Mental Health Issues of Child Maltreatment

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To my family, who has supported my ongoing work throughout the years, and to Drexel University, for their active support in educating the next generation of nurses to provide comprehensive and sensitive care to victims of violence.

Paul Thomas Clements, PhD, RN

To my graduate students, who inspired me and kept me honest, and to my family, who support me in whatever I choose to do.

Elisabeth N. Gibbings, PsyD

Mental Health Issues of Child Maltreatment

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Foreword

As demonstrated by the Adverse Childhood Experiences (ACE) Study, child maltreatment is correlated with a number of deleterious mental and physical health outcomes that persist throughout life. This serves to highlight the critical need for effective child maltreatment professionals. Starting with a practicum position at a child advocacy center during graduate school, my entire career as a clinical psychologist has centered on trying to be just that. Having spent the majority of my career working in a child advocacy center, I know that mental health professionals play a critical role in the forensic and clinical services provided to maltreated youth. We are confronted daily by the enormous needs of children and families struggling with the specter of child maltreatment. We are also continuously amazed by the resiliency and determination of these same children and families.

Mental health professionals have a unique perspective and role in the child maltreatment world. We frequently witness and influence the entire journeys of families impacted by child maltreatment: disclosure, investigation, legal proceedings, treatment, and recovery. This can be both a blessing and a curse. We are blessed by the opportunity to facilitate healing in so many different ways. We are cursed in the sense that to do our job well requires a breadth and depth of knowledge that is truly intimidating. Knowledge is our greatest tool, and there is so much to learn.

It's almost easier to list the things a mental health professional in the child maltreatment field doesn't need to know than to list those they do. First, it is necessary to have a solid understanding of the occurrence of child maltreatment. How common is child maltreatment? How common is chronic, repeated maltreatment? What are the risk factors for child maltreatment at individual, familial, and societal levels? What factors reduce the risk of child maltreatment or ameliorate its impact?

Next, we must have an understanding of the impact of child maltreatment. How does child maltreatment impact development? How does the impact of child maltreatment on brain development affect clinical outcomes? What role does attachment play in the impact of child maltreatment? Do different types of maltreatment or trauma result in different outcomes? Does greater exposure to maltreatment result in worse outcomes? Does the impact of child maltreatment look different depending on the age of the child? How do I assess for the presence of child maltreatment and its impact?

Finally, we must also know how to intervene on behalf of these children. How can we protect the rights of maltreated children? What interventions have been found to be effective in reducing the impact of child maltreatment and trauma? What can child welfare systems, eg, families, schools, juvenile justice, and protective services, do to protect children and/or reduce the impact of child maltreatment?

If, in the immortal words of Thomas Hobbes (and *Schoolhouse Rock!*), knowledge is power, then *Mental Health Issues of Child Maltreatment* is a vital "power source" for child maltreatment professionals. You may have found yourself feeling overwhelmed while reading what a child maltreatment professional needs to know–I know I did while writing it. Take heart. As you can see by scanning the table of contents, this book provides answers to those questions. These answers are provided in the form of a comprehensive, "state of the science" overview of current child maltreatment literature. Furthermore, readers will appreciate that this information is made accessible through the use of key points, case studies, and effective visual presentation.

The esteemed editors of and contributors to *Mental Health Issues of Child Maltreatment* start by detailing the concept of developmental trauma with chapters that highlight the neurodevelopmental and psychobiological impact of trauma. Next, readers are introduced

to the impact of developmental trauma, including general clinical manifestations and outcomes associated with specific trauma types, such as intrafamilial violence and human trafficking. Readers will also appreciate the detailed overview of factors associated with risk and resilience in the context of child maltreatment. Of great utility is the extensive coverage given to the clinical presentation and assessment of maltreated children, with a particularly helpful emphasis given to assessment at different developmental stages. Finally, the contributors provide a detailed overview of child maltreatment prevention and intervention strategies, clearly establishing the need for evidence-based practice.

The knowledge base regarding the occurrence, impact, and treatment of child maltreatment has exploded in the new millennium. To be effective, child maltreatment professionals require a high degree of fluency related to this knowledge. *Mental Health Issues in Child Maltreatment* does a wonderful job of condensing this information into a form that is comprehensive yet accessible. I commend the editors and contributors for their efforts, and encourage all readers to use this information to transform themselves into the most effective child maltreatment advocates they can be.

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Foreword

With this brilliantly edited work, authors Dr. Paul Thomas Clements, Dr. Soraya Seedat, and Dr. Elisabeth N. Gibbings provide an informative and readable book dealing with the important issue of child maltreatment. Psychologists, psychiatrists, social workers, and other mental health professionals need to be concerned with the crucial physical, social, cognitive, and emotional needs of individuals subjected to abuse and trauma. It is imperative that professionals in this field have a comprehensive understanding of child development and the components that enhance or impede developmental processes. Perhaps even more essential is an awareness of the seriousness of child maltreatment and courses of action that may prevent these traumatic events. Certainly, it is necessary that professionals have the skills and competencies to ensure accurate diagnosis, which may, in turn, lead to more effective treatment. In addition, clinicians must be aware of the resources available for children in need of special care. Without special facilities and talented professionals to provide the specific type of help a child needs, even the most comprehensive diagnosis is meaningless.

The authors of *Mental Health Issues of Child Maltreatment* approach the topic from an international perspective, thereby reducing the possibility of insular or prejudiced work. The authors' multidisciplinary orientation ensures that the problems of maltreated children are not only perceived through the window of one's own specialization. The sensitivity of these clinicians, manifest in their ability to comprehend and integrate data related to the prevention of child maltreatment and the diagnosis and therapy of maltreated children, is a great strength in this work.

The introductory section of the text provides a general discussion of child abuse and the emergence of improved treatment for maltreated children. The second section deals with clinical manifestations of trauma, intrafamilial violence, societal causes of violence, and human trafficking. In a general discussion of clinical manifestations, Dr. Carla Kmett Danielson, Dr. Angela Moreland, and Dr. Kate Walsh point out that a range of significant psychosocial problems may follow exposure to traumatic events. They discuss in detail how PTSD may result from early traumatic exposure and illustrate how mood symptoms, anxiety disorders, and depression may develop following traumatic experiences.

Further sections of the book cover in great detail a wide range of issues, including familial and community influences, probability of risk, resilience, and the incidence of delinquency related to child abuse. Excellent chapters dealing with assessment, intervention, and prevention explain to the reader crucial factors in dealing with child maltreatment. In a particularly interesting and pertinent chapter, Dr. Gibbings discusses manifestations of child maltreatment in the school setting. She stresses the importance of school personnel being alerted to any indications of childhood trauma and emphasizes how teachers can play a vital role in detecting early signs of physical or mental abuse. The consequences of such traumatic experiences, such as poor academic performance, low self-esteem, and behavioral problems, are also discussed in detail.

Interestingly, there is an entire chapter devoted to ethical considerations, a subject not usually discussed in texts on child psychopathology. In this chapter, Dr. Knauss addresses ethical issues that must be observed when working with abused children. Issues of competence, informed consent, confidentiality, mandated reporting, record keeping, and boundaries are thoroughly explored.

The book concludes with a chapter looking forward in the area of child maltreatment. This chapter emphasizes future directions in the field, including prevention, diagnosis, intervention, and research.

Mental Health Issues of Child Maltreatment is highly readable and rewards readers with a wealth of information presented in a manner that makes the material easily digestible. For example, a section of key points precedes each chapter. In these sections, contributors highlight the most important topics in their chapters, thereby providing a quick summary of the material. Furthermore, specific case studies are discussed in a number of chapters, lending authenticity to the material.

There is no question that child maltreatment is a significant problem that society must solve. The authors of this book have undertaken a difficult task in addressing the many problems inherent in providing mental health care to children who have suffered abuse and maltreatment. *Mental Health Issues of Child Maltreatment* not only highlights the crucial importance of this issue but also provides significant and concrete information about how to deal with it. Anyone working with children will profit from reading this book, and certainly all mental health professionals, including psychiatrists, psychologists, and social workers, will find it immensely helpful in dealing with cases of child abuse.

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Preface

According to the World Health Organization, 155 000 children around the world aged 15 years or younger die annually as a result of abuse or neglect. Biological parents are responsible for 80% of such abuse cases and stepparents for 15%. Child maltreatment can be more than bruises and broken bones. While physical abuse might be the most visible kind, other types of abuse, such as emotional abuse, sexual abuse, or child neglect, also leave deep, long-lasting scars. Child maltreatment is associated with adverse physical and mental health outcomes in both children and their families, with negative effects that can last a lifetime.

Child abuse and neglect occurs in all types of families, even in those who look happy from the outside, but children are at a much greater risk in certain situations, such as living with interpersonal violence, alcohol and drug abuse, untreated mental illness, or with a lack of parenting skills. Child maltreatment is any act intended to harm or endanger the emotional or physical development of a child. It can be a violent act of commission or an act of omission resulting in negligence of a child's needs for adaptive physical and emotional growth and development. Contrary to common stereotypes and myths, child maltreatment can take place in every stratum of community, regardless of culture, religion, ethnicity, and income. Child maltreatment can happen in any family, anywhere, given the right circumstances. It is not confined to families with a history of familial abuse. Unemployment, finances, illness, and divorce can all exert terrible pressure on parents, and as pressure escalates, so does the tendency to lash out at the smallest members of the family.

Child maltreatment has long-lasting effects on brain development, resulting brain architecture, and brain functioning. Child maltreatment can also increase the risk of mental illness, substance abuse, suicidality, learning problems, aggressive and oppositional behavior, social problems with other children and adults, teen pregnancy, lack of success in school, domestic violence and chronic illness. In addition to impacting abused children and their families, child abuse and neglect impacts whole communities, from medical and mental health agencies, to law enforcement and judicial systems, and to educational and social services. One analysis of the immediate and long-term economic impact of child abuse suggests it costs the nation approximately $103 billion each year.

In most settings child abuse is significantly underreported, even by school staff members and community health employees who have continuous contact with children. Unfortunately, this phenomenon of underreporting also extends to professionals in primary care, mental health, and law enforcement. Research suggests that reasons for this underreporting include lack of awareness about the signs of maltreatment, the processes for reporting to child protection agencies, and the perception that reporting might do more harm than good. Even when maltreatment is suspected, professionals often do not report cases without a high level of certainty that maltreatment has occurred.

Clinicians, researchers, supervisors, and professors face the impact of child maltreatment on a regular basis. It may be a child in the therapy room who suddenly shuts down when asked about her recent weekend visit with her father; it may be a doctoral student with questions about how or if to report suspected child abuse for a clinic client; or it may be a review of statistics on child trafficking in preparation for a lecture. We, the authors of this book, are a nurse, a psychologist, and a psychiatrist, who practice, teach, supervise, and research in the United States and internationally. Our goal in this text is to pool not only our own resources but the resources of the wise people in our collective orbits to create a comprehensive handbook on assessing, treating, and preventing child

maltreatment. This is a book for the professional in need of a quick resource check and for the student just learning about the scope of child maltreatment. It is not limited to a particular discipline or a particular part of the globe. Congruent with the World Health Organization's goals for prevention and response, *Mental Health Issues of Child Maltreatment* is intended to do the following:

— **Define the problem** of child maltreatment conceptually and numerically, using statistics that describe the scale of maltreatment and the characteristics of those most affected by it

— **Identify causes and risk factors** that appear to affect susceptibility to maltreatment, such as factors that increase a child's risk of abuse or obstacles to delivering effective child protection services

— **Design interventions and programs,** subject to evaluation, with a high probability of minimizing risk factors to both individuals and communities

— **Disseminate information** about the effectiveness of these interventions and increase the profile of proven interventions

— **Educate students and future professionals** in psychology, medicine, nursing, and social work to mitigate the effects of child maltreatment for future generations

Professionals in a position to prevent maltreatment and to improve responses to maltreatment need high-quality, reliable information. Research, routine data collection, and monitoring and evaluation of programs are essential to the success of a systematic approach to child maltreatment. It is our sincere hope that *Mental Health Issues of Child Maltreatment* will be a valuable resource in all these endeavours.

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Soraya Seedat, MBChB, FC Psych (SA) MMed Psych, PhD
Elisabeth N. Gibbings, PsyD

Reviews

Mental Health Issues of Child Maltreatment *is an invaluable resource that offers the depth and breadth necessary to conceptualize the complexity of mental health issues surrounding child maltreatment. The text addresses the evolving science of neurobiological development of trauma in infancy; clinical manifestations of neurodevelopmental trauma; assessment and diagnosis of neurodevelopmental trauma; multifactor interventions; and prevention strategies at the primary, secondary, and tertiary levels. Key points offered in every chapter directly compliment the richly detailed text. The authors evoke the complexity of accurately identifying and diagnosing child maltreatment and demonstrate how this difficulty may translate in a court of law. Finally, the text provides strategies and research priorities needed to address the science evolving around mental health sequelae of child maltreatment. This book should be read by any professional who wants to provide responsible child maltreatment services in primary care, community-based care, or within a forensic setting.*

Stacy A. Drake, PhD, MPH, RN, AFN-BC, D-ABMDI
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Child maltreatment is intrinsically complex, with many covert dynamics and serious consequences. Mental Health Issues of Child Maltreatment *is an informative guide to relevant statistics, useful theories, and practical ideas for implementation by all those working in the child trauma and mental health fields. It unravels some of the interwoven ethical dilemmas in the field; explores working with both child victims and maltreatment offenders; and locates etiology, interviewing, and treatment within familial and societal contexts. This imperative resource gives one hope to engage in a positive manner within a daunting field.*

Edith Kriel
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Mental Health Issues of Child Maltreatment *is a comprehensive review of the prevalence and clinical presentation of and various treatment approaches to this troubling issue. It provides both seasoned mental health professionals and students with substantial research data and clinical strategies suitable for clinical and school settings. Most importantly, this book highlights the role frequently played by child maltreatment in the formation of symptoms commonly encountered in clinical practice.*

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Mental Health Issues of Child Maltreatment *is a comprehensive and well-researched volume that examines the causes, effects, and clinical presentations of and treatments for child maltreatment. The book presents, in eight logically organized and easy-to-follow sections, current research regarding the neurobiological, psychological, and sociological aspects of the many ways children are affected by exposure to violence, traumatic events, and physical or sexual abuse. Detection and prevention of child maltreatment are explored in detail, providing extremely valuable guidance for all adults involved in caring for, educating, and clinically treating children. The chapters regarding developmental and psychological disturbances arising from maltreatment are thorough and clear, and clinicians seeking to understand and treat traumatized children will likely return to them repeatedly as questions arise during their work.*

Educators, child care personnel, physicians, and mental health clinicians will find Mental Health Issues of Child Maltreatment *an invaluable resource for working with children, adolescents, parents, and adults who have experienced childhood trauma.*

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Contents in Brief

Chapter 1

Child Abuse and the Emergence of the Diagnosis of Developmental Trauma*

Richard A. van den Pol, PhD‡
Richard Manning‡

Key Points:

1. Trauma is a normal response to an abnormal situation.
2. Developmental trauma resulting from emotional abuse physically injures the brain.
3. The understanding of developmental trauma is rooted in knowledge of posttraumatic stress disorder (PTSD) but grew from the landmark Adverse Childhood Experiences (ACE) Study and the National Child Traumatic Stress Network (NCTSN).
4. Developmental trauma differs from PTSD in that the injury, often inflicted by a caregiver, occurs while the brain is developing and arrests part of that brain development.
5. Traumatic stress is a combination of mental and somatic responses to a perceived threat mediated by the limbic system and the vagus nerve.
6. Interventions for developmental trauma are based on cognitive behavioral therapy but also address somatic elements with relaxation techniques and exposure by recall of the traumatic event.

Introduction

The understanding of psychological trauma in the development of children builds on earlier research into ***posttraumatic stress disorder (PTSD)*** in combat survivors. The problem of childhood exposure to multiple traumatic events is different, however, in that it is far more prevalent than most assume and, perhaps most importantly, because it victimizes individuals whose brains are still developing and, as a result, alters that course of development. Psychological trauma in children is not a separate issue from physical head trauma; rather, psychological trauma is simply another way of physically damaging children's brains through child abuse. Frequent co-occurrence of physical and psychological abuse further blurs the distinction.

Many researchers describe PTSD as a failure of recovery because most children and adults exposed to only a single trauma demonstrate transient symptoms and then

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‡*The authors thank Amy Garret, PhD; Victor Carrion, MD; and their colleagues with Stanford University School of Medicine for sharing and interpreting fMRI images of traumatized youth.*

return to their former levels of functioning.[1-2] PTSD sufferers cannot return to a normal condition and, as a result, remain locked in the moment of trauma. PTSD produces a classic set of symptoms, including flashbacks, re-experiencing traumatic events, nightmares, depression, and suicide. Children who suffer repeated traumatic events, which is typical of child abuse victims, may show some of these symptoms, but PTSD does not adequately describe the cause and effect; this led to the proposal of a new diagnosis of ***developmental trauma***. The evidence supporting this shift emerged from nearly two decades of epidemiological research, the efforts of a formal network designated by Congress to study the effects of childhood trauma, and the rapidly increasing capabilities of neuroscience. See **Figure 1-1** for a timeline of major developments in understanding trauma.

Adverse Childhood Experiences (ACE) Study

The foundation of the epidemiological research is the landmark Adverse Childhood Experiences (ACE) study, a continuing project headed by the Centers for Disease Control and Prevention (CDC).[3] The ACE study originated in the early 1980s with an intervention for obesity sponsored by Kaiser Permanente, a health maintenance organization based in California. When clinicians noticed that people enjoying success

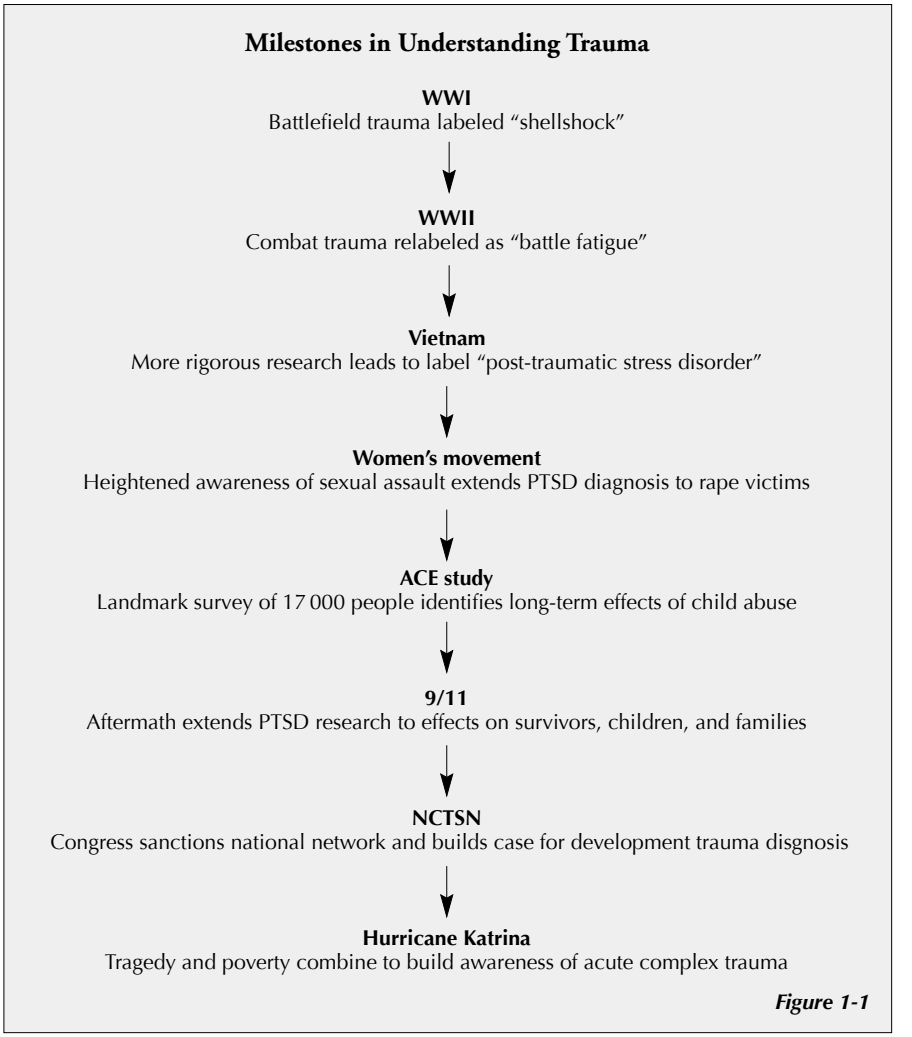

Figure 1-1. *Conceptualizing psychological trauma: battleground to playground.*

in their weight reduction tended to drop out of the program and then regain the weight, the clinicians began systematically questioning the dropouts. The questioning produced anecdotal accounts of child abuse, especially sexual abuse, occurring more frequently than the participating physicians had previously thought.

The epidemiological research of child abuse has spawned more than 50 publications,[4] but through the long history of this body of research, the key findings have produced a remarkably consistent and urgent message. The results claim that:

— Child abuse is more common than generally acknowledged.

— Child abuse is a significant cause of our world's leading social, economic, and public health problems.

— The damage from child maltreatment plagues individual health and well-being for decades, even a lifetime.

A recent ACE publication[5] concludes that adults who were significantly abused as children die, on average, 20 years earlier than the rest of the population.

As the trend became more apparent, Robert Anda, an epidemiologist with the CDC, joined Kaiser Permanente's Vincent Felitti in designing a follow-up questionnaire to measure the effects of child abuse. They called the questionnaire ACE's "affected health." The researchers administered the questionnaire to 17 000 middle-class, educated clients of Kaiser Permanente. It consisted of a simple list of questions concerning the following eight categories of childhood experiences:

— Recurrent and severe physical abuse

— Recurrent and severe emotional abuse

— Contact sexual abuse

— Growing up in a household with an alcoholic or a drug user

— Growing up in a household with a member being imprisoned

— Growing up in a household with a mentally ill, chronically depressed, or institutionalized member

— Growing up in a household with the mother being treated violently

— Growing up in a household with both biological parents being absent

For each "yes" answer, a respondent was given 1 point on his or her ACE score. Fewer than half of the respondents had an ACE score of zero, meaning a majority of this middle-class, employed sample had suffered some form of child abuse, and 7% had a score of 4 or more. These findings speak to issues beyond prevalence. Researchers correlated ACE scores against the 10 leading causes of premature death in the nation. CDC summarizes the findings:

> The ACE Score is used to assess the total amount of stress during childhood and has demonstrated that as the number of ACEs increase, the risk for the following health problems increases in a strong and graded fashion: alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease, liver disease, risk for intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, unintended pregnancies.
>
> In addition, the ACE Study has also demonstrated that the ACE Score has a strong and graded relationship to health-related behaviors and outcomes during childhood and adolescence including early initiation of smoking, sexual activity, and illicit drug use, adolescent pregnancies, and suicide attempts. Finally, as the number of ACEs increases, the number of co-occurring or "co-morbid" conditions increases.[6]

The results presented strong correlations between high ACE scores and addictive behaviors, such as smoking, intravenous drug use, and alcohol abuse, all of which have long-term, negative health effects. The researchers, however, normalized their data for these problematic behaviors and found that these addictive behaviors alone did not account for early death and or morbidity; rather, they concluded that child abuse, by itself, was harmful to health.

The data ultimately generate the basis of what qualifies as a paradigm shift in our conception of the human condition, with the following conclusion reached by Felitti:

> The current concept of addiction is ill-founded. Our study of the relationship of adverse childhood experiences to adult health status in over 17 000 persons shows addiction to be a readily understandable although largely unconscious attempt to gain relief from well-concealed prior life traumas by using psychoactive materials. Because it is difficult to get enough of something that doesn't quite work, the attempt is ultimately unsuccessful, apart from its risks. What we have shown will not surprise most psychoanalysts, although the magnitude of our observations is new, and our conclusions are sometimes vigorously challenged by other disciplines.
>
> The evidence supporting our conclusions about the basic cause of addiction is powerful and its implications are daunting. The prevalence of adverse childhood experiences and their long-term effects are clearly a major determinant of the health and social well-being of the nation. This is true whether looked at from the standpoint of social costs, the economics of health care, the quality of human existence, the focus of medical treatment, or the effects of public policy.[7]

Network Science

A second line of research independently provided a closer link to earlier work on PTSD in combat veterans. Bessel van der Kolk, a lead researcher in both PTSD and developmental trauma at the Trauma Center in Boston, worked with veterans in the 1970s and was a part of the research that formally identified and categorized the diagnosis. PTSD itself is not new and had been known as battle fatigue or shell shock in earlier wars.

van der Kolk founded a clinic for the treatment of adult victims with PTSD and anticipated that it would specialize in combat victims and survivors of various catastrophes, such as natural disasters and automobile wrecks; however, he found, that the patients who sought his help for traumatic stress were overwhelmingly victims of domestic violence. His work eventually evolved into the National Child Traumatic Stress Network (NCTSN), sanctioned by Congress in 2000 and funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services (DHHS). NCTSN has two hubs, the Neuropsychiatric Institute at the University of California, Los Angeles (UCLA) and the Duke University Medical Center, that house the network's core data set, a compilation of research by the 60 member centers of the network. The core data set includes research on more than 20 000 children, most of whom are survivors of abuse. NCTSN also includes seven treatment adaptation centers responsible for modifying evidence-based treatments to meet the cultural and developmental needs of diverse populations of children and youth with trauma.

NCTSN's research produced a long list of key findings that paralleled those of the ACE study, helped explain the long-lasting effects of child abuse, and established causal links to explain the correlations that emerged in the ACE study. The formal proposal for the revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to include a new diagnostic category of developmental trauma emerged from the NCTSN and was written by van der Kolk; Robert S. Pynoos, codirector of the UCLA center; and 10 other physicians and clinical psychologists in the network.

Much of the NCTSN's work has filled in details that support ACE findings about the spinoff effects of child abuse. For instance, one study in Cook County, Illinois found that more than 90% of the children adjudicated in the juvenile justice system had been abused.[8] Child abuse is widespread, with one study having found that more than half of the children in a representative national sample had been subject to some sort of physical assault within one year. In that same study, one in eight children were found to have been victims of physical abuse or neglect.[9]

Child abuse presents economic costs to society because it is pervasive and it contributes to a range of problems, including crime, substance abuse, suicide, and poor performance in school. One NCTSN study concluded that annual costs related to child abuse, not including indirect medical costs, amounted to $103.8 billion nationwide.[9] The network's research goes beyond establishing a statistical case that the problem exists; it also assembles a conceptual framework for understanding the unique nature of child abuse, which is the core argument for creating a diagnosis separate from PTSD.

Network researchers argued there is a critical distinction between adult PTSD and what those researchers prefer to label "developmental trauma," the parallel problem in children. Adult PTSD victims usually suffer a traumatic response to a single readily identifiable and catastrophic event, such as combat, that occurred while they were adults. Developmental trauma, on the other hand, usually stems from multiple events and clusters of problems that may occur over the course of several years and, more importantly, occur as a child's brain is developing. The critical distinction is that damage caused by developmental trauma interrupts normal brain development.

The proposal for a potential future revision of the DSM summarizes this critical distinction between adult PTSD and developmental trauma in the following core argument:

> In fact, multiple studies show that the majority [of abused children] meet criteria for multiple other DSM diagnoses. In one study of 364 abused children, 58% had the primary diagnosis of separation anxiety/overanxious disorders, 36% phobic disorders, 35% PTSD, 22% attention deficit hyperactivity disorder (ADHD) and 22% oppositional defiant disorder. In a prospective study[10] of a group of sexually abused girls, anxiety, oppositional defiant disorder and phobia were clustered in one group, while depression, suicidality, PTSD, ADHD and conduct disorder represented another cluster.
>
> A survey of 1699 children receiving trauma-focused treatment across 25 network sites of the National Child Traumatic Stress Network (NCTSN) showed that the vast majority (78%) was exposed to multiple and/or prolonged interpersonal trauma, with a modal 3 trauma exposure types; less than one quarter met diagnostic criteria for PTSD. Fewer than 10% were exposed to serious accidents or medical illness. Most children exhibited posttraumatic sequelae not captured by PTSD: at least 50% had significant disturbances in affect regulation; attention & concentration; negative self-image; impulse control; aggression & risk taking. These findings [2009] are in line with the voluminous epidemiological, biological and psychological research on the impact of childhood interpersonal trauma of the past two decades that has studied its effects on tens of thousands of children. Because no other diagnostic options are currently available, these symptoms currently would need to be relegated to a variety of seemingly unrelated co-morbidities, such as bipolar disorder, ADHD, PTSD, conduct disorder, phobic anxiety, reactive attachment disorder and separation anxiety.[11]

The evidence indicates that a cluster of problems in abused children leads to a cluster of outcomes and behavioral problems. The greater the number of incidents and forms of abuse and maltreatment a given child suffers, the greater the number of diagnoses the child is given under existing categories of the DSM.[12] The emerging body of neuroscience supports and even explains this core finding.

Trauma in the Body

The proposed diagnosis is called developmental trauma because the injury occurs before a child is 17 years old, while the brain is physically developing. The human birth canal cannot accommodate a fully developed brain, so evolution devised an elegant solution to the problem, analogous to building a ship in a bottle. Genes influence this development, but brains only reach their genetic potential if they are guided by appropriate relationships with other humans, especially caregivers.

Child maltreatment is a breakdown in a child's relationship with caregivers in which caregivers either directly inflict violence and neglect or, due to being traumatized by violence, cannot engage the child in a healthy relationship. Children do not have the cognitive tools to understand or process these threats, which are the key elements to understanding developmental trauma. A child's responses to abuse are largely handled by the ***infratentorial brain***, the primitive lower part of the brain that is the only portion fully developed in children and common to humans and the rest of the animal kingdom. The primitive brain delivers a response that is common in all animals, an evolved and necessary response to danger that allows them to survive existential threats.

The only major nerve in the body that leads directly from the brainstem is the ***vagus nerve***, the primitive portion of the brain that enervates the body cavity containing all of the major organs. These major organs carry out routine body functions that are largely involuntary responses, such as heart rate and digestion. Similarly, in animals, a response to an immediate threat is also involuntary and telegraphed by the vagus nerve. The human body responds to threats by increasing heart rate and respiration and tensing the muscles, measures designed to deal with threats. The body also takes less obvious steps when confronting a threat, such as shutting down the digestive and immune systems. Both systems are energetically expensive and can be temporarily shut down to channel all available energy to meeting the threat. These responses are mediated by complex biochemistry, especially glucocorticoids and cortisol. Elevated cortisol levels are a reliable indicator of stress in both animals and humans. Cortisol serves a unique function in that it does not trigger the traumatic response but, rather, triggers the body's return to normal after the trauma has passed. Once a threat passes, all of the body's emergency measures need to be cancelled because a living being cannot live for long with a permanently elevated pulse, without digestion or an immune system, or in a permanent state of terror.

The traumatic response is more complex than the elevated cortisol response and involves a chain reaction in the brain and the rest of the body. The traumatic response begins in the amygdala, a central area of the primitive brain, and then stimulates in succession the hypothalamus; the pituitary, through corticotropin-releasing hormone; adrenocorticotropin; and the adrenal gland. Researcher Michael De Bellis summarizes the results of this chain reaction: "This results in tachycardia, hypertension, increased metabolic rate, hypervigilance, and increased levels of epinephrine, norepinephrine, and dopamine. Cathecholamines contribute to dilation of pupils, diaphoresis, renal inhibition, and decreases in peripheral blood flow."[13]

Three distinct behavioral characteristics of a traumatic response correspond to this physical response: fight, flight, or freeze. Each response can be adaptive and successful depending on the nature of the threat, the person's or animal's position in the pecking order, and the skills and resources of the person or animal; however, it is important to remember that this traumatic response is a normal response to an abnormal situation. In the case of traumatized children, the abnormal situation becomes routine, ie, the threat is repeated, sometimes daily, and becomes a way of life.

Children lack the resources and developed brains that might allow them to devise solutions to permanently escape threats, so they cope and devote all of their personal resources to daily survival. Meanwhile, their bodies gradually lose the ability to turn off the traumatic response and return to normal; in other words, they enter a permanent state of terror. There are clear and famous examples of diagnosing childhood trauma. Childhood trauma is not diagnosed through psychological screening but, rather, by recording an elevated pulse rate lasting long after immediate danger has passed.

The body's normal response to trauma explains the somatic issues that surface in the lives of adults who were abused as children, as demonstrated in the landmark ACE study. Several issues stem from compromised immune systems. While these issues appear as behavioral and psychological problems in children, they emerge more frequently as somatic issues as children age. In adults, physical problems, such as unexplained neck pain, obesity, and susceptibility to a range of illnesses as a result of compromised immune systems, are observed; however, the behavioral and psychological issues of these children are rooted in the physical damage inflicted by repeated abuse. The brain is probably the most damaged organ in children who experience abuse and domestic violence.

Trauma in the Brain

The implications for brain functioning in the flight, fight, or freeze response include the key neurotransmitters dopamine, epinephrine, and norepinephrine. These neurotransmitters are intimately connected to brain functioning, especially with problems such as substance abuse, depression, and anxiety. Beyond neurochemistry, one can also approach this issue using recent findings of developmental psychology and neurobiology. Infants are born with primitive regions of the brain, such as the infratentorial, already well formed; however, the new brain, the supratentorial region that includes the prefrontal cortex, is largely absent. The region is known as the higher region of the brain because it is physically above the infratentorial region and allows the functioning that makes people uniquely human and social. The supratentorial region controls self-conscious behavior and allows reasoning, self-control, learning, language, and other skills that enable an individual to negotiate by engaging with fellow humans.

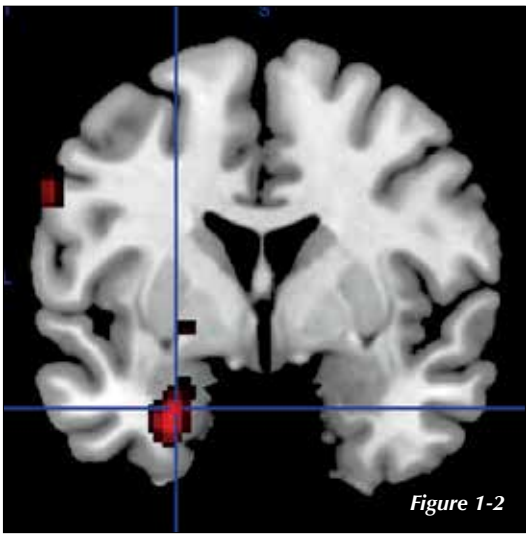

Figure 1-2. *fMRI data on abused youths with PTSD shows pronounced activation in the left amygdala and hippocampus (pictured) and lower activation in the dorsolateral prefrontal cortex (not pictured). This activation pattern, the neural response to photographs of angry, fearful, happy, sad, and neutral facial expressions, suggests that abused children have exaggerated fear responses to social cues and deficient responses in regulatory, executive control regions.*[17] *(Contributed by Amy Garrett, PhD; Stanford, CA.)*

Neither the physical dimensions of the prefrontal cortex nor its function are wholly determined by genetics. The neural pathways and the cellular structure of this part of the brain hold the physical record of an individual's relations with his or her social environment. The higher brain is built by relationships, especially early relationships with caregivers, particularly mothers. To a profound degree, interactions with caregivers build a child's brain over the course of the first 17 years of his or her life.[14-16] The neurochemistry outlined above suggests how this process might be disrupted by abusive behavior in social relationships. Neuroimaging is very suggestive of this disruption (see **Figure 1-2**).

Magnetic resonance imaging (MRI) and functional magnetic resonance imaging (fMRI) are recently developed tools that give science profound insights

into the functioning of the brain and its development. These tools have been directed at the problem of child abuse and have made important findings. A series of studies by De Bellis and colleagues reveal that brain imaging shows a smaller intracranial volume in children with a history of abuse when compared to children with less-troubled histories. Brain volume, which is crucial to processing long-term memory, is reduced in the prefrontal cortex as well as in the corpus callosum and hippocampus in children with histories of abuse.[13]

Treatment

Child abuse has existed throughout history, but there has been a lack of proper understanding of its long-term effects until recently, leading to misdiagnoses. These recent findings not only generate new insights into a serious social problem but also provide for potential approaches to treatment. Pinpointing the roots of the problem, in addition to realizations from neuroscience about neurogenesis and neuroplasticity, implies that much of this damage is reversible with proper evidence-based treatment.

The NCTSN recognizes at least 40 evidence-based practices with a proven ability to improve the lives of traumatized children. The first tool toward dealing with this issue is proper diagnosis. The DSM attempted to deal with all traumatic events with the diagnosis of PTSD. However, PTSD is best applied to adults who experience exposure to a one-time event like combat or a natural disaster; therefore, children with a history of abuse often do not meet the criteria for a PTSD diagnosis. Many children suffering developmental trauma are sorted into existing DSM categories, such as bipolar disorder, attention deficit hyperactivity disorder (ADHD), or depression. All of these diagnoses involve medication, many times with serious side effects.

An interesting finding of recent work offers a separate term for developmental trauma: ***complex trauma***. The rationale for using the term complex trauma is that it often involves many and varied traumatic events and, therefore, a complex number of causes. The researchers also found that the more complex a trauma history, the more diagnoses a given child would meet under the existing criteria of the DSM.

Nonetheless, researchers have now developed and deployed screening instruments that reliably identify both the existence and severity of trauma in children. This opens the way to treatment that ranges in intensity according to the degree of trauma in and resilience of an individual child.

The suite of available interventions is largely based on cognitive behavioral therapy and rarely involves medication, at least not in the long term. In all of these interventions, there tends to be a key common factor that acknowledges the somatic side of trauma and its effects. Therapists use a variety of devices to help clients remember traumatic events, and these memories can trigger a traumatic response. The therapist then teaches both cognitive and relaxation techniques to help clients process traumatic memories.

Trauma-Focused Cognitive Behavior Therapy (TF-CBT) incorporates psychoeducation about sexual abuse and PTSD; a description of the cognitive behavioral triad, ie, the interrelationships among thoughts, feelings, and behaviors; affect regulation; and relaxation skill training. It typically entails 12 therapeutic sessions. A critical element of TF-CBT is reciprocal inhibition, first described in 1958 by Wolpe in his work with World War II combat veterans.[18] In a classical sense, reciprocal inhibition refers to the prevention, inhibition, or interruption of a conditioned trauma response in the presence of a trauma stimulus, sometimes called a trauma trigger. Reciprocal inhibition can be effected by presenting the trauma stimulus abruptly, eg, implosion therapy or flooding,

Chapter 6

Intrafamilial Violence

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Key Points

1. Interfamilial (intrafamilial) violence has been described as a phenomenon that encompasses intimate partner violence (IPV) and child maltreatment, which are both serious public health issues.
2. IPV and child maltreatment are both associated with a variety of psychological and psychiatric comorbidities; therefore, mental health providers are among those professionals most often presented with the effects of family violence.
3. Many theories have been hypothesized to explain the development and transmission of child maltreatment and IPV, including social learning theory, attachment theory, biological theory, cognitive contextual model, and learning theory. Recently, the ecological model, also called the multifactor approach, has also been used to describe many forms of violence, including child maltreatment and IPV, that integrate key components of earlier theories.
4. Child maltreatment and IPV often co-occur, so some researchers suggest that children who are exposed to IPV may share characteristics with physically abused children.
5. In a home environment characterized by IPV, children may be affected in various ways, from witnessing violent acts, to being injured during violence between intimate partners, to being directly victimized. Many parents involved in IPV also engage in child maltreatment.
6. Youth reared in households with family violence carry risk for negative health, mental health, cognitive, and social outcomes.

Introduction

Interfamilial (intrafamilial) violence has been described as a phenomenon that encompasses intimate partner violence (IPV) and child maltreatment, which are both serious public health issues. The 2008 National Child Abuse and Neglect Data System (NCANDS) report identified 3.3 million referrals of child abuse and neglect from Child Protective Services (CPS) data. Of these referred cases, 1.5 million cases were assessed, 23.7% of which found that there was at least one child victim of abuse or neglect. Of the 772 000 children victimized by maltreatment, 71% experienced neglect, 16% were physically abused, 9% suffered from sexual abuse, and 7% were emotionally abused.[1]

The 2010 United States Department of Health and Human Services[1] (HHS) report also approximated that 1740 children died from abuse and neglect, a number that increased from its 2004 report. The National Violence Against Women Survey (NVAWS) 1995-1996 reported 1300 deaths from IPV annually.[2] Research on IPV and child maltreatment

examined both as a single construct and as separate phenomena, have identified contributing factors and broad zones of impact in the social, interpersonal, physical, and psychological realms. A World Health Organization (WHO) global study found IPV lifetime prevalence rates of 15% to 71% in 15 countries.[3] Thus, both child maltreatment and IPV have been identified as significant public health problems worldwide.

IPV and child maltreatment are associated with a variety of psychological and psychiatric comorbidities, therefore mental health providers are among those professionals most often presented with the effects of family violence. However, patterns of familial violence and their effects can be difficult for individual clinicians to discern, necessitating continued research into the insidious and lifelong impact of child maltreatment and IPV. This research is able to provide important insights into prevention of interfamilial violence and treatment of those affected. In this chapter, the authors will review the literature and current definitions of interfamilial violence, evaluate conceptual models, provide an overview of typical clinical presentations, investigate the societal impact, and finally, make recommendations for prevention and future directions for research. Although intrafamilial violence denotes a wide variety of relationships involving violence within a family, the authors will focus on IPV as a co-occurrence with child maltreatment, with the intent of informing mental health providers about this special subpopulation of child maltreatment survivors.

Background

The current terminology and concept of IPV is the result of a metamorphosis of many encapsulating titles, and has had a long and difficult social and legal history in American society. In early America, legal concepts were modeled on their ancestral British counterparts. The "Rules of Marriage," a common law of England in the 15th century, is such an example.[4]

The law allowed a husband to physically "discipline" his wife with a stick. The stipulation included that the stick diameter could not be wider than the diameter of his thumb, hence the phrase "rule of thumb" was coined.[4,5] However, actual practice of such "discipline" greatly varied.

In 1856, reports of domestic violence included the term "wife beating," which was used in a campaign for divorce reform in the United Kingdom.[6] By the 1870s, the first states banned a man's right to beat his wife and children. According to the "Wife Beaters Act" of 1882, the law allowed the courts to detain and imprison wife and child beaters.

Public awareness of IPV increased during the women's movement in the mid 1970s, when victims were recognized as "battered women" and male perpetrators were known as "batterers."[7] In 1974, the first battered women's shelter was established. The term ***domestic violence*** was used by many women advocates in order to stress a woman's risk of harm in the household and family.[7] In 1976, the "Domestic Violence Act" was introduced and allowed women to obtain a court order against a violent partner. During the time span of 1978 to 1984, further attempts were made to help victims of IPV. An office addressing domestic violence was established in the HHS in 1979, but was closed in 1981. The "Domestic Violence Prevention and Services Act" was proposed but did not pass. Then, a similar act entitled "The Family Violence Prevention Services Act" was passed in 1984, providing grants for programs.

Despite these legal accomplishments, the issue of IPV was neither publicly respected nor emphasized until the early 1990s. In 1994, the "Violence Against Women Act" helped to support research, law enforcement, and social services for IPV. The manner

in which police would respond to IPV and domestic disturbances was changed. In the 1970s, the protocol was to respond verbally by quelling situations and rendering warnings. By the 1990s, however, these warnings were increasingly replaced by making arrests and issuing temporary restraining orders. Previously, "domestic violence" was primarily used to describe female victims and male perpetrators,[7] with *intimate terrorism* denoting a patriarchal form of IPV.[8] Recently, however, perceptions of the perpetrator-victim have also been challenged by research into gender factors. Recent findings have increasingly recognized male victimization by women perpetrators.[7]

The term ***intimate partner violence*** (IPV) was developed to denote the shifting societal perceptions and research to describe those in a romantic relationship without regard to gender.[6] In this chapter, the authors will use this terminology throughout the text to denote violence within the context of a romantic relationship.

Definitions and Descriptions

IPV can occur between same-sex couples and heterosexual partners and may arise within the context of marriages, dating, family, friends, or cohabitation. The Centers for Disease Control and Prevention (CDC) definitions noted that sexual intimacy may not be involved in IPV and that the violence may vary in severity and frequency.[9] IPV is prevalent in all societies without respect to differences in race, age, sex, geography, culture, religious values, social context, and economic circumstances. Additionally, IPV can impact those beyond the family, including witnesses, friends, coworkers, and the community at large.

The term "intimate partner violence" has been used interchangeably in literature with the terms "domestic violence," "domestic abuse," and "spouse abuse." Common definitions and descriptions of IPV and differences in the terminology are listed in **Table 6-1**. Increasingly, researchers have focused on delineating and defining patterns of IPV to better inform legal and policy issues, as well as to aid in diagnosis, treatment, and prevention. Kelly and Johnson[7] described 4 forms of IPV—coercive controlling violence, violent resistance, situational couple violence, separation-instigated violence—and provided an additional descriptor, mutual violent control. ***Coercive controlling violence*** refers to emotional abuse and intimidation, coercion, and control that may overlap with physical violence. Of note, the current authors suggest that this description encompasses what women's advocates have termed "domestic violence." The pattern of ***violent resistance*** denotes that an IPV victim may resist a violent partner by also responding in a violent manner in an attempt to stand up to or stop the violence. ***Situational couple violence*** occurs without the influence of power and control. ***Separation-instigated violence*** refers to violence that arises with the separation of partners who have no previous history of violence. Finally, ***mutual violent control*** denotes a pattern of IPV in which both partners are coercive, controlling, and violent (see **Table 6-1**).[7]

Literature Review

The authors used the PsychInfo database to search for citations on the topic of intrafamilial violence from 1967 to 2010. The databases were queried using the MeSH terms "intimate partner violence" and "child abuse," as well as the term "child maltreatment." This search yielded 30 published manuscripts, chapters, and books. Five of those articles were selected, gathered, and summarized based on their relevance to IPV, child maltreatment, and/or the co-occurrence of IPV and child maltreatment. Outside of this initial search,[10] additional manuscripts were identified and reviewed as references from those 5 articles and sources of information from experts in the field of child maltreatment.

Table 6-1. Descriptions of Terms

Term	Types/Descriptions
Intimate Partner Violence (IPV) (also termed domestic violence, domestic abuse, spouse abuse, partner abuse, and battering)	Physical, sexual, or psychological harm by a partner or spouse in a current or past relationship. — *Physical violence*[9] — Use of intentional physical force that puts the victim at risk for death, disability, injury, or harm. — Examples include scratching, burning, and use of a weapon. — *Sexual violence*[9] — Use of physical force so a person engages in sexual activity (completed or not completed) against his/her will. — Engagement of any sexual act with a person who cannot understand the nature of the act and thus cannot decline or communicate unwillingness. — Examples include the inability to understand or communicate due to illness, disability, substance influences, intimidation, or pressure. — "Abusive sexual contact." — *Threats of physical or sexual violence*[9] — Use of words, gestures, or weapons in relaying the intent to inflict disability, injury, physical harm, or death. — *Psychological or emotional violence*[9] — Use of acts, threats of acts, or coercive tactics that cause trauma to the victim. — Examples include humiliating, controlling, and withholding information or resources from the victim. — *Economic abuse*[7] — Control of purchases, withholding of funds. — *Stalking*[2,9-11] — Involvement of indirect and noncontact acts that produce emotional distress or fear of harm. — Examples include written and verbal nonconsensual communication, threats, surveillance, harassment, loitering. — *Cyber-stalking* — A form of stalking that uses technology such as cell phones, fax machines, Internet, global positioning systems (GPS), Text Telephone/Telecommuniations Device for the Deaf (TTY/TTD) systems, and wireless video cameras.
Poly-victimization (also termed multi-type maltreatment and complex trauma)	Involves IPV and child maltreatment co-occurrence.

(continued)

Table 6-1. Descriptions of Terms ***(continued)***

Term	Types/Descriptions
Interfamilial violence (also termed family violence)	Incorporates partner-child maltreatment, nonoffending parent-child maltreatment, women's IPV, men's IPV, elder abuse, parent abuse, sibling violence, and domestic violence by police officers.[11]
Child exposure to IPV	Includes eyewitness to violent events, exposure to aftermath of violence, and the use of a child as an instrument for the perpetrator.[12]
Terrorizing	Use of threats or behaviors that may intimidate and terrify a child.[13] Some researchers suggest that child exposure to IPV may be a form of child maltreatment (psychological or emotional)[14] and that terrorizing may be a form of such psychological or emotional abuse.[13]

Epidemiology

As issues of IPV received increasing public and legal scrutiny, researchers were able to measure national frequency rates with more precision. The pervasiveness of IPV, child maltreatment, and their co-occurrence can be illustrated by the following statistics. The current prevalence and incidence rates in the literature data vary, with the lifetime prevalence rates for IPV against women ranging from 25% to 54%.[11] Statisticians noted that the numbers may be underestimated because of underreporting and single-date sources.[15]

Overall rates of IPV and child maltreatment are described in this section. As mentioned previously, the HHS report noted that 772 000 children were victims of maltreatment in 2008.[1] The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4) reported that their most recent child maltreatment rates are the lowest in the past 5 years.[12] Since 1993, IPV rates have also been declining. Based on population estimates, approximately 32 million women and men have been affected by IPV.[2,10] Looking specifically at child exposure to IPV, the United States Department of Justice finds that 35.2% of children were exposed to violence in households with IPV victims.[13] Similarly, the National Child Traumatic Stress Network (NCTSN) shows that 40% of children overall were exposed to IPV.[14] Finally, the base rate of co-occurrence of IPV and child maltreatment in a representative community sample is 6%.[16]

When reviewing cultural data within the United States, it is important to note that the rates among race and ethnicity data vary. Past reports, including the HHS report, indicated that the child maltreatment rate was twice as high among African American children compared to white or Hispanic children.[17,18] However, the NCTSN emphasizes that African Americans, American Indians, and Latin American children are overrepresented in reports of child maltreatment.[19] In a study of mothers who were victims of IPV and residing within the United States, it was postulated that the foreign-born status of mothers may increase the risk of child maltreatment.

The 2008 HHS report showed that almost one-half of child maltreatment victims were white at 45.1%, one-fifth were African American at 21.9%, and one-fifth were Hispanic at 20.8%.[1] The NCTSN assessed the association of ***complex trauma*** (defined as 2 or more trauma types) exposure within various ethnic groups and noted the following: 40% of these children overall were exposed to IPV; 60% of the children experienced 2

or more types of trauma. Among the group of children experiencing complex trauma, 69% of those children were white, 58% were black, 54% were American Indian, 39% were Asian, and 72% were Hispanic.[19] Looking at child exposure to IPV among ethnic groups, the NCTSN shows that 49% of children were white, 35% were black, 46% were American Indian, 30% were Asian, and 53% were Hispanic.[19]

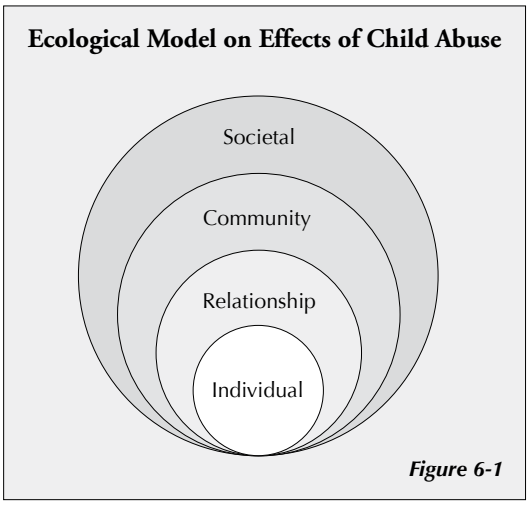
Reviewing the data on gender, population-based estimates report that 1.5 million women are abused, physically or sexually, within the context of IPV in the United States each year.[20] According to the United States Department of Justice report, there was an annual rate of abuse within IPV of 22% for female victims of IPV and 4% for male victims of IPV between 2001 and 2005.[18] Other authors have identified lifetime prevalence rates for females at 25% to 54%.[11,21,22] Varying estimates of male IPV victimization have been reported, ranging from 7.6% to 22.9%.[11,23] The NVAWS 1995-1996 found the occurrence of 1300 deaths annually from IPV.[20] Between 2001 and 2005, IPV partner perpetrators committed 30% of homicides against females and 5% against males.[13] Among female IPV victims, those aged 20 to 24 years were at greater risk for IPV.[13] Research suggests that IPV rates are increased during pregnancy. One study found that during and after pregnancy, 33% of mothers and 40% of fathers were affected by IPV.[24] This type of violence places both mother and infant at risk of perinatal death. As such, the leading cause of maternal death is IPV-related homicide, occurring at a rate of 13% to 24% of all deaths in pregnancy.[10]

Conceptual Models/Etiologies

Many theories have been hypothesized to explain the development and transmission of child maltreatment and IPV, including social learning theory, attachment theory, biological theory, cognitive contextual model, and learning theory. Recently, the ***ecological model***, also called the multifactor approach, has also been used to describe many forms of violence, including child maltreatment and IPV, integrating key components of earlier theories.[25]

First developed by Bronfenbrenner in 1979,[26] the ecological model emphasized that the individual exists within a social environment and hence must be understood within the context of these relationships.[27] The Panel on Research on Child Abuse and Neglect of the National Research Council also used this model, which consisted of several systems called "chronosystems" (individual, family, community, societal, and cultural) that interact with each other and operate over time.[28,29]

Figure 6-1.
Ecological Model.[32]



Garbarino applied ecological principles to the study of abuse and neglect, thus introducing the interactional nature of the roles of the parent and child, family, social stress, and social and cultural values.[30,31] The ecological model has repeatedly shown itself to be a useful paradigm from which to address factors associated with child abuse and neglect. In this chapter, the authors will describe the ecological model and how it incorporates concepts of prior theories, as illustrated in **Figure 6-1**.

Individual Level

At the core of the ecological model is the individual, with his or her unique characteristics. These unique characteristics are called ***ontogenetic development***, a term that has been used in literature to address

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