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Report by - Dr Rebecca Sng, Churchill Fellow 2017

Churchill Fellowship to explore how best to support parenting after domestic violence.

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Signed: Rebecca Sng Dated: 2nd October 2018

KEYWORDS: Domestic Violence; Parenting; Family Violence; Intimate Partner Violence; Parenting Programs

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EXECUTIVE SUMMARY

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In July, 2018, I visited both the United Kingdom and the United States of America to learn more about international practice regarding the assistance of parents after surviving domestic violence (sometimes called intimate partner violence or family violence). I met with both service providers and academics in southern UK, Boston, New York City and Chicago. This journey came at a particularly pertinent time in my professional life as I had just completed pilot testing of a five-session group program for these parents called Black Box Parenting. A week before my fellowship trip, I received news of a successful grant from Womens NSW to train therapists all over the state in running this program. Therefore, the conversations I had on this trip consisted of three sections: I shared a summary of the content Black Box Parenting, I heard about the services and situations of the people I was visiting, and then we spoke of some of the common challenges we faced and discussed possible solutions.

I learnt a great deal in these conversations and gained many useful insights but it was also gratifying to realise that our practices in Australia were largely in line with the strong work being done overseas and it was exciting to see the number of people who felt like the Black Box Parenting program might fulfil an unmet need for them and asked to have a copy of the final version.

In response to these learnings, I will make the following changes to Black Box Parenting Program

1) Harness the powerful stories of parents who had previously completed the program.
2) Allow time to discuss the sociocultural influences on violence and parenting including the role of gender.
3) Normalise the need to work on affect regulation skills in parents, so that they can help children do the same.
4) Improve our engagement with non-participating parents, most commonly fathers.
5) Allow time to discuss emotional needs and how these might be met, including how the denial of these needs can leave parents (and children) vulnerable to being involved in unhealthy relationships in the future.

The new version of the program will be presented in October, 2018 at the Australian Association of Family Therapy conference and up to 300 clinicians will be trained to facilitate the program in their local area in the next three years, with a particular focus on training facilitators in rural and regional NSW.

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PROGRAM

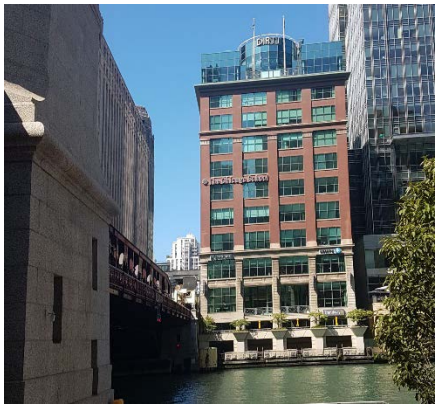
This Churchill Fellowship trip consisted of the following meetings:

In the United Kingdom, I met with several therapists from the Haywards Heath location of Beacon House, one of the largest private providers of child and family psychotherapy in the southern part of the England. Whilst the organisation provides services for payment, usually supplemented by private health insurance rebates, it also provides a large service for adopted children funding by a government grant. The area was mostly middle-class but those children who had been adopted commonly had experiences of abuse and witnessing domestic violence.

I also met with Heather Carmichael and Rebecca Rudge from the Child and Family Intervention Service, West Sussex. Both therapists run a group for parents who have violence in their relationships. The group encourages adults to consider the effects of their violence on their children and is run with a separate men's and women's group. The consumers of this service were chiefly Caucasian couples from a lower socioeconomic background.

In the United States, I met with Dr Jana Pressley at the Justice Research Institute (JRI) in Boston. The JRI, led by Professor Bessel van der Kolk, is renowned for their approach to trauma treatment. Dr Pressley is a therapist but also a senior trainer in the ARC program (Affect Regulation and Competency), a widely used program in therapy for children who have experienced violence and trauma.

In New York City I visited Greenwich House, a large not-for-profit organisation with many programs including a music school and a kindergarten. I spoke with Cecelia Land, the head of the Children's Safety project. I was able to observe the final showcase and art walk from a small art and music therapy program for children who had survived sexual abuse.



My visit to Chicago was facilitated by Associate Professor Cynthia Lubin Langtiw at the Chicago School of Professional Psychology (CSPP). I met with Taylor Jasper, a graduate of the psychology program, who is herself a survivor of domestic violence. Taylor introduced me to the work of the CSPP Forensic Clinic, which runs a

supervised access program so that after family violence, children can have safe contact with their non-custodial parent. This clinic had a significant portion of African American families as consumers. I also met with Assistant Professor Anita O'Conor, a therapist from Milwaukee, and member of the teaching staff, who works extensively with survivors of violence as well as Margaret Martyn, Campus Dean. I spoke with Melissa Robertson, a survivor and now volunteer at Deborah's Place, one of the oldest Women's Shelters in Chicago. On my last day, I was able to meet with Amrita Hanjrah, Program Manager from Apna Ghar, a domestic violence service devoted to women in the refugee and immigrant (especially south Asian) communities.

It is worth noting that although all these services differed, it was interesting to see the effects of funding structure on the programs. In both the UK and USA, public services are either non-existent or have prohibitively long wait-lists. Clinical Psychologist at Beacon House, Hamish Hill, was a typical example of the therapists at this service. He had previously worked in the National Health Service but had made the transition to private work after a number of frustrations with the system. In particular, he commented on the very long wait lists at the public services and therefore the pressure to see families for as little as three sessions. In America, services were heavily reliant on private wealthy donors or payment through a very complex system of health insurances. This meant that staff were often forced to spend time in fundraising activities and/or the focus of the service was influenced by the desires of the main funder. Some, such as Greenwich House and Beacon House, ran fee-for-service programs such as music tuition, a kindergarten or private therapy in order to subsidise the free programs for survivors of violence. In Australia it is possible for many survivors to access a number of funding supports including Medicare's Better Access to Psychological Care scheme as well as state and federally funded programs as well as Victims of Crime counselling in NSW. Whilst all these systems have many challenges, hearing of the international experience, I realised the great resources these funding sources represent in this country.

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LESSONS LEARNT

BACKGROUND

A meta-analysis of 60 studies by Evans, Davies and Delillo (2008) linked domestic and family violence (DFV) exposure to both mental health difficulties and behavioural issues in children and adolescents. The journal Partner Abuse stated female survivors have increased rates of depression, anxiety, post-traumatic stress disorder and substance abuse. So at a time when children are most in need of strong parenting, after exposure to violence, their custodial parent is often managing their own difficulties. Therefore it is not surprising that a fully prospective study by Narayan and colleagues (2017) of 176 subjects found that exposure to DFV in childhood clearly predicted both perpetration and victimization of violence by age 23 years.

Specialised support is needed for parents after DFV. Existing parenting groups are strong in behavioural training but do not consider adequately the specific challenges of parenting after DFV to both the parent's own well-being and the family dynamics. As such they often have poor outcomes in community samples with effectiveness and retention (eg: Carr, 2014). The predictive factors for later involvement in DFV relate not just to parenting skills, such as setting rules, but to the much more challenging task of creating strong attachment relationships.

Those who live in rural communities are particularly at risk for DFV but clinicians working in these areas often have very few opportunities to attend specialist training, particularly face- to-face in their local community for little or no cost. As such, it is difficult for them to build skills in evidence-based practice in this area. Travelling for training is not only expensive but time consuming, taking clinicians away from the frontline where they are most needed. Therefore, whilst working with families after violence might be complex and challenging, a good manual-based program allows rural generalist clinicians access to some of the basics of specialist practice.

The Black Box Parenting program is 5-week group program for parents with a history of DFV. It combines well-researched techniques such as behavior management and play skills training with education on the effects of trauma and attachment

disruptions. Innovatively, it includes a module on dealing with grief and guilt over the past and uses the metaphor of a Black Box to describe how the experiences of the past can affect the present. This is particularly important to include so that the group can discuss this topic without having to hear the details of past traumas from others and potentially being retriggered. It is specifically written for parents with experience of DFV but no longer living in that situation. Whilst primarily for survivors, an earlier version has been piloted with fathers in residential substance abuse rehabilitation, many of whom would have been perpetrators of violence. By improving the

parent's ability to manage behavior and make positive relationships with their children, the program aims to help families to process past trauma and to model safe and respectful relationships. This not only improves well-being in the short-term but evidence suggests it is likely to decrease the risk of both perpetration and victimization of intimate partner violence in adulthood.

The Black Box Program has recently been by Womens NSW to run free "Train the Trainer" workshops for the program in a number of locations throughout NSW, with a focus on regional areas. Participants in the workshops would be expected to run groups in their own workplaces in the 6 months after the training and would be offered 3 tele-consultation sessions with specialized clinical psychologists to support this. Trainees would be encouraged to work collaboratively with other agencies in their area to run joint groups. In a 3 year period, the project will run around 18 workshops within commutable distance for 50 of the 59 local government areas identified as having higher than average rates of DFV in NSW.

Research Base:

Although parenting programs based on behavioural learning principles are well supported in a research context, the results are often less positive in community samples with these programs remaining ineffective for up to 1 in 3 families (Carr, 2014; Scott&Dadds, 2009). In writing the Black Box program, a study was conducted by Osborne, Sng, Kelly and Ng (in progress) with at-risk parents. Many identified issues not covered by the traditional programs such as past experiences of violence. Attachment-based parenting program such as Circle of Security are better suited to this cohort but these also fail to address their past experiences explicitly and are often lengthy (up to 20 sessions). The 5 sessions of Black Box encourage attendance by parents and promote further parenting work if necessary. A pilot of Black Box

with fathers in drug and alcohol rehabilitation facilities demonstrated 83% were so satisfied with the program that they wanted to continue to work on their parenting after the conclusion of the group.

Black Box Parenting contains elements from Social Learning Theory based parenting programs (such as Triple-P) and Parent Child Interaction Therapy. In 2016, the Washington State Institute for Public Policy published a comprehensive summary of the evidence for a variety of child interventions. In the category of Child Welfare, Triple-P Positive Parenting Program received a "research-based" rating, indicating good support from published controlled trials. Parent Child Interaction Therapy received the highest rating as "evidence- based" with evidence from both research and community-based trials. Although not written specifically for this demographic, there are elements of these models which are obviously applicable and these have been adapted for the BB program.

In developing an intervention specifically for this population, it was decided to add psychoeducational components. The effects of trauma were explained using the research of Bruce Perry and of attachment disruption using concepts of researcher Patricia Crittenden. The discussion of the effects of grief and guilt is based eminent psychiatrist, Karl Tomm. The most innovative component, the Black Box metaphor itself was based on many years of clinical experience and borrows from the concept of Externalisation from Narrative Therapy, developed by Michael White.

The development of Black Box Parenting involved focus groups of parents involved in welfare services (N=15) (Osborne, Sng, Kelly&Ng, in progress) and a pilot of the program with parents in substance abuse rehabilitation facilities (N=31) (Torres, Sng&Deane, 2015). After participation in the pilot program, parents showed a significant decrease in guilt regarding their relationship with their children ($p<0.5$) and 93% found the Black Box metaphor useful. One participant said they had learnt that "stuff isn’t pushed aside that’s forgotten. There is a storage and that can foster understanding where real concerns come from".

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THINGS TO KEEP IN MIND

One of the clearest themes which emerged from the various conversations was the ever-present need for parenting assistance after escaping a situation of domestic violence but lack of appropriate programs for this group. It was mentioned in both the UK and USA that mainstream programs were often not only ill suited to this population, but actually could be detrimental. Survivors often reported they were being asked to accomplish parenting tasks that they could not possibly succeed at. Whilst all practitioners agreed it is sound practice to ask a parent to provide predictability via clearly stated limits and rules, many identified with my own clinical experience where many women feel their failure to do so is completely demoralising. I explained the part of the Black Box Parenting that encourages parents to consider themselves when they think about reward charts and breaking down tasks into achievable goals. I explained that sometimes we would say, "think about the easiest day to be 'good' parent – maybe it's a Wednesday because it's the most calm. Let's just start with doing these parenting skills on a Wednesday, and work from there". This was particularly enthusiastically received by one therapist at Beacon House who talked about the importance of giving parents permission to "do nothing" if they did not have resources to be changing all their parenting practice that day. This is a good example where this kind of group might differ markedly from a mainstream parenting group where consistency is all. While it may be the long-term goal, asking a survivor parent who is still living in a shelter, or in a protracted custody battle, or still in fear for her/his life to be calm enough to follow through every day with their child can actually set them up for failure. Whilst, of course, all practitioners believed great parenting was possible for survivors of violence, it is particularly important in this population to give permission to start small.

At Beacon House, the importance of the "train the trainer" curriculum for Black Box Parenting was raised. In the UK, as in Australia, many of those who work with disadvantaged families may be new graduates or, in the case of rural locations, counsellors who are, by necessity, generalists. Therefore, it was raised that the training of group facilitators needed to include discussion about *how* to the run the Black Box Parenting Program as much as *what* should be talked about. The importance of listening, not just teaching information, was raised. This is consistent with the content of the group with speaks of the damaging effects of shame and tries to use the Black Box metaphor to encourage parents to see their difficulties

make sense given the experiences of their family. However, this is not always easy, particularly with fathers who may have been the perpetrators of the violence. Therefore, the therapeutic stance of the facilitator is very important in engaging parents and giving them a space where they might not feel blamed or defensive. Only in such a space is real change possible.

CHANGES TO INCLUDE IN THE REVISION OF BLACK BOX PARENTING

Previous Participant Experience – The Power of Peers

The School of Professional Psychology in Chicago has a strong focus on Community Psychology – understanding that treatment often requires the use of "natural supports" such as a person's neighbours, family or religious community. This idea is particularly relevant in this population of parents who often express strong feelings of isolation and the absence of supports such as extended family. Often these parents have no contact with at least one side of the family and have often had to move away from their existing social networks in order to escape violence. In the case of the refugee and immigrant families seen by Apna Ghar, this is particularly pertinent. This was acknowledged by multiple service providers as a challenge. One idea to assist this issue is the use of other parents with similar life experience as peers or mentors. However, this was often on an ad hoc basis, such as seen in Deborah's Place where Melissa, a previous resident, regularly returns to assist in the kitchen and chat with the present residents.

Rebecca Rudge described the intention to ask previous participants to return to the group to speak of their experience. She felt this would be particularly powerful as she had noticed that many parents had begun the group feeling reluctant to be there but had become very engaged by the time they had finished, recognising the impact of the group on themselves and their children. One suggestion was to record the experiences of previous group participants and share these in the pre-group session where the facilitators met with the parents one-on-one before the group started. I felt that this was a practical way of managing this and was likely to increase the motivation and engagement of parents before the group begins. This is an idea easily incorporated into the Black Box program.

Discussion of Sociocultural Influences – How Did I Get Here?

Community Psychology also strongly recognises the strength of sociocultural influences on things like domestic violence. In Chicago, Assoc Prof Langtiw described a phenomenon where African American women such as herself were very aware of the overrepresentation of African American males in the prison populations of their city. Therefore, some felt that reporting their partner's abuse of them was "just one more black man in prison". Therefore, many tried to avoid using the justice system. Likewise, Taylor Jasper described working with an African American woman who had her children removed by protective services for her punitive parenting. However, she described how in that particular neighbourhood, a mother's desire to have strong and unbreakable limits was actually, in some way, reflective of a positive desire to keep her children safe and alive. In the UK, Heather Carmichael described a subsection of family violence seen in immigrant communities known as "honour violence", where women were punished for doing things which were supposed to have brought shame upon the family. She also described an increase in "ladette behaviour" where young women were becoming increasingly intoxicated and violent in an imitation of the typical "lad" behaviour that has existed in England for a long time. They used a video entitled "Dear Daddy" to discuss how a father's attitude towards women might influence that of his children and described it as a powerful tool for sparking discussion. All of these examples point to a need for Black Box to have some capacity to discuss the influence of sociocultural factors on violence and the difficulties in recovering from it. It became apparent to me that this would be particularly important in Indigenous and Culturally/Linguistically Diverse populations. It was also clear that it would not be possible to write content that would applicable for all and perhaps a section where the facilitator could just lead a discussion, using a few discussion questions, would be more real and powerful for participants.

Affect Regulation – Parents Managing Themselves So They Can Manage Their Kids

The meeting with Jana Pressley at the JRI in Boston offered a strong structure for post-trauma work. Specifically, the Affect Regulation Competence Model offers skills to children and their parents in managing affect. Jana described these skills as "downregulating" and "upregulating". Like the Black Box program, this model charts different zones of arousal with the exception that the ARC model includes a "Blue Zone" which is when a person is completely lacking in energy or sleepy. The

importance on keeping therapy in the "Therapeutic Window", a concept first written about by John Briere, was discussed. However, Jana pointed out the idea Pat Ogden proposes of therapy actually trying to expand the therapeutic window so that the client is able to tolerate a greater range of affect. Jana and I discussed how relevant this concept was when working with parents who have experienced violence. I observed that when we had started running the Black Box groups some parents had said they understood all the concepts and thought they found them useful but often failed to implement the strategies when they were needed due to their own heightened states of arousal. This was particularly true of parents who found their children's aggression triggered traumatic flashbacks of the abuse they had suffered from their former partners. Jana offered a structure for asking the parent to "play scientist" and use their curiosity in finding what techniques worked to allow them to manage their own affect before they could help their children manage theirs. She suggested a kind of "toolbox" of affect regulation activities including physical grounding activities, such as breathing exercises, as well as sensory input. However, she framed these in the larger idea of parents searching for the answer to this question: "When am I most vulnerable to becoming dysregulated?". In the language of our program, "When is my Black Box biggest?". Once they understood their vulnerabilities, a parent could then plan for those times by asking:

1) "What do I need to do before that time?
2) What techniques can I use in the moment?
3) How do I get back online after a blow up?
4) What ongoing self-care do I need to practice in order to leave myself less vulnerable? "

Of course, this role as "scientist" or "detective" can come more easily to some parents than to others and the ability to analyse when things might go awry and construct a useful plan is extremely challenging. The role of the therapist as a collaborator in this was discussed, particularly for parents who were still struggling with active post-traumatic symptoms. Jana Pressley suggested some very simple questions for parents to ask themselves, such as "What does my child's face look like, just before she has a blow-up?". Heather Carmichael and Rebecca Rudge spoke of the use of video recorded interactions to assist coaching parents. Speaking from an attachment point of view, they spoke of the Video Interactive Guidance model. Here the child and parent are filmed as they play together. The therapist then edits

together three very short (usually a few seconds) interludes from the interaction where there was an attachment-rich exchange between child and parent. The therapist then shows this edit to the parent, narrating as they go. For instance: "See how when he dropped the rattle, he looked straight at you. I wonder why he looked at you when he needed help". Whilst it might not be plausible to use video tape in the Black Box Parenting Program, it is possible to speak about these larger concepts in the facilitator training, allowing clinicians to consider what individual and family therapy might be a useful adjunct to the group component of the treatment. The JRI gave an example of this in their ARC program for individual child work which includes affect regulation skills but also relational skills (what are my needs and who can I ask to help me get them met?), executive function coaching in planning, inhibition and so on, self-development and identity, and life narrative work.

Engaging Fathers

I also spoke with Jana Pressley about our difficulty in engaging fathers in the current form of Black Box at Grand Pacific Health. In an earlier pilot of the program, we had run the group exclusively with fathers in drug and alcohol rehabilitation facilities. Whilst there were some practical difficulties with this venue, the feedback from the participants was that they strongly desired parenting assistance and that they found the content of the program very useful. In a more mainstream service context, the majority of participants are mothers and the engagement of fathers or step-fathers is extremely limited. Jana and I discussed the great value of safe involvement by male caregivers in children's lives – a finding supported by the literature as well as the clinical experiences of the both the teams we manage. We both identified the frequent reports of mothers that their ex-partner was not "on the same page" when it came to parenting and that this discrepancy often intensified as the mother sought to implement some of the strategies contained the Black Box program. As a result, the child often experienced unpredictability and the value of implementing new parenting skills was undermined by the differing approaches of the parents. Amrita Anjrah from Apna Ghar pointed out that this was particularly prevalent in some of the immigrant and refugee families where the father was traditionally the disciplinarian and the mother more nurturing. In family therapy, this is often referred to as a "hard/soft split" and a cycle observed where the father's judgement of the mother as a "pushover" leads him to be even more strict, leading the mother to become even more "soft" to compensate for what she considers to be too much harsh punishment. This leads to an escalating cycle of discrepancy between the

parents. Amrita observed that in their refuges, the absence of the father might also mean the absence of rules and limits for the children, leaving them lacking in predictability and the feeling that adults cannot be trusted to be in charge.

I explained to Jana that we often had only one phone call or session with the father but she described a better engagement by male caregivers in the children's trauma treatment program. When we unpacked why this might be, two factors emerged. Firstly, the very strong ethical stance of all clinicians in the JRI team that fathers were valuable, not just because of what they could do for their children, but because they were human beings, deserving of consideration. Upon reflection, I was not able to say that I had ever discussed this concept with my team. In fact, I knew in myself that working with fathers who were or are very aggressive to their ex-partner had often made their humanity hard to see. Jana suggested discussing with the team the concept of perpetrators as often being victims of abuse in their own childhoods. She offered the illustration of thinking of a male child in our present practice and imagining he did not receive the help he needed to recover from his experience of violence. Holding that child in mind as he grew up and was failed by the system really brought to life for me a different way of seeing abusive fathers. Jana mentioned some of the prompts she found helpful including: "Talk me through your decision to become a Dad". Jana suggested that it would be important that clinicians in my team have permission and space to name the experience of working with fathers who can be aggressive to their families and even to clinicians. Of course, we both acknowledged that there was no room for naivete in this work and the importance of keeping firm boundaries when needed to keep everyone, including ourselves and our teams, safe.

Secondly, following on from this concept, Jana explained that JRI had a set of clearly delineated principles that underpinned this service, including statements like "We think all carers want the best for their kids" and "When carers have current difficulties, this is often related to pain from the past.". These statements were explained to fathers on the phone at the first contact. We theorised that this might alleviate the anxiety some men might have that treatment would be about blaming them and devaluing their bond with their child. It also, I noticed, opened the door for men to speak about some of their own experiences on a deeper level, should they choose to. This is a particular phenomenon I had observed in my own short contact with fathers, that they were often comfortable discussing the practical aspects of

what might occur in therapy but did not give any sign of wanting to open up. This meant that we often had amicable but not particularly powerful conversations. Whilst it would take some team discussion to arrive on the few tenants we felt needed to be stated to all participants, I felt this idea was likely to be useful in the Black Box Program and hopefully will assist our work with engaging fathers, not just for the sake of their families but also for their own sakes.

Future healthy relationships – "Just What We Need".

I spoke with Heather Carmichael and Rebecca Rudge about our observations that some women who had escaped abusive relationships were vulnerable to being involved in unhealthy and sometimes violent relationships in the future. Rebecca described a group she is facilitating called "Just What We Need". This program is based on the model of Human Givens Therapy and looks at the nine emotional needs that all humans share, for example Autonomy. This group then looks at how the experience of domestic violence affects these needs. The aim of the group is for participants to have some insight into how they might meet these emotional needs in safe and healthy ways, without needing destructive relationships.

Children who live in these families also have these needs and suffer these effects. In speaking about parenting after violence, we discussed how sometimes the needs of the parent and needs of the child might actually be in conflict and it becomes necessary to compromise. For instance, the parent might have a need for space while the child has an increase need for closeness. Therefore, it is necessary to consider how the child or parent might have these needs met in some other way, perhaps using another adult or service provider. Rebecca pointed out that after an escape from violence, many parents were focusing on what Maslow would term the "basic needs" such as safety. She used the metaphor "bricks in the wall" to describe meeting these needs. She described how many group participants find that when these basic "bricks in the wall", like safety, are not solid, the wall often collapses. Therefore, she described the work of "scaffolding" these parents for a time but that eventually, they are the ones who need to put the bricks back in the wall.

Whilst it is perhaps not practical to use the "Just What We Need" program, I liked the concept of talking about emotional needs and having a realistic discussion about how these are difficult to meet in our children when we feel they are not being met for ourselves. I feel this would add to the relevance of Black Box Parenting for this

population, recognising that this topic is not discussed in mainstream parenting programs.

Practical Matters – File Notes

One of the practical questions I asked the people I met on my trip was how they kept file notes on their group participants. This is complex in the Black Box Parenting Program as we are dealing with parents but often have a file under the child's name. Unless there are court orders, parents not involved in treatment will still have full access to the file of their child. Therefore, they would often have access to notes regarding what an ex-partner may have shared in group. This presents a particular issue when there are court proceedings or custody disputes regarding the children. Different services handled this in different ways, some had files kept by the social services who referred the parents, some had separate files for parents and children but this was more work for clinicians, who had to write their notes in different files. The purpose of file keeping was discussed and the answer was usually that it was to provide a record for the treating to clinician to remember what had been said or to communicate to a new clinician who many need to take over the case. With this in mind, many services said that if there was one child file, they would be extremely general in what they wrote regarding information shared by either parent. For example, instead of writing "Mother shared details of sexual assault from last April", to write "Mother discussed past incident which might effect present parenting". It remains to be seen how we manage this particular dilemma at our service, but it was useful to have a number of approaches discussed.

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CONCLUSION

This report represents the main learnings from the trip, although there were many more incidentals lessons learnt. However, one of the most valuable parts of this fellowship was the ability to take time to consider the work I am already doing and how that might be improved through reflection and by the input of the many generous experts who agreed to speak with me. I am extremely grateful to the Winston Churchill Memorial Trust for such a rare and extraordinary opportunity. I would also like to acknowledge the support of Grand Pacific Health in releasing me from my work duties for this fellowship.

RECOMMENDATIONS

In response to these learnings, I will make the following changes to Black Box Parenting Program

1) Harness the powerful stories of parents who had previously completed the program.
2) Allow time to discuss the sociocultural influences on violence and parenting including the role of gender.
3) Normalise the need to work on affect regulation skills in parents, so that they can help children do the same.
4) Improve our engagement with non-participating parents, most commonly fathers.
5) Allow time to discuss emotional needs and how these might be met, including how the denial of these needs can leave parents (and children) vulnerable to being involved in unhealthy relationships in the future.

In terms of the national stage, I feel that many of the challenges faced by my own practice were echoed in the experience of my international colleagues. Therefore, it would be advantageous for those practicing in this area to be sharing knowledge and ideas. This is not easily accessible to practitioners working outside of the academic settings. Whilst journal articles can be useful, the are often not read by practitioners on the front line, especially those working in rural areas who are required to be more generalist in their practice. Specialists may find keeping up to date on the

latest thinking in this area much easier than a practitioner who is being called upon to treat any number of presentations.

Professional conferences provide an opportunity to share our idea and for the sharing of findings such as those detailed in this report. I have already been accepted to present these findings at the Australian Association of Family Therapy conference in Sydney on October 11th and 12th. This conference is well attended by practitioners, not just academics or policy makers. It is my intention at this presentation to not only present my findings, but also discuss with the listeners the process of developing up a community of practice in this area. It is clear that isolative practice in this field has led to some wasted effort in "reinventing the wheel" in some areas and some simple and effective ideas being unavailable to the all practitioners on the ground. Gathering techniques to combat this professional isolation is one of my strong recommendations.

Lastly, there is a paucity of research into what is and is not effective in this population. Particularly with regards to the ultimate long-term goal of breaking the cycles of intergenerational violence. We know that that exposure to DFV in childhood leaves many children vulnerable to being victims or perpetrators of DFV in adulthood. However, we know that around one third of children who witness DFV are able to cope well and go on to have healthy lives. What makes this difference? We know that their relationships with the parents play a part but how do we support parents to build the kind of relationships that insulate a child from these cycles of violence? The answer is still unclear and so my final recommendation is for both short-term and long-term evaluation of this intervention so that we can see if these pivotal relationships are being truly improved. If so, we can confidently say that we are having a significant effect on the intergenerational cycles of family violence and have succeeded in giving the next generation a greater chance than the last at happy, safe, thriving lives.