



CARING FOR THOSE WHO CARE FOR VIOLENT AND AGGRESSIVE CHILDREN

Introduction:

The topic of domestic violence is an emotive one conjuring visions of child abuse by parents or carers, or marital violence, in general abuse by men of their wives or partners. According to published police statistics in Scotland for the years of 2012 – 13 male violence of women accounted for 80% of all domestic abuse, and in 2014 over 2,600 children in Scotland were identified as needing protection from abuse (www.gov.scot). This is particularly concerning since the NSPCC suggests that, for every child who has been identified, there are 8 other children who are at risk but who are ‘under the radar’. These statistics, highlighting the underlying nature of inter-family abuse relationships, i.e. the abuse of less powerful and more vulnerable family members by more powerful adults, undoubtedly account for the majority of the abuse situations within family homes. However this is, sadly, not the whole story. Understanding abuse within a family means recognising the impact of sibling aggression on every family member. It also needs to encompass the growing recognition of child to parent aggression and it is this latter aspect of inter-family relationships with which this article is primarily concerned.

The neuro-biological impact of childhood trauma:

There is now a large body of research and theoretical evidence of the profound long term impact that repeated early trauma has on children’s development. The impact of pre and post-birth toxic environments, birth trauma and illness, neglect, physical and sexual abuse and multiple separations, singularly or in combination, cause impairment to traumatised children’s psychological, neurological and physiological development. In essence the brains, bodies and neurological pathways of these children become ‘hard wired’ to the expectation of trauma, an expectation that impacts the way they understand themselves, other people, especially those in a parenting role, and the meaning they give to experiences.

Experiences and the neurological brain patterning developed in the womb and in traumatised children's earliest months and years are likely to continue to predominate their way of thinking and behaving for many years even when they are removed from the source of their traumas; e.g. by being accommodated in residential or foster care, or being adopted. In essence, when traumatised children enter the care system the 'internal working model' (John Bowlby) they developed within their birth families continues to impact their understanding of new parenting figures and situations which, in turn, is expressed in their behaviour.(Archer and Gordon 2013; Bowlby 1969) Alongside this, experiences in care can further impact a traumatised child's ability to settle and start to form more secure attachments; for example, the average number of times children move between foster homes or other care placements rose from four in 2010 to five in 2011 (Richardson).This, inevitably, increases an already traumatised child's feelings that the world is a chaotic and unpredictable place. It also means that they are unlikely to have a concept of what 'permanence' means.

There are three primary responses to a traumatic event: fight, flight or freeze. When faced with a traumatic incident all of these responses might be available to adults especially if the trauma is a one-off event in an otherwise relatively stable environment. For traumatised babies and young children most of these natural responses to trauma are unavailable; they are too dependent for the flight response and too powerless for the fight response. Furthermore, children rarely enter the care system as a result of a single traumatic incident. Instead the environments in which they lived pre-placement tend to be unstable, unpredictable and chaotic. Rather than having their needs met in a predictable manner, traumatised children are likely to experience acts of commission (abuse) or omission (neglect) as random and dependent on adult rather than child needs and also in a manner over which they have no control. As a result traumatised children's only response might be a dissociative one, in effect a freeze response or passive fight, which allows them to switch off not only from specific traumatic incidents but also from their chaotic and unpredictable environments and from the anger, sadness and fear that might otherwise overwhelm them. Dissociation can include a switching off in a sensory way, for example children who are not able to feel pain or to differentiate feeling states (Mulder et al 1998, Perry et al, 1995).

Bessel van der Kolk with his concept that 'the body keeps the score' (Van der Kolk 1994)

highlights that, even when traumatised children move to safe and secure homes, the feelings and sensations that underlie their dissociative responses are still there. As a result these children are often a powder keg of unacknowledged feelings, feelings that can emerge when they move to safe families where they are offered love and security. Instead of recognising the benign intentions of new carers, traumatised children may reframe these intentions as potentially abusive or neglectful (Iacoboni et al, 2005). This is not surprising. Learning about who we are and the nature of inter-personal relationships is an intersubjective experience; i.e. is dependent on the nature of parent/child relationships. ‘Learning’ that parents cannot be relied on to meet one’s needs will have a potentially long lasting impact on a child’s understanding of future intersubjective experiences (Hughes 2007).

How traumatised children express their feelings:

How then might these children express their feelings? They may develop a belief that they were responsible for their early traumatic experiences. This may feel like a ‘safer’ belief system to embrace than acknowledging the reality of having been born to parents who were not able to meet their needs. Recognising that responsibility lies with parents implies that children have no power to reduce the nature or extent of their traumatic experiences; feeling that they could make a difference by becoming less dependent might offer children a sense of efficacy and control and a feeling that they, and they alone, can make the difference that will allow them to feel safer. This belief, while offering a degree of safety within a traumatic family is likely to make it difficult for children to settle in new families. Instead of accepting the loving authority of parents, they might respond with a fight response, becoming oppositional and acting out their feelings in controlling behaviours. They might find it difficult to depend on adults for comfort or reassurance. As babies and toddlers they may have felt that their abuse occurred because they were dependent on parents and believe (perhaps unconsciously) that it was this dependence that led to the abuse. They may continue with the ‘switched off’, dissociative response. Having internalised the belief that they were responsible for their traumatic experiences, they may struggle to express feelings and work hard to be the ‘good kid’ whose role in life is to ensure that nobody sees the ‘bad kid’ they believe themselves to be underneath the façade. They may feel that expressing feelings (crying) led to them being traumatised and therefore try to remain ‘under the radar’ in an attempt to reduce further traumas. They might develop a flight response, distancing themselves from carers in the fear that

developing attachments will lead to further abuse, neglect and/or abandonment.

Often children are a confusing mix of all of these responses. Having lived in an unpredictable environment they have no stable belief system to make sense of their experiences and display this in a complex mixture of feelings and behavioural responses. Since their experiences were developed within relationships with parents and carers who modelled unhealthy ways of managing stress, it is understandable that children, who have developed trauma related and unhealthy belief systems, often at an unconscious level, generalise, from these experiences, a belief system that interprets all relationships as potentially traumatising, neglectful and/or abusive. It is understandable that, given this generalised belief system, traumatised children display behaviours that reflect their lived experiences and that they struggle with dependence on parents when they move to new families.

Sometimes children deal with difficult feelings in an aggressive and violent way. This may be seen as the extreme end of the fight response to trauma. However anger may well also be a dissociative response where minor reminders of past traumas can trigger the feelings that accompanied these traumas; i.e. overwhelming fear amounting to terror. Indeed angry, aggressive children are likely to experience a mixture of the feeling states that reflect the fight for survival and the dissociative responses that were endemic to their early traumatic experiences.

Before considering the impact on parents we need to recognise that children who display aggression are expressing deep seated feelings which make little sense to them and over which they have little control. While it may be more understandable that dissociative children are responding from a basis of fear to early abuse and/or neglect we need to recognise that aggressive behaviour is equally a fear based response to early life experiences. Recognising this allows us to have empathy for aggressive children and is a precursor to helping them find ways to repair from early trauma and to developing less harmful ways of interacting with others.

Having highlighted that aggression makes sense in terms of traumatised children's lived experiences, aggressive behaviour is clearly not acceptable or safe for either the children themselves or their families, and it will certainly bring approbation if not criminal

involvement if this behaviour occurs outside the family and continues into adult life. Without help the ‘cute’ toddler who, in a tantrum, hits his carer could become the bully that nobody wants to play with in school or the adult who is arrested for assault. Helping aggressive children recognise the underlying reasons for their difficulties, acknowledging that they have learned inappropriate ways of acting out their fear based feelings and supporting them to find different, healthier ways of interacting can encourage and support them to become less fearful and therefore more able to alter unacceptable behaviours.

Aggressive children often present as being powerful and in control; they have a tendency to blame others for their anger. It is important to recognise that this outward presentation often hides a child who is fearful and who feels an overwhelming sense of powerlessness and lack of self-esteem. In our experience, very few aggressive children feel ‘good’ about themselves or their aggression, although they work hard to hide this from themselves and others. Helping children recognise that the aegis of their behaviour lies in their early traumatic experiences and helping them recognise the bio-neurological impact of these experiences can help children make sense of the feelings that underlie their behaviour and increase understanding of why they struggle to manage positive interactions (Morgan 2013). Rather than becoming an ‘excuse’ for continued aggression, it is our experience that understanding helps children feel a ‘real’ sense of efficacy and an increased ability to develop healthier ways of interacting with themselves and others.

Young People’s Stories:

Martin, aged 13yrs, is the youngest child in a family of three children. He was accommodated at the age of 18 months after his father was arrested for assaulting a neighbour and also the police who had been called to the incident. The family were known to the police who had visited the family home on at least 10 previous occasions as a result of incidents of domestic violence. Martin had been present during some of these incidents but the police had felt that his age had protected him from the impact; he was usually in his cot apparently asleep when they visited. Social Services had also been involved and had, at times, taken the two older children to spend the night with an aunt because they had been felt to be at risk. Martin had been left at home, again because he was assessed as being less impacted.

After Martin’s father was arrested the home environment deteriorated. Previous concerns about poor hygiene standards and lack of food intensified and the children were

accommodated in foster care; Martin was placed in a different foster family to his siblings. He moved to his adoptive family at the age of 3yrs.

Martin went happily to his adoptive family, calling them 'mum' and 'dad' from the beginning. He was a contented toddler, although his adoptive mother noted that he slept and ate more than she would have expected. After six months, Martin's behaviour changed. He became increasingly demanding and struggled when his mother said no to him; he would throw himself on the floor, throw his toys around the room and hit out at her. His mother felt that these behaviours were more extreme than she would have expected for a toddler but her friends and Martin's nursery reassured her by saying that she was experiencing the 'terrible two's' and that 'all children do that'.

As Martin progressed through primary school he presented challenges at home and increasingly at school. He challenged his parents' authority and often continued to present as a 'terrible two', for example when asked to tidy his room or when his parents said no to unreasonable demands. He refused to do homework and his parents were often called to the school because he would shout out in class and struggled with peer relationships. Martin's parents felt that they were being judged by teachers who claimed that every other child had produced their homework and by other parents who asked their children not to play with Martin.

Now at the age of 13yrs Martin's parents are struggling to manage him. He is rude and aggressive at home, he steals and his parents have had to lock up their money and personal possessions. They describe their home as a 'war zone' where they are constantly on edge and they are unsure how to engage with Martin in a way that will not provoke an aggressive outburst. He sometimes refuses to attend school and his parents are worried that he might have experimented with cannabis.

Susan is aged 12yrs and has lived in her long-term foster home for 5yrs. She was accommodated at the age of 4yrs after the police found a quantity of heroin in the house. The police were concerned about the unhygienic state of the house and the lack of food. Both parents were regular drug abusers and the police had suspected that they were dealing heroin and amphetamines. Neighbours had reported people known to the police as heroin users arriving at the home late at night.

The wider family had expressed concern about Susan because her parents left her in her cot alone for prolonged periods and they were worried that her parents did not offer her the attention she needed; their dependence on drugs meant that there were occasions when she was left crying in a wet nappy for several hours. Susan was regularly cared for by an aunt and her grandmother; her grandmother was known to have an alcohol problem and her aunt was suspected of using drugs.

When she was accommodated Susan was placed in a short-term foster home where she remained for four months before moving to another foster carer; she had three subsequent moves of foster carer before moving to her current family. While in foster care Susan made disclosures that suggested that she might have been sexually abused.

Although Susan presented as well behaved at school, she regularly ‘lost’ her homework and she struggled with peer relationships; other children said she was bossy and did not share.

At home with her foster carers Susan alternated between being loving and compliant to being rude and aggressive. She frequently accused her foster carer of being ‘mean’ to her and would say, for example, that her foster carer had deliberately not helped her with homework so that she would get into trouble at school. She had lashed out at her female foster carer and had broken the bathroom door by banging on it. She had gouged holes in her bedroom walls and damaged her own and her foster carers’ property. The family dog was nervous around Susan and the foster carers suspected that Susan had pulled the dog’s tail and kicked him at times; Susan denied this saying that her carers were mean to her and did not trust her. When she was calm she would beg forgiveness and apologise; however she struggled to hear her foster carers accepting her apology and she could repeat her apologies for up to an hour at a time.

Susan had started to ask questions about her past. She has a sister who was born after her mother became drug free and who is living at home. Susan questioned why her sister remained at home while she was accommodated and has said she believes this is because she cried a lot as a baby. She alternated between saying that she wanted to go and live with her mother and clinging to her foster carers saying she loves them and wants

to stay with them. Her foster carers felt that, even after four years, she did not trust that they were there for her and wanted to help her.

While Martin and Susan's experiences differed they shared the fact that they had been abused and neglected within their birth families and that their needs had not been prioritised. When they moved into new families they presented their parents with significant behaviour problems. They had an extremely low frustration threshold and dealt with their frustration by displaying violence and aggression.

When Martin moved into his adoptive family his adoptive parents were told that he was a 'delightful' child who had settled well in foster care and did not seem to have been unduly impacted by his early experiences because he had been so young at the time. Susan's foster carers were told that Susan had struggled in previous foster homes because there were other children in placement. Both sets of parents were told that the children needed stability and security to help them heal from their past experiences. There was a presumption that with time, love and commitment Martin and Susan would settle and be happy and contented. There was no suggestion that the children's behavioural problems were likely to continue for many years or increase with time. There was no discussion about the level of aggression the families might experience at the hands of the children they had taken into their homes. There was certainly no discussion about the potential impact on parents of living with violence.

Impact on parents:

Martin and Susan's carers were committed to their children; they worked hard to understand their behaviour and to offer them love and commitment. Although the children seemed to be building bonds of attachment the level of aggression did not abate and the parents were at a loss to know what to do to make a positive impact. They had tried tolerance, love and understanding to no effect. They could not understand what they were doing wrong and felt responsible for the fact that they appeared to have had so little impact on their children's behaviour.

One reason for these feelings was the messages the parents were given from professionals when the children were placed; i.e. that love, commitment and security would help their child heal. This carried with it the underlying message that the lack of

progress was the responsibility of the parents; i.e. the children had not changed because, despite their best efforts, the parents had not offered them enough of what they needed.

There are other reasons. Very few parents of aggressive children know other parents who are struggling with similar problems. Parents may therefore find it difficult to talk about or acknowledge their struggles. When they do they may be given conflicting advice which can make them feel blamed. This advice can range from suggestions that they are too strict or too lenient, that they are too loving or not loving enough. They might be told that the best solution is to give up on their children and place them back within the care system on the premise that the children are not really their children. They might conversely be told that they are doing a great job and then left to struggle on their own. This is likely to lead to parents feeling isolated, alone, misunderstood and powerless. They struggle on alone, with little opportunity to talk about the reality of their experience. This has sometimes been likened to living in a war zone, but a war zone that nobody sees and which parents have to present as a state of peace.

Earlier in this article we highlighted the impact on children of living with the trauma of abuse and neglect. In our experience the impact on parents is often similar. Living with an angry, aggressive child is traumatic since the nature and extent of the behaviours they display are not single incidents, but ongoing lived experiences that permeate every facet of family life, often for many years. Traumatised children are frequently described as hyper-vigilant; parents may also become hyper-vigilant, unable to relax and enjoy times when their children are more settled. They may have internalised a belief that, if they let their guard down, disaster is likely to follow. Like their children the response to living with this level of trauma may be to develop one or more of the trauma responses: flight, fight or freeze. However, also like children some or all of these responses might not be available to parents.

The flight response implies placement breakdown and this is something that many parents, however desperate they feel at times, cannot countenance. They love their children and have made the commitment to them that has allowed them to manage the challenges presented by their children over many years. This love and commitment may preclude disruption. The flight response may, therefore, not be available to parenting figures because it means giving up on their child.

Living with aggression from a child is frightening and we recognise why parents might feel anger and frustration; i.e. the fight response. However, while being an understandable response to provocation, acting on anger by shouting at or smacking a child is only likely to increase the child's violence and put the parent/carer at risk of accusations of having physically abused their child. Responding to aggression with anger is therefore not a helpful response from parents who are the adults and who must take responsibility for their actions; the fight response is therefore not one that is available to parents.

The only response may therefore be the freeze or dissociative one. This, in many ways, can be likened to the dissociative response of traumatised children who had no one to talk to and no language to articulate what was happening to them. They believed that the abuse occurred because they were bad babies or children. They gave up trying to make sense of a world that was confusing and frightening. They retreated into a world of their own. Parents, who are not given the opportunity to have their experiences validated, may feel they have no voice and no language to articulate their experiences. They may feel that they are 'bad' parents and that they are responsible for their child's difficulties. They may struggle to make sense of what is happening in their family and may respond by retreating from the support of friends and relatives whom they either want to protect or whom they feel will not understand.

Parents may be afraid of their child's violence but, being unable to articulate it or protect themselves from further abuse, they learn ways to accommodate it into their belief system. Like women abused as adults they may rationalise and minimise the abuse, for example by referring to it as 'hitting' rather than assault. They may appear to be flat and emotionless and laugh at situations that the average person would be likely to find frightening and potentially abusive. At the same time they may lack the ability to articulate what is happening or protect themselves from further abuse. They feel that they are being blamed by people around them and begin to believe that they are worthless and blameworthy.

These responses may be particularly intense in adults who have had an early traumatic history themselves. This does not mean that these parents will act on their feelings. Rather their early experiences might give them greater opportunities for tuning into the inner world

of their children and to really know what is going on for them. Conversely, therefore, these parents while seeming to be angrier or more dissociative might be doing a really good job of tuning into and mirroring their child's distress.

Returning to the fight response to a child's aggression, many parents with whom we work acknowledge that they have responded to their child's anger, aggression and rejection by shouting at them and occasionally smacking them. All have expressed feelings of failure at doing this; they do not feel good about shouting at or smacking their child. They feel 'bad' about their reactions and are aware that they are not being effective in dealing with their child's difficulties. They talk about having a level of anger they did not know they possessed and did not demonstrate prior to the child's placement. Often the parents' relationship is in disarray; they may find themselves arguing about the child and about the way to deal with him/her. They are likely to have little time for themselves as individuals or as a couple. Most parents with whom we worked would like to be calmer and more understanding. All are keen to consider more appropriate and less angry responses to their child's difficult behaviours and are looking for support and help for them and for their children.

What can professionals do to help?

First and foremost professionals must work to understand the profound and pervasive impact of abuse and neglect on the children they are placing in new families. They need to be honest with prospective parents and carers about the potential impact on families, to be pro-active and consistent in the support and understanding they offer both during the difficult times and when children present as being more stable. Traumatised children are likely to have long-term needs above those of their non-traumatised counterparts; their carers therefore will need long-term, consistent and empathetic support and understanding if they are to meet their children's needs in the long-term.

Professionals need to help parents retain feelings of self-worth and self-esteem by valuing them and the contribution they have made, and continue to make, to their children's lives. Noticing the positives while not dismissing parents' concerns is crucial. Parents do not need to hear that 'all children do that' when they have been brave enough to share some of the difficulties; their worries and concerns need to be validated and supported. This needs to be balanced with an acceptance that parents are doing the best they can in very

difficult circumstances.

Professionals need to be alive to the possibility that parents are being subject to aggression and violence and give them the opportunity to express this in a non-judgemental way. Awareness that a child has been abusive in the past should signal the need to ask questions about whether any acts of hitting or violence has occurred since the previous visit. Recognising the possibility that parents might minimise this and demonstrating understand and empathy will allow parents to talk about the extent of continuing violence and aggression. This is essential so that parents do not feel isolated and alone.

While not condoning aggressiveness towards children it is important that professionals understand the context in which parents might respond to violence with anger. This will help professionals demonstrate the understanding and empathy that is a precursor to helping parents deal in a more appropriate way with their children's behaviours. Trying to put yourself in a parent's place and wondering how you might respond, for example, to a child swearing, lying, hitting you, rejecting you, or damaging things you hold precious might help to develop a spirit of understanding and of working together to make things better. This needs to reflect the fact that parents may well be managing these behaviours on a daily if not hourly basis. We need to treat parents with respect and to validate and value the crucial role they play in the lives of some of the most vulnerable children in our society. This understanding provides the context for working with parents to help them develop different emotional and behavioural responses to violence and aggression. In doing so we can help both parents and children; both have a right to be listened to and both have a right to feel safe and free from fear. Both need strategies for managing their feelings in a more helpful way and practising different ways of behaving; neither will do this if they feel blamed and misunderstood. Having an understanding 'listener' who can 'hear' the parents' pain is also likely to reduce the potential that they act out their feelings by shouting at or smacking their children; being able to share feelings in a caring and supportive environment helps dissipate parents' anger and frustration, even when the child's behaviour remains challenging.

Parents can find that their current life reflects the chaos that was endemic to the early lives of their traumatised children. Helping parents to explore, in a non-judgemental manner, ways to make family life less chaotic is vital. Offering pro-active support and comfort forms

the basis for the development of a trusting relationship between parents and professionals and allows for the reduction in the sense of isolation that many parents of aggressive children feel.

Since their outbursts are difficult to contain, parents might find themselves giving in to unreasonable demands to reduce angry outbursts in their aggressive children. As a result, aggressive children often control the emotional tenor of family life. This is not helpful for children, since it reflects the chaos of their early experiences and their inner world. Neither is it helpful for their families. Instead we need to support parents to provide the structure that will help change the balance of control within the family and, in doing so, create the atmosphere that is more likely to reduce their children's aggression.

Positive parent/child interaction is dependent on relational reciprocity. This is hard to achieve when parenting an aggressive child who challenges parental authority and who rejects every attempt for positive engagement. In this situation parents may feel that parenting is a chore and a joyless experience. This, in turn, results in a lack of the hormone oxytocin which depletes the brain's capacity to parent and can increase parents' feelings of trauma and lead to blocked care (Hughes and Baylin 2012). Offering aggressive children safe and fun ways to engage in family life is crucial. We therefore need to help parents and children experience joy and acceptance in their relationship, while recognising how difficult this might be for both parents and children. Alongside encouraging parents to reinforce the message that aggression is not an acceptable way to express feelings, we must support joyful family experiences. Love and the expression of it needs to be unconditional. In this way children will begin to internalise the message that it is their behaviour that is being challenged and not themselves as worthwhile individuals. For this reason it is important that some family activities are sacrosanct regardless of the child's behaviour; for example a bedtime story, or song should not be dependent on whether a child 'deserves' it. Parents may struggle to do this unless professionals also offer support unconditional support that recognises that parents are doing the best they can in very difficult circumstance.

There is a link between decreases in the level of the hormone serotonin and an increase in aggression (Damasio 2007). This suggests that helping children and parents to increase their serotonin levels will decrease violence. One way of doing this is to help parents feel

more relaxed by increasing their feelings of efficacy. Offering practical strategies for helping parents and children express their feelings in non-aggressive ways is therefore an essential component in working with families.

Adrenaline decreases and serotonin increases when engaging in physical activities such as walking and cycling. Introducing these activities within the structure of family life can be time well spent when compared with the more stressful, time consuming and less productive time spent managing a child's aggressive outbursts. Supporting parents and children to play together is likely to benefit family life in a way that insistence on completing homework tasks will not. We may have to work with school to help them recognise the priorities for children and their parents. If aggression is reduced parents' feelings of efficacy and self-worth is likely to increase; and if change is more tenuous the exercise itself can make parents feel better.

Noticing the times of the day that are most difficult for a child can be helpful. Many of the parents we work with at Adapt (Scotland) report that their children are highly aroused and difficult to manage when they are collected from school. Understanding the reasons for this, for example recognising that a child, who has had five different families before placement in their adoptive family, is likely to have feelings on abandonment, allows parents to remember that their child's serotonin levels may be depleted by the end of the school day. Offering their child a healthy snack such as a banana at the end of the school day and walking home from school, perhaps encouraging children to skip, run and/or sing during the journey may well give them the serotonin boost they need to reduce their propensity for acting out their feelings in aggression. If the snack has been agreed during the morning routine, this will convey a message that the parent will be there at the end of the day and potentially reduce feelings of abandonment during the school day.

So, too, is supporting parents to 'name' their children's behaviour alongside a clear message that aggression, while understandable in light of the child's history, is not acceptable. This must be accompanied by the message that parents are willing to help their children manage their anger in different, healthier, ways. Such discussions can only be effective during periods of calm when both parents and children are more likely to be in cortical, thinking mode. This means that naming feelings and behaviours should be done either in the 'calm before' or the 'calm after' the storm (of an aggressive outburst). As this

can be difficult to manage parents may need help to think about when and how to reflect on their children's behaviours and the potential underlying reasons.

Having a range of alternatives and having these, perhaps, printed on a family poster, with a pictorial representation of safe alternatives to anger, that can be referred to may help to provide this message. This is especially important for those occasions when anger is threatening to spill over into aggression. At these times both parents and children are likely to be operating from their fear based limbic systems meaning that their capacity for cortical processing, i.e. their thinking ability, is reduced. Having strategies to hand that have been agreed during periods of calm reflection and that can be 'pulled out of the bag' at moments of stress offers children the message that parents are there to help them manage their feelings in a healthier way.

Having a pre-prepared range of strategies also reduces the need for words. This is important. When children are operating from their limbic and/or brain stem – in flight, fight or freeze - their capacity to respond to verbal cues is reduced. This means they are not likely to be able to respond to verbal messages to calm or to questions about the how, why and what that caused their aggression to erupt. Such questions are likely to increase rather than decrease anger and therefore aggression. Instead, the sight of a parent skipping into the room holding their agreed 'Calming Poster' and singing or acting out the previously agreed alternatives is likely to be more effective. At the very least this strategy will help to keep parents on track by increasing their feelings of efficacy and, consequently, their serotonin levels.

Teaching parents about the neuroscience of aggressive behaviour and supporting them to remember that, however deliberate or controlling their child's behaviour seems, the underlying reasons for aggression lies in their children's early histories and in the neurobiological impact of trauma can help parents maintain a positive attitude. Recognising that children 'can't do' rather than 'won't do' can support positive interactions and remove the feeling of 'it's my/her fault', 'I'm a bad parent/child' for everyone.

Conclusions:

All of the above strategies have one thing in common: they stem from a belief that traumatised children may need a different type of parenting than is required to parent non-

traumatised children. This different parenting approach is embedded in the work we do at Adapt (Scotland). This, in turn, stems from our belief in the principles espoused by proponents of ‘developmental re-parenting’ (Archer and Gordon 2013; Golding and Hughes 2012). These principles are captured in the mnemonic P(L) ACE; i.e. that parents need to come from a place of love by parenting their children in a playful, accepting and empathetic way. The ‘C’, reflecting the need for curiosity and understanding of the reasons why the child is struggling, means remembering the child’s history and the way the messages they received within abusive and neglectful households have become encoded in their way of understanding themselves, their parents and the world around them.

We must remember that the strategies suggested above may not come naturally to parents who have been raised in families who espouse more ‘traditional’ forms of parenting. Parents may need to practise ways of parenting that might seem counter-intuitive and which may not be understood by family and friends; it takes time and commitment to develop the ‘mind-set’ of developmental re-parenting. Just as we fell off our bicycles several times before we learned to cycle, ‘mistakes’ are an inevitable part of the process and should be seen as a learning tool. Professionals need to recognise this and support parents on their journey towards creating a safe, calm and aggression free family where children are supported in repairing from the early traumas that blighted their early months and years. Professionals also need to convey the message that no parent is perfect and that, while practising new ways of interacting, parents are likely to make ‘mistakes’. We can all have a ‘bad hair day’.

Although crime in Scotland is falling it is estimated that around 3% of adults in Scotland were a victim of violent crime in 2012-13 (www.gov.scot). Supporting the families who are caring for children who could become the next perpetrators of violent crime will not only lead to a happier and healthier family life for those families, but also potentially for a safer society at large.

Christine Gordon and Karen Wallace; ADAPT (Scotland)
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