Child to Parent Violence and Abuse:

Understanding the Types of Traumas Experienced by Families and Whānau

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June 2026

Dedication

To all parents, caregivers, and whānau living with Child to Parent Violence and Abuse. Your experiences are too often unseen, minimised, or misunderstood. This report is written to give voice to your lived realities, acknowledge both the harm and the strength carried within your journeys, and contribute to greater understanding the types of trauma associated with living with violence from your child.

Thanks to:

Jonathan Tautari for his wisdom and cultural insights.
Olivia Bloom for her continued support in our CPVA mahi.

Purpose of the report

This report is intended for government departments, organisations, and professionals who work with families in the community, including those experiencing family and sexual violence. It is also intended to reach parents and caregivers living with Child to Parent Violence and Abuse (CPVA), helping them understand that the experiences they are facing are not their fault, and that their responses, which are often dismissed or minimised are often reactions to trauma.

The report aims to:

1. Examine CPVA through a trauma-informed lens that recognises the cumulative and overlapping forms of trauma experienced by parents, caregivers, siblings, and whānau.
2. Highlight gaps in current systems and service responses, including the disconnect between statutory recognition under the Family Violence Act 2018 and the realities of families' lived experience, where interventions can inadvertently minimise harm or misinterpret trauma responses.
3. Advocate for relational, culturally responsive, and trauma-informed practice that moves beyond individualised approaches and towards support that prioritises safety and healing for the whole family, supported by sustained professional training and systemic change.
4. Integrate lived experience with existing literature to discuss diverse types of trauma that families may experience to provide a coherent, trauma-informed framework.
5. Address the gaps in literature related to systemic minimisation, blocked care, disenfranchised grief, and the long-term relational impacts on families experiencing CPVA.

VisAble recognises that many other people will be interested in the report. To assist with access and understanding, a Glossary of the terms is included at the end of the report. An Easy Read version will be made available on VisAble's website.

https://www.visable.co.nz/cpva/services-and-resources.

The importance of the Pōhutukawa

Through powerful winds and harrowing storms, the pōhutukawa tree, with roots penetrating deep into earth and rock, stands resilient, holding sometimes fragile and craggy cliffs together. Yet, after facing the harshest weather, the tree explodes into a summery bloom of deep red flowers.

For families experiencing CPVA, the pōhutukawa provides a powerful and deeply meaningful symbol. CPVA often exists in places unseen by others. Behind closed doors, whānau can experience fear, grief, exhaustion, and isolation while still holding immense love for their child. Like the pōhutukawa growing from rocky cliffs, many parents and caregivers continue to hold their families together under extraordinarily difficult and complex circumstances.

The twisted roots of the pōhutukawa reflect the complex realities surrounding CPVA. Violence does not emerge from a single cause. It is often intertwined with trauma, disability, neurodiversity, mental distress, unmet needs, and experiences of disconnection. The sprawling and gnarled pōhutukawa roots remind us that our understanding and support of whānau facing CPVA must reach into the foundations, beneath the behaviour, judgemental perspectives and misconceived commonly held narratives. It challenges us to look deeper, engage more thoughtfully, and carefully hear the lived experience of parents, caregivers, and whānau. If we have an open heart and mind to do this, we will provide meaningful support to parents and whānau on their pathway to healing and transformation.

Jonathan Tautari
Chief Executive, VisAble

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About VisAble

VisAble is a disabled person-led organisation in Aotearoa New Zealand. We work to strengthen national capabilities across agencies and sectors to prevent and respond to violence, abuse and neglect affecting disabled people and their whānau.

Our focus includes tāngata and whānau whaikaha Māori, disabled people, Adults at Risk, tagata sa'ilimalo and āiga-tele, d/Deaf, neurodivergent people and their families.

- **This includes parents/caregivers who are living with Child to Parent Violence and Abuse (CPVA) and therefore can be an Adult at Risk.**

VisAble enables safer communities, providing advice, guidance, networking, training, resources and follow-up support.

- **VisAble works across sectors and communities to raise awareness of the impact of family and sexual violence (FVSV) on disabled people and their whānau.**
- **We work to strengthen organisations' capabilities, enabling them to prevent and respond effectively to FVSV violence, abuse, and neglect.**

Partnering effectively with disabled people and their whānau is essential to providing high-quality services and achieving outcomes with and for people. We do this by:

- **helping make our services, and other organisations' services, more inclusive of disabled people, and more accessible to them**
- **improving safeguarding / whakahaumarutia capability, so that those organisations working in family and sexual violence (FVSV) prevention and response are better able to detect, prevent and stop violence, abuse and neglect**
- **providing specialist knowledge, advice, skills and resources in safeguarding practices to those organisations who are responding to situations of concern**
- **promoting the rights of disabled people**
- **jointly developing strategies to ensure culturally safe, whānau-centred responses.**

VisAble's commitment to Te Tiriti o Waitangi ensures that our work contributes towards equitable outcomes for Māori. We also extend our commitment to the Pasifika and disabled communities who are underserved and face significant inequities.

For more information about VisAble, see https://www.visable.co.nz/about-us .

Child to Parent Violence and Abuse: Understanding the Types of Trauma Experienced by Families and Whānau

Introduction

Child to Parent Violence and Abuse (CPVA) is a complex form of family violence. It includes a wide range of behaviours used by children and adult children towards parents, caregivers, siblings, and sometimes wider whānau, such as:

- **Physical abuse**
- **Emotional abuse**
- **Verbal abuse**
- **Sexual abuse**
- **Financial abuse**
- **Digital abuse**
- **Coercive control**
- **Damage to property**
- **Harm to pets**

Despite its prevalence and seriousness, CPVA is under-recognised, poorly understood, and inconsistently responded to within existing service frameworks in Aotearoa New Zealand.

Families and whānau living with CPVA are frequently exposed to multiple, overlapping, and cumulative forms of trauma that affect physical, emotional, cultural, social, and spiritual wellbeing. These impacts are shaped not only by violence within the home, but by relational rupture, chronic stress, and repeated exposure to systems that struggle to recognise or respond to the realities of CPVA. The cumulative nature of trauma is a key theme explored throughout this report.

Although CPVA falls within the statutory definition of family violence under the Family Violence Act 2018, service pathways remain largely oriented toward intimate partner violence or parent

to child abuse and legislative recognition has not translated into safe, trauma responsive practice for families and whānau living with CPVA. Parents and caregivers frequently report disbelief, and blame, that overlooks family safety, contributing to the cumulative harm.

For Māori whānau, the impacts of CPVA and systems failure are intensified by the enduring effects of colonisation, intergenerational trauma, cultural disconnection, and structural inequities.

Drawing on empirical evidence, international research, and lived experience, this report examines the multifaceted trauma associated with CPVA and the significant unmet needs within this community. It demonstrates a need to shift beyond existing approaches, or lack thereof, and towards relational, trauma-informed and culturally grounded practices. The Practice Framework for Professionals presented at the end of this report outlines the principles and capabilities required to reduce harm and support sustainable wellbeing.

It is important to note that the factors contributing to CPVA arise from a complex interplay of individual, relational, developmental, and systemic variables. There are common myths and assumptions that CPVA is primarily a response to children experiencing harm themselves, or that it is caused by disability, neurodivergence, or mental health difficulties. While these factors may be relevant in some cases, they do not provide a complete explanation. Not all children who engage in CPVA will have experienced trauma, nor will all be neuro disabled, neurodivergent, or have identifiable developmental or mental health needs. Understanding each family's specific context, strengths, needs, and risks is fundamental to ethical and effective support.

For the purposes of this report, the term 'children' includes adult children, as CPVA frequently continues into adulthood.

Understanding Types of Traumas in CPVA

Trauma is not defined by the event itself, but by its lasting impact on the brain, mind, and body when an experience overwhelms a person's capacity to cope (Van der Kolk, 2014). For families and whānau experiencing CPVA, trauma is often layered and cumulative, affecting each family member differently. Trauma may also arise from systemic factors such as barriers to accessing appropriate services, an issue examined in detail later in this report.

Parents and caregivers experiencing CPVA are often unable to leave the home or disengage from the relationship when the child is under the age of 18, nor can they abdicate their legal, moral, and caregiving responsibilities. This enforced proximity to ongoing harm creates a unique and inescapable trauma context, in which parents or caregivers must continue to provide care and protection while being exposed to violence.

CPVA frequently intersects with other family adversities that may occur simultaneously, including intimate partner violence (IPV), separation, illness, or bereavement. Any existing trauma, such as childhood trauma, can further amplify the impact of CPVA, contributing to ongoing and deepening distress. This can undermine emotional regulation, mental health, and a sense of safety for the whole family, highlighting the need for trauma-informed, whānau centred approaches.

This report is not exhaustive and does not attempt to capture every possible form of trauma. The types of traumas discussed have been selected because of their relevance to CPVA and are informed by lived experience. Parents or caregivers and other whānau may recognise additional or different trauma experiences in their own lives or family contexts, reflecting the highly individual nature of trauma and its impacts. It's useful to share these experiences with trusted professionals, who are then better equipped to provide support, based on the full context.

We recognise the systemic constraints, competing priorities, and limited resources that make responding effectively a challenge.

Primary Trauma

Primary trauma: *The emotional, physical, or psychological impact experienced directly by a person who has lived through a harmful, threatening, or distressing event.*

Primary trauma occurs when parents, caregivers or whānau members experience direct physical or emotional harm, including coercive control, from their child. Many live in a constant state of fear and hypervigilance, often triggered by the unpredictability and intensity of their child's behaviour. When people talk about violence, we often think of physical violence. While physical violence may be easier to recognise and document, the often invisible forms of abuse, such as verbal aggression, emotional manipulation, and coercive control, can be equally damaging, affecting parents' or caregivers' sense of safety, wellbeing, and self-worth. Recognising this is essential to understanding that violence is not limited to physical harm but includes a broader range of behaviours that can be just as harmful.

One parent described the intensity and profound loss of loving a child who is violent:

> *"So, we've lived with a lot of child-to-parent violence ... it can be very extreme … Our daughter ended up back in the care system because it was too unsafe for the rest of the family for her to live at home, because we were getting violent instances that would last for four or five hours each day towards us. And this went on for years." (FASD-CAN, 2025, p. 26).*

In 2025, VisAble carried out New Zealand's first survey of parents and caregivers living with CPVA. The report, titled *The Impacts of Child to Parent Violence and Abuse in Aotearoa New Zealand* (Tempest & Bloom, 2025), found that 19% of parents and caregivers reported experiencing violence from their child multiple times each day, and a further 42% reported daily incidents. One parent reported, *"I have an impaired physical ability due to an injury 4 years ago that never healed"* (Tempest & Bloom, 2025, p.15), highlighting the long-term physical consequences of sustained CPVA. When services fail to recognise or validate parents' experiences, the problem is often misidentified as parenting failure, behavioural issues, or attachment difficulties rather than violence and coercive control. This mis-framing shifts attention away from the harm being experienced and leads to inappropriate responses that do not address safety. As a result, parents can feel blamed or dismissed, which may cause them to disengage from support services altogether and stop seeking help.

Secondary Trauma

Secondary trauma: *The stress or emotional impact experienced by someone who is exposed to another person's trauma, such as a caregiver, parent, or a professional who is supporting someone who has been harmed.*

> *"Trauma affects not only those who are directly exposed to it, but also those around them"* (Van der Kolk, 2014, Prologue).

Parents and caregivers can experience secondary trauma through repeated exposure to their child's trauma, emotional dysregulation, and distress, particularly when caring for children who are neurodivergent, have neuro-disabilities, or are care-experienced. Gibbs, (2024) and Hood and Hume (2024) found that neurodivergent children or those with neurodevelopmental disabilities frequently interact with environments that do not accommodate their ways of thinking, processing, or responding. Their communities, including schools, health systems, social services, friends, and wider whānau, often fail to understand their perspective. As a result, children may experience stigma, social rejection, bullying or inadequate and at times inappropriate support or interventions from the systems meant to support them. This reinforces feelings of inadequacy and failure. The lack of external accommodation can be a contributing factor of CPVA towards the primary caregivers.

When advocating for their children, parents and caregivers of neurodivergent and neuro-disabled children face significant barriers to accessing external support within their communities (D'Arcy et al., 2024). As there is usually a deep bond between parents or caregivers and their children, this suffering is often internalised and can become a source of trauma through witnessing their child trying, and often failing, to navigate an inequitable society. D'Arcy et al., (2024) found that the combination of their child's complex needs and systemic obstacles has a substantial impact on the parent or caregivers' wellbeing and sense of identity. These barriers contribute to their experiences of secondary trauma. Emerging evidence further highlights the extent of this impact. Duncan, Fearon, and Woolgar (2024), carried out the first study to specifically focus on adoptive parents and found that they all had high levels of secondary trauma symptoms from parenting children who also had experienced Adverse Childhood Experiences (ACES).

> *My daughter called me … and we went round there, and she had been self-harming and her legs and arms, [they] are covered in self-harm marks. But she's not entitled to see anyone under mental health. No one will see her….. What about our rights to a safe, decent life as well? … that it's not happening for any of us. If I'm honest, … I don't have a happy life. I don't see a future for my family. I just see more of the same, because we've lived in such crisis mode for so many years."* (FASD-CAN, 2025 p. 27).

This example illustrates both primary and secondary trauma, as well as the way these experiences can overlap within families and whānau affected by CPVA. In this case, the parents are directly traumatised by witnessing their child's self-harm and managing repeated crisis situations. The secondary trauma arises from exposure to their daughter's trauma. In many CPVA contexts, these forms of trauma are not separate but deeply intertwined.

Secondary trauma can persist even after the child reaches adulthood and is no longer living at home. Parents and caregivers may experience significant distress as they observe, often from a distance, how the patterns of violence that were once directed towards them have carried over into their adult child's intimate partner relationships. Even as their child navigates adulthood, they may continue to face barriers to inclusion, support, and equitable opportunities. Witnessing their adult child experience systemic inequities, discrimination, and exclusion can exacerbate parents' or caregivers' distress, particularly when these challenges echo the difficulties the family faced earlier in life.

Professionals can acknowledge secondary trauma in the same way as other forms of trauma by naming it clearly and recognising it as a valid and real response to prolonged exposure to distress. They should treat parents and caregivers with empathy and respect, validating their experiences without minimising or overlooking the impact on their wellbeing.

Filial Trauma

Filial trauma: *The emotional, psychological, or physical harm experienced by a parent or caregiver as a result of violence, abuse, or harmful behaviors from their own child.*

The term “filial trauma” describes the complex, relational trauma that can arise within parent–child relationships. Tremblay and Page (2023) highlight that parent–child relationships are built on the premise of unconditional love, connection, trust, and emotional safety. These attributes often apply regardless of whether the parent or caregiver and the child are biologically related, as all parenting is fundamentally relational.

When CPVA is present, it can inhibit the parent’s or caregiver’s ability to nurture their child, who may often be in a dysregulated state and resist attempts at connection through directing violence and abuse toward them. The absence of emotional reciprocity, which is central to all meaningful human relationships, can undermine the caregiver’s sense of self-esteem and identity as a parent. Over time, parents and caregivers may begin to doubt their worth and effectiveness, leading to intense feelings of helplessness, isolation, shame, despair, and loss of identity as a parent:

> *“I had suicide ideation and loss of identity. I was a non-person inside my home due to the control - and outside my home, I was blamed for the violence by so many people both personally and professionally”* (Tempest & Bloom, 2025, p. 5).

Repeated rejection at attempts to establish a parent–child connection can generate ambivalent feelings within parents and caregivers, who may alternate between feelings of intense love for their child and dislike towards them (Tremblay & Page, 2023). This emotional ‘flip-flop’ often produces guilt, shame, and personal feelings of failure:

> *“I feel very ashamed that my child behaves this way towards me. I blame myself that our relationship is so dysfunctional and he treats me this way”* (Tempest & Bloom, 2025, p. 17).

Filial trauma compounds the mental health challenges experienced by parents and caregivers living with CPVA and is associated with post-traumatic stress disorder (PTSD), anxiety, and depression (Champagne, 2025). This emotional complexity is rarely acknowledged in mainstream parenting discourses. Our social systems and services often overlook filial trauma and place unrealistic expectations on the caregiving capacity of parents and caregivers raising children with high and complex needs. These expectations can exacerbate isolation and stress, particularly when professionals do not fully understand the depth and complexity of the parent–child relationship. The strong relational bond shaped by love, responsibility, and commitment can make it difficult for parents to prioritise their own safety or disengage, yet this is often misunderstood or underestimated in service responses

Understanding filial trauma and its impacts will help professionals respond with greater empathy, recognise the complexity of the parent–child relationship, and provide more balanced, trauma-informed support that prioritises the wellbeing of both caregivers and children.

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD): *A condition that can develop after someone experiences or witnesses a traumatic event. It can cause flashbacks, intense distress, anxiety, and changes in thoughts, feelings, or behaviors as the person processes the trauma.*

Certain forms of trauma are more likely to result in PTSD, particularly those involving deliberate harm by others, such as physical or emotional abuse, including CPVA.

People with PTSD experience a range of distressing psychological, emotional, and physical responses following exposure to trauma (Mental Health Foundation, 2022). In a CPVA context, these responses often show up in ways closely linked to parenting and the home environment, for example:

- **Intrusive thoughts and re-experiencing:** parents may have recurring, unwanted memories of violent incidents or self-harm, sometimes feeling as though they are reliving those moments.
- **Hypervigilance and exaggerated startle response:** a common feature of PTSD, this may look like parents "walking on eggshells," constantly anticipating escalation, or reacting strongly to sudden noises such as banging, shouting, or doors slamming.
- **Negative beliefs about oneself or the world:** PTSD can lead to persistent, distorted beliefs. In CPVA, this might include parents feeling they have failed, are "not good enough," or believing their home is unsafe or unpredictable.
- **Persistent emotional distress:** ongoing feelings of fear, guilt, shame, anger, or helplessness are common PTSD symptoms and may be intensified by repeated incidents and lack of support.
- **Sleep disturbance and cognitive impacts:** difficulties with sleep, concentration, memory, and decision-making can arise, particularly when families and whānau are living in sustained crisis.

- **Avoidance:** parents may avoid situations, conversations, or environments that could trigger conflict or remind them of traumatic incidents.
- **Emotional numbing and disconnection:** some individuals with PTSD experience reduced ability to feel joy, love, or connection, which may impact relationships within and outside the family.
- **Dissociation:** a recognised trauma response, where parents may feel detached from their thoughts, emotions, or body, especially during or after distressing incidents.

These responses reflect core features of PTSD, while also highlighting how trauma manifests in the day-to-day realities of families and whānau experiencing CPVA impacting caregiving, sense of safety, identity, and relationships.

When trauma is prolonged or repeated, particularly within close relationships such as those involving CPVA, it can lead to Complex PTSD. Complex PTSD includes additional difficulties with emotional regulation, self-perception, and interpersonal relationships, reflecting the ongoing and relational nature of the trauma.

> *"You feel numb to the amount of trauma that you are going through and at times disassociate yourself in disbelief."*
> (Tempest & Bloom, 2025, p. 15).

In the context of CPVA, professionals play an important role by recognising parents and caregivers as victims of trauma. Without this recognition and support, PTSD can remain unaddressed and may increase the likelihood of depression, self-harming behaviours, and suicidal thoughts.

> *"[I] want to leave or end [my own] life as a way of escaping a situation that [I am] powerless to stop"* (Tempest & Bloom, 2025, p. 13).

Complex Trauma

Complex trauma: *Trauma that happens repeatedly or over a long period, often in close relationships (like family or caregivers), and can affect emotional, psychological, and physical wellbeing, as well as how a person relates to others.*

Complex trauma arises from ongoing violence or abuse in interpersonal contexts. In the context of CPVA, this trauma can be severe and may persist over many years. While complex trauma is frequently discussed in relation to child abuse perpetrated by a parent or caregiver, CPVA demonstrates that it can also occur within the parent–child relationship, perpetrated by the child and with similarly profound impacts.

Complex trauma can deeply affect a person's sense of safety, trust, identity, and self-esteem, often leading to difficulties with emotional regulation and forming healthy relationships. People may experience chronic fear, anxiety, shame, guilt, or feelings of unworthiness, making everyday interactions and decision-making feel overwhelming.

According to the Kezelman and Stavropoulos (2019), complex trauma is more prevalent than is generally recognised, yet it often goes undetected by professionals. This underscores the need for trauma-informed approaches that acknowledge the chronic and multifaceted nature of harm experienced by families and whānau affected by CPVA.

Cumulative Trauma

Cumulative trauma: *The build-up of stress or harm from multiple traumatic events over time, which can have a stronger impact on a person's wellbeing than a single event.*

Cumulative trauma develops when multiple stressful or traumatic events occur over time, slowly overwhelming coping abilities. In families and whānau affected by CPVA, this might include repeated exposure to violent, aggressive, or threatening behaviours, alongside other stressors such as family conflict, mental health challenges, or past trauma. While each incident may not be overwhelming on its own, the overall build-up of these experiences can intensify emotional dysregulation, increase anxiety, and reduce resilience.

Unlike complex trauma, which typically refers to prolonged and often interpersonal trauma occurring over extended periods, cumulative trauma emphasises the gradual build-up of multiple stressful or traumatic experiences over time.

VisAble's parent and caregiver survey (Tempest & Bloom, 2025) shows that parents and caregivers identified multiple health and wellbeing impacts associated with living with CPVA. The experiences of physical and emotional pain contribute to complex, cumulative trauma that affects the whole body, including the nervous system, stress response, and long-term physical and psychological health.

Physical impacts:

- Muscular pain
- Headaches
- Heart palpitations
- Physical injuries from the violence
- Sickness / general unwellness
- Exhaustion

Emotional impacts:

- Shame / guilt
- Fear
- Depression
- Anxiety
- Suicidal ideation

Social impacts:

- Isolation
- Feeling blamed
- Being judged
- Reduced contact with family and friends
- Reduced ability to work or having to stop work

Spiritual/Cultural Impacts

- Lack of belief from others undermines confidence and self-worth.
- Damage to the home and degrading behaviours reduce pride and sense of safety.
- Daily life is affected by needing to prepare for potential incidents.
- Experiences influence major life choices, including decisions about having children.

These findings highlight the multi-dimensional impacts of CPVA that affect parents' and caregivers' physical health, emotional wellbeing, and social functioning, and contribute to cumulative trauma over time.

VisAble's survey (Tempest & Bloom, 2025) further highlights how cumulative trauma develops over time, with CPVA often persisting beyond childhood and, in some cases, across the lifespan. While 65% of children using violence were under the age of 18, the oldest was 38, demonstrating that parents and caregivers may be exposed to repeated incidents for decades. Nearly half reported that the frequency of violence increased as their child grew older, and 78% stated that the violence was ongoing at the time of reporting. In some cases, neurodevelopmental differences and the impacts of early trauma may contribute to patterns of violence continuing into adulthood, reinforcing the chronic and cumulative nature of these experiences. Given this sustained exposure, families and whānau require ongoing, trauma-informed and relational support to manage risk and strengthen emotional and relational stability over time.

Unexpressed Anger

Many parents and caregivers experience profound anger in response to the violence directed towards them, alongside anger at the persistent lack of support arising from limited understanding of CPVA. This anger often has no safe or socially acceptable outlet and is therefore internalised. Societal expectations position parents as solely responsible for emotional regulation, even in the aftermath of violent incidents, rendering it unsafe for them to openly express anger to wider whānau or to professionals who lack understanding of CPVA. This silencing is further intensified when the violence is framed as being rooted in neurodevelopmental disability, trauma, or both, as parental anger is more likely to be interpreted as intolerance, blame, or rejection of the child rather than as a legitimate response to ongoing harm.

While parents may feel anger towards systems and services, these entities are largely faceless. Individual professionals may be kind, accommodating, and personally supportive, yet parents are simultaneously subjected to the rigid, punitive, or harmful practices of organisations most acutely within statutory, policing and justice system responses. This dissonance leaves parents with anger that cannot be directed outward without risk and cannot be directed inward without cost. As a result, anger is frequently suppressed, contributing to shame, self-blame, emotional exhaustion, and further erosion of parental wellbeing.

Māori Perspectives on Trauma

Te Tiriti o Waitangi (The Treaty of Waitangi) provides the foundation for relationships in Aotearoa New Zealand (Te Pou o te Whakaaro Nui, 2018), guiding interactions between the Crown and Iwi, and shaping the relationship between the government and citizens. Despite its significance, forced assimilation and ongoing cultural oppression experienced by Māori through colonisation have resulted in collective and historical trauma that persists across generations. Colonisation, loss of culture, and systemic inequities have disrupted traditional Māori social structures and wellbeing (Pihama, Cameron, & Te Nana, 2019), yet the ongoing impacts of this trauma are often overlooked in policy and service provision.

Jonathan Tautari, Chief Executive at VisAble (personal communication, October, 2025) explains how Māori understand trauma as a disruption of balance within the individual, whānau, and community, encompassing physical, emotional, and spiritual harm. Filial trauma is experienced not only emotionally but also spiritually, with the concept of whakamā (deep shame) adding further complexity. Violence or emotional harm within the sacred parent–child bond can be understood by the concept of "patu wairua" (to strike or batter a person's spirit). In te ao Māori, abuse, whether physical or emotional, can disrupt spiritual connection and cause disconnection from self, whānau, and whakapapa (genealogy).

In this context, tapu applies equally to both adults and children. When a child uses violence toward a caregiver or parent, the wairua of both is affected. A child engaging in violence can be understood as acting from a place of spiritual disruption or disconnection, where their own tapu and wellbeing have already been compromised. At the same time, violence directed toward an adult breaches the sacred nature of the relational bond, constituting a patu to the parent's wairua and mana (dignity). This reversal of expected roles can intensify experiences of whakamā, spiritual injury, and relational rupture for all involved. Violence by a child not only represents behavioural distress, but a collective spiritual injury, fracturing balance within the whānau and contributing to disconnection that may reverberate intergenerationally unless addressed through collective, culturally grounded healing (Jonathan Tautari, personal communication, October 2025).

Restoring balance therefore requires more than behavioural interventions; it calls for spiritual and cultural healing grounded in tikanga Māori (cultural practices and values). For Māori whānau, healing must be collective, spiritual, and relational, involving intentional reconnection to wairua (spirit), whenua (land), and whānau. Recovery occurs both individually and collectively, guided by Māori cultural frameworks and Kaupapa Māori approaches, with the wellbeing of parents and caregivers, children, and whānau central to restoring connection, identity, and collective wellbeing (Jonathan Tautari, personal communication, October 2025).

Systems Trauma

Systems trauma: *Harm or distress experienced when a person is affected by failures, mistreatment, or harm within institutions or systems, such as schools, healthcare, social services, or the justice system.*

Systems trauma, often described as structural violence (Galtung, 1969), occurs when institutions designed to provide care instead cause harm. Rather than alleviating distress, service interactions can generate additional stress, disempowerment, and emotional harm particularly when individuals must repeatedly navigate systems that lack understanding of lived realities or systemic inequities.

Families and whānau caring for neurodivergent children or those with neurodevelopmental conditions frequently encounter this form of harm. Research highlights persistent gatekeeping, fragmented provision, and inconsistency across education, health, and social services (D'Arcy et al., 2024), alongside a lack of transparency and continuity that undermines trust (Reid et al., 2025). These conditions create an exhausting and unreliable system to navigate, often leaving parents and caregivers feeling blamed for circumstances beyond their control and directed toward inappropriate or ineffective interventions.

Within the context of CPVA, these systemic failures intensify existing harm. Parents and caregivers report being dismissed or blamed by professionals and left without meaningful support (Tempest & Bloom, 2025). VisAble's Survey findings show that only 42% were able to access support, and of those, 67% found it unhelpful. For Māori respondents, this rose to 94%, highlighting significant inequities in service effectiveness.

Lived experience accounts reinforce the damaging impact of these systemic barriers. King (2023) describes prolonged delays, bureaucratic resistance, and a lack of practical support as deeply harmful, noting that system responses can feel obstructive rather than enabling.

In some cases, this systems trauma is experienced as more damaging than the violence itself, particularly when families understand the underlying drivers of behaviour but encounter policy and service responses that fail to reflect these realities.

A key issue is the siloed nature of services. Child-focused interventions often prioritise behavioural management without recognising the violence and trauma experienced by parents, caregivers, and siblings, while family violence services frequently lack specific recognition of CPVA. This creates critical gaps in care and leaves families without coordinated or appropriate support.

As a result, many parents and caregivers are left managing ongoing violence, fear, and trauma in isolation. This support vacuum deepens exhaustion, isolation, and burnout, reinforcing the cumulative nature of harm over time. Addressing systems trauma therefore requires a shift away from compliance-driven approaches toward relational, trauma-informed, and equity-focused responses that acknowledge lived experience, reduce harm, and rebuild trust.

Disenfranchised Grief

Disenfranchised grief: *Grief that is not openly acknowledged, socially supported, or recognised, leaving the person feeling isolated or unsupported in their loss.*

Disenfranchised grief (Champagne, 2025) also known as hidden or unacknowledged grief refers to the experience of grief that is not openly recognised, socially validated, or publicly mourned. This type of grief often arises in families and whānau experiencing CPVA, raising children with neuro-developmental disabilities, or attachment difficulties, where behaviour can be unpredictable and violent. It is normal for parents and caregivers to grieve periodically for the child they thought they would raise, the family life they imagined they would have, the loving nurturing parent they thought they would be, the loss of family, friends and community (due to judgment) and the loss of future hopes, milestones and dreams. These thoughts and emotions are not related to their commitment or deep love they have for their children.

When parents and caregivers' grief is invisible, it is harder for them to process or express themselves leaving many emotionally stuck, disconnecting them from their wider whānau, social circles and community. If they do express their grief, it is often minimised or invalidated with platitudes such as *"Focus on the positives" "God doesn't give you more than you can handle" "You signed up for this when you adopted".* This reflects a form of toxic positivity, where difficult emotions are minimised or dismissed in favour of forced optimism, leaving little space for the reality of grief and distress. These comments, often intended as supportive, may leave families and whānau feeling more isolated as they withdraw further from interactions outside of the home. Disenfranchised grief is further compounded by societal expectations of what constitutes "good" parenting, especially when a child's behaviours are associated with neurodivergence, neuro disability, or trauma.

Grief in caregiving is not a failure. It is a natural, human response to the loss of hopes, dreams, and emotional safety. However, many parents and caregivers can feel that expressing their challenging experiences is disloyal and may lead to judgement or carry a sense of shame for having these feelings at all.

King, 2023 wrote of her own grief:

> *"I am unsure how to heal as the grief is so deep….i have cried every day for the last twelve years"* (p, 215).

Validating this grief is a critical part of healing.

Disenfranchised Grief from Wider-Family Estrangement

Parents and caregivers who disclose CPVA frequently experience victim-blaming, with extended family members often attributing the behaviour to the parent's or caregivers supposed lack of discipline or family dysfunction. This disbelief is compounded by the fact that many children engaging in CPVA mask their behaviour outside the home. This is a pattern well-documented in the neurodivergent and neuro-disability community, who often suppress distress or behaviours in public settings to avoid judgement (Hull et al., 2017; Pearson & Rose, 2021). As a result, extended family may see a 'well behaved' child and assume the parent or caregiver is exaggerating the severity of the situation.

Parents and caregivers often receive advice such as *"you just need firmer boundaries or consequences"* or being told *"they do not do that for me"* which further reinforces parental shame and self-doubt. Many parents and caregivers subsequently withdraw from their wider whānau to protect themselves emotionally, which leads to the profound loss of family support. This presents difficulty to openly mourn because the belief of the wider whānau is that CPVA is caused by the parent or caregiver themselves.

These dynamics share notable similarities with victim-blaming in intimate partner violence (IPV), where the person being hurt is often held responsible for the abuse they experience. Meyer (2016) found that in IPV relationships, the credibility of the person being hurt is questioned, the perpetrator's behaviour is minimised or excused, and well-meaning advice can inadvertently reinforce shame and self-blame. Just as IPV survivors may face disbelief or unsolicited suggestions to *"leave"* or *"change their behaviour,"* parents and caregivers experiencing CPVA often encounter comparable patterns of judgement and minimisation, which can exacerbate isolation and emotional distress.

Blocked Care: A Biological Response to Relational Trauma

Blocked care: *When a parent or caregiver wants to provide love, support, or protection, but feels unable to connect with their child because their child's behaviours or trauma responses overwhelm them, causing emotional exhaustion, nervous system shutdown and/or fear.*

Blocked care emerges when parents and caregivers remain deeply committed to their child but experience high levels of stress in the child's presence (Champagne, 2025). Chronic threat, unpredictable behaviour, and ongoing safety concerns can erode felt trust within the parent–child relationship, leaving caregivers emotionally numb, hyper vigilant, or shut down. While their nervous system is operating in survival rather than relational mode, many parents and caregivers continue to function externally, masking the depth of their internal distress.

Under non-violent conditions, the parent–child relationship activates the brain's attachment system, supporting connection, empathy, and emotional attunement through the release of hormones such as oxytocin, often referred to as the "love hormone" (Shorey, Asurlekar, Chua & Lim, 2023). In families and whānau experiencing CPVA, this biological process can become disrupted. Instead of connection, interactions with the child may repeatedly trigger stress responses, resulting in the release of cortisol, the body's primary stress hormone (Champagne, 2025).

Over time, sustained exposure to fear, unpredictability, exhaustion and harm within the caregiving role can reshape the parent or caregiver's nervous system. Rather than operating from a place of relational safety, parents and caregivers may become locked into chronic survival responses, including fight, flight, freeze, or fawn. This is not a failure of parenting or attachment, but a natural biological adaptation to prolonged threat, particularly in the context of CPVA, complex child needs, and limited external support.

For children who have experienced trauma, this relational dynamic is further complicated by the perception that the caregiver's visible distress, frustration, or emotional pain is a threat. The child may interpret these cues as evidence that the relationship is unsafe or at risk (PATCH, 2025). This perception can rapidly activate the child's own survival response,

leading to heightened dysregulation that may manifest as violence, aggression, withdrawal, shutdown, or attempts to exert control over their environment.

As these patterns repeat, caregivers often adapt in ways that prioritise de escalation and self protection. Many learn consciously or unconsciously that suppressing their own emotions and needs may create a fragile sense of safety within the household. Over time, caregivers may silence their distress, minimise their experiences, and remain emotionally contained. The sustained requirement to prioritise a traumatised child's regulation while being unable to express one's own emotional pain can erode caregiver wellbeing, contributing to exhaustion, nervous system shutdown, and a diminished sense of self.

Lived Experience of Blocked Care

The writer attests to the significant impact that blocked care can have on everyday parenting. Her biological trauma responses affected how she parented her other adopted child, who had prenatal trauma, was neurodivergent, and had experienced childhood adversity after witnessing sustained violence in the home from their sibling. Attempting to adapt her responses to meet this child's needs while she herself was in a state of 'freeze' created conflict between the actions of supporting her child and how her own nervous system was functioning, making daily parenting efforts overwhelming and exhausting.

These challenges were compounded by professional responses that consistently minimised the repeated violence she experienced, sometimes multiple times a day, from her neuro disabled child. During an assessment for disability supports, the assessor told her that she *"needed to get over it and put the hard work in, as you are the adult here."* This response reflected a profound lack of recognition of the impact that sustained violence and trauma can have on daily functioning and on a parent or caregiver's capacity to engage with behaviour support strategies that fail to account for family safety or trauma.

Interactions such as these intensified the writer's feelings of shame and perceived failure, reinforcing a belief that she was letting down both of her deeply loved and wanted children.

Parents and caregivers living with blocked care are frequently too exhausted to engage in meetings to discuss interventions they have already tried and were not effective. The writer has attended multi agency meetings in a professional capacity where parents and caregivers have been blamed for the violence occurring in their homes, based on assumptions that compliance with professional advice would resolve the situation. These responses occurred in the absence of knowledge of CPVA and resulted in guidance that did not align with the realities of living in a home where there is violence, chronic stress, trauma exposure, and nervous system overload.

Without recognition of blocked care as a trauma response, professional interactions can deepen distress and entrench hopelessness. In these circumstances, well intentioned interventions may unintentionally reinforce harm rather than support recovery.

Sibling Trauma from the Violence and Abuse

> *"To this day I have heightened anxiety around my brother. Despite it being a number of years since he has threatened violence towards me, that threat is always there. And the anxiety leaves me scared to disappoint anyone."* (Tempest & Bloom, 2025, p.13).

Within the context of CPVA, the experiences of siblings remain largely overlooked, minimised or ignored by everyone except the parents and caregivers. Baker and Bonnick (2021) note that there are no studies specifically investigating the developmental and psychological impacts of growing up with a violent sibling, despite strong indications that these impacts are significant.

Evidence from broader research on family violence, trauma, and child development has found that children growing up with violence in the home are significantly impacted. The Joint Venture on Family and Sexual Violence (2022) wrote *"This includes a higher risk that children and young people who experience family violence and sexual violence will have poor outcomes in adulthood (primarily poorer health and mental health, a higher likelihood of involvement in the justice system, and poorer socio-economic status" (p.3).*

The extent of harm and trauma to siblings can be severe with them experiencing the range of different types of traumas discussed in this report. VisAble's 2025 survey of the parent/caregiver voice (Tempest & Bloom, 2025) found that 57% of siblings were direct targets alongside the parents and caregivers. Findings from the PEGS (2022) UK survey revealed that 13% of siblings in CPVA households had been strangled or suffocated by the child displaying violent behaviour.

Young children are often unable to leave the house to escape the violence. As they enter adolescence, many attempt to cope by withdrawing to their bedroom, avoiding shared spaces, or spending as little time at home as possible to reduce the likelihood of confrontation. Alongside receiving less parental attention, siblings frequently endure secondary trauma from witnessing verbal or physical assaults against their parents. Some siblings feel responsible for protecting their parent and may attempt to intervene, sometimes resulting in them being injured, or retaliating against the sibling who is being violent.

Parents and caregivers are constantly managing competing needs among their children. Holt (2023) describes how mothers living with CPVA are often caught in an impossible dilemma; the needs of one child can be incompatible with the needs of the child using violence. Parents and caregivers commonly prioritise the needs of the most challenging child in an effort to prevent escalation and protect others in the household. They also try to minimise potential triggers of violence and live in a state of hypervigilance as a result.

> *"He was just over the violence and told me that, as he was walking up the driveway, he would be scared to enter the house because he thought that he might find me dead on the floor"* (Tempest, 2024, p.41).

Growing up in an environment defined by unpredictability and conflict can have long-term consequences. Children who spend their formative years suppressing their own needs and constantly anticipating the reactions of a violent sibling may, as adults, struggle with assertiveness, setting boundaries, and prioritising their own wellbeing. These experiences align with the Adverse Childhood Experiences (ACEs) framework, which conceptualises chronic and cumulative childhood stressors as disrupting healthy neurodevelopment and significantly increasing the risk of later mental health, relational, and behavioural difficulties. The psychological imprint of "walking on eggshells" can persist long after the violence has ended.

Professionals have an important role in recognising siblings as both directly and indirectly affected by CPVA, rather than overlooking their experiences. Support should include validating their feelings, ensuring their safety, and providing opportunities for them to express their experiences, alongside access to age-appropriate therapeutic support to address the impacts of trauma.

Trauma Experienced by the Child Using Violence

Many children affected by CPVA have histories of prenatal ACEs, developmental trauma, or neurodevelopmental differences, all of which can shape emotional regulation, attachment, and behaviour. These factors rarely occur in isolation; rather, children who use violence toward their family often experience multiple, intersecting forms of trauma that influence their overall wellbeing and responses to stress. When these underlying drivers are not recognised, there is a risk of misinterpreting behaviour, perpetuating cycles of harm, and increasing distress for both the child and their family. It is therefore critical to consider the broader context in which CPVA occurs and to avoid placing responsibility solely on the child, recognising instead the complex interplay of trauma, development, and environment.

The harm experienced by children who are violent to their family and whānau is multifaceted. Some may sustain physical injuries to themselves during violent episodes, while others may be placed into the care system due to safety concerns (Baker & Bonnick, 2021). They may also experience significant psychological distress, including low self-esteem and strained family relationships, as family members become fearful or less able to engage. Children are highly attuned to parents' and caregivers' verbal and non-verbal cues, and awareness of avoidance or withdrawal can intensify feelings of frustration, shame, and self-loathing. These experiences often occur across multiple layers of trauma, including primary trauma from physical injury, secondary trauma from witnessing the impact of their behaviour on loved ones, and systemic trauma arising from interactions with statutory and support services (Baker & Bonnick, 2021).

Over time, persistent violence toward family members is associated with an increased likelihood of involvement with the youth justice system, substance misuse, conduct problems, and other antisocial behaviours (Baker, 2021). Evidence also suggests (Fanslow, Hashemi, Gulliver and McIntosh., 2021) that this pattern of behaviour elevates the risk of perpetrating intimate partner violence in adulthood.

Professionals play a key role in recognising and responding to the underlying trauma and needs of children who use violence, rather than focusing solely on the behaviour itself. This includes providing trauma-informed, developmentally appropriate support that helps reduce harm and improve wellbeing.

Trauma from CPVA is a Public Health Burden

The pervasive effects of CPVA demonstrate that addressing family violence requires more than immediate safety measures to reduce harm and prevent long-term societal costs. Research from the University of Auckland (Fanslow, 2024) estimates that violence and trauma cost New Zealand's health system and society NZ $4–7 billion per year, including direct costs such as hospitalisations, mental health services, social services, and justice system involvement, as well as indirect costs like lost productivity at work, disrupted education, and long-term impacts on families, whānau, and communities.

Within this context, CPVA contributes to these costs through repeated police callouts, increased demand on crisis and emergency responses, and involvement with child protection systems, including the risk of children entering state care when families cannot access adequate support. The impacts also extend to health and wellbeing, as parents and caregivers often experience chronic stress, injury, and mental health challenges, alongside reduced capacity to work. This was reflected in VisAble's survey, where 67% reported being unable to work or reducing their hours due to CPVA (Tempest & Bloom, 2025). Educational disruption, justice system involvement, and ongoing reliance on social services further add to these cumulative and intergenerational effects.

Supporting families and whānau affected by CPVA therefore requires more than crisis intervention. It involves validating lived experiences, addressing systemic barriers, and providing trauma-informed support that promotes healing, resilience, and relational connection. This includes practical and emotional support, safety planning, and recognition of the trauma experienced by all family members. Early, coordinated support is not only critical for safety and wellbeing, but also cost-effective, as it can prevent escalation into high-intensity interventions and reduce long-term social and economic impacts.

Conclusion

Families and whānau living with Child to Parent Violence and Abuse (CPVA) navigate a complex and often invisible web of harm that affects every dimension of life physical, emotional, social, cultural, and spiritual. As this report has demonstrated, intersecting layers of primary, secondary, filial, complex, developmental, systemic, and intergenerational trauma contribute to chronic stress, grief, and relational strain. These impacts are frequently compounded by disbelief, fragmented responses, and entrenched systemic barriers.

CPVA is a multifaceted form of family violence that remains inadequately understood and poorly responded to within existing service frameworks. While the Family Violence Act 2018 provides a statutory basis for recognising CPVA, service pathways remain ill-equipped to translate this recognition into safe, relational, and trauma-responsive practice. The result is a persistent gap between legislative intent and lived experience.

All forms of abuse including verbal, emotional, psychological, physical, financial, and coercive control can be deeply harmful within the inescapable relational context of CPVA. Parents and caregivers are required to continue providing care under conditions of sustained threat, often with limited external support. Recognising this reality is essential to preventing further harm.

Effective responses must therefore prioritise safety, validation, workforce capability, systemic accountability, and culturally grounded, relational care. Support must address the cumulative and embodied impacts of harm across the whole family system including parents, caregivers, siblings, children, and wider whānau while also recognising neurodevelopmental differences, structural inequities, and the effects of chronic stress. This is particularly critical for Māori whānau, neurodivergent and neuro-disabled children, and care-experienced children, whose needs have historically been minimised or misunderstood. Validating parent and caregiver expertise, supporting relational repair where safe, and resourcing accountable, coordinated systems are essential to disrupting cycles of harm and promoting long-term wellbeing.

Ultimately, addressing CPVA requires coordinated, ethical, and trauma-informed action across systems. By validating lived experience, prioritising safety, and embracing collective responsibility, services can reduce harm, prevent further trauma, and support children, parents, caregivers, and whānau toward healing, resilience, and sustainable wellbeing.

Practice Framework for Supporting Families and Whānau Experiencing CPVA

Purpose

Families and whānau experiencing CPVA live with complex, cumulative trauma. This framework supports professionals to respond in ways that are:

- Trauma-informed and relational
- Culturally responsive
- Safety-focused
- Collaborative and coordinated

It aims to promote safety, reduce harm and re-traumatisation, and support families and whānau toward stability and healing.

Safety and Recognition of Harm

Safety must be prioritised for all family members.

- Recognise CPVA as family violence under the Family Violence Act 2018
- Acknowledge all forms of harm (emotional, psychological, coercive, and physical etc)
- Avoid minimising or pathologising caregiver experiences
- Ensure responses do not escalate risk

Trauma, Blocked Care, and Survival Responses

Caregiver experiences must be understood through a trauma and neurobiological lens.

- Responses such as exhaustion, anger, withdrawal, and hypervigilance reflect survival, not failure
- Blocked care can occur when chronic stress and fear reduce a caregiver's capacity for empathy and connection
- Expectations of co-regulation are often unrealistic when caregivers are in survival states
- Without support, ongoing stress can lead to burnout, relational breakdown, and increased risk

Relational and Whole-of-Family and Whānau Approaches

CPVA must be addressed within the full family context.

- Avoid child-only interventions when violence is present
- Recognise impacts on siblings, parents and caregivers and provide targeted support

Culturally Responsive Practice

Practice must be grounded in relational and cultural understanding.

- Build trust through empathy, transparency, and consistency
- For Māori whānau, align responses with tikanga Māori and Kaupapa Māori approaches
- Support identity, belonging, and collective wellbeing

Early Intervention and Ongoing Support

Early and sustained support is critical.

- Intervene before escalation and across care settings
- Support caregiver wellbeing alongside child needs
- Provide ongoing training, resources, and risk management support

Peer Support and Connection

Peer support is a key protective factor.

- Reduces isolation and validates lived experience
- Strengthens resilience and coping
- VisAble runs a twice monthly peer support group for parent and caregivers

System Responsibility and Coordination

Families often experience additional harm through fragmented systems.

- Reduce gatekeeping and service fragmentation
- Coordinate across Oranga Tamariki, health, education, police, and community services
- Work collaboratively with families in decision-making
- Ensure professionals are trained in trauma, CPVA, neurodivergence, and relational practice

Practice Commitment

Professionals commit to:

- Believing and validating families and whānau
- Prioritising safety over compliance
- Understanding trauma and blocked care as central to behaviour
- Practising relationally and culturally responsively
- Advocating for coordinated, equitable support systems

Glossary

ACE: Advertise Childhood Experience.

Adult at Risk: An Adult at Risk is:

- An adult who has needs for care and/or support, and
- Is experiencing violence and abuse (or risk of), and
- Because of their needs for care and/or support are unable to remove or protect themselves from the abuse (or risk of).

Autism Spectrum Disorder: A neurodevelopmental condition which covers a wide spectrum of how people see and interact in the world.

Blocked care: When a parent or caregiver wants to provide love, support, or protection, but feels unable to connect with their child because their child's behaviours or trauma responses overwhelm them, causing emotional exhaustion, nervous system shutdown and/or fear.

Care-experienced: Describes a person who has spent time living in the care of the state, such as in foster care, residential care, or other out-of-home placements.

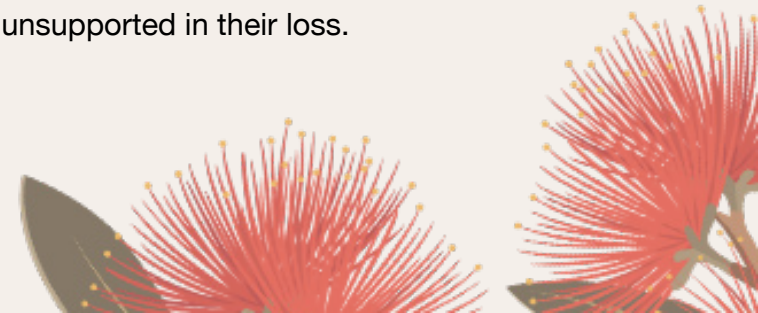
Complex trauma: Trauma that happens repeatedly or over a long period, often in close relationships (like family or caregivers), and can affect emotional, psychological, and physical wellbeing, as well as how a person relates to others.

CPVA: Child to Parent Violence and Abuse.

Cumulative trauma: The build-up of stress or harm from multiple traumatic events over time, which can have a stronger impact on a person's wellbeing than a single event.

Developmental trauma: Trauma experienced by a child during critical periods of growth, often in close relationships, which can affect emotional, social, and brain development, shaping how they relate to themselves and others.

Disenfranchised grief: Grief that is not openly acknowledged, socially supported, or recognised, leaving the person feeling isolated or unsupported in their loss.



Family violence: Family violence refers to any form of violence or abuse used by one person against another person with whom they have, or have had, a family or close personal relationship, and which includes a pattern of coercive or controlling behaviour that causes harm or fear. In New Zealand, family violence is recognised as being broader than physical violence and includes: physical abuse, sexual abuse, psychological or emotional abuse, economic or financial abuse, coercive or controlling behaviour, threats, intimidation, harassment, and isolation. Defined as occurring within close personal relationships: e.g. with intimate partners, within whānau and extended family, within flatmates, between caregivers and those they support, and in any gender or sexuality configuration.

FASD: Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe the neurodevelopmental impacts on the brain and body of individuals prenatally exposed to alcohol.

Filial trauma: The emotional, psychological, or physical harm experienced by a parent or caregiver as a result of violence, abuse, or harmful behaviors from their own child.

Intimate partner violence (IPV): A pattern of abusive, coercive, or controlling behaviours within an intimate relationship that cause physical, sexual, psychological, emotional, or economic harm, and is used to maintain power and control over a partner.

Language of violence: The terms *family violence, intimate partner violence and domestic violence* are used in Aotearoa New Zealand to refer to violence and abuse that happens within a family or domestic relationship.

Neuro-disability: Some disability groups prefer to use the term neuro-disability as they find it is more helpful to understand the primary impairments/challenges and strengths of those with certain diagnoses (such as Fetal Alcohol Spectrum Disorder - FASD). Neuro-disability is not a negative term.

Neuro-divergent: Neurodiverse (or neurodivergent) describes the natural diversity of human brains and ways of thinking, recognising that people's neurological differences are a normal part of human variation rather than deficiencies or disorders.

The term is often used in relation to people who are autistic, have ADHD, dyslexia, dyspraxia, Tourette syndrome, or other neurodevelopmental differences, but it refers broadly to diversity across all minds.

Parent/caregiver: The term includes parents, caregivers, grandparents, and other whānau who have assumed the parental role, whether kin or non-kin.

Post-Traumatic Stress Disorder (PTSD): A condition that can develop after someone experiences or witnesses a traumatic event. It can cause flashbacks, intense distress, anxiety, and changes in thoughts, feelings, or behaviors as the person processes the trauma.

Primary trauma: The emotional, physical, or psychological impact experienced directly by a person who has lived through a harmful, threatening, or distressing event.

Secondary trauma: The stress or emotional impact experienced by someone who is exposed to another person's trauma, such as a caregiver, parent, or a professional who is supporting someone who has been harmed.

Sexual violence: Commonly call rape, sexual abuse and sexual assault and is inclusive of a range of offences and abuses.

Systems trauma: Harm or distress experienced when a person is affected by failures, mistreatment, or harm within institutions or systems, such as schools, healthcare, social services, or the justice system.

Whānau: Family

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VisAble is a disabled-person-led organisation based in Aoteatoa New Zealand

We work to strengthen national capabilities across agencies and sectors to prevent and respond to violence, abuse, and neglect affecting disabled people and their whānau.

Our focus includes tāngata whaikaha Māori and whānau, tagata sa'ilimalo and āiga-tele, d/Deaf, neurodivergent, and Adults at Risk.

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