



Children's Mental Health and Intervention in View of Domestic Violence, Parental Alcoholism and Parental Separation

By: Gary Direnfeld, MSW, RSW

A parent sees the physician, complaining of a child's behaviour and possibly even somatic concerns. The child may present with any number of issues such as, school anxiety, inattention, depression, anxiety, social withdrawal, aggressive behaviour, non-compliance, substance abuse, headaches, and/or stomachaches. Attention is typically drawn directly to the child and interventions tend to be behavioural in nature. The parent is advised on appropriate discipline strategies. As for the somatic complaints, while there may be medical investigations, they tend to be ambiguous at best in terms of determining a physiological basis for the somatic complaints. Despite behavioural and medical intervention, problematic behaviour and somatic complaints continue unabated.

Underneath the child's behaviour problems and somatic complaints, may be lurking a number of contributing problems. The child may be subject to witnessing domestic violence, or the child may be coping with the effects of parental alcoholism, or if the parents are in the throws of a separation, the child may be caught in the legal web of their parents' high-conflict entanglements. Of course, just like you can have a broken leg and the flu at the same time, the child may be subject to several or all of these underlying problems, concurrently.

Persons with specific training and expertise, best provide intervention in view of these variables. Inappropriate intervention is akin to arranging the deck chairs on the Titanic. While it may look good, the ship still sinks. Hence it is vital for physicians to understand the challenges underlying these issues to appreciate what appropriate intervention may be and may not be.

Domestic Violence

Domestic violence is not gender specific. Either gender may offend. However, the rationale for violent behaviour between adult intimate partners is known to differ by gender. Statistically, men are more apt to engage in violent behaviour as control strategies than their female counterparts. Women are more apt to engage in violent behaviour as a defensive strategy to cope with their partner's behaviour. Further, lethality studies demonstrate that women are at substantially greater risk of harm, the result of male partner violence than are men of women. Violence between intimate partners is not at all restricted to heterosexual partners, and is seen similarly in same sex partners.

Brian Schwartz, MD, CCFP (EM), FCFP, Director, Division of Prehospital Care and Staff, Emergency, Sunnybrook and Women's Health Sciences Centre; Assistant professor, Family Medicine, University of Toronto, Toronto, Ontario looks at domestic violence in the context of abuse against women. He provides a definition of violence against women as well as incidence statistics in terms of female versus male victimization rates. Accordingly:

Abuse against women may be defined as "physical or psychological abuse directed

by a man against his female partner, in an attempt to control her behaviour or intimidate her." While abuse may take many forms including sexual, emotional, psychological and financial this [*his*] article will focus on physical abuse, or violence against women (VAW). It should also be noted that males constitute 15% of victims (62 male victims vs 344 female per 100,000 population in 2001) and that domestic violence occurs in same-sex relationships with approximately the same frequency as in heterosexual relationships.¹

**Domestic violence
parental alcoholism
and
parental separation
are contributory
issues with respect
to children's mental
health and require
specialized
intervention.**

¹ Brian Schwartz, MD, Cover Story: Violence against women, *CMAJ*, October 15, 2004, http://www.cma.ca/index.cfm/ci_id/10013255/la_id/1.htm

Estimates of the incidence of children witnessing domestic violence vary widely. However the most recent and scientifically rigorous estimates suggests 1 in 100 Canadian children are exposed to domestic violence.² Further, the impact of witnessing domestic violence on children is known to have serious consequences for their psychological, social, academic, behavioural and emotional development:

Children who witness domestic violence are at risk for emotional and physical harm. Canadian research suggests that children who are exposed to adults or teenagers physically fighting in the home are less likely to have positive or effective interactions with their parents, and have lower levels of social competence than other children. They are also more likely to be living in households with high parental depression, and to experience depression, anxiety, health problems and stress-related disorders themselves.³

Witnessing family violence is also linked to negative behaviour in children, including physical aggression, indirect aggression, emotional disorders, social withdrawal, hyperactivity, bullying and delinquent acts against property.⁴

In addition to witnessing domestic violence, statistically, in a national survey of more than 6,000 American families, 50 percent of the men who frequently assaulted their wives also frequently abused their children.⁵ Thus wife assault and child abuse are often co-occurring events.

² Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., et. al. (2005). Canadian Incidence Study of Reported Child Abuse and Neglect-2003: Major Findings. Ottawa, ON: Minister of Public Works and Government Services Canada.

³ Behind Closed Doors: The Impact of Witnessing Domestic Violence on Children in Canada, UNICEF Canada Fact Sheet, http://www.unicef.ca/portal/Secure/Community/502/WCM/WHATWEDO/ChildProtection/pdf/bodyshop/Canada_Fact_Sheet_Domestic_Violence.pdf

⁴ D. Wolfe, P. Jaffe and S. Wilson. (1990). Children of battered women. Newbury Park, CA: Sage.

⁵ <http://endabuse.org/resources/facts/>

Assessment for domestic violence requires sensitivity to issues of trust and safety, often achieved by specific training or experience in screening for these matters. Intervention typically begins with a view to determining safety issues and making sure family members are and will be safe from harm or retaliation the result of disclosure. Further, while all persons in the Province of Ontario are required to report even suspected child abuse, the onus on health care professionals is perceived to be even greater. Noteworthy, one cannot discharge the obligation to report to a third party. Section 72 (3) of the Child and Family Services Act states:

A person who has a duty to report a matter under subsection (1) or (2) shall make the report directly to the society and shall not rely on any other person to report on his or her behalf.⁶

Thus physicians must report suspected child abuse even if it is known that a third party such as a counsellor may also report.

After safety issues have been addressed, then intervention can proceed to address the sequelae of issues emanating from the domestic violence.

Parental Alcoholism

The definition of alcoholism has been the subject of much public scrutiny. Definitions vary from physiological to psychosocial. In view of the discrepancies in definition, a 23-member multidisciplinary committee of the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine conducted a 2-year study of the definition of alcoholism in the light of current concepts printed in the Journal of the American Medical Association:

The committee agreed to define alcoholism as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug

⁶ Child and Family Services Act, R.S.O. 1990, c. C.11, s.72, (3), Province of Ontario.

alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.⁷

In terms of impact on self and others, reaching criteria alcoholism increases the risk of academic, vocational, social, familial or marital problems. Children of parents who consume alcohol on a regular and problematic basis are at risk of social and school related problems during their childhood as well as social, vocational, marital and parenting problems in their adulthood. As a clinical group, these children are known as, Children of Alcoholics or COAs (or ACOA for adult children of alcoholics). Characteristics of Children of Alcoholics are well reported by the Canadian Task Force on Preventive Health Care:

Growing up in a household with alcoholic parents is more likely to produce lower self-esteem, greater dysphoria and more anxiety in adulthood. Rates of emotional problems, especially anxiety, depression and nightmares are doubled in children of relapsed alcoholics as compared to children of non-alcoholics or to children of recovered alcoholics. COA are more likely to describe their childhood as unhappy, and to have a greater level of depressive affect, when compared to the general population.

Parental alcoholism, in addition to creating an adverse family environment, increases the risk for maladjustments as measured by scores on the Child Behaviour Checklist (CBCL). Children of alcoholic parents scored significantly higher on the total behaviour problem scale, as well as on both the internalizing and externalizing scales of the CBCL. They also scored significantly higher on the somatic complaints scale. In a comparison of COA and children of non-alcoholics, the

⁷ R. M. Morse and D. K. Flavin, The definition of alcoholism, The Journal of the American Medical Association, Vol. 268 No. 8, August 26, 1992

former reported more alcohol and drug problems, stronger expectancies for positive reinforcement from alcohol, higher levels of behavioural undercontrol, more neuroticism and more psychiatric distress. They also showed lower academic achievement and lower verbal ability than controls.⁸

The Canadian Guide to Clinical Preventive Health Care also provides a "Children of Alcoholics Screening Test".⁹ While the 10-item questionnaire can provide evidence of concern for parental alcoholism, the issue

Even light to moderate parental alcohol consumption can be an intervening variable in children's mental health issues.

that remains for the physician is that of intervention. In view of parental alcoholism and despite distress in the child, the intervention for minor children must include one or both parents if the source of the child's distress is to ever be addressed. Placing the child alone in counselling only serves to maintain the dysfunction of the parent(s) if focus is never directed to the parents. In view of denial as a function or symptom of alcoholism, parents can in fact apply pressure on the referring physician and even service providers to treat the child on an individual basis. The challenge for the referring physician and even the service provider is to not inadvertently collude with the parents, keeping the underlying issue of parental alcoholism a secret. If treatment is

only provided on an individual basis, there is the illusion of help and the child continues to be subject to the vagaries of the parental alcoholism.

Again, and in view of the Child and Family Services Act, while the child may not be subject to abuse in the traditional sense, the child may be subject to neglect, the result of parental alcoholism. Indeed if this is determined to be the source of the child's distress, the physician has an obligation to report this matter to child protection authorities:

s.72 (1). Despite the provisions of any other Act, if a person, including a person who performs professional or

⁸ McNamee JE and Offord DR, Children of alcoholics. In: Canadian Task Force on the Periodic Health Examination. Canadian Guide to Clinical Preventive Health Care. Ottawa: Health Canada, 1994; 470-85.

⁹ IBID / see: http://www.ctfphc.org/Full_Text/Ch41full.htm#CTF%20Recs

official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society (child protection agency):

1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
 - i. failure to adequately care for, provide for, supervise or protect the child, or
 - ii. pattern of neglect in caring for, providing for, supervising or protecting the child.¹⁰

Hence in view of parental alcoholism and resultant impact on the child, intervention must not only include the parent but may require a report to child welfare authorities. It should be noted that physicians as well as members of the public can make a call to a child protection agency on a consultation basis to determine if the concerns actually reach criteria for reporting. By obtaining a consultation on the matter, the physician could be put to ease that his or her reporting obligations have been met and in view of a need to report, could then do so.

Parental Separation

The literature on divorce has had much to say about the impact on children. It used to be argued that any divorce had dire consequences for children. Now however, the outcome data suggests that it is not divorce per se that determines the outcome for children, but rather the degree of parental conflict children are subject to by separated parents. In effect, the higher the parental conflict the greater the risk in terms of the impact on children and their psychosocial adjustment and well-being.

Matters determinative of high parental conflict include an inability of the parents to achieve an ongoing parenting plan, substantially different parenting styles and expectations, and use of litigation to settle matters. Underlying these more external markers are often seen power and control imbalances between the parents,

¹⁰ Child and Family Services Act, R.S.O. 1990, c. C.11, s.72, (1), 1, i, ii, Province of Ontario.

domestic violence, alcohol and drug abuse as well as parental mental health problems, most notably, personality disorders, depression and anxiety.

Children subject to high conflict parental separation are at risk of the same set of presenting problems as children subject to witnessing domestic violence and parental alcoholism. However, when these parents seek help from their physician, while the entrée is the child, what is sought by the parent is support for their position in the litigation process. This may occur knowingly or unknowingly to the physician. When knowingly, the parent overtly solicits letters of support from the physician. When unknowingly, the parent may more manipulatively seek the physician's counsel, by meeting with the child to hear the child's custody and access preference and then bear witness to it.

Physicians, in view of the child's symptoms, may succumb to parental pressure for support or alternately make a referral for counselling on behalf of the child.

In view of the ongoing parental dispute and likely unsettled parenting regime, many mental health practitioners will meet with the child and be inducted to support the parental position on the basis of a one-sided account of the issues at hand:

Some therapists, who see only one of the parties to the divorce conflict, encourage uncompromising stands, reify distorted views of the other parent, write recommendations, and even testify on behalf of their adult client with little or no understanding of the client's needs, the other parent's position, or the couple or family dynamics. Unfortunately, some courts are willing to give credence to this kind of "expert testimony." In some high-profile cases, the parents' mental health therapists squabble among themselves, playing out the parental dispute in a community or court arena.¹¹

Standards of practice for conducting custody and access assessments from the fields of child psychiatry,

¹¹ Johnston, Janet R., and Vivienne Roseby, In the Name of the Child: A Developmental Approach to Understanding and Helping Children of Conflicted and Violent Divorce. New York: The Free Press. 1997: 9-10

psychology and social work prohibit such one-sided assessments and indeed may be grounds for disciplinary action by the respective college. Certainly in the context of a trial, such one-sided reports are frowned upon by the Courts, yet are still frequently sought by litigators and parents alike. It may be that the utility of the document is less for Court, but more for intimidation on the way to Court so as to bring about a settlement.

In terms of intervention, here it becomes vital to understand the issues underlying the child's distress so as not to inadvertently become a pawn in the parents' settlement process of custody and access issues.

Best Practices

In view of the many underlying matters that may be contributing variables to children's mental health issues, it becomes imperative for the physician to screen for domestic violence, parental alcoholism and high conflict separation issues. While there are many tools or instruments or questionnaires available, the average family physician has nary the time to commit to a detailed or prolonged screening process. Notwithstanding, there are a few questions, easily asked that can give a clue that these issues may be active. Thereafter more informed treatment may be directed.

With respect to domestic violence, a physician may privately ask a parent if there is any hitting, throwing of objects, slamming of doors, yelling or screaming that goes on inside the home. If so, then the physician can probe deeper and explore safety issues for that parent and child. Some parents may argue that the child hasn't seen or been privy to domestic violence, but closer scrutiny usually reveals that the child was in the home, often hiding or may have been witness to the aftermath of domestic violence such as by viewing injuries like swollen lips, bloodied nosed, black eyes, other bruising or damage to property, let alone the impact of the parent emotionally dishevelled by abusive events. In view of a positive finding of domestic violence, the physician is better able to refer appropriately and for women, should consider referral to women's shelters for counselling and ancillary services. Further, it may

be necessary to refer to child protective services and if uncertain, the physician should call the local child protection agency for a consultation to determine the necessity of reporting.

As for parental alcoholism, the physician can perform a quick alcohol-screening inventory. This can begin by asking about the quantity of alcohol consumed daily, weekly and monthly. Many persons respond with his or her own assessment of their alcohol consumption and

the most frequent reply is to say one is a social drinker. This phrase is remarkably subjective and totally obscures the quantitative data. Hence the physician must resist accepting the parent's assessment of their drinking and return to the request for quantitative data. Simply add up the number of standard alcoholic beverages consumed on a regular basis.

Categories of alcohol consumption include light, moderate, heavy, abusive, and binge. These categories are differentiated by quantity of standard alcoholic beverages consumed and pattern of consumption. While some persons may believe that beer is less consequential than wine and that both are less consequential than liquor, this is but another myth. A beer yields the same alcohol equivalent as 4 ounces of wine and the same alcohol equivalent as an ounce of liquor. Hence it really doesn't matter what form the alcohol comes in, just the number of

standardized drinks.

By definition for men, approximately 6 standard alcoholic beverages per week is categorized as light drinking, 12-14 as moderate, 24-26 as heavy and 36 or more as abusive.¹² Rates for women are about 2/3's that of men. Furthermore, abusive drinking infers that that level of consumption places the drinker at a high likelihood of contracting an alcohol related physical disorder, such as liver disease, diabetes, pancreatitis, and Korsakov's syndrome. It is noteworthy that any level of regular drinking increases the risk of these and other associated diseases, but that the more alcohol consumed on a regular basis, the greater the risk.

¹² Abel EL, Kruger ML, Friedl J., How do physicians define "light," "moderate," and "heavy" drinking? *Alcohol Clin Exp Res.* 1998 Aug;22(5):979-84.

Screening for issues of domestic violence, parental alcoholism and/or parental separation need not be an onerous task however, intervention requires specialized knowledge.

Binge drinking is defined as five or more standard alcoholic beverages per occasion, at least once per month on a monthly or so basis. The risks associated with binge drinking are injury and death, the result of misadventure, accident/poor judgement, loss of consciousness, falls and violence.

Once the quantity of alcohol consumed and consumption pattern has been established, the physician can discuss alcohol use as a concern in the home. Thereafter the physician is in a position to counsel the patient on alcohol as a contributing factor to the child's distress and recommend treatment as may be required. It is noteworthy here that the single most researched and most effective relapse prevention program remains Alcoholics Anonymous. Virtually every community offers at least one group program and people can usually consult the Internet for locations nearest them.

As for the matter of parental separation, one need only ask the parent the status of the relationship with the other parent and about any unresolved issues. Even unresolved financial or support issues can adversely affect the child. The physician may learn that matters are with the lawyers and/or Courts. If matters are apparently settled, it may be that the parental conflict has continued and the child's relationship to the other parent is at issue. In view of child problems emanating from the parental separation, it becomes imperative to include both parents in the treatment process. Counselling referrals should only be made to persons with clinical-legal expertise.

Specialized practitioners of child problems related to issues of parental separation have a number of strategies for working with such families. Intervention may require a parallel process in terms of working with the parents separately as opposed to seeing parents together. The specialized practitioner will assess for issues of domestic violence and alcoholism as well as parental mental health issues which together may be contributory to distress in the child. What becomes important in terms of the referral from a physician, is that the physician refers to practitioners with specialized knowledge, training and experience in working with children whose distress is traceable to parental conflict. Even when a referral is appropriately made, if the practitioner cannot gain access to both parents, service may be withheld until such time as both parents are accessible. Working on a one-sided basis may inflame the parental conflict and worsen the child's living conditions. Lawyers who might be

advising their client to avoid treatment in an effort to manage the litigation process may complicate this matter. Hence not every referral will result in immediate treatment. However, this may be appropriate to the circumstances.

Further, specialized practitioners dealing with child problems emanating from parental separations will be knowledgeable of the impact of legal matters on child functioning and may direct parents to less adversarial resources for settling disputes, assuming they are not already engaged in a process of their choice. Less adversarial approaches to dispute resolution are seen to reduce risk to children's mental health problems.

The thinking used to be that in view of children's mental health, any counsellor might suffice. It is now known that like sub-specialties in medicine, there are subspecialties in counselling with regard to children's mental health issues. Hopefully this article raises the physician's awareness of issues inherent to assessment and treatment of children such that intervention is more appropriately aligned to the needs of the child. The aim is to avoid the iatrogenic effects of inappropriate treatment and as stated earlier, avoid arranging the deck chairs on the Titanic.

Gary Direnfeld, MSW, RSW
(905) 628-4847
gary@yoursocialworker.com
<http://www.yoursocialworker.com>

Gary Direnfeld is a social worker. Courts in Ontario, Canada, consider him an expert on child development, parent-child relations, marital and family therapy, custody and access recommendations, social work and an expert for the purpose of giving a critique on a Section 112 (social work) report.

Gary Direnfeld provides counselling and professional workshops on matters pertaining to the content of this article and other matters of family life.

This article is intended for reading by physicians. However, it may be shared and distributed openly as long as at no cost to others. It is my pleasure that it be of service. For questions or comments, please feel free to call or email me directly.