HAGUE MOTHERS

Hague Domestic Violence Forum
Expert Paper #3

The impact of domestic violence and coercive control on children: applying evidence-based assessments of children to 'the grave risk exception'

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Biography

Stephanie Brandt, MD, is a board-certified adult and child psychiatrist in private practice in Manhattan. She has over 40 years of experience in diagnosing and treating adults, children, and their families before and after complex child-focused litigation. Her specialty is in childhood trauma syndromes. She is a respected forensic expert witness in domestic and international litigation, often appointed where domestic violence, child maltreatment, and parental alienation are ed. These are cases where the differential diagnosis of PTSD, malingering, narcissism, and psychosis can be essential. She has testified in multiple federal cases Hague Convention cases. As Ethics Chair at NYPSI, she has extensive knowledge of the legal and ethical aspects of her profess on. She is an assistant professor at Weill Cornell New York Presbyterian Hospital and a faculty member at the New York Psychoanalytic Institute. She is a member of AACAP, APSAC, the AFCC, and the Shera research group, and she is on the international strategy group of The Hague Mothers Legacy Project. Dr Brandt frequently presents and is widely published about the assessment and treatment of childhood traumatic syndromes due to various causes, including medical illness, sex trafficking, abuse, and neglect.

'It is easier to build strong children than to repair broken men' - Frederick Douglas

This paper will summarize the evidence-based research that provides our scientific understanding of the dangerous impact on children of exposure to domestic violence. A massive body of research now undergirds our recognition of the harmful, often irreversible effects of domestic violence ('DV') on the course of a child's development. Lack of recognition or misinformed views about DV and the irreversible and even life-threatening damage this imposes on a growing child often results in an inadequate evaluation of the child's safety and inadequate protection from preventable ongoing harm. Sadly, this is the literal opposite of the purpose of the Hague Convention.

In recent decades, there has been an explosion of research on the nature and consequences of domestic violence. In 2007 Stark formulated the definition of domestic violence, coining the term 'coercive control '(Stark 2007). His redefinition brought about the diagnostic clarity and precision that allowed for interdisciplinary consensus on terminology and produced a wealth of scientifically valid studies on all aspects of DV. Coercive control ('CC') is defined as a complex multi-vehicle strategy deployed consciously and intentionally by a perpetrator to intimidate and control a victim (including a child) in an intimate, usually a family relationship. Physical violence itself is not centered nor even necessary as a defining feature. The public knows this dynamic differs from a 'communication problem'. It is understood now that DV (or CC) is a quite malignant dynamic in a relationship that is often hidden from public view, difficult to interrupt, and sometimes does not end. Social scientists in many academic fields have established bodies of specialized clinically useful knowledge about the incidence, nature, course, and treatment options, as well as the lasting impact on adults and children. Nowadays, professional expertise, especially if offered in litigation, should be based only on studies that meet the very high standards of valid scientific methodology, i.e., standards that meet Daubert's requirements. Subjective opinion has no place in that context.

Other researchers renewed their interest in studying trauma within the same period. Though it is hard to imagine now, before the 80s, there was almost no recognition of the difference between severe distress and the more complex processes that are the result of indisputably traumatic events. Some think the term has been so broadened to be no more than jargon. (Haslam and McGrath, 2020). Though overstated, it is true that terms associated with trauma treatment are sometimes clinically imprecise and may result in simplistic and misguided applications. Something as common as an incident of parental misunderstanding is too easily labeled as childhood trauma. (Amaya-Jackson et al., 2021; Brandt, 2023; D'Andrea et al,2012; Friedman, 2004; NCTSN, 2023; Tronick, 2021)

A massive epidemiological study on the consequences of Adverse Childhood Experiences' (ACEs) also produced substantial information on factors that cause harm to the growing child. (Felitti et al., 1998; Marks, 1998) These items included what we would refer to as abuse and neglect but also included societal factors such as racism and poverty. Not surprisingly, multiple ACES compound the harmful effect of each one on a child, and the use of the term Ace Score is standard. But in the specific context of Hague litigation, it is ESSENTIAL to understand that not all ACES imply traumatic exposure, nor are they likely to result in the consequences of traumatization discussed here. Adversity is not always trauma and does not always result in the severe consequences to a child described here. As stated by the National Child Traumatic Stress Network (NCTSN, 2023):

'Traumatic events can evoke strong negative emotions and physical reactions, including terror, powerlessness, and intense physiological arousal. Traumatic experiences overwhelm the capacity to

cope with intense feelings, which persist long after the event and can be triggered by reminders. In contrast, 'adversity' is a broader term used to describe serious hardship or misfortune that requires significant adaptation by a child in terms of psychological, social, and neurodevelopmental systems, and which are outside the normally expected environment and which may or may not be a traumatic event or lead to traumatic stress reactions.'

The term 'trauma' as it is used in valid studies, is defined by the experience of the person impacted, not by an observer's assessment of the event. Although some experiences will traumatize most children, the term 'trauma' 'means that the child is experiencing something that is beyond his ability to manage. It is an experience that, in a phrase, 'blows his fuses and results in a mental state that is way beyond distress.' In our current nomenclature, trauma is defined by both American and worldwide groups as follows:

'The person was exposed to death, threatened death, actual or threatened injury, or actual or threatened sexual violence, as follows: 1. Direct exposure 2. Witnessing, in person 3. Indirectly, by learning that a close relative or close friend was exposed to trauma 4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of the professional duties: for children under 6, the criteria are exposure to actual or threatened death, serious injury, or sexual violence, as follows: 1. Direct exposure 2. Witnessing, in person, especially as the event occurred to the primary caregiver) 3. Indirect exposure learning that a parent or caregiver was exposed.' The authors *especially emphasize the importance of witnessing an attack on a caregiver* (Kitzmann et al., 2003)

The criteria for the diagnosis of PTSD,[1] PTSD Dissociative Type,[2] Childhood PTSD,[3] and Complex PTSD[4] (the last two being more relevant here) are in the Endnote section. We recognize a form of PTSD in childhood that is the nearly inevitable result of repeated traumatic exposure such as occurring to children exposed to ongoing domestic violence, which includes being the direct object (i.e., child abuse) or witnessing DV perpetrated on a caregiver, usually the mother. (Maerker, 2022) Childhood PTSD is easily overlooked by those who are not familiar with child abuse. It is well known, however, that PTSD in childhood is more severe and unremitting, carries a significant risk of relapse when triggered by what may seem like a benign setting, and the greater the frequency and duration of exposure or relapse, the more likely it is that the child's ENTIRE development will be impacted permanently and at all biological levels. These are genuinely life-altering, potentially lethal physical and psychological health consequences that should never be minimized because they are invisible to an observer and may have delayed onset. Childhood PTSD puts that child at risk of early death. (Gordon, 2021; Teicher, 2018; Teicher, 2022)

Post-traumatic stress disorder is a normal reaction to an abnormal situation – a traumatic one. Although many people may recognize the effects of this on adults, e.g., fight /flight and freeze and shut down actions, it is often overlooked in children.

Other childhood experiences that are universally traumatizing include: 1) being separated indefinitely from a primary caretaker for any reason (Teicher, 2018); 2) being exposed to relentless and severe interparental conflict; 3) being denied a stable adult attachment figure, i.e. a reliable loving parent (sometimes that is referred to as a 'good enough mother '-though the gender is not necessarily female). We know that anything that disrupts the stability and security of that early relationship is extremely dangerous. Normal child development can and often does occur in the context of only one reliable consistently present adult caretaker. (Goldstein, 1996) On the other hand, we also know, that it is not necessarily traumatic, though certainly distressing, disappointing and suboptimal for a child to lack a

relationship with both parents. To determine if that absence is actually traumatic would mean assessing the quality of that relationship, not its wished-for potential. It is also not necessarily traumatic, though certainly a disadvantage for a child, to experience various other kinds of adversity such as poverty, racism, parental illness, various disruptions in the environment. However, what is truly essential for a child is the stability and security of at least one parent who is attuned and attached to that child over him or herself. Often the public does not readily believe that one parent can be sufficient for normal development though examples are all around us. This assumption, i.e. the need for both biological parents of opposite sex, is based solely on a certain heteronormative and even prescriptive standard of Western childrearing which tends to inform much of family law policy. Unfortunately, in practice, the prioritization of the relationship with both parents as if a necessity rather than a preference can obscure a realistic assessment of the child's needs for the safety, security and stability of one reliable parent. In reality, and often in cases where there is DV and child abuse, there is only one adult who functions as a parent. Not all parents want to be nor can be parents and no judicial order makes that happen. (Brandt, 2023; Meier, 2021; Goldstein et al., 1996)

Another false assumption about the impact of DV on children is that it simply ends when the parents separate. There is an extensive body of research that reveals that there is a large overlap between children exposed to DV and those who become victims of direct child abuse, often post-separation. Edelson has done groundbreaking work in this area, showing that the rate of overlap between domestic violence and child abuse is both alarming and significant. Research consistently demonstrates that children who reside in households where domestic violence occurs are at a markedly higher risk of experiencing abuse themselves. Studies estimate that between 30% to 60% of families experiencing intimate partner violence also report concurrent child maltreatment. (Edleson,1999; Edleson,1999; Edleson,2007; Edleson,2008) Moreover, it is important to recognize that domestic violence and child abuse are not isolated incidents, but rather pervasive issues deeply rooted in societal structures and cultural attitudes. Both forms of abuse thrive in environments where power imbalances and gender inequality are tolerated or even perpetuated. (Davis et al., 2018; Spearman et al., 2023; Zolotor et al., 2007) The impact of child abuse itself, in addition to witnessing the abuse of a parent, has quite predictable consequences as described above and is, thus, often combined in the lives of these children. The American Professional Society on the Abuse of Children (APSAC) has written protocols for the assessment of child maltreatment in the context of domestic violence, as well as many other useful position papers on the nature of child maltreatment and neglect. Their list of items that qualify as maltreatment is in this Endnote.[5] Often, children exposed to DV also suffer various kinds of neglect. Although it may be harder for both adults and children to recognize the *absence* of caretaking, neglect has equally traumatic effects on children, sometimes even worse. The betrayal trauma of a child having to accept indifference or the absence of parental love by an adored parent is usually a lifelong struggle. Neglect has the same devastating consequences as abuse but also tends to fly under the radar even of the most well-intentioned adults. (APSAC, 2008; Davies et al., 2010; National Scientific Council on the Developing Child., 2012)

It is also well known that child protective agencies' evaluation of children is quite differently focused than an ordinary custody evaluation (the common but incorrect standard for Hague litigation). These two fields often do not agree or coordinate – sometimes leaving a child at risk. After a literature review of Canadian cases, Shlonsky and Friend discussions with experts across Canada, suggested that a significant challenge rests with competing ideas on appropriate risk assessment tools to assess child risk for psychological and physical harm including, child homicide. The domestic violence and child abuse areas have unique histories that led to the development of different risk assessment tools that

may fall short in assessing both child and adult risk of lethal violence, particularly in the context of family violence. To address these issues, there is a need for more research on assessment strategies, promising case management strategies, information sharing, and collaboration between criminal and family courts. (Shlonsky, A., & Friend, S., 2007). They explain:

'The history of risk assessment in child welfare is very different from its history in the domestic violence field. Whereas in criminal justice and social services addressing domestic violence, there has been a fairly steady progression towards the development, application, and confidence in risk assessment tools and technologies, in child welfare, there has been no such gradual linear process. Instead, ideas regarding the most effective methods for assessing risk have been heavily debated, escalating at times into what has been described as 'risk assessment wars.'

In Hague Convention cases where the question is primarily about safety of the return, the APSAC evaluation protocols and the standards used in emergency room evaluations of children are more appropriate and valuable ways to assess a child's mental state and relevant circumstance adequately but rapidly. (APSAC, 2020; APSAC 2022; APSAC, 2023; Butala et al., 2023; Jain, 2023; Leetch, 2013). Nonetheless, recent studies on the use of various instruments designed to determine 'immediate safety' used by child welfare agencies do not sufficiently reveal danger, and there are no current instruments that are normed for use in the context of DV. (Vial, et al., 2020)

In addition, it is well known that undermining the relationship with the protective parent in the context of domestic violence quickly becomes a favored vehicle of abuse post-separation when contact with the other parent is not prohibited. Emma Katz described this in detail in her writing (Katz, 2019; Katz, 2023). The legal system is also often used as a means of jeopardizing the protective parent via financial and custodial threats that unwittingly enable persistent abuse. (Duron et al., 2020; Douglas and Fell, 2020)

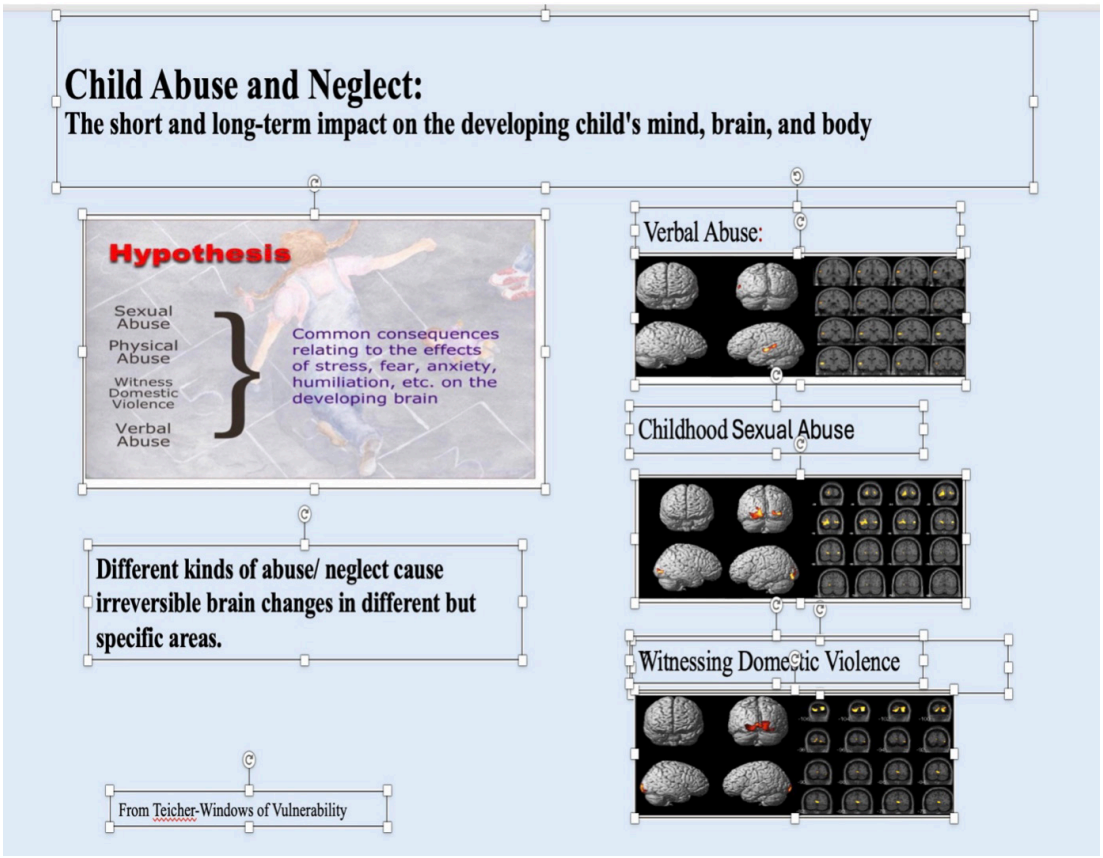
A summary of the effects of domestic violence on children at different ages, presented by the Government of Canada, Department of Justice. Risk Factors for Children in Family Violence During Separation. 5. Risk Assessment Strategies and Tools - Risk Factors for Children in Situations of Family Violence in the Context of Separation and Divorce, 12 2021, www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rfcsfv-freevf/p7.html#se 58 is available in this Endnote.[6]

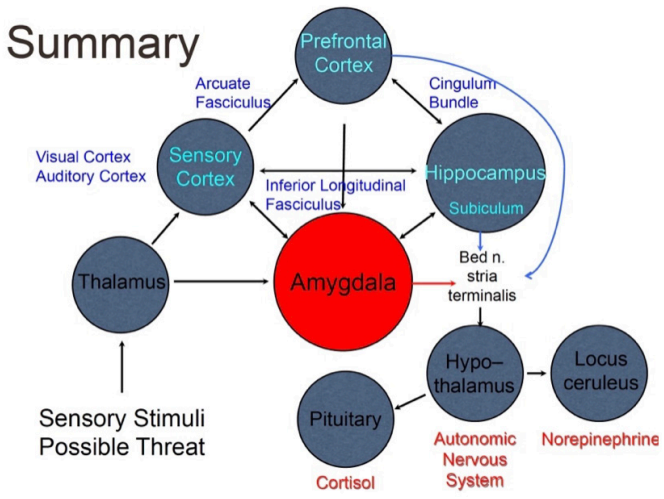
Exposure to DV and the catastrophic consequences to the entire trajectory of development have been studied at the most basic cellular level. We now know unequivocally that trauma due to DV exposure that is severe enough to cause PTSD and other delayed and damaging changes can result in a change in the genetic makeup of the victim child. There are 'epigenetic' changes that are documented and are, of course, irreversible. These alterations occur in the DNA of the exposed child. These are not inherited traits but rather are changes in a child's genetic makeup that are due to the trauma exposure itself. These changes cause related changes in the child's development depending on the sites involved, and they are also passed on. They are a vehicle of intergenerational trauma transmission that does not rely on the environment. This is a profoundly disturbing discovery and should not be underestimated in its impact. (Tronick, 2016; Tronick, 2007; Anda, 2006; Lester et al., 2011)

At the next level, we can show brain scans that show the specific sites of permanent changes determined by the nature of the abuse. For example, 'witnessing DV' can cause changes in a different area than sexual abuse.

It is the work of Marin Teicher and his group that have done these elegant studies on the brain. They have also discovered sensitive periods for specific types of abuse when the damage is most significant and have also completed a host of other studies on the alterations in brain mechanisms that control the entire body's homeostatic mechanisms, including emotional responses of the limbic system, which are unregulated, i.e., the hypothalamic-pituitary. This results in a sustained level of heightened reactivity or its opposite, i.e., a shutdown. Suffice it to say if a child's entire emotional regulatory system is hijacked, there is little option for ordinary development. Thus, clinically, we see the acute effects of PTSD and, later, the long-term sequelae of increased psychopathology and medical illness.

Below are some graphics from Teicher's basic science lab studies that clearly show an impact that is so broad-based that the devastating effect is potentially on every organ system.





In the context of Hague Convention litigation where DV is alleged, now the majority of cases (Finkelhor, 2017), it is quite imperative to obtain a detailed child and case specific understanding of the prior, ongoing and potential damage that can result from a return, *i.e*. whether the child qualifies for the 'Grave Risk Exception.' The ability for a judge to make that determination is much enhanced by providing a professional assessment of that child's mental status, psychiatric vulnerabilities and strengths. With this kind of specific data, it is much more likely that an informed opinion about that child's safety if returned, or not, will be made.

Also, an understanding of the child's mental status automatically pertains to any attempt at ameliorative measures which, as noted by many, including the unanimous U.S. Supreme Court in *Golan v Saada* (2022), are almost impossible to fashion reliably and effectively in such cases, and especially not on an expedited timeline.

The use of a qualified forensic clinician to examine the child can occur rapidly and with precision despite the short time frame, as that is similar to any risk assessment of a child that often is done by child trained clinicians in an emergency. An evaluation by child protective workers is not a substitute for providing a professional level diagnostic and prognostic assessment that addresses the question posed in a Hague Convention litigation. Child welfare workers and even forensics who are not trained in the assessment of children are not competent to provide a child focused assessment. There are numerous protocols available to use for this purpose, and much research on the quality of risk assessment in the context of domestic violence. Regardless of the debate over the details of how this is accomplished, it should be clear that this kind of evaluation can provide very critical data that supports or may refute a claim of 'Grave Risk.' Given that this can be done within the expedited time frame and is often done in the US on a pro bono basis, it is puzzling that this kind of information is not routinely requested in the same way that a standard medical evaluation would be when relevant. Many cases that have qualified for a Grave Risk exception in the U.S. hinged largely on the very specific data that flowed from these kinds of assessments.

There is a large literature about risk assessment in the context of DV (Cunha et al., 2024; Campbell et al., 2003; Campbell et al., 2009; Ericksson et al., 2022; Trimmings et al., 2023, Reece, 2022) Much of this research stems from assessment of the 'taking' parent or, in these cases, the presumptive protective parent. Instruments such as the Danger Assessment and other ways to assess risk of homicide are crucial in this context. Although the Convention does not address the safety issues for the parent if the child is returned, it is not beyond my scope as a child psychiatrist to state that it is undeniably and plainly traumatic to separate a child from a primary parent if that is the situation. The harm that does occur must be factored into any decision. It is that early and stabilizing attachment that has an ameliorating effect on any other ongoing traumatic state already present. If that parent cannot or will not accompany the child, then any decision to separate that child from the primary parent will do intolerable damage to an already overburdened child by destroying a primary attachment. This is a standard principle of child development that has been acknowledged worldwide for decades. Although the law in this situation is complex and not within my professional expertise, it is not at all complicated to state unequivocally that a forced separation from a primary and presumably protective parent is one of the most traumatic and dangerous experiences any child could endure. The level of trauma that would cause would ensure the immediate development of all the terrible consequences of childhood trauma that have been described in this paper.

Applying evidence-based assessments of children to 'the grave risk exception'

The following is a summary of the information on the impact of domestic violence on children as it pertains to the overarching, complex legal question of establishing the 'Grave Risk Exception' in Hague Convention litigation. It is imperative to understand that a child is equally, if not more, damaged by witnessing severe domestic violence than by being a direct object. As discussed, both kinds of abuse are very likely to cause significant PTSD of a chronic complex kind and will deform an entire developmental trajectory of that child. Having explained the type of irreversible damage to the brain, body, mind, and future health that occurs if the child is not protected from relapse or ongoing traumatization, it is fundamental that any judge in a Hague litigation understands that being a witness to DV is abuse and is highly traumatic. Unfortunately, the myth that children, especially very small children, are unaffected by witnessing DV remains a widespread belief that, in this context, can result in minimizing and even ignoring the safety needs of the child. (Barnett, 2014; Barnett, 2019; Barnett, 2020; Barnett, 2020; Barnett, 2020; Barnett, 2020; Barnett, 2020; Barnett, 2021, Dalgarno, 2023)

- A wealth of potentially critical data is obtained by a professional psychological or psychiatric examination of the child - if done by a qualified expert trained in assessing children. Adult observations of the child, reviewing the child's history and circumstances, digesting volumes of documentary evidence, using non-normed checklists and other 'testing,' reviewing evidence that is disputed, having a deep knowledge of the body of science described above, and even having natural competence in the treatment of traumatic syndromes does not replace the case-specific factual data that is revealed by examining the child. This kind of evaluation is not a lengthy custody evaluation and is easily tailored to the context of this kind of expedited litigation. A psychiatric mental status evaluation of the child provides a diagnosis (or not) and a prognosis. It is the only way to address the internal safety needs of the child credibly. That kind of child-focused, case-specific data is especially relevant to any decision about safety on return and/or any effort at ameliorative measures. PTSD has enormous implications in this context but recognizing other disorders of childhood and the related vulnerabilities, such as autism or other disabilities, may well impact decisions about the safety of a child. If the child had a severe chronic medical illness, such as cancer or leukemia, that child would be examined by a professional, and the prognosis and recommendations for treatment would be part of any evaluation about the safety of a return. PTSD and other childhood disorders are no less dangerous to the life of a child than other illnesses. Often, these are children who can be so impaired that they never function despite adequate potential. Frequently, they are condemned to a state of constant panic. Often, they can become chronically suicidal.
- A layperson cannot make the diagnosis of childhood PTSD. Even if it is suspected, a diagnosis by a lawyer, parent, or judge will not be scientifically reliable. PTSD is often complex to diagnose, especially in a tiny child. Nonetheless, very small children are often the subjects of this kind of litigation, and they are likely to suffer the worst sequelae. Once a child has childhood PTSD, it can be as dangerous to overlook as any ordinary medical diagnosis is. PTSD has symptoms that can be triggered by a context that seems benign to an adult. Without a knowledge of the child's mental state, it is easy to imagine that the adult perspective on safety is all that matters. In these cases, nothing could be further from the truth. Even the idea of return is often a trigger for relapse. And the more one relapses, the more likely the disorder is permanent. What matters is that child's entirely predictable relapse, which often occurs even during an interview at the mention of a return. In *Elyashiv v. Elyashiv,* 353 F. Supp. 2d 394, 409 (E.D.N.Y. 2005), two of the children had PTSD and were thrown into panic states and became suicidal. The same was true in *Reyes Olguin v Santana. (Reyes Olguin v. Cruz Santana*, No. 03-CV-6299, 2005 WL 67094, at *7 (E.D.N.Y. Jan. 13, 2005)

- It should be known that evaluation of younger, even nonverbal children is entirely possible. The Zero-to-Three population is a specialty of many child-trained clinicians. Precluding evaluation of the very young child, who honestly cannot speak for themselves, is an incredibly misguided decision that can exclude crucial information. Evaluation of the very young children in *Davies v. Davies*, 16 CV 6542, 2017 WL 361556 , (S.D.N.Y., January 25, 2017), and in *Saada v Golan (Saada v. Golan*, 18-CV-5292 (AMD) (LB), 2019 WL 1317868 (E.D.N.Y. Mar. 22, 2019); *Golan v. Saada,* 142 S. Ct. 1880 (2022); *Saada v. Golan,* 18-CV-5292 (AMD) (RML), 2024 WL 262951 (E.D.N.Y., Jan. 24, 2024)) provided essential information in both those cases. (Fernando, 2023; Kaye, 2023; Maxwell, 2023; Masterson, 2022; Hague Mothers Briefing Paper n/d)
- Although the scope of what is included under the 'Grave Risk Exception' is determined by many factors far beyond my area of competence, I hope this presentation on the traumatic impact of domestic violence on the child and the critical data a professional assessment brings to the court will inform and improve the difficult process of decision making that falls to the judge. Child protective determinations are always painful and fraught. Still, all participants must remember that the outcome —returned or not—, is lived by the innocent children involved. For that reason, the purpose of the Hague Convention is to prioritize the child's safety over any other conditions. (Edleson, 2010)

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FiLiA Hague Mothers

FiLiA Hague Mothers is a MVAWG project. Our overarching aim is to end the injustices created by The Hague Convention on the Civil Aspects of International Child Abduction, specifically for mothers and children who are victims of domestic abuse.

Endnotes

1. DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled 'Posttraumatic Stress Disorder for Children 6 Years and Younger' (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., 'I am bad,' 'No one can be trusted,' 'The world is completely dangerous,' 'My whole nervous system is permanently ruined').
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

2. DSM Criteria for PTSD Dissociative Type

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

3. DSM Criteria for Childhood PTSD (under age 6)

Diagnostic Criteria for Posttraumatic Stres Disorder for Children 6 Years of Age and Younger:

Criterion A: Stressor

In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in 1 (or more) of the following ways:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers. This does not include events witnessed only in electronic media, television, movies, or pictures.
- Learning that the traumatic event(s) occurred to a parent or caregiving figure.

Criterion B: Intrusion Symptoms

Presence of 1 (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred as follows:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
- Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s)
- Dissociative reactions in which the child feels or acts as if the traumatic event(s) were recurring
- Intense or prolonged psychological distress on exposure to internal or external clues that symbolize or resemble an aspect of the traumatic event(s)
- Marked physiological reactions to reminders of the traumatic event(s)

Criterion C: Avoidance

One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s).

- Persistent Avoidance of Stimuli
- Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s)
- Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s)
- Negative Alterations in Cognitions
- Substantially increased frequency of negative emotional states
- Markedly diminished interest or participation in significant activities, including constriction of play
- Socially withdrawn behavior
- Persistent reduction in the expression of positive emotions

Criterion D: Alterations in Arousal and Reactivity

Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by 2 (or more) of the following:

- Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums)
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

Criterion E: Duration

Persistence of symptoms in Criterion A, B, C, and D for more than 1 month.

Criterion F: The disturbance causes significant functional impairment or distress in various areas of life, such as social or educational.

4. ICD 11 Criteria for Complex PTSD

Complex post traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met.

In addition, Complex PTSD is characterised by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others.

- Severe and pervasive problems in affect regulation. Examples include heightened emotional reactivity to minor stressors, violent outbursts, reckless or self-destructive behaviour, dissociative symptoms when under stress, and emotional numbing, particularly the inability to experience pleasure or positive emotions.
- Persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor. For example, the individual may feel guilty about not having escaped from or succumbing to the adverse circumstance, or not having been able to prevent the suffering of others.
- Persistent difficulties in sustaining relationships and in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively, there may be occasional intense relationships, but the person has difficulty sustaining them.
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features: Suicidal ideation and behaviour, substance abuse, depressive symptoms, psychotic symptoms, and somatic complaints may be present.

Course Features: The onset of Complex Post-Traumatic Stress Disorder symptoms can occur across the lifespan, typically after exposure to chronic, repeated traumatic events and/or victimization that have continued for a period of months or years at a time.

Symptoms of Complex Post-Traumatic Stress Disorder are generally more severe and persistent in comparison to Post-Traumatic Stress Disorder. Exposure to repeated traumas, especially in early development, is associated with a greater risk of developing Complex Post-Traumatic Stress Disorder rather than Post-Traumatic Stress Disorder Read more: http://traumadissociation.com/complexptsd

5. APSAC PSYCHOLOGICAL MALTREATMENT

According to the Federal Child Abuse and Treatment Act of 2010 [10, 11], Child abuse and neglect means, at a minimum, 'any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.' Child abuse and neglect, also referred to as child maltreatment, includes all forms of violence against children. There is no uniform legal definition of each type of child abuse, including psychological maltreatment (PM), across state child abuse statutes [12], which are found in one or more of civil or criminal statutes.

The term psychological is used because PM is (a) a symbolic, sometimes verbal, communication from the perpetrator to the child and (b) unless the child dies immediately from maltreatment, the most prominent lasting features, central meanings, and impact of the victim's maltreatment experience are mental, affecting the thoughts and feelings the child has in response to the abuse or neglect. The major psychological domains affected are thinking (cognitive), feeling/emotion (affective), and from these, impulse or will to action (conative/volitional). Human beings are constantly searching for meaning and understanding. As developmentally possible, they interpret what is being done to them and around them, which then shapes efforts to have their needs met [13, 14, 15]. PM includes acts of commission (e.g., verbal attacks on the child by a caregiver) and acts of omission (e.g., emotional unresponsiveness of a caregiver). Most of the state legal definitions of PM (often labeled in state laws as 'emotional abuse' or 'mental injury') refer to the impact on the child as opposed to the caregiver behaviors. In contrast, these guidelines define PM as caregiver behavior that is likely to harm or has harmed a child.

Psychological maltreatment is defined as a repeated pattern or extreme incidents) of caretaker behavior that thwart the child's basic psychological needs (e.g., safety, socialization, motional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting mother's needs, and/or expendable. Its subtypes and their forms follow.

Spurning embodies verbal and nonverbal caregiver acts that reject and degrade a child, including the following:

1. belittling, degrading, and other nonphysical forms of hostile or rejecting treatment;
2. shaming and or ridiculing the child, including the child's physical, psychological, and
3. behavioral characteristics, such as showing normal emotions of affection, grief, anger, or fear;
4. consistently singling out one child to criticize and punish, to perform most of the household chores, and/or to receive fewer family assets or resources (e.g., food, clothing);
5. humiliating, especially when in public;
6. any other physical abuse, physical neglect, or sexual abuse that also involves spurning the child, such as telling the child that he or she is dirty or damaged due to or deserving sexual abuse; berating the child while beating him or her; telling the child that he or she does not deserve to have basic needs met.

Terrorizing is caregiver behavior that threatens or is likely to physically hurt, kill, abandon, or place the child or child's loved ones or objects in recognizably dangerous or frightening situations. Terrorizing includes the following:

1. subjecting a child to frightening or chaotic circumstances;
2. placing a child in recognizably dangerous situations;
3. threatening to abandon or abandoning the child;'
4. setting rigid or unrealistic expectations with threat of loss, harm, or danger if they are not met;
5. threatening or perpetrating violence (which is also physical abuse) against the child;
6. threatening or perpetrating violence against a child's loved ones, pets, or objects, including domestic/intimate partner violence observable by the child;
7. preventing a child from having access to needed food, light, water, or access to the toilet;
8. preventing a child from needed sleep, relaxing, or resting;
9. any other acts of physical abuse, physical neglect, or sexual abuse that also involve terrorizing the child (e.g., forced intercourse; beatings and mutilations).

Exploiting/corrupting are caregiver acts that encourage the child to develop inappropriate behaviors and attitudes (i.e., self-destructive, antisocial, criminal, deviant, or other maladaptive behaviors). While these two categories are conceptually distinct, they are not empirically distinguishable and, thus, are described as a combined subtype. Exploiting/corrupting includes the following:

1. modeling, permitting, or encouraging antisocial behavior (e.g., prostitution, performance in pornography, criminal

activities, substance abuse, violence to or corruption of others);
2. modeling, permitting, or encouraging betraying the trust of or being cruel to another person;
3. modeling, permitting, or encouraging developmentally inappropriate behavior (e.g., parentification, adultification, infantilization);
4. subjecting the observing child to belittling, degrading, and other forms of hostile or rejecting treatment of those in significant relationships with the child such as parents, siblings, and extended kin;
5. coercing the child's submission through extreme over-involvement, intrusiveness, or dominance, allowing little or no opportunity or support for child's views, feelings, and wishes; forcing the child to live the parent's dreams, manipulating or micromanaging the child's life (e.g., inducing guilt, fostering anxiety, threatening withdrawal of love, placing a child in a double bind in which the child is doomed to fail or disappoint, or disorienting the child by stating something is true (or false) when it patently is not);
6. restricting, interfering with, or directly undermining the child's development in cognitive, social, affective/emotional, physical, or cognitive/volitional (ie., acting from emotion and thinking; choosing, exercising will) domains, including Caregiver Fabricated Illness also known as medical child abuse;
7. any other physical abuse, physical neglect, or sexual abuse that also involves exploiting/corrupting the child (such as incest and sexual grooming of the child).

Emotional Unresponsiveness (ignoring) embodies caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring, and love for the child) and showing little or no emotion in interactions with the child. It includes the following:
1. being detached and uninvolved;
2. interacting only when absolutely necessary;
3. failing to express warmth, affection, caring, and love for the child;
4. being emotionally detached and inattentive to the child's needs to be safe and secure, such as failing to detect a child's victimization by others or failing to attend to the child's basic needs:
5. any other physical abuse, physical neglect, or sexual abuse that also involves emotional unresponsiveness.

Isolating embodies caregiver acts that consistently and unreasonably deny the child opportunities to meet needs for interacting/communicating with peers or adults inside or outside the home. Isolating includes the following:
1. confining the child or placing unreasonable limitations on the child's freedom of movement within his or her environment;
2. placing unreasonable limitations or restrictions on social interactions with family members, peers, or adults in the community;?
3. any other physical abuse, physical neglect, or sexual abuse that also involves isolating the child, such as preventing the child from social interaction with peers because of the poor physical condition or interpersonal climate of the home.

Mental Health, Medical, and Educational Neglect embodies caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs of the child. This includes the following:
1. ignoring the need for, failing, or refusing to allow or provide treatment for serious emotional/behavioral problems or needs of the child;
2. ignoring the need for, failing, or refusing to allow or provide treatment for serious physical health problems or needs of the child;
3. ignoring the need for, failing, or refusing or allow or provide treatment for services for serious educational problems or needs of the child;
4. any other physical abuse, physical neglect, or sexual abuse that also involve mental health, medical, or educational neglect of the child.

6. Summary of impact of DV at different ages

Pregnancy: Due to the heightened risk to pregnant mothers, unborn children are also at an increased risk for mortality.

Ages 0-3: Highly vulnerable time as this is when early attachment security is so essential. Impact is seen in the development of PTSD, aggressive behavior, psychosomatic symptoms, a lower IQ and even an effect on the genetic material of the child (telomeres) that result in more rapid cellular aging.

Ages 4-12: PTSD as well as self blame, internalizing symptoms'of anxiety and depression, social withdrawal or acting out.

Adolescence: Onset of serious depression, suicidal and self-harm states, avoidance of attachments to others, anti-social behavior, eating disorders.