistent data showing high levels of adult domestic violence victimisation and perpetration among people attending substance use services. It would, therefore, seem reasonable to hypothesise that CPV prevalence may also be high among family members attending substance use family support groups and among people attending for their own substance use. Research in the UK by Condry and Miles (2014) found substance use was a factor in the violence and abuse adolescents perpetrated against parents. However, evidence from north America suggests that violent disputes with parents are more likely to be about substance use itself rather than the perpetration of abuse under its influence (Walsh and Krienert, 2007).

While research is slowly developing in the area of *adolescent* to parent violence (APV), there is still very little known about the wider grouping of child-to-parent violence (CPV), including pre-adolescent and older or adult children. What is known is that among adolescent perpetrated CPV it is usually sons who are perpetrators and mothers who are victims (Condry and Miles, 2014; Hong et al. 2011). Emerging work in this area, however, has also reported violence by daughters and violence directed towards fathers although on a smaller scale (Wilcox et al. 2015).

Policy wise CPV falls uncomfortably between the stools of adult domestic abuse, youth offending and, for younger people, child protection. This presents considerable challenges for developing appropriate practice responses resulting in ignorant and inconsistent responses from a range of professionals; responses which do not adequately consider parents as victims of abuse (Condry and Miles, 2014; Holt, 2013). In recognition of this dearth of information, the UK's Home Office has issued the first document of its kind which contains summative information on CPV alongside introductory advice to professionals in different social and health care contexts about how to respond to adolescent to parent violence (Home Office, 2015a). Further initiatives across Europe are also emerging and different models of practice and intervention are being developed (Wilcox et al 2015) although they primarily focus on violence and abuse perpetrated by younger or adolescent children and none specifically consider the relationship with substance use.

Adding substance use to the CPV mix creates further complications and raises questions about the role of substance use in the perpetration of violence particularly younger child or adolescent-to-parent violence and whether its influence differs from the role of substances in adult domestic abuse. If so, this may require a different set of

practice responses than those offered by current guidance on responding to substance-related adult domestic abuse.

Current explanatory frameworks for the relationship between substance use and domestic abuse suggest a number of factors inform the abusive behaviour including the anticipated effects of substances (expectancy theory - Brain 1986) and socio-cultural factors such as attitudes to violence and beliefs about gender roles (Kantor and Jasinski, 1998). While these explanations would hold for adult children perpetrating abuse against parents, the lesser physiological, behavioural and emotional maturity of adolescents and younger children suggests that a more nuanced interpretation and practice response may be needed to substance-related violence. This is also the case in the domestic violence sector where the acknowledgment of relationship violence among teenagers, and the need for a professional response that differs from their adult counterparts, has led to the expansion of the UK's Home Office definition of domestic violence to include 16 and 17 year olds (Home Office 2015b). As new programmes to address CPV begin to develop around the UK, there is evidence that CPV support programmes exclude any family member - parent or child - who has substance problems (Holt, personal communication, 2015). As such it is possible that family members may turn to substance specific family support services for help and practitioners need to be equipped to respond appropriately. For substance use professionals, facilitating discussion about, and disclosure of, CPV and its relationship to their own substance use, requires support from both informed managers and relevant safeguarding policies. Importantly, they need to be supported to prioritise safety and ensure that they do not inadvertently exacerbate abusive relationships by responses that blame the victim or the substance use.

There is clearly further work to be done to establish evidence, develop good practice and support substance use practitioners to identify and respond to CPV. This study was limited by its sample size and by its initial focus on domestic violence and substance use. A much larger study of service providers of all sizes is needed, as is a survey of parents and families who are attending for support with their own or someone else's substance use. This was a small study focussing on domestic abuse, nevertheless the fact that child-to-parent violence emerged very clearly from the study suggests that a study focussed on CPV and substance use may confirm the findings presented here.

CONCLUSION

CPV is an area that has not yet been considered in the UK in relation to substance use service responses, be that individual or family focussed practice. While good practice guidance for responding to adult domestic abuse is available, the parent-child dynamic adds complexity for both the parent victim, child perpetrator and the professional response. This exploratory study raises questions about how family member support group facilitators are equipped to assess and respond to child-to-parent violence, and the perceived role of substance use in that violence. It does not provide answers to questions of good practice but it does suggest that all substance use service providers need to consider potential links between CPV and substance use. They need to identify

and respond to such links through direct but sensitive questioning, thus giving individuals permission to disclose the perpetration or suffering of CPV.

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