

Editorial Introduction: Child Abuse & Victimization

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Childhood trauma, including abuse and neglect, is probably our nation's single most important public health challenge, a challenge that has the potential to be largely resolved by appropriate prevention and intervention. While isolated traumatic events, such as medical trauma and accidents are likely produce discrete conditioned behavioral and biological responses to reminders of the trauma, chronic maltreatment has pervasive effects on the development of mind and brain. Developmental trauma sets the stage for unfocused responses to subsequent stress leading to dramatic increases in the use of medical, correctional, social and mental health services.

Almost one million cases of child maltreatment were substantiated in the U.S. in 2001. It is estimated that the true incidence of children at risk of harm through abuse and neglect is almost 3 million. Considering that complex trauma may take many other forms in addition to maltreatment (e.g., chronic exposure to community violence; loss of a primary caregiver in early childhood), it is undeniable that child complex trauma is an urgent public health problem.

The direct costs associated with child abuse and neglect (estimated at 24.4 billion dollars) includes hospitalization, chronic health problems, mental health, child welfare, law enforcement, and judicial system costs. Indirect costs (estimated at 69.7 billion dollars) include special education, juvenile delinquency, adult mental health and health care, lost productivity to society, and adult criminality.

Surveys of childhood trauma (see Spinazzola et al, this issue) reveal a relatively low prevalence of childhood exposure to non-interpersonal traumas such as accidents, disasters, or severe illness compared to exposure to intrafamilial traumas such as physical abuse, emotional abuse, neglect and exposure to domestic violence.

The family plays a crucial role in determining how the child experiences and recovers from traumatic experiences: parental support is a key mediating factor in determining how children adapt to victimization. Familial support and adequate parental emotional functioning mitigate against the development of posttraumatic pathology. In

addition, the extent to which the family environment itself was responsible for the victimization, parental response to the traumatic event or disclosure, and the extent to which parents themselves are influenced by their own childhood histories of loss and/or trauma, as well as other parental psychopathology all have a major impact on the child's adaptation to trauma.

When the child-caregiver relationship is the *source* of trauma or is profoundly impacted by other traumatic exposure, many critical developmental competencies may be severely disrupted. *Insecure* attachment patterns have been consistently documented in up to 90% of maltreated children. An insecure attachment relationship occurs when the primary caregiver is too preoccupied, distant, unpredictable, punitive, or distressed to be reliably responsive and nurturing. Other factors such as socioeconomic adversities, family conflict, caregiver's psychopathology or addiction contribute further to complex trauma reactions in the child. Key features of disorganized attachment: are (1) increased susceptibility to stress (e.g., difficulty focusing attention and modulating arousal) (2) inability to regulate emotions without external assistance (e.g., feeling and acting overwhelmed by intense or numbed emotions), and (3) altered help-seeking (e.g., excessive help-seeking and dependency or social isolation and disengagement).

If children are exposed to unmanageable stress, and if the caregiver does not take over the function of modulating the child's arousal, as occurs when children exposed to family dysfunction or violence, they are unable to organize the experience in a coherent fashion. Unlike adults, children do not have the option to report, move away or otherwise protect themselves- they depend on their caregivers for their very survival. When trauma emanates from within the family children experience a crisis of loyalty and organize their behavior to survive within their families. Being prevented from articulating what they observe and experience, traumatized children are likely to organize their behavior around keeping the secret, deal with their helplessness with compliance or defiance, and accommodate in any way they can to entrapment in abusive or neglectful situations.

When professionals are not attuned to the fact that children need to somehow cope with their traumatizing environments and expect that children should behave according to adult standards of self-determination and independent, rational choices, the children's trauma-related behaviors, that are meant to insure survival, tend to inspire loathing and rejection.

Diagnosis

The question of how to best organize the very complex emotional, behavioral and neurobiological sequelae of childhood trauma has vexed clinicians and researchers for several decades. Because the DSM IV has a diagnosis for adult onset trauma, PTSD, this label often is applied to traumatized children, as well. However, the majority of traumatized children do not meet diagnostic criteria for PTSD. In addition, the PTSD diagnosis does not capture the developmental impact of childhood trauma: the complex disruptions of affect regulation, the disturbed attachment patterns, the rapid behavioral regressions and shifts in emotional states, the loss of autonomous strivings, the aggressive behavior against self and others, the failure to achieve developmental competencies; the loss of bodily regulation in the areas of sleep, food and self-care; the altered schemas of the world; the anticipatory behavior and traumatic expectations; the multiple somatic problems, from gastrointestinal distress to headaches; the apparent lack of awareness of danger and resulting self endangering behaviors; the self-hatred and self-blame and the chronic feelings of ineffectiveness.

These manifestations of chronic dysregulation may be triggered by genuine environmental threats, perceived threats resulting from the child's misinterpretation of actual events, and/or the child's extreme response to seemingly innocuous stimuli. When faced with threatening signals, children with traumatic stress respond in ways that are not appropriate for the demands of the social environment. Information processing is often disoriented or disorganized.

In an attempt to more clearly delineate what children with Complex Trauma suffer from and to articulate guidelines for rational therapeutic, the Complex Trauma Taskforce of the National Child Traumatic Stress Network has started to conceptualize a new diagnosis provisionally called: "Developmental Trauma Disorder". This proposed diagnosis is organized around the issue of triggered dysregulation in response to traumatic reminders, stimulus generalization, and the anticipatory organization of behavior to prevent the recurrence of the trauma impact.

“Developmental Trauma Disorder” is predicated on the notion that multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults or witnessing domestic violence have consistent and predictable consequences that affect many areas of functioning. These experiences engender 1) *intense affects* such as rage, betrayal, fear, resignation, defeat and shame. and 2) *efforts to ward off the recurrence* of those emotions, including the avoidance of experiences that precipitate them or engaging in behaviors that convey a subjective sense of control in the face of potential threats.. . These children tend to *behaviorally reenact* their traumas either as perpetrators, in aggressive or sexual acting out against other children, or in frozen avoidance reactions. Their physiological dysregulation may lead to *multiple somatic problems*, such as headaches and stomachaches in response to fearful and helpless emotions. They *anticipate and expect the trauma to recur* and respond with hyperactivity, aggression, defeat or freeze responses to minor stresses. All of these problems are expressed in dysfunction in multiple areas of functioning: educational, familial, peer relationships, problems with the legal system, and problems in maintaining jobs.

Treatment

Because these children now receive multiple, often fluctuating, diagnoses there necessarily is a lack of clinical consensus on effective treatments for child trauma victims. No systematic research studies can be undertaken without a consensus of what these children look like and what symptoms require intervention. What is clear is that it is essential to identify and treat mental health problems early enough to prevent chronic developmental and psychosocial impairment.

Another major challenge to the development of effective interventions for traumatized children is that the same factors that place a child at risk for exposure to traumatic events also contribute to an unstable social environment. Traumatized children frequently live under conditions that are detrimental to healthy child development, where poverty, racism, inadequate schools, and community violence may compound domestic violence and neglect.

This issue of *Psychiatric Annals* includes two papers that outline promising treatment approaches to chronically traumatized children. They agree on the fundamental issues for effective prevention and intervention, including the need to build healthy attachments between children who have experienced trauma and their caregiver(s); and creating a safe environment for healthy recovery that has been impacted by the trauma. These goals are achieved through a attention on four principles: (1) Creating a structured and predictable

environment by establishing rituals and routine; (2) Increasing caregiver capacity to manage intense affect; (3) Improving caregiver-child attunement, so that the caregiver is able to respond to the child's affect, rather than react to the behavioral manifestation; and (4) Increasing use of praise and reinforcement, to facilitate the child's ability to identify with competencies, rather than deficits.

Future Directions.

In order to treat the impact of complex trauma on children there first needs to be a diagnostic category that captures the reality of these children's clinical presentations, rather than continuing to rely on the adult diagnosis of PTSD that ignores the developmental aspects of adjustment to trauma exposure. It also is critical to understand the interrelation between multiple symptoms that are now captured by multiple, seemingly unrelated "co-morbid" diagnoses that address affect dysregulation ("bipolar illness"), chronic distrust of authority (oppositional defiant disorder), inability to focus and concentrate (ADHD) etc., but that do not provide a comprehensive understanding of what traumatized children suffer from.

It is critical to review and evaluate promising programs and innovative intervention models that span service sectors (e.g., Head Start; juvenile justice; mental health) and attempt to reach complexly traumatized children through multiple contexts (e.g., parent-child, peer-based, faith-based communities) and across multiple domains (e.g., clinical services; auxiliary services, academic, physical and vocational development).

It is important to establish and cultivate ongoing partnerships between academic settings and community clinics to develop and test community-based, culturally relevant, age-appropriate interventions for traumatized children and adolescents.

In addition to focusing on pathology and lack of social adjustment it is critical to understand coping and resilience and to investigate the impact of strengths-based initiatives that focus on building mastery, competence, and positive self-regard.

All this cannot be done unless there is a widespread recognition of complex child trauma as a public health problem impacting millions of children in the United States each year and genuine efforts to close the gap between available resources and the needs of children and families impacted by complex trauma.

The choices on what to do for traumatized children are choices that are being debated in civilized societies around the globe: whether to provide active assistance to children and their families before they fall into chronic patterns of disorganization and

destructiveness against self and others, or whether to pay later, in the form of family dysfunction, criminal behavior, psychopathology, medical illness and unemployability.