Health Council of the Netherlands

Treating the effects of child abuse

Gezondheidsraad
Health Council of the Netherlands

To the State Secretary of Health, Welfare and Sport

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Dear State Secretary,

I hereby submit the advisory report entitled *Treating the effects of child abuse*, which was requested by the former Minister for Youth and Families in a request for advice dated 17 February 2010. I have also sent a copy of this advisory report to the Minister of Security and Justice, for information purposes.

Every year in the Netherlands, an estimated 100,000 children are abused or neglected, some of whom suffer serious psychological damage. In recent years, much has been done to improve the prevention, detection, and reporting of child abuse. This has led to greater awareness about the seriousness, complexity, and scope of this major social problem. However, there must be a much greater awareness of this issue before we can even start work on a solution. This advisory report addresses the next step: treating the effects of child abuse.

The Committee has been forced to conclude that only a few types of evidence-supported treatment are available. This issue is not restricted to the Netherlands, it is a worldwide problem. The fragmentation of care, however, is a Dutch problem. This stands in the way of an integrated approach to the diagnosis and treatment of children, families, and adults who were abused during childhood.

Before this situation can be improved, the further encouragement of an evidence-based approach to work is an absolute necessity. It is also vital to create a solid foundation for scientific research, by monitoring and evaluating the procedures used in all of the care

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domains involved. Such practice-based evidence is invaluable for the final scientific support of commonly used interventions.

The Academische Werkplaats Kindermishandeling (Academic Collaborative Centre on Child Abuse) of the Haarlem Kinder- en Jeugdtraumacentrum (Centre for Traumatized Children and Adolescents), together with VU University Amsterdam and the Fier Fryslân multidisciplinary centre for the treatment of victims of child abuse are initiatives that will be launched this year. They will integrate the above-mentioned points. Accordingly, the Committee recommends that these initiatives be used as a testing ground for further policy development. The results of these initiatives on the effectiveness of an integrated approach, evidence-based working, and properly preparing the field for better research will not only be applicable to child abuse, but also to the care of juveniles with mental or developmental problems in general.

The advisory report has been reviewed by the Standing Committee on Public Health and the Standing Committee on Medicine.

I endorse the Committee's recommendations.

Yours sincerely,

(signed)
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to:

the State Secretary of Health, Welfare and Sport

No. 2011/11E, The Hague, June 28, 2011

The Health Council of the Netherlands, established in 1902, is an independent scientific advisory body. Its remit is “to advise the government and Parliament on the current level of knowledge with respect to public health issues and health (services) research...” (Section 22, Health Act).

The Health Council receives most requests for advice from the Ministers of Health, Welfare & Sport, Infrastructure & the Environment, Social Affairs & Employment, Economic Affairs, Agriculture & Innovation, and Education, Culture & Science. The Council can publish advisory reports on its own initiative. It usually does this in order to ask attention for developments or trends that are thought to be relevant to government policy.

Most Health Council reports are prepared by multidisciplinary committees of Dutch or, sometimes, foreign experts, appointed in a personal capacity. The reports are available to the public.

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Executive summary

Request for advice

Child abuse has always been with us and it takes many different forms. It is estimated that more than 100,000 children are abused in the Netherlands each year. In recent years, the government has taken strong measures to improve the prevention, detection, and reporting of child abuse. Given the lack of clarity concerning the available treatment options for juvenile and adult victims of child abuse, the Minister for Youth and Family has requested the Health Council's advice on this matter. He asked for a summary of the current level of knowledge regarding treatment of the effects of child abuse, and an explanation of the nature of these effects. He further requested an indication of the care requirement, and recommendations on how the care for victims can be improved.

Effects of child abuse

Child abuse can have a very significant impact on children's development and on their ability to function, the repercussions of which can continue into adulthood. Abuse adversely affects the development of children's brains, as well as their physical development. During childhood, the brain is characterised by enormous plasticity, so young children are more easily damaged. In very young children, abuse prevents them from establishing a secure attachment relationship with their parents, which severely impairs their general social abilities in later life.

Older children may develop behavioural problems and psychiatric disorders, the impact of which continues on into adulthood. It has also been shown that adults who were abused as children are more likely to suffer from chronic disorders like diabetes, cardiovascular diseases, and asthma.

Assessment

In cases of child abuse it is vital to get an accurate picture of the issues involved. This involves the child's development, its physical and psychological condition, as well as its safety. Consideration must also be given to factors in its surroundings, such as the social context and role of its parents or guardians, both as individuals and as mentors. At present, many different agencies and professionals are involved in collecting information of this kind. As a result, one or more elements of the assessment are often incomplete. A complete assessment is just as important in the case of adults who were abused as children. This is usually easier, as adults have greater autonomy and are more often able to supply information directly.

Treatment

Articles in the international scientific literature on well-researched, demonstrably effective treatments for the effects of child abuse are few and far between. In both children and adults, there is good evidence that Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are effective in treating the symptoms of post traumatic stress. Post-traumatic stress can result from various types of abuse. Currently, parent-child interaction therapy (PCIT) is the only intervention that has been shown to be effective in improving parent-child relationships, following the physical abuse of children.

Treatment guidelines (giving details of interventions) are available for a range of psychiatric disorders in which abuse can be a contributory factor. However, these do not always make specific allowance for a background of abuse.

The lack of demonstrably effective interventions is not restricted to the Netherlands, it is a worldwide problem. The fact remains that therapists in the Netherlands use a wide range of interventions whose mechanism of action and effectiveness have not been properly substantiated.

An integrated approach is of critical importance in terms of accurate assessment and effective treatment. Accordingly, rather than identifying and tackling issues one at a time, assessment and treatment take place simultaneously in several different areas. This might involve providing a safe environment and treatment for the child, while at the same time addressing the parents' problems, where applicable.

Care requirement

Quantifying the care requirement is no easy matter. Firstly, there is no accurate data on the occurrence of child abuse. Secondly, there is no way to predict which type of harm will result from a given type of abuse, or indeed the period of time for which these effects will persist. What is clear is that this is a substantial problem, involving a year-on-year requirement for the psycho-education of all new victims. In addition, many of these cases will need further care.

The adult victims of child abuse are keen to end the taboo on discussing child abuse, both among caregivers and in society at large. They further emphasise the importance of skilled and empathetic caregivers.

Availability of care

The care infrastructure for victims of child abuse is enormously complex. The children involved, and their parents, will be seen by professionals from social services, youth care services, child healthcare, youth mental health care, and the regular health care system. They may also receive general mental health care, addiction treatment and care, and assistance with debt restructuring. In addition to being seen by social workers, adults who were abused as children may receive mental health care, health care, and public mental health care, as well as addiction treatment and care. Sadly, the various health care domains do not always interact with one another as effectively as they should.

TF-CBT, PCIT, and EMDR are not currently available in all parts of the country. The use of TF-CBT and EMDR requires proper training and supervision. There is insufficient compliance with guidelines in which CBT is the preferred treatment.

Recommendations

The Committee urges that care development be directed towards an integrated approach. This would involve intensive, multidisciplinary collaboration between caregivers and agencies at key moments in care. In addition, there would be an integrated approach to the issues affecting abused children and those closest to them, or to the issues affecting adults who were abused as children. Two initiatives have been launched to develop a comprehensive approach over the next few years, and to explore its effectiveness. The first of these, the *Academische Werkplaats Kindermishandeling* (academic work centre on child abuse issues), is a collaborative venture between VU (Free University) Amsterdam and the Haarlem *Kinder- en jeugdtraumacentrum* (centre for traumatised children and young people). The second is a plan by Fier Fryslân to establish a multidisciplinary centre for the treatment of victims of child abuse. The Committee recommends that these initiatives be supported, for instance by facilitating their effective assessment.

Since these two initiatives focus on children, the Committee also recommends installing an academic work centre focussing on adults who were abused as children, complementing the activities of the *Landelijk Centrum Vroegkinderlijke chronische Traumatisering* (Netherlands Centre for Chronic Early Childhood Traumatisation).

The ground must be properly prepared before further, more effective research can be conducted into treatment options following child abuse. The first step involves making a systematic and structured record of the intervention chosen (including the reasons behind this choice), and its outcome. This approach makes it possible to gather practice-based evidence. This can then be used to implement larger-scale scientific studies that are capable of providing a springboard for evidence-based practice. In theory this is already an aspect of psychiatric practice, in the form of routine outcome monitoring. Youth care services in particular also need a system of this kind. While the ground is being prepared for research, other work can pave the way for evidence-based practice in all areas of care that deal with child abuse, particularly youth care services. A possible option here is community-based learning, as used in various parts of the United States.

If the quality of care is to be improved then a great deal of training will be needed for caregivers in the field of child abuse. The assessment and treatment of the

effects of child abuse is a specialised job, one that requires considerable expertise. This specialised training requirement could be met with support from the recently established *Landelijk Opleidingscentrum Aanpak Kindermishandeling (*national training centre for tackling child abuse issues).

Chapter 1

Introduction

1.1 Background

Child abuse is a major social problem, affecting more than 100,000 children each year. The adverse effects of child abuse often are often a lifelong burden. Adults who were abused during childhood are more prone to psychological and physical problems, homelessness, domestic violence, criminality, and addiction. They are also more likely to abuse their own children. In this way, damaging effects at the level of individuals are translated into significant social damage involving high social costs. Despite the long-standing history of government policy on child abuse (dating back to the introduction of “Children’s legislation” in 1901) this remains a persistent problem.[1]

In recent years, the government has taken measures to improve the prevention, detection, reporting, and eradication of child abuse.[2] This advisory report takes the next step, by addressing the treatment of child abuse. As yet, there is no detailed understanding of the exact care needs of victims of child abuse nor is it known whether the currently available options are adequate. There is also an inadequate awareness of the range of evidence-supported treatments for the victims of child abuse. These considerations, together with a request from the Lower House of the Dutch parliament, prompted the Minister for Youth and Families to approach the Health Council of the Netherlands for advice.

1.2 Request for advice

In February 2010, the Health Council received a request for its advice on the following questions (Annex A):

1 Do we have a clear understanding of the types of physical and psychological disorders that can develop as a result of child abuse?
2 What are the needs of child abuse victims, in terms of psychiatric care and trauma care? Are these needs primarily clinical or social in nature?
3 What evidence-supported interventions are currently available in the area of treatment, both in clinical and social terms?
4 What scientific gaps can be identified in the area of treatment?
5 Are the requisite interventions available throughout the country and are they and accessible to all victims (children and adults)?
6 If not, then can you advise on ways of improving their availability and accessibility?

The Minister asked the Health Council to base its response to these questions on the forms of child abuse defined in the Youth Care Act, and to frame its reply with reference both to abused children and to adults who were abused during childhood and who are still affected by this experience.

This request for advice is entirely separate from the investigations launched in 2010 into sexual abuse in the Roman Catholic Church (the Deetman Committee), sexual abuse in child welfare institutions (the Samson Committee), and the sexual abuse of children in three Amsterdam crèches (the Gunning Commission). Discussions have taken place at secretarial level to avoid potential overlap.

1.3 Methodology and demarcation

In preparation of this advisory report, the Health Council appointed a committee chaired by Prof. E. Schadé (Annex B). The Committee, which started its deliberations in March 2010, has met on a total of six occasions.

The Committee has carried out a literature survey into the effects of abuse and the current level of knowledge regarding their treatment. In addition, the Committee has focused particularly on systematic reviews, supplemented with grey literature (reports, publications by government institutes, or research institutes that have not been published in peer-reviewed journals). Full details in support of this approach are given in Annex C. As the literature occasionally

failed to provide sufficient information, the clinical and scientific experience and expertise of the Committee members themselves also served as an important source of information.

The care needs of victims were broadly identified through discussions with various victims' associations and from the reports of meetings and conferences held by victims and care practitioners (Annex D). The Committee is cognisant of the fact that this approach omitted an important group, namely children who are abused. In view of various legal concerns, the Committee decided against including this vulnerable group in its discussions. In retrospect, the care needs of children were, to some extent, distilled from talks with victim's associations.

An overview of care provision was obtained through interviews with care practitioners and institutions, and through surveys focusing mainly on grey literature and the websites of institutions and partnerships.

As part of the whole advisory process, interviews were held with various experts (Annex D).

The advisory report deals with children (aged 0-12), adolescents (aged 12-18), and adults (aged 18 and above) who were abused during childhood. Given the broad nature of the request for advice and the limited time available, the Committee has divided the complex and comprehensive material into various categories. Primary prevention, the detection and reporting of child abuse, as well as the legal (e.g. effects of authority issues in terms of treatment) and forensic (e.g. treatment of delinquent youths with a history of abuse in Youth Custody Centres) aspects were not taken into consideration. Prevention and detection, which were not specifically included in the request for advice, have been central pillars of government policy in recent years. These issues will continue to be a focus of attention in the years to come. The legal and forensic aspects of child abuse are diverse and complex in nature. Accordingly, what is needed is something other than a purely health-based approach.

The advisory report has been reviewed by the Standing Committee on Public Health and the Standing Committee on Medicine.

1.4 Structure of the advisory report

In Chapter 2, the Committee gives a well-considered outline of the context of this subject. Drawing partly on a historical survey, this focuses on what child abuse involves, and how often it occurs. The advisory report's approach, which is mainly clinical in nature, is introduced through the social aspects of child abuse.

Chapter 3 then outlines the possible repercussions of child abuse in children and adults. Chapter 4 explores the issue of assessment.* and to the treatment of abused children. This is followed, in Chapter 5, by a consideration of the assessment and treatment of adults who were abused as children, and of the care needs of victims of child abuse. Chapters 4 and 5 also deal with issues pertaining to the care infrastructure. Finally, the Committee presents its conclusions and recommendations in Chapter 6.

For an explanation of the numerous abbreviations used in this advisory report, see Annex E.

* The Committee takes assessment to mean assessing the social context of the child, family or adult who was abused during childhood. It also refers to the diagnosis of somatic and psychological symptoms resulting from this abuse.

Chapter 2

Child abuse: a social and clinical problem

This Chapter describes the landscape of what is meant by "child abuse" in 2011, and what is known about its occurrence. While the request for advice focuses on the clinical context, child abuse is also a social issue in which standards are involved. In outlining the background issues, the Committee seeks to depict the interrelationships of the various elements involved.

2.1 Child abuse down through the years

The phenomenon of child abuse is as old as the hills. It has taken many forms in numerous cultures throughout the world, and continues to do so today. Children have been – and still are – subjected to physical punishment, exploitation and abuse as labourers, and to sexual abuse, as well as physical and emotional neglect. Descriptions of this phenomenon have been found in sources dating back to the dawn of written history. This section provides a brief historical overview of the focus on child abuse, in the social and clinical senses of the term.

2.1.1 Social focus on child abuse

From the 19th century onwards, there was a visible change in attitudes on how to deal with children. The view that children were miniature adults evolved into a realisation that children need to be supervised during their path to adulthood. Excessive punishment was made a criminal offence, child labour for children

below the age of 12 was banned (1874), and the first Compulsory Education Act came into effect (1901). In 1905, this was followed by the “Children’s legislation” promulgated by Cort van der Linden, which included measures relating to child protection and juvenile law. As a result, there was a radical shift in the relative positions of parents and children. Children were no longer the property of their parents, and parenting became a duty. A similar piece of legislation was the 1922 Family Supervision Act, which allowed juvenile courts to assign a temporary or permanent family guardian to assist parents (with or without their consent) in raising their children. In 1956, the Child Care and Protection Board was established. Its duties still include advising the courts on child protection measures and parental authority.

In the mid-Sixties, publications by the American paediatrician Henry Kempe caused child abuse to be identified (or rediscovered) as a major social problem. Kempe was the first to draw attention to child abuse and to cite it in a medical context. His article “The battered-child syndrome” was published in the Journal of the American Medical Association (JAMA) in July 1962.[3] In 1969, in the Netherlands, this led to the establishment of a committee of inquiry (chaired by Roelof Kruisinga, then State Secretary of Health) into ways of dealing with child abuse. The Dutch Society for the Prevention of Cruelty to Children (now known as *Stichting Voorkoming Kindermishandeling*) was founded in 1970. The Child Abuse Medical Counselling Centre (BVA) was established in 1972, at the recommendation of the Kruisinga committee of inquiry. Physicians and others were able to report suspected cases of child abuse to the BVA. Initially the emphasis was mainly on physical abuse. Scant consideration was given to the issue of psychological abuse, even though a book was published on this topic as early as 1957.[4]

There was an increasing focus on child abuse during the 1970s and 1980s. One of the themes was the sexual abuse of children (including young children). The “sexual revolution” of the 1970s sparked a debate on the “liberalization” of paedo-sexuality. By the early 1980s, however, many were pointing out the downside of this trend, which was “child sexual abuse”. This led Hedy d'Ancona (then a State Secretary) to place violence against women and girls on the political agenda by organising a study conference on this issue (Kijkduin, 1982) and by launching scientific research in this field (the studies by Römkens and Draijer).

There were no standard procedures for the reporting of child abuse or for care referral. Nor were parents always involved in youth care. Following the Bolderkar Affair (suspected but unproven cases of child abuse) in 1988, a

committee was appointed to formulate rules to this end. A widely discussed topic at that time, was the plight of abused women. The term “domestic violence” was introduced and the Dutch College of General Practitioners devoted its annual conference to the subject.[5] (although it did not follow up on this issue until 2009, when the *Landelijke Eerstelijns Samenwerkingsafspraak Kindermishandeling* (National Primary Care Collaborative Agreement on Child Abuse) was published.[6])

There was a tendency to view child abuse as a form of domestic violence. As a result, there was a risk that the specific interests of the child would fade into the background.

In 1989, the United Nations adopted the International Convention on the Rights of the Child. This convention also provided for an expansion of the concept of child abuse. This was because child abuse gradually came to be equated to the violation of major children’s rights, including the right to care and protection.

In 1992, the Youth Services Act was passed to unify the fragmented care available in care facilities and institutions at that time. This legislation shifted responsibility from central government to the provincial authorities. The latter set up a Youth Care Agency to act as a network and to better coordinate the general support given to young people. The Lower House of the Dutch Parliament also decided that high-profile, child abuse reporting centres (using transparent and uniform procedures) should be established at provincial level. Based on a recommendation by the Working Group on Reporting Centres for Child Abuse and Neglect, this takes the form of Advice and Reporting Centres for Child Abuse and Neglect (AMKs).[7]

From the start of the 21st century, following various tragic events (cases such as Rowena, Savanna, and the Meuse Girl), youth care services increased its focus on the safety of the child.

In 2005, the Youth Care Act replaced the Youth Services Act, which was deemed no longer fit for purpose. The Youth Care Agency gained the official status of a separate institution whose role is primarily one of coordination, indexing and referral.[8]

From 2007 to 2010, André Rouvoet (the first and, as yet, only Minister for Youth and Families) took strong measures to improve the prevention, detection, and reporting of child abuse. Work is currently in progress at ministerial level on a

new adaptation to the youth care system. The biggest change involves decentralisation of youth care services to the local authorities.

The details set out above show that child abuse has been a recognised social problem for many years. Clearly, it is also difficult to get a grip on this issue, and to organise effective clinical and social care.

2.1.2 Child abuse in the clinical context

Kempe's 1962 article, (referred to above) also caused quite a stir in medical circles. Since then, increasing numbers of medical articles have been published about identifying child abuse. More recently, there have been a spate of articles on treatment of the effects of such abuse.

As a result, the social problem of child abuse has now acquired a clear medical component. However, here too, it has proved difficult to get a grip on the problem. Accordingly, the medical/scientific focus does not necessarily result in the effective organisation of medical identification and care. In 2008, for example, an investigation by the Netherlands Health Care Inspectorate revealed that most hospitals in the Netherlands have no child abuse policy in place. Last year, the same was found to be true of general practices. Nor, in the psychiatric treatment of adults who were abused during childhood, is consideration automatically given to their own role as parents. Despite a continually renewed public focus on child abuse, the health service still has relatively poor record when it comes to detecting such cases. However, this situation is gradually improving. [9-11] Witness the debate surrounding the introduction of a reporting code or obligatory notification, many healthcare professionals are still largely unaware of how to deal with suspected child abuse. Since the 1980s, the emphasis on child abuse in educational programmes and training courses has periodically waxed and waned. As yet, however, this has clearly failed to take root, as shown by the lack of a consistent focus on this topic.[12]. The Netherlands Youth Institute (NJi) has now launched a stocktaking survey into the focus on child abuse in medical training programmes.

2.2 Child abuse, what does it involve?

Over the years, changing normative insights have been reflected by changing definitions of child abuse.

The 2005 Youth Care Act defines child abuse as:

any kind of interaction (involving threats or violence to a minor) of a physical, psychological, or sexual nature, passively or actively imposed by the parents or other individuals with whom the minor is in a relationship characterised by dependency or lack of freedom, actually or potentially resulting in serious harm to the child in the form of physical or psychological injury.[13]

The World Health Organization (WHO) defines child abuse as the mistreatment and neglect of children below the age of 18. This includes all types of physical and/or emotional abuse, sexual abuse, physical and emotional neglect, and commercial and other forms of exploitation resulting in actual or potential harm to the health, survival, development or dignity of the child, in the context of a relationship of responsibility, trust or power. The WHO also views exposure to domestic violence between the child's parents/guardians as a form of child abuse.[14]

These definitions are much broader than those cited in the first real clinical article on this topic, published by Kempe et al in 1962 (see above).[3] This article's definition of child abuse referred only to physical abuse by the parents. Prof. H.E.M Baartman, Emeritus Professor of Prevention and Care in Child Abuse (VU University Amsterdam) considers this expansion of definitions along two lines: horizontal and vertical.[15]

Horizontal expansion means that the term child abuse has come to involve a widening range of different behaviours (physical violence, sexual abuse, emotional neglect, etc.) and a widening range of possible offenders including (parents, other relatives, male or female neighbours, teachers, etc.).

Vertical expansion relates to the cultural component, i.e. exactly what it is that society considers to be abuse. Whereas "spanking" or a smack on the hand with a ruler were once accepted aspects of parenting, such actions are less tolerated in Dutch culture today. They are seen as being in contravention of current norms, and are therefore more readily viewed as abuse. This varies from one culture to another.

A third development outlined by Baartman, is that child abuse has come to symbolise a focus on the importance of a safe environment in which to raise children. It has now become clear that children who "just" witness domestic violence, can indeed become traumatized by this.[16] This means that witnessing

domestic violence is now also considered to be a form of child abuse. In addition, half of those children who witness violence between their parents are themselves also abused.[17] Accordingly, this focus on the safety of children has also contributed to an expansion of the concept of child abuse.[15]

The Committee notes that the various definitions have a high degree of *sensitivity* inasmuch as they cover all forms of child abuse. However, this high *sensitivity* is reflected by a decrease in *specificity:* what really is neglect or abuse, and what is not? In many cases this will be quite obvious, but sometimes it is difficult to know where to draw the line. There is a normative aspect to the issue of whether something is seen as abuse or neglect.

The Committee also notes that the word “serious” involves a value judgement that is difficult to interpret in objective terms. What is viewed as “serious” will differ from one victim to another. This may complicate the task of tailoring treatment and other forms of assistance to the victim and those around them.

In the definition of child abuse, literature sources and those in everyday practice recognise various types of child abuse. On the one hand, it has just evolved this way over the course of time, and on the other it is a product of diagnosis, as different types of abuse can have different effects. The Child Abuse Action Plan draws a distinction between: sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect, and witnessing acts of domestic violence.[2] Baartman distinguished between violence, neglect, sexual abuse, exploitation, violation of the right to – or capability for – self-determination, and Munchausen by proxy.[15] In the 2005 NPM (National Prevalence Study on the Abuse of Children and Adolescents) study, Van IJzendoorn et al draw a distinction between sexual abuse, physical (bodily) abuse, emotional abuse, physical neglect, neglect of education, emotional neglect and other forms of abuse.[18] The 2005 NPM study also provides extensive definitions of the various forms of abuse. These are needed to consistently assign occurrence scores.[18]

In 2007, the Trimbos Institute’s NEMESIS study (Netherlands Mental Health Survey and Incidence Study) identified sexual abuse, physical abuse, emotional neglect, and psychological abuse.[19]

For the purposes of this advisory report, the Committee has used the definition given in the Youth Care Act. This is primarily based on cases of child abuse where physical or mental damage has been inflicted that is sufficiently severe to

require treatment, now or in the future. The Youth Care Act is the portal to treatment and care.

2.3 How prevalent is child abuse?

2.3.1 The limitations of estimates

Determining the occurrence of child abuse is no easy matter. This is borne out by the fact that different studies have produced substantially different figures. In April 2010, the Australian National Child Protection Clearinghouse (NCPC) produced a resource sheet on the occurrence of child abuse and neglect. This well-structured document sets out a number of methodological factors that have a powerful strong influence on estimates based on retrospective population studies. These factors are the definition of child abuse, the formulation of questions asked in interviews, the number of questions asked, and the population being studied.[20]

The breadth of the definition of child abuse, or specific forms thereof, directly affects estimates. The narrower the definition, the lower the occurrence.

If the study involves interviewing a group from the general population, then the way in which the questions are formulated affects the type of replies given. Many people prefer not to think of themselves as victims (were you emotionally abused as a child?). According to the NCPC, questions that describe behaviour generally elucidate more truthful answers (did your parents systematically humiliate you?). Which individuals are selected for questioning also makes a difference. Patients in the mental health system are more likely to report a history of abuse as children than the average citizen. Researchers generally attempt to draw samples that are as representative as possible of the general population. Nevertheless, the study populations in many studies still exhibit a degree of selection, which may produce overestimates or underestimates of abuse as a result.

Other factors that affect estimates are the period to which the questions relate, the period in which the study takes place, the degree of non-response, and the country in which the study is carried out. Those studies that use reports issued by professionals suffer from the restriction that such reports are selective.

2.3.2 How prevalent is it in the Netherlands?

In the Netherlands too, estimates of the occurrence of child abuse vary from one study to another. Occurrence has been the subject of research since the 1980s.

Table 1 summarises some important Dutch studies. These studies' estimates are based on various reports (such as NPM 2005) and on retrospective population studies (NEMESIS, "School Pupils On Abuse", Draijer and Römkens).

According to the 2005 NPM study by Van IJzendoorn et al, it is estimated that more than 107,000 reports of the neglect or mistreatment of children are made in the Netherlands each year.[18*] Nearly 30% of respondents in the NEMESIS study indicated that they had suffered some form of abuse during their childhood.[19]

Among the participants of the School Pupils On Abuse study (SOM), 37% reported that they had at some time been victims of abuse. For 20% of these individuals, that had occurred in the preceding 12 months.[21]

Differences between the various Dutch studies can, to some extent at least, be accounted for by methodological factors. Figures derived from reports made by professionals are consistently much lower than data obtained from a sample of the general population. It would seem that a great deal of abuse either remains invisible and/or is not reported. One possible factor is that details of abuse may not emerge until the victims reach adulthood (even late adulthood) and develop psychiatric or physical problems. Given the enormous focus on the reporting of child abuse in recent years, it will be interesting to see whether the occurrence figures for these two approaches will start to converge.

2.3.3 *How prevalent is child abuse in other countries?*

The Committee has examined a number of recent foreign studies. In the U.S., the Centers for Disease Control and Prevention (CDC) indicated that, based on research from the U.S. Department of Health and Human Services (drawing on reports from child protective services), in 2008 over 10% of all children were victims of some form of abuse, three quarters of them for the first time. Another study estimated occurrence at 20%.[24,25]

The Australian NCPC has conducted a survey of major Australian studies into the occurrence of child abuse. The relevant studies all used retrospective interviews with a sample of subjects drawn from the general population. These figures indicate the number of people who suffered abuse at some time during their childhood. The data reveals that 5-10% suffered physical abuse, 11% emotional abuse, 12-23% witnessed domestic violence, 4-16% involved the sexual abuse of boys and 7-36% the sexual abuse of girls. Based on the available

* The results of NPM 2010 have been published in August 2011.

data, it was not possible to make any definitive statements about the occurrence of neglect. The studies make no comment on overall prevalence, as a given type of abuse is usually accompanied by other forms of abuse.[20]

The most recent study from the United Kingdom dates from 2005. Nearly 3000 young adults between the ages of 18 and 24 were selected at random (*postcode address file* as a sampling frame) and interviewed by trained interviewers. Ninety percent of these individuals expressed the view that they had grown up in a loving, caring family. Sixteen percent of respondents had encountered some form of abuse before their sixteenth year, some of them outside their own family.[26]

A recent systematic review on the prevalence of sexual abuse in Switzerland indicates that the included studies exhibit such widely differing results that it is difficult to draw conclusions about the true occurrence. The numbers given range up to 40% for girls and up to 11% for boys. The authors conclude that sexual abuse is just as common in Switzerland as in other European countries.[27]

Data from other countries differ from one study to another, as in the Netherlands. Given the nature of the problem and the complexity of prevalence studies estimates should be used. Generally speaking, it can be concluded that the figures for other Western countries are of the same order of magnitude as those for the Netherlands. Child abuse is a significant problem everywhere.

2.4 Under what circumstances does child abuse occur?

Child abuse is not restricted to a particular culture or social class, it occurs in all walks of life and all ethnic groups. What is clear is that, under certain circumstances, the risk of child abuse increases (there are known risk factors). There are also circumstances that are known to actually reduce the risk of abuse (so-called "protective factors"). The factors in question operate at different levels:

- factors that have an impact on the occurrence of abuse
- factors that have an impact on the effects of abuse
- factors that determine sensitivity to treatment .

For the sake of completeness, this section will briefly explore the factors that have an impact on the occurrence of abuse (topic not listed in the request for advice). Chapter 3 discusses the factors that have an impact on the effects of abuse and susceptibility to treatment.

Table 1 Summary of Dutch studies on the occurrence of child abuse.

Author	Study	Study population	Method	Estimate of the scope of the problem			
				Sexual abuse	Physical abuse	Emotional abuse	Neglect
Van IJzendoorn (2007)[18]	NPM 2005	Children aged 0-17, reported by AMKs and professionals n = 858	Registrations Current abuse	4834	19 815	11 732	61 958 (physical and emotional)
				Estimation of the total number of children in the Netherlands, from 0-17 years of age, who were registered as having been abused in 2005, by type of abuse			
Verdurmen (2007)[19]	NEMESIS	Adults aged 18-64 n=7076	Multistage, stratified random sampling, diagnostic interviews Retrospective	6.9%	7.3%	11.8%	22.8% (emotional)
				Estimation of % adults, aged 18-64, in the Dutch population, who have stated that they suffered abuse at some time during their childhood, by type of abuse			
Lamers-Winkelman (2007)[21]	SOM	Secondary school pupils aged 12-16 n = 1845	Specially designed questionnaire (VVNG) Current/ retrospective	79	157	221	52 (physical and emotional)
				Estimate of number of individuals per 1000 young people aged 12-16 who have suffered abuse at some time during their childhood, by type of abuse			
Draijer (1988)[22]	National sexual abuse study by Ministry of Social Affairs and Employment (SZW)	Women aged 20-40 n = 1054	Interviews Retrospective	15.6% by relatives 7% inside and outside the family	11.5% (one third of which also involves abuse within the family)		6.5%
				Estimation of percentage of women, aged 20-40, claiming to have suffered abuse at some time during their childhood, by type of abuse			
Römkens (1989)[23]	National study into violence against women University of Amsterdam (UvA)	Adult women n = 1016	Interviews Retrospective	18%	34%	17% (witness domestic violence)	
				Estimation of percentage of adult women who have stated that they suffered abuse at some time during their childhood, by type of abuse			

2.4.1 *Risk factors that promote abuse*

There is no single cause of child abuse. In the 2003 “League table of child maltreatment deaths in rich nations”, UNICEF warned against placing undue weight on an association between child abuse and a single, distinct risk factor.

That would be unfair to families that succeed in raising their children without abuse, despite the presence of such a risk factor. Meanwhile, there is broad consensus within the youth care service on the best way of identifying children who are at genuinely increased risk of abuse. This involves the cumulative effect of various combined risk factors. UNICEF identifies four factors as major risk factors[28]:

- Alcohol and drug abuse by the parents – often associated with poverty and low socioeconomic status, but also an important risk factor in its own right
- Domestic violence
- Poverty and stress
- Violence in society – in areas where violence is common, such as war zones, child abuse is also more common.

Risk factors that also have an impact in the Netherlands are related to the family's socioeconomic situation (unemployment, social isolation, family breakdown), to mental health (psychological problems, domestic violence), to the parents' teaching skills, and to the child's mental and physical health (premature birth, physical or intellectual disability, developmental disorders, temperament). The presence of such risk factors places a family under great pressure. An additional stressor, or simply a combination of two or more of these risk factors, may induce abuse. The specific interaction of risk factors and protective factors between parent and child is also important here. For example: temperamental parents with a quiet healthy baby can be just fine, while the same parents might quickly lose patience with an infant that tends to cry a lot.[15,17,18,21,29-33]

2.4.2 Protective factors against abuse

Protective factors counterbalance the risk factors affecting the child, those entrusted with its upbringing, and its family environment. They ensure that, despite any risk factors that might be present, no abuse actually takes place. Protective factors may involve both the child and those entrusted with its upbringing. They are mainly related to social welfare (harmonious relationships, social support, no unresolved issues), intelligence and personality.[28,29,34,35]

2.5 Conclusion

Despite being at the focus of government and public attention for more than a century, child abuse continues to be a relevant and common social problem.

There are many different definitions of child abuse, partly because the concept is subject to cultural and normative interpretation. In the Netherlands and elsewhere, the term “child abuse” has been continually expanded over the past century. Initially, it related only to physical abuse by parents. Later on, it came to include psychological abuse, neglect, and witnessing domestic violence.

The prevalence of child abuse cannot be determined with any accuracy. This is usually because it is not clear exactly when the abuse started, also different forms often occur side by side, and a great deal of abuse may not be revealed until the victims reach adulthood. Furthermore, there are still taboos about discussing abuse, or reporting actual or suspected cases. In addition, the outcome is affected by the nature of the research method used (who is questioned, and when and how is this done). What is clear, however, is that abuse is common. This makes it a major public health problem, one that merits urgent and sustained attention.

Chapter 3

Effects of child abuse

This Chapter addresses the possible impact of child abuse on children in different age groups up to, and including, adulthood, and the implications for treatment. Firstly, the Committee outlines factors inherent to the individual victim that can either limit or aggravate the effects of child abuse.

3.1 Resilience

The extent to which victims of child abuse are actually damaged depends on a range of factors. Accordingly, there is no “one size fits all” when it comes to the damage inflicted on victims. The ability to continue functioning effectively in terms of behaviour, emotions, social skills, and social participation (such as education and work) after an earth-shattering event or during a particular stage of development is referred to as resilience. Resilience is a dynamic process, which involves a positive adjustment in the face of adversity.[36,37] Rutter defines resilience as relative resistance to high-risk experiences, or as the ability to cope with stress or adverse effects.[38,39] In the literature on personality, resilience is also seen as a relatively stable characteristic that influences the way children deal with their environment (i.e. even with a threatening environment).[40]

What exactly is resilience? Are there factors that can be used to predict an individual's level of resilience? Child abuse is less common in highly intelligent individuals of good socioeconomic status. Intelligence, gender, and living in a

good, quiet neighbourhood do not appear to be associated with resilience.[41-43] Jaffee et al did find relationships between IQ and an easy temperament and resilience in boys. The authors present a model involving the rising effect of stressors on resilience, or in terms of damage inflicted. Where the stressors involved are short term, or few in number, intelligence coupled with an easy temperament can help individuals to resolve the traumatic experience in question. As the stressors become more frequent or more intrusive, the effect of IQ and temperament diminishes. Where the stress is frequent and severe, all victims become damaged.[41]

Studies of resilience invariably cite good-quality interpersonal relationships as a major factor in dealing with threatening situations in the vicinity. These are relationships that occur from early childhood well into adulthood.[41,42,44-46] In this connection, secure attachment as an infant and toddler (the first and most basic of interpersonal relationships) is of crucial importance (see also Section 3.3). In addition, a child's personal characteristics will affect the nature of its relationships.

Physical and sexual abuse often occur in a context of emotional neglect and insecure attachment relationships, which themselves have an adverse impact on a child's developmental potential and subsequent mental health. Accordingly, the national survey study on sexual abuse showed that emotional neglect was a determinant for subsequent complaints, but that abuse operated independently to compound the damage.[22,46] The accumulation of adverse life experiences also serves to exacerbate later effects. Those who have suffered multiple types of abuse are often the most severely affected. Conversely, a secure attachment creates a sort of inner shield (or resilience) against the adverse effects of stressful experiences.

In the field of developmental psychology, research has recently been carried out into differential susceptibility. Differences in children's temperaments are linked to differences in their sensitivity (positive or negative) to environmental factors.[47] This could also involve susceptibility to damage induced by traumatic experiences. Consequently, susceptibility to damage and the way in which this is manifested are partly determined the individual's temperament. Temperament is a component of personality and is not the same as behaviour. An individual's temperament is fairly stable over time, and appears to be reasonably well formed by the third year of life. Research shows that children with easy temperaments often do well. The way in which they are raised does not have a huge influence on this. In children with difficult temperaments, things are more complicated.[48-50]

Children with easy temperaments are generally better able to engage in good, stable relationships, thereby limiting their risk of abuse and any associated damage.[51] Temperament is also important in terms of adverse effects, e.g. whether they manifest themselves as externalising or internalising behavioural problems. It is important always to examine such children carefully, and to exploit their intrinsic strengths.

At the same time, there is evidence that temperament can be influenced by traumatic experiences such as child abuse. According to the "scar" hypothesis, traumatic experiences can permanently scar a child's temperament. This would be particularly important (but not exclusively so) in cases of early abuse during babyhood and infancy before the child's temperament has developed a degree of stability.[52]

3.2 Neurophysiology

Over the past twenty years, it has become clear that stress and trauma affect the organisation and function of the brain. It was long believed that children are very resilient, partly because their brain still retains a high degree of plasticity. However, it is now clear that the very plasticity of children's brains means that adverse experiences can lead to major disturbances of brain function. In young victims of abuse, this can include a reduction in the amount grey matter in the prefrontal cortex, abnormalities in the white matter, disrupted development in areas such as the hippocampus and corpus callosum, and impairments of the hypothalamic-pituitary-adrenal (HPA) axis or stress axis. Disturbances in this stress axis involve impaired stress hormone relationships, which include cortisol, leading to a permanent state of alert associated with a rapid flight-fight response to stress.[53-57] These impairments to brain structures and hormonal systems have far-reaching implications in terms of development and behaviour.

In recent years, research carried out in the Netherlands and elsewhere has shown that genetic makeup also affects brain development, the stress response, and resilience in the face of trauma.[55,58-63]

In the field of molecular genetics too, research is being carried out into susceptibility and resilience. There are already indications that the CRHR1 and FKBP5 genes (which are involved in regulating the HPA axis) affect resilience.[56,57,64]

3.3 The impact of abuse on infants and toddlers (aged 0-4)

Attachment is a selective and lasting emotional connection that develops in the first year of life, between the child and its primary caregiver (or caregivers).[65] The quality of its early attachment relationships is a major influence on a child's development. A secure attachment is associated with better relationships and socialisation with parents/primary caregivers, with more effective emotional regulation, and a cognitive advantage.[53,65-67]

Neglect and abuse of young children by parents/primary caregivers often leads to unsafe, disorganised attachment. The person with whom the child should be able to attach and who should be a sanctuary for comfort and security is, at the same time, a source of unpredictable threats. The experience of unresolved fear and threat is characteristic of abused children and is probably the main process by which these children develop a disorganised attachment. Children with disorganised attachment are at greatly increased risk of later behavioural and developmental problems.[67-71]

The physical effects of abuse in very young children may consist of bruises, fractures, and other visible signs of physical abuse. Also, their general physical development can be impaired (failure to thrive). Injuries to the head can cause permanent brain damage, possibly resulting in blindness and deafness, as well as motor and cognitive impairment.[72,73]

Child abuse in very young children is associated with relatively high levels of mortality, due to their physical vulnerability.

3.4 The impact of abuse on children of school-going age (aged 4-12)

The physical effects of abuse in very young children generally consists of bruises, fractures, and other visible signs of physical abuse. The CDC has calculated that, in 2008, more than 1700 children in the United States died as a result of abuse or neglect.[73] In the Netherlands, this has been estimated to involve 50 to 80 children per year.[74] Another aspect of physical abuse is failure to thrive. Such children do not grow well, and are often ill. The threat of obesity is also very real. This is more common in young children who are neglected.[75] Psychosomatic symptoms such as headaches and stomach aches are the most common chronic conditions in children of school-going age.[76] It is often the case that no cause can be found, but these symptoms can be associated with abuse.[77]

The stress of chronic abuse may induce a state of permanent vigilance in some parts of the brain, characterised by hyperactivity, concentration problems, sleep disorders, and behavioural problems. Many children develop symptoms of post-traumatic stress and dissociation. The rates cited in the literature range from 20% to 60%.[78-80] There may also be problems with toilet training. Such children may experience concentration and learning difficulties at school.[81-83] This group, too, is still characterised by periodic mortality, especially in younger children, due to their physical vulnerability.

3.5 The impact of child abuse on adolescents (aged 12-18)

During adolescence, abused children are at increased risk of addiction to tobacco, alcohol and drugs. They are also prone to high-risk sexual behaviour.[84-87] Criminal behaviour and teenage pregnancies are also more common in abused and neglected children. School performance also suffers.[87] Child abuse and neglect, especially at a very young age, may also affect the individual's ability to form healthy relationships during childhood and adulthood.[88,89]

In adolescents, the physical effects include signs of physical violence. However, obesity and asthma are also more common among abused adolescents than among their non-abused peers. Their general health is also poorer than average. Here too, psychosomatic symptoms such as headaches and stomach aches may be evidence of abuse.

Psychological effects are behavioural disorders, personality disorders, depression, post traumatic stress, dissociative disorders, psychosis and schizophrenia.[83,87,90,91]

3.6 The impact of child abuse on adults (aged 18 and above)

Child abuse has long been associated with psychiatric problems in childhood and adulthood. Those who were abused during childhood are significantly more likely to develop psychiatric disorders than individuals with no history of abuse, even when adjusted for factors such as socioeconomic status. Examples include depression, dissociative disorders, personality disorders, eating disorders, and anxiety disorders, as well as simple and complex posttraumatic stress disorder.[88,92-98]

Due, in part, to the ACE Study (Adverse Childhood Experiences), it has recently become clear that individuals who experienced traumatic events during childhood (from abuse, neglect, natural disasters, violence, or the loss of a loved one, for example) are more likely to suffer from chronic physical disorders such as diabetes, asthma and cardiovascular diseases, as well as psychosomatic complaints such as headaches and stomach aches.[85,88,99,100] The ACE study involved a cohort of 17,000 middle-class American patients (80% white, with a mean age of 57). Many of the participants had a university degree.

This group involved few of the "standard" risk factors for child abuse (low socioeconomic status, less well educated, living in poor neighbourhoods), yet the occurrence of child abuse was unexpectedly high, as shown in Table 2.

Table 2 The prevalence of stressful experiences in the ACE study.[85,99]

Type of stressful experience (ACE category)	Prevalence
Emotional abuse	11%
Physical abuse	28%
Sexual abuse	22% (28% women, 16% men)
Domestic violence against mother	13%
Family member with an addiction	27%
Family member in prison	6%
Family member with psychiatric problems	17%
Not raised by both biological parents	23%
Physical neglect	10%
Emotional neglect	15%

Based on these categories, the ACE score was introduced. One point is awarded for each "yes" answer to any of the categories (i.e. not the number of times that abuse took place within a given category). Eleven percent of participants had a score of five or above, and women were 50% more likely than men to score more than five.

According to Felitti, the social taboo on abuse and the shame experienced by the victims explained why the relatively high incidence of child abuse in this class had not previously come to light. The topic is never raised or discussed.

The ACE study showed that patients claiming to have suffered abuse at some time in their lives were significantly more likely to suffer from psychiatric disorders, and especially somatic disorders. Accordingly, Felitti advises against dismissing somatic disorders on the assumption that they are being purely genetic in origin. Chronic stress has a major impact on the immune system and on the body's stress response. The latter, in turn, affects the coronary arteries and

other blood vessels, for example.* These retrospective findings have been since been confirmed in prospective epidemiological studies.[80,101-105]

Felitti et al (2010) concluded that child abuse is one of the most basic, long-term determinants of health. Many current public health problems, such as obesity, diabetes, and cardiovascular diseases are at least partly associated with it. When seen in this light, an unhealthy lifestyle is not a "choice" but rather a way of dealing with the traumatic memories in question. Obese individuals are less attractive in terms of sexual contact, In addition, alcohol, smoking, and drugs can suppress memories of the abuse.[99] *

The ACE study's findings have been confirmed (albeit on a modest scale) in the Netherlands by a TNO study commissioned by the Augeo Foundation. The survey revealed that more people in the Netherlands claim never to have been abused or neglected (56%) than was the case in the ACE study (36%). In actual fact, however, 44% have encountered abuse or neglect. In this group, as in the ACE study, disorders such as asthma, diabetes, addiction and depression are significantly more common than in the group with no history of abuse.[106] The NEMESIS 2 study collected data that could cast light on the association between child abuse and mental health issues in adulthood. Due to lack of funding, it is not yet possible to complete an analysis of the data that has been collected.[107]

3.7 The relationship between abuse and psychological complaints

In recent years, efforts have been made to clarify the relationship between abuse and psychological complaints. Most studies that have identified a relationship, are based on retrospective reports of child abuse obtained in the course of interviews with study participants. So these are, in fact, recollections of abuse. Doubts have been raised about the reliability and validity of these reports, given that so much abuse is never reported.[108-110] For this reason, Scott et al conducted a prospective study in which child protection records were linked to data from the New Zealand Mental Health Survey.[80] This approach also discovered significant relationships between child abuse and mood disorders, anxiety disorders, and addiction.

Studies carried out in recent years have attempted to determine whether certain types of abuse are more strongly associated with specific psychiatric disorders.

* VJ Felitti. The ACE Study. A presentation given at the Round Table Conference staged by the Netherlands Centre for Chronic Childhood Traumatisation (LCVT) and Zorgverzekeraars Nederland (an association of Dutch healthcare insurers), on November 17, 2010, at Zeist, the Netherlands.

However, this is difficult to study, as individual forms of abuse seldom occur in isolation. Usually, the children involved are exposed to several types of abuse at the same time. Nevertheless, there is now evidence to suggest that certain types of abuse involve a greater risk of specific psychiatric disorders than others.

Accordingly, witnessing domestic violence appears to be more strongly correlated with behavioural or emotional problems. [111,112] There is also a relationship between child abuse and personality disorders. Of these, it seems that sexual abuse is more often correlated with paranoid, schizoid borderline, and avoidant personality disorders.[46] Physical abuse seems to be more commonly correlated with antisocial personality disorders, and emotional abuse with paranoid schizotypal borderline. Emotional neglect seems to be more strongly correlated with borderline personality disorder.[113]

Suicidality and depression seem to be more correlated with sexual abuse than with other forms of abuse.[114] Lewis et al (2010) also showed that any abuse in childhood affects treatment outcome. This means that, when dealing with psychological problems, the patient's background (and history of abuse) should be taken into account.[114]

The Committee would like to emphasise that, while specific correlations have been identified, they are rather weak. The relationship with specific types of abuse is neither specific nor compelling. The psychiatric disorders in question can also result (either fully or in part) from other factors. Nor, indeed, does abuse inevitably cause psychiatric disorders.

Moreover, Kessler's group has demonstrated that the correlation between child abuse and psychiatric disorders is more strongly correlated with the initial manifestation of the disorder than with its persistence. For this reason, a focus on the primary prevention of abuse is – and will remain – important.[93-95]

The psychiatric repercussions of child abuse involve very serious disorders, which can be extremely debilitating in nature. They inflict great economic harm both on the individual victims and on society at large, as a result of prolonged work disability and substantial demands on medical and psychiatric care.[115]

3.8 Conclusion

The repercussions of child abuse are many and varied. Some children escape permanent damage (including psychological damage), but many others are less fortunate. An individual's personality traits and genetic makeup affect their resilience in the face of trauma. In the case of children (especially young

children) the converse is also true. Stress (including chronic stress) influences brain development and temperament.

The effects of abuse range from various types of physical injury to psychological problems surface. Some aspects of these effects are immediately noticeable, however the real extent of the damage often does not appear until much later, during adolescence or adulthood, for example.

Adults who were abused during childhood are at increased risk of psychiatric problems and disorders such as mood or anxiety disorders, personality disorders and addiction problems. Some of these issues may be quite persistent. There is also clear evidence that, in later life, child abuse increases an individual's risk of somatic diseases, such as asthma and obesity.

Some types of abuse seem to result in certain disorders more often than others. Yet it is not possible to establish a clear cause and effect relationship between a specific type of abuse and a specific disorder.

The consequences of child abuse can be quite debilitating, inflicting significant economic damage both on the individual victims and on society at large.

Chapter 4

Assessment and treatment of children

Before children who are suffering child abuse (or who have done so in the past) can be treated, it is necessary to find out exactly what is going on. In other words, an assessment needs to be carried out. Such children should not be considered in isolation. They should always be seen in their family context.* In this Chapter, the Committee explores the substantive elements of the assessment. In addition, it reviews the current level of knowledge concerning treating the psychological effects of child abuse, in children. Interventions targeting the role of parents, particularly parenting support, are also briefly discussed. Attempts to solve social and socioeconomic problems (e.g. interventions in addiction treatment and care, reintegration into the workforce, forming a social network) fall outside the scope of this advisory report, however relevant that may be in terms of breaking the pattern of abuse.

4.1 What's going on? Assessment

Before adequate help can be offered to families in which a child is being (or has been) abused (within the family unit, or outside it) and to the child itself, it is

* Abuse can occur within the family unit, or outside it. In both cases, the child should be viewed and treated in the context of its family. Where abuse has taken place within the family unit, the child may be removed from its home. While such children cannot be treated at home, treatment should still take place in conjunction with the family. The location where the abuse took place has substantial implications for the treatment and support of both the child and its family.

important to find out exactly what is going on. This involves a sociological understanding of the family's situation and of the system in which it is embedded, an understanding of the parents both as individuals and as mentors, understanding of the safety of the family unit and of its individual members, understanding of the parent-child relationship and knowledge of the psychological, physical and social problems that the child is facing. It is important not to focus purely on those things that are not going well. Particular consideration should also be given to what is going well, including the child's resilience.

The process of obtaining such knowledge is often referred to as diagnostics. Given the clinical overtones of this term, the Committee prefers to use the term "assessment". The Committee uses the term "assessment" to mean establishing a clear understanding of the child's safety, an investigation of the family, the social system, socioeconomic factors, the child's development, and the diagnosis of any existing physical and psychological effects of abuse.* Figure 1 illustrates the basic details of the assessment.

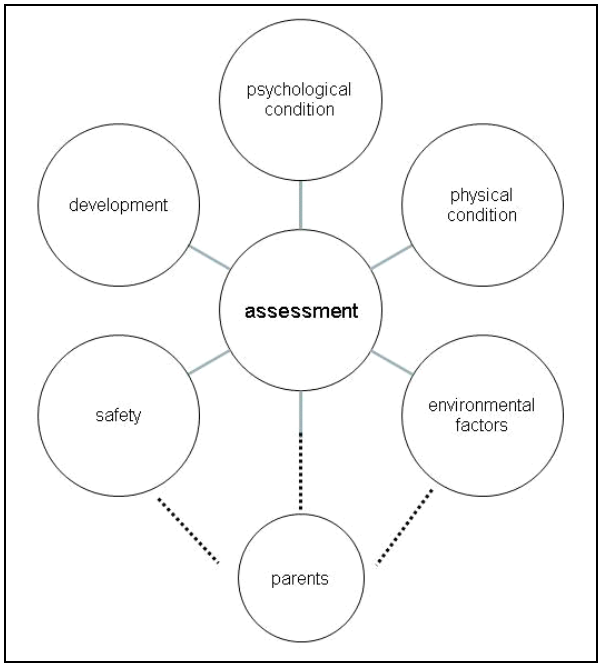

Figure 1 Elements of assessment in child abuse.

* Accordingly, diagnosis is a component of the assessment.

The Committee believes that, as Figure 1 shows, the components of assessment should not be arranged in a temporal sequence. Ideally, the assessment should encompass every single component, preferably using parallel temporal sequences. However, it is important to keep track of which items of knowledge (to be used in their analysis) belong where, in time. This is shown in Figure 2.

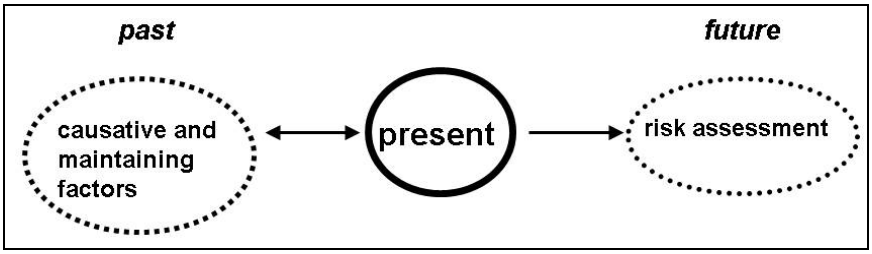

Figure 2 Temporal arrangement of the knowledge that is obtained during the assessment procedure about the child and its family, to be used in the analysis of this knowledge. This approach is an important part of the process of balancing the supply of care with demand.

The Committee sets great store by endorsing the importance of effective assessment. Assessment does not necessarily lead to treatment. If it can be shown that the child has suffered no damage (physical, mental, or developmental), that its safety is guaranteed, and that it has an effective social safety net, then no treatment is needed. Where treatment is indicated, however, assessment is an essential component of this process.

4.2 The elements of assessment

4.2.1 Safety

In the context of assessment, the Committee feels that there are three specific aspects to "safety":

- Is there any immediate danger (including physical danger) at the present time?
- Does the child's situation meet the basic conditions for its healthy physical and mental development? (past, present)
- Is there is a future risk of abuse (risk assessment, future)?

Checklists are used to determine the child's physical and emotional safety. These include *Veilig Thuis?* (Safe at home?), the first part of *LIRIK* (Light Risk

Assessment Instrument for Child Abuse), and the *Delta Veiligheidslijst* (Delta Safety List).[116-118]

These checklists explore aspects such as:

- Presence/absence of physical, emotional, or sexual abuse
- Presence/absence of basic care and protection
- Affective relationship between parent and child, amount of attention shown by the parent to the child
- Presence/absence of regularity, structure, and continuity
- Presence/absence of adequate adult supervision
- Extent to which the child itself feels safe
- The parents' potential to change
- Presence/absence of support from the social network.

These checklists are not validated instruments. At the present time, they are mainly used as reminders. The Committee emphasises the importance of scientifically substantiating the reliability and validity of such instruments, even though this is not an easy undertaking. However, well-validated checklists do exist, such as the Quality of Life questionnaires.[119,120]

Comparable checklists are being used for the purpose of risk assessment. In the Netherlands, various instruments are currently being used for risk assessment in cases of child abuse. These include the Child Abuse Risk Evaluation (Dutch version: CARE-NL), the California Family Risk Assessment (CFRA), the *Delta Veiligheidslijst* (Delta Safety List), and *LIRIK* (Light Risk Assessment Instrument for Child Abuse). These instruments are partly under development, and have not yet been subjected to extensive scientific research.[117,118,121,122] The child healthcare guideline entitled Secondary Prevention of Child Abuse, which was published in 2010, describes early signs that may indicate child abuse.[123]

4.2.2 *Environmental factors*

Part of the assessment involves the identification of social and socioeconomic factors. Regarding the family as a whole, for instance, this relates to the neighbourhood in which the family lives, local amenities, safety on the streets, housing (adequate or not), family income and their ability to get by, any debts, and the social network. For the child's sake, it is important that it have its own social network of peers.

4.2.3 *Parents*

While the child is still a minor, it is either subject to the authority of its parents or it is under the guardianship of other caregivers. It is therefore vital that parents/ caregivers be included in the assessment:

- What are they like as individuals – do they also have problems (including mental health problems) or they are stable, do they have an easygoing temperament?
- What are they like as parents – how competent are they at raising one or more children?

Both points should be assessed in the assessment, as they are often linked.

Safety and environmental factors are closely related to the parents' educational and protective role with respect to the abused child. If they are not the actual perpetrators, and if they are capable of providing sufficient protection, then the child is safe with them. If one or both parents were involved in the abuse, or if the parents were unable to provide the child with adequate protection, then the parents too will have to be given treatment.

4.2.4 *Development*

Prior to a thorough psychological and medical diagnosis, it is important to determine the state of the child's overall motor, physical, cognitive and social-emotional development. Are the growth curve and motor skills adequate for a child of that age? What is its state of health? Does the child have any friends? How are things at school? Conspicuous developmental issues may indicate potential problems at home or at school. They may also require further psychological and medical diagnosis and treatment.

4.2.5 *Psychological condition*

The assessment of the child's psychological condition in terms of its behaviour and social-emotional functioning. The diagnosis of attachment, behavioural problems and psychiatric disorders given in DSM-IV makes use of diagnostic tools such as questionnaires (including validated questionnaires), observation (including child play observation), and interviews (where possible). There are separate questionnaires for individuals of specific ages, with specific problems.

In the present document, an in-depth treatment of this topic would be inappropriate. The book entitled Child and Adolescent Psychiatry. Research and Diagnosis gives a summary of the diagnosis of DSM-IV disorders, together with the associated limitations and options.[124]

Screening tools such as the Teacher's Report Form (TRF), the Child Behaviour Checklist (CBCL), the Strengths and Difficulties Questionnaire (SDQ) and the *Sociaal Emotionele Vragenlijst* (Social Emotional Questionnaire; or SEV) are used to test for suspected behavioural, social-emotional, or psychiatric problems outside the context of the mental health services. Being broad in scope, these screening and diagnostic tools are capable of identifying wide-ranging aspects of the problems in question. However, these tools were not specifically designed for cases of child abuse, yet a need for them can arise during assessment. Accordingly, further research has recently been conducted into trauma-specific diagnostic questionnaires for children. In Amsterdam, for example, the Academic Medical Center (AMC) and *de Bascule* are studying the Clinician-Administered Post-traumatic Stress Disorder Scale for Children and Adolescents (CAPS-CA). The National Expertise Centre for Child and Adolescent Psychiatry's working group on Trauma and Child Abuse and the Netherlands Centre for Chronic Childhood Traumatization (LCVT)* are working on guidelines for the diagnosis of children with trauma symptoms (including complex symptoms) resulting from systematic child abuse.[125,126]

Children are not always very specific in expressing the damage they have suffered, which means that it is not always possible to make a clear diagnosis. A prime example of this is post-traumatic stress disorder (PTSD). This clinical picture was first described in war veterans. The classification of PTSD is therefore tailored to adults. However, trauma symptoms affecting children do not readily support a diagnosis of PTSD, which is based on a number of different PTSD symptoms from various symptom clusters. For this reason it is important to check for symptoms of PTSD, by carefully drawing up a case history, together with the child and its parents. Instruments such as the Trauma Symptom Checklist for Children (TSCC) or the TSC for Young Children (TSCYC) are helpful in assessing the severity of trauma.[127-129] The presence or absence of PTSD symptoms in children has important implications for the treatment offered.

* As of 1 January 2012 the LCVT will cease to exist as a separate organisation. The affiliated centres will continue to collaborate in two new networks on child & adolescent and adult traumatisation, respectively. The collaborations will in principle continue to make use of the instruments and guidelines developed within the LCVT framework.

DSM-5 (the successor to DSM-IV, which is still being used) involves plans for a diagnosis of developmental trauma disorder.[130] There is a proposal for a diagnosis of PTSD in children aged from 2 to 4 (preschool age) as well.

4.2.6 Physical condition

Any investigation of suspected child abuse should include a paediatric medical examination. This involves examining the child for bruises, fractures (fresh or healed), burns (fresh or healed), signs of sexual abuse, or other physical signs of abuse. In addition, a medical differential diagnostic examination should take place to explore other possible medical causes for abnormalities or underlying disease which might account for signals of child abuse.[131] One problem is that this still does not always take place on a systematic basis.

It has been shown that adults with chronic conditions like diabetes, obesity, asthma and cardiovascular diseases are more likely to have been abused during childhood than healthy adults (see Chapters 3 and 5).[85,99,101-103] There is evidence that, in children too, abuse has an impact on physical health. For instance, children from abuse situations are known to have higher incidences of stomach ache and to be more prone to infections.[75,77] However, this has not yet been researched as extensively as in the ACE study.

4.3 Treatment

4.3.1 Conditions for good quality treatment

If a treatment (of the child itself, as well as of the parents and other family members) is to be successful, then a number of conditions must be met. These are:

- Safety of the situation
- Parental support
- Integrated, multidisciplinary approach.

Perhaps unnecessarily, the Committee strongly underlines the view that before a child can be treated it must be in a safe situation. If the abuse or neglect continues, then the treatment given to the child will have only a limited chance of success. Signs of Safety, an approach developed in Australia by Turnell and Edwards, can help to create and maintain a secure environment. This method uses the family's network, resources, and strength. Stakeholders agree on what is

needed to ensure the safety of these children (both now and in the future) and to prevent them from ever again becoming the victim of abuse or neglect. However, the effectiveness of the Signs of Safety approach has yet to be scientifically established.[132,133]

A second factor is the support of the child's parents or guardians. They must support the treatment, take the child's problems seriously, and acknowledge what happened. This factor is so important that, in the U.S., research is taking place into the use of a "clarification". This is a letter from the parent/guardian to the child containing a recognition of what happened, expressing regret for the abuse or for their failure to adequately protect the child from such abuse, recognizing the parent's/guardian's responsibility for the child's safety and welfare, and setting out agreements for the future. The clarification is being studied as a preparation for CBT (cognitive behavioural therapy) following physical abuse[134]. In Charleston, South Carolina, it is a prerequisite for treatment[135]. Even if the parents/guardians are unwilling to write a full clarification, just making a start may help to sustain a dialogue about the incident, especially where the parents themselves were the perpetrators.

The parameters of the treatment depend on the findings of the assessment. The Committee notes that, following incidents of abuse, the parents and child concerned always require psycho-education, even where the child has suffered no demonstrable harm. Psycho-education helps to place the abuse in the right context: violence (verbal or physical) is not the right way to resolve conflicts; violence is not a normal part of family relationships; it is not normal to control someone by means of force; the perpetrators of domestic violence should be punished.

Treatment must be integrated, i.e. focused on different problems affecting the child and the system around it.[35,136,137]

Finally, just as in the assessment, treatment must not involve a chain-based approach, in the sense of a sequential, stepwise treatment and solution of the various problems. These issues deserve to be dealt with simultaneously. In other words, it is important not to lose sight of the big picture. Given the numerous considerations involved, prioritization is of the essence. Where to start? Can anything else be done at the same time? What is the best course of action once other problems have been solved?

Chapter 3 contains a brief explanation of the potential impact of child abuse. There are treatment interventions for many such effects. However, these seldom make specific allowance for the fact that abuse was partially or completely

responsible for the situation. Also, clinicians often have insufficient knowledge of (and experience with) trauma-specific care and treatment.

4.3.2 Models

Treating the effects of child abuse is a complex matter, actually involving a continual interaction between assessment and treatment. To provide guidance, various models and protocols have been developed over the years. The Committee wants to make specific mention of two of these models. This is because they are already being actively used in the Netherlands, and because the Committee considers them to be substantively relevant and useful.

A model that is widely used in the ultimate approach to the treatment of behavioural, social, emotional or psychological problems is the Attachment, Self-Regulation and Competency Model (ARC model) devised by Blaustein and Kinniburgh.[137,138] This model identifies three layers of components that are required before the process of trauma experience integration can begin (Figure 3). At the very apex of the pyramid is trauma experience integration. The model's designers have given special consideration to what is going well and to those areas in which the child still performs well. Ultimately, it means that the treatment of trauma can only commence when the child in question is able to talk about what happened.

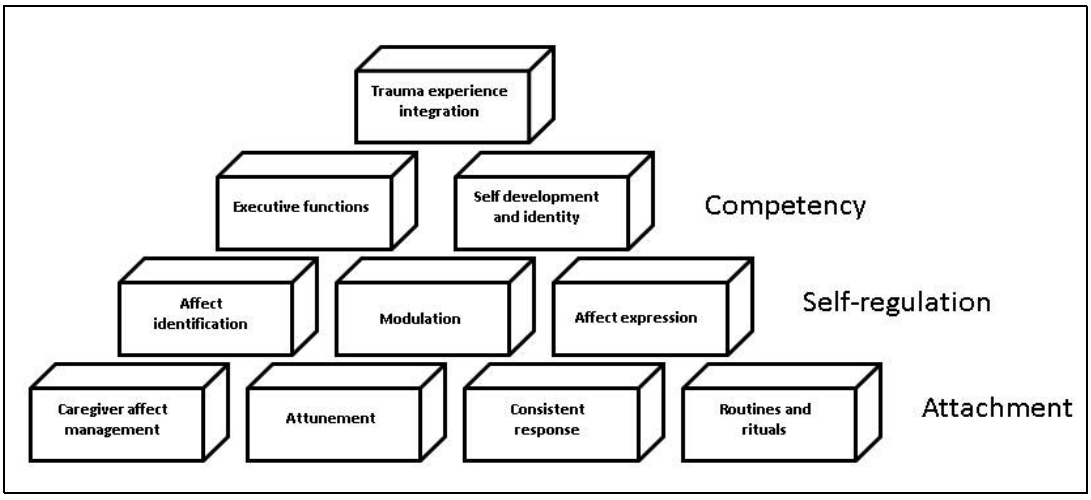

Figure 3 The ARC model.[137]

Another model (developed by the Chadwick Center) is the Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP) model.[234] It is an intervention model for the assessment and treatment of children and adolescents, between the ages of 2 and 18, who have undergone traumatic experiences. An associated "trauma wheel" is used during the treatment phase. The aim is to provide a guideline for the treatment of traumatized children based on a continuous assessment of the results of treatment and on the child's further needs (assessment based treatment). Given its continuous nature, this treatment is represented as a circle (hence trauma wheel). The TAP-model is primarily focused on children with PTSD (including complex PTSD), but is more widely applicable. The highly specialised (tertiary care) trauma centres within the Netherlands Centre for Chronic Childhood Traumatization (LCVT) operate in accordance with this model. It takes into account the social context of the victim, the impact experienced by the victim, and the effects of treatment. It underlines the importance of effective, careful and continuous assessment to the treatment's ultimate success. In addition, the model reflects the importance of involving the social system in which the child grows up, as well as the social context in which the individual abused during childhood will have to function as an adult.

4.3.3 Treatment of abused children

Treatment of the physical effects of abuse usually involves somatic medicine, in accordance with that discipline's internal guidelines. Although the background of abuse has no direct effect on actual treatment, it is now clear that persistent abuse and unresolved traumas can adversely affect the extent to which chronic disorders like diabetes, cardiovascular diseases and asthma, in particular, respond to treatment. In this advisory report, however, the Committee focuses on the treatment of the psychological effects of abuse.

The Committee worked on the basis of reviews and guidelines concerning interventions aimed specifically at abused children. Only a limited number of reviews and guidelines were found. While there are a great many articles on interventions for a range of mental problems in children, very few of these specifically concern abused children. An exception can be made for articles about attachment and attachment problems. After all, abused children often have impaired attachment or problems with entering into trusting relationships with other people. As the ARC model shows, children must be sufficiently stable before they can deal with trauma experience integration. A child that is sufficiently stable is one who enjoys a relatively safe environment, and who can

rely on primary mentors for attachment. Another important aspect is that the child must also have the requisite coping skills to be able to talk about the traumatic experience in question.

The summer of 2010 saw the publication of the Guideline on Domestic Violence (FHG) by the Dutch Psychiatric Association (NVvP)/Dutch Institute for Healthcare Improvement (CBO), which provides a summary of the available literature.[139] The Committee found little additional literature.

Table 3 Summary of systematic reviews and meta-analyses of therapeutic interventions for the treatment of children traumatized by abuse.

Intervention	Evidence
Trauma-focused cognitive behavioural interventions (TF-CBT) have a beneficial effect on PTSD symptoms resulting from sexual abuse, domestic violence, and other traumatic events. Research into various trauma populations is needed. B[139-146]	Level 2
Eye movement desensitisation and reprocessing (EMDR) is an effective treatment for the symptoms of posttraumatic stress in children B[147]	Level 2-3
There is evidence that group therapy is effective for sexually abused children. C[148]	Level 3
Concerning the treatment of PTSD, there is insufficient evidence to support a ruling on the effectiveness of psychotherapeutic interventions in combination with pharmacotherapy compared to the separate use of these individual interventions. B[149,150]	Level 3
There are no effective treatment programmes for children that focus on the resolution of emotional and/or physical neglect D[139 151,152]	Level 4
There are no effective treatments for children that are aimed at resolving the effects of physical abuse, other than PTSD D[139]	Level 4
For children over the age of five who have witnessed violence between their parents/guardians, there are no effective treatments aimed at resolution of the effects D[139]	Level 4
It seems likely that Parent Child Psychotherapy (CPP) would be effective both for children aged 2-5 who witness domestic violence and for their abused mothers, in terms of ameliorating the child's behavioural problems. The mothers showed significantly less trauma-related avoidance behaviour. B[153,154]	Level 3
For children with sexual behavioural problems, whether or not these are related to sexual abuse, Bonner's CBT group treatment programme seems to be effective in reducing sexual behavioural problems and sexual crimes for a period of ten years following completion of the treatment. B[139,155]	Level 3
Staying with relatives is a viable option for children who are removed from their homes due to abuse. Children who are in the care of relatives seem to enjoy better mental health, behavioural development and placement stability than children who are placed with non-relatives. C [156]	Level 3

Table 3 gives a summary of interventions and the evidence of their effectiveness, largely in accordance with the Guideline on Domestic Violence (FHG). The Committee used the classification developed by the Dutch Cochrane Centre to designate the strength of the evidence. In this system, level 1 represents the highest level of evidence, and level 4 the lowest (Annex C).

For the moment, Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are the best options for the treatment of PTSD symptoms in children, resulting from child abuse.

At this juncture the Committee would also like to point out that it is often thought (mistakenly so) that children who are removed from their homes require no further treatment. Sadly, nothing could be further from the truth. It is also important that those providing foster care be familiar with the assessment of trauma in such children, and with the available treatment options. This issue merits due care and attention.

Cognitive Behavioural Therapy (CBT) is a blend of behavioural therapy and interventions developed from cognitive psychology. In essence, this is based on the assumption that so-called irrational cognitions (thoughts) create dysfunctional behaviour, such as avoidance or aggression. The techniques used in cognitive behavioural therapy focus on changing the content of such irrational thoughts. Various types of Cognitive Behavioural Therapy (CBT) have been developed for a range of different conditions. Cohen, Mannarino and Deblinger developed Trauma-Focused Cognitive Behavioural Therapy (TF-CBT).[160] TF-CBT is a multimodal individual trauma treatment consisting of 12 to 16 sessions. It is based on cognitive-behavioural therapy principles, trauma theory, attachment theory and systems theory. When treatment is being administered to children, the parents are closely involved in this process.

Eye Movement Desensitisation and Reprocessing (EMDR) is an individual therapeutic intervention technique developed by Shapiro. Details were first published in 1989. [157-159] This form of trauma treatment involves retrieving memories of the traumatic experience in question, while the client is simultaneously distracted by means of bilateral stimulation. Bilateral stimulation involves the use of eye movements. The client’s eyes track the therapist’s hand. This method of treatment also includes various effective elements of

psychotherapy (psychodynamic, cognitive behavioural therapy, interpersonal and body-oriented elements).

While the published studies did not specifically target all types of abuse, the proven effectiveness of TF-CBT and EMDR is so broad that they are probably suitable for a wide range of applications. As CBT and EMDR are umbrella terms for a range of treatments centred on CBT or EMDR, it is important that practitioners restrict themselves to protocolled versions of CBT and EMDR. They should also follow the appropriate training courses and adhere to the supervisory requirements.[159,160]

While TF-CBT and EMDR are available in many parts of the Netherlands, coverage is still far from complete. Even today, trauma therapy often involves the use of treatments whose effectiveness has not been established.

The literature survey highlighted the fact that, in recent years, an increasing number of studies have targeted interventions aimed specifically at abuse. However, such studies are often limited in scope and – for various reasons – difficult to compare. As a result, conclusions about effectiveness often include the inevitable caveats.

Incidentally, issues of limited scope and poor comparability are not limited to this field alone. They have an impact across the board when it comes to the treatment of children with psychological problems. For example, in its advisory report entitled *Autism spectrum disorders: a lifetime of difference*, the Health Council concluded that research into interventions for the treatment of autism (and its effects) were beset by the very same difficulties.[161]

There are several reasons for the lack of well-designed studies of sufficient scope. Firstly, children who are victims of abuse are a vulnerable group, so great care must be exercised when dealing with them. Secondly, the problem is often complex in nature. This leads to various issues, such as the difficulty of creating a sufficiently homogeneous experimental group. Thirdly, before children can take part in studies, permission must be obtained from their parents. In the case of child abuse, this can be a problem. Fourthly, studies involving children are inherently difficult, due to the ethical and legal reasons involved. In this connection, see the advisory report by the Advisory Council on Health Research (RGO) entitled *Diseases in childhood: research for health* (2010).[162] Fifthly, as it is an emotionally charged issue, child abuse is not a popular research topic. Finally, the existence of a culture of academic research is certainly not a foregone conclusion in those domains involving the treatment of abuse victims (such as

youth care services). The past five years have seen an expansion of research into the effectiveness of approaches to child abuse (Netherlands Organisation for Health Research and Development's (ZonMw) *Care for children and adolescents* programme and the Netherlands Youth Institute). This research focused almost exclusively on detection and prevention. There are still substantial gaps in the area of treatment. This situation is gradually changing, thanks to the unceasing efforts of organisations such as the Netherlands Youth Institute (NJi) and to the Academic Collaborative Centre on Child Abuse supported by ZonMw (one of six academic workplaces for children and adolescents that it supports). It should be noted that the NJi and ZonMw are largely funded by the Ministry of Health, Welfare and Sport.

4.3.4 Interventions targeting the parents' role

As previously indicated, abused children should not be considered in isolation. Children are the responsibility of their parents/carers and are subject to their authority. They are also dependent on them for their healthy development and welfare. Accordingly, the child's entire system should be involved in this treatment (indeed, it is often the target of such therapy). The interaction between parents and children is a major element here.

In recent years, there has been a greater focus on the parents' role in terminating the abuse and in the healing process. Table 4 summarises guidelines and the results of various reviews. The Committee notes that the listed parenting interventions are abuse-specific interventions in the context of a given course of treatment. Parenting support programmes in a preventive setting are not included in this summary.

The Table shows that, to date, evidence for the efficacy of interventions targeting the parents' childrearing role in situations involving abuse or neglect the evidence has also been disappointing. Well-designed studies of sufficient scope are needed for this specific target group.

Table 4 Summary of systematic reviews and guidelines pertaining to interventions targeting the parents' role.

Intervention	Evidence
Parent-Child Interaction Therapy (PCIT) is effective in terminating physical abuse and improving the parent-child relationship. No studies have yet been carried out to determine whether PCIT actually relieves the child's problems (such as the symptoms of PTSD). B[139,163-165]	Level 2-3
The safe care programme (Project 12-Ways) for neglectful parents seems quite promising D[151,152]	Level 4
There is insufficient evidence to support a recommendation that parenting programmes be used for the treatment of physical abuse or neglect. However, there is a limited amount of evidence that some parenting programmes could be effective in improving various outcomes associated with physically abusive parenting. B [166]	Level 3
The Dutch Horizon Method (a form of TF-CBT for parents and children) seems effective in the treatment of sexually abused children. Parents were able to identify positive changes in their own parenting behaviour B,C [136,167-171]	Level 3
Parent Management Training Oregon (PMTO), Functional Family Therapy (FFT), Triple P Level 4 / 5, Multi System Therapy - Child abuse and neglect (MST-CAN) are more intensive system interventions. They have a sound theoretical basis and may be effective in the secondary prevention of child abuse. C[172-177]	Level 3

One development that the Committee would like to draw attention to at this point concerns interventions for vulnerable women and their unborn (or young) children. Such interventions are currently available at various locations throughout the Netherlands. Programmes and interventions are available in both primary and secondary health care. In primary health care, the *VoorZorg* programme is an example of prenatal care and perinatal counselling for poorly-educated young mothers.[178] Two other projects have been set up by Radboud University Nijmegen Medical Centre (RUNMC). The first of these is MeMoSa (Mentor Mothers for Support and Advice), which is intended for abused women (with young children). The other project provides web-based counselling for children and adolescents. A Rotterdam-based study has explored the MeMoSa programme's effectiveness as an intervention. The implementation study is based in Nijmegen.[179,180]

In secondary health care, for example, there are the various POP clinics (Psychiatry, Obstetrics and Paediatrics). They offer perinatal counselling for pregnant women with psychiatric disorders referred by GPs, youth care services, or the Child Protection Board. Erasmus MC has a combined Psychiatry/Child and Adolescent Psychiatry outpatients department. This offers day treatments for infants up to 12 months of age and their mothers, as well as individual treatments for children up to 4 years of age and their mothers, in coordination with care practitioners and the Youth and Families Centre.[181,182] A third example is a

regional network for vulnerable pregnant women in Dordrecht. Set up by the hospital, this network oversees pregnancy care through to the end of the child's first year of life. The latter project differs from the POP and the combined outpatients clinic in that it spans a wider group of vulnerable individuals. Such cases may involve psychosocial problems, intellectual disability, and addiction, with associated problems such as abuse and neglect.[183,184]

These interventions, projects and programmes stem from an understanding that abuse and neglect can be transmitted from one generation to the next. They are also based on the concept of prevention in high-risk groups. The goal of these interventions is to assist pregnant women or young mothers with their problems, to hone their teaching skills, and give them a better appreciation of the extent and timing of their child's development ("a 3-month-old baby does not cry just to irritate its parents"). The goal of this approach is to facilitate the secure development of a mother/child attachment. As already explained in Chapter 3, secure attachment is an invaluable asset to the child's development.

4.4 Care infrastructure

The care infrastructure for victims of child abuse is enormously complex. This is due to the large number of professional disciplines and care domains involved. The following figures identify existing infrastructural facilities for the assessment and treatment of abused children.

4.4.1 Assessment

Figure 4 is intended as a diagrammatic representation of the current infrastructural facilities for the assessment of abused children. The starting point is Figure 1 in section 4.1, which contains the elements of assessment. The ovals indicate the professionals involved, per element. Outside each oval is an indication of the type of organisation or care domain in which these professionals work. The many and varied details required for a proper assessment cover a wide range of care domains. Accordingly, such information is gathered and filed by many different professionals.

The Child Abuse Reporting Agency (AMK) compiles all elements of the assessment in a child abuse investigation. It also gathers information directly from the parents and children involved, and by consulting informants from the various domains. The purpose of the investigation is to identify the nature of the

child abuse in question, and to ensure the targeted transfer of such cases to the appropriate care services, in order to terminate the abuse. Checks are carried out within a period of six months to determine whether or not this care is actually being provided.

There has been a marked qualitative improvement in the assessment of these children's development, psychiatric health, and physical health. Expertise at the diagnostic level has improved and has taken on a multidisciplinary dimension, due to the improved detection of child abuse by hospital staff. Periodically, multidisciplinary teams (which include a medical counsellor) draw up an assistance action plan. This development prompted an increase in the number of reports being submitted to the AMK, while also boosting the number of direct referrals for assistance.[185,186,235]

In addition, the introduction of specific training courses for paediatricians in 2008 has enhanced their expertise in this area.[187] Various hospitals (including university hospitals) provide multidisciplinary assessments (e.g. the Goofypoli SKZ in Rotterdam and the AMC in Amsterdam). A few hospitals employ medical counsellors (e.g. the Amphia hospital in Breda and the Maasstad hospital in Rotterdam).

4.4.2 *Treatment*

Figure 5 shows details of the care infrastructure for the treatment of children who have become victims of abuse. Physical treatment is provided by somatic medicine practitioners such as GPs, paediatricians, and other specialists, although paramedics, speech therapists, and physiotherapists may also be involved. Psychological treatment is largely provided by youth mental health services (primary and secondary health care) and by centres for traumatized children and adolescents. The youth care services also provide psycho-education services. The professionals involved include psychologists, special education staff, and social workers.

Parents are also indicated in the figure, as they are inextricably linked to the child. If the abuse of their child took place outside the family, they can be an important source of comfort and support for their child. However, they themselves may need counselling to help them to come to terms with what has happened. If their circumstances played a part in the abuse of the child, then these issues need to be addressed in order to prevent a recurrence and to help the

child in question. Three groups of professionals are involved in this process: social workers, psychologists, and psychiatrists.

If a report has been made to the Child Abuse Reporting Agency (AMK), that body will first complete an assessment before making a recommendation concerning the type of treatment to be administered. This recommendation takes account of the nature and severity of the confirmed abuse, the nature and severity of its impact on the child and/or the nature and severity of causative/perpetuating factors. Based on the findings and recommendation, treatment is assigned to a centre for youth and families, for example, to a highly specialised tertiary psychiatric facility such as the RMPI (Rotterdam Medisch Pedagogisch Instituut) or to a combination thereof.

4.4.3 Bottlenecks

Based on the experience of committee members, plus various interviews with external experts, it seems that situation assessments in cases of child abuse do not always go well. There is a lack of effective harmonisation in the provision of information by the various domains. In addition, there is no specific expertise in the assessment and diagnosis of the impact of child abuse. Finally, professional practitioners are largely ignorant of the activities of their counterparts in other domains. Several points are specified in further detail here:

- Effective psychiatric diagnosis in relation to child abuse requires specific training and experience in this area. This should be supplementary to the training programmes for child and adolescent psychiatrists, behavioural scientists/child and family psychologists or diagnostically registered psychologists (preferably in the form of a specialisation). Few of these practitioners possess such knowledge and experience.
- Where there is a strong suspicion that a child (who has not previously been seen by a paediatrician) has been abused, the physical examination should be conducted in consultation with a Child Abuse Reporting Agency (AMK) physician, within the context of that agency's advisory and consultative role. AMK physicians have access to the social map for examinations and assistance, which includes a list of expert paediatricians and forensic physicians. This approach would allow children to be referred to appropriate specialists more often than is presently the case. A proper medical diagnosis should be performed by a paediatrician trained in the area of known or suspected child abuse, neglect, and sexual abuse. Few, if any, paediatricians specialised in this area are employed by youth care services, so children who

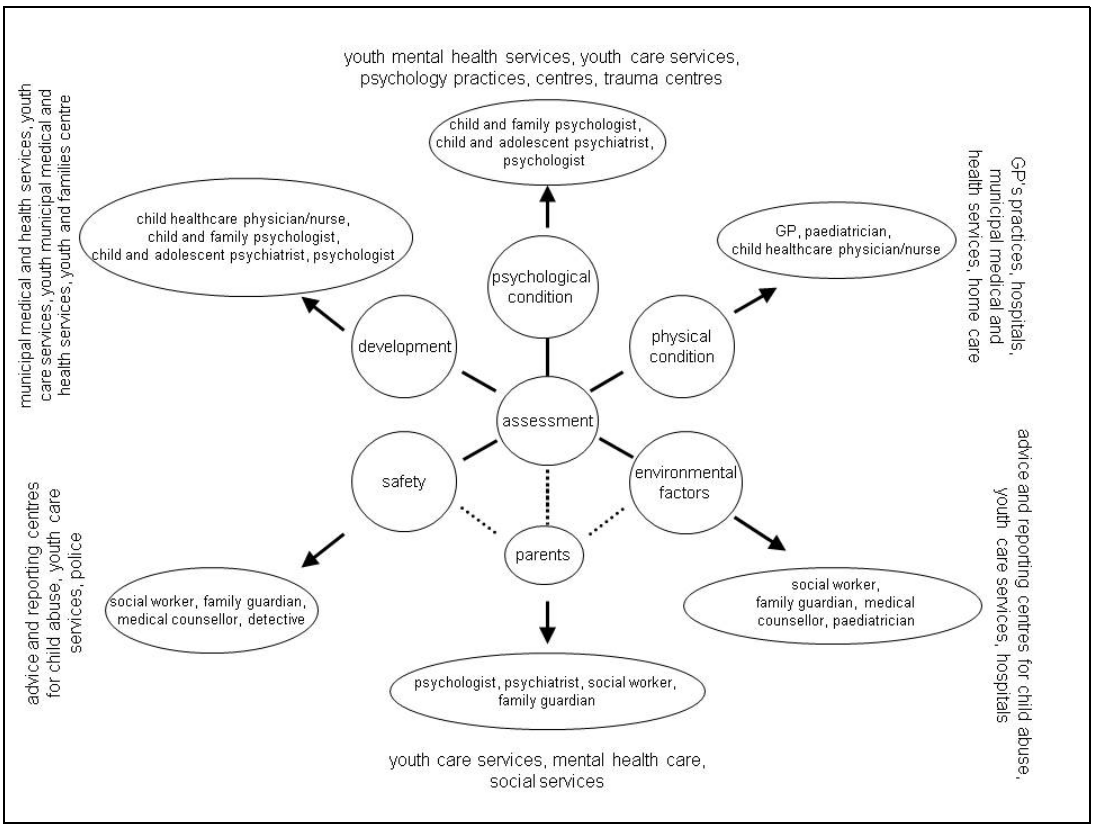

Figure 4 Infrastructure for the assessment of children.

have been abused (or neglected) are not seen by a paediatrician. This is a serious omission in the post-abuse diagnosis of children.

- As yet, there is no single professional practitioner capable of assessing parents both in their parenting role and as individuals. The assessment of their parental role is currently assigned to a child and family psychologist from youth care services. The assessment of parents as individuals is carried out by a psychologist or psychiatrist from the adult mental health care service.
- A proper assessment should be independent of institutional paradigms and situations involving a lack of cooperation (in which no single caregiver or care service bears ultimate responsibility). At present, these very factors often obstruct effective assessment.

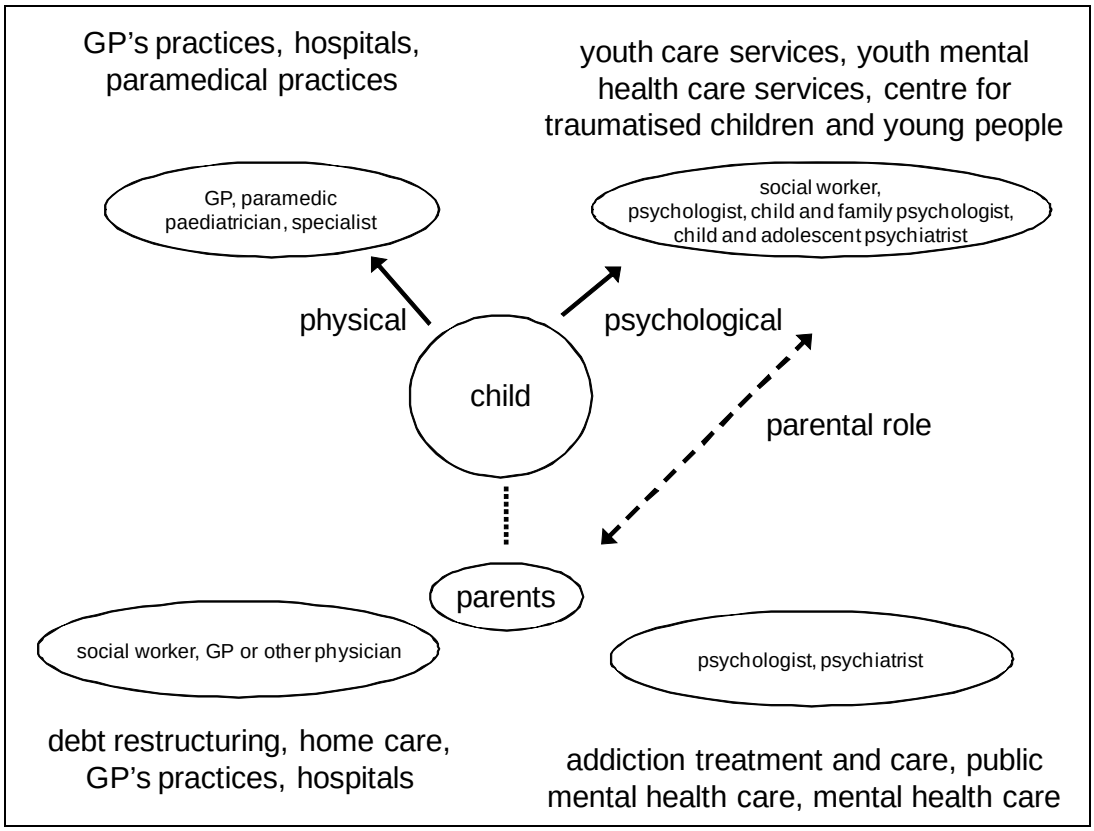

Figure 5 Infrastructure for the treatment of children.

Treatment bottlenecks have been reported by various sources, such as the fourth progress report of the nationwide implementation project of the Regional Prevention of Child Abuse (RAK), with the theme of care provision.[188] Details of some major problems in different regions are given:

- Care provision is inadequate in some areas due to a lack of capacity, catering to a limited target group, or because it is not sufficiently specific to deal with child abuse
- Care provision is underused due to a lack of familiarity on the part of care practitioners
- Lack of funding and manpower
- There is no system-oriented, integrated approach.

4.5 Research and knowledge infrastructure

Research mainly takes place in universities. This research focuses primarily on prevention, prevalence, and neurophysiology. In addition to research into the development of new interventions, small-scale efficacy studies into new and existing interventions are under way. The Netherlands Organisation for Applied Scientific Research (TNO), the Trimbos Institute, and the Verwey-Jonker Institute also perform research in the field of child abuse, usually in collaboration with a university. An increasing amount of research is also being carried out within youth care services. This involves small-scale, applied research. However, the lack of a research tradition means that the quality of such research often leaves much to be desired. As the findings are rarely published, potentially valuable information is not widely accessible. The experience of Committee members, coupled with the results of various interviews, indicates that the lack of a strong research culture causes people to view evidence-based working with some suspicion. Professional practitioners often tend to view this as a very rigid approach, with no scope for growth and innovation.

In practice, interventions are often developed based on situations that arise at a given time. If the intervention's methodology and theoretical foundation are well described and its results accurately recorded, this may lead to practice-based evidence. Sufficiently robust practice-based evidence can lead to good quality scientific research and evidence-based practice. Thus the underlying concept is that there is a productive interaction between evidence-based practice and practice-based evidence.

In the current situation, a major obstacle to innovation is the failure to monitor intervention outcomes. As a result, many interventions have been used for years without any clear evidence that they are actually effective.

One area currently under development in the field of child and adolescent psychiatry is routine outcome monitoring child and adolescent psychiatry (ROM-CAP). This involves a partnership between the major academic institutions and peripheral institutions, in which pre- and post-treatment measurements are carried out. This spans the entire field of child and adolescent psychiatry, so trauma is also included.

The Netherlands Centre for Chronic Childhood Traumatization (LCVT) has taken the initiative in trauma specific routine outcome monitoring (ROM) for adults: the Treatment Monitor. This database forms the basis for the Dutch Chronic Trauma Studies. The aim of these studies is to improve our understanding of the effectiveness of the interventions used. For reasons of capacity

and organisation, however, the implementation and execution of these initiatives has been suspended.*

In recent years, the Netherlands Organisation for Health Research and Development has funded a great deal of research within the context of its Care for Children and Adolescents programme. The programme is not currently funding any research projects specific to the treatment of the impact of child abuse. This is because no applications of sufficient quality were submitted. Where projects bear some relation to child abuse, this involves prevention (beyond the scope of this advisory report). Over the past two years, a survey has been carried out to determine the extent of psychotrauma research in the Netherlands. This work was commissioned by the Netherlands Organisation for Health Research and Development.[189,190] It found that the field of psychological trauma research is fragmented, as is the associated funding. The investigation of psychological trauma resulting from child abuse represents only a small part of the full range of psychological trauma research being carried out in the Netherlands.

The Trimbos Institute is conducting research into preventive interventions for the children of parents with mental health problems.

Despite its importance, little implementation research into evidence-based working in the field of child abuse is being carried out in the Netherlands. In the U.S. state of South Carolina, work is under way on a learning collaborative approach within the Bringing Evidence-Supported Treatments to South Carolina Children and Families project (BEST).[191-193] This involves a regional partnership in order to provide professionals with training and refresher courses in the latest insights on evidence-supported interventions. This is a continuous process, enabling the participating agencies to stay up-to-date. It is based on the principle that the care practitioners' sense of duty dictates that they ought to be aware of the latest discoveries and views, that they must provide the best possible care and that they must engage in continual professional development. The project is being coordinated from the multidisciplinary centre in Charleston.

* As of 1 January 2012 the LCVT will cease to exist as a separate organisation. The affiliated centres will continue to collaborate in two new networks on child & adolescent and adult traumatisation, respectively. The collaborations will in principle continue to make use of the instruments and guidelines developed within the LCVT framework.

4.6 Initiatives for collaboration and an integrated approach

There is an increasingly widespread realisation that child abuse requires an integrated approach, and that cooperation between agencies is an essential prerequisite for success. This is partly reflected in several new initiatives to foster extensive collaboration, and in an integrated approach to problems arising from child abuse.

One example of a new partnership is the Covenant on an Intersectoral Approach to Child Abuse in the province of Gelderland.[194] In the spring of 2011, thirty-two youth organisations for youth care services, for the Moderately Mentally Handicapped (LVG), the mental health care association (GGZ) and the province of Gelderland addiction treatment and care service signed the covenant, to provide greater safety for children. This involves incorporating the safety of children into care protocols. It also requires effective coordination and cooperation between the institutions involved. In addition, all mental health care institutions in Gelderland have signed up to the link with the Referral Index. A project plan is currently being prepared that will enable every point of the agreement to be implemented. This plan is scheduled for completion in the autumn of 2011.

One type of integrated approach is exemplified by those institutions that have set up a Family Psychiatry Hotline, like Yulius (formerly the Rotterdam Medisch Pedagogisch Instituut – RMPI) in the Rotterdam region, the province of Drenthe mental health care association, and *de Bascule* in Amsterdam. Within the field of family psychiatry, this relates to families with multiple problems, in which child abuse is taking place. The procedures used involve problem-solving methods and Signs of Safety.

Another collaborative initiative is the multidisciplinary centre for the treatment of victims of child abuse in the province of Friesland.[195] This initiative goes beyond simply improving cooperation and coordination of the available care. Within the multidisciplinary centre for the treatment of victims of child abuse, a multi-disciplinary team will be set up to tackle child abuse issues on the basis of a shared view of child abuse cases. This team will consist of representatives from various organisations with expertise in the field of child abuse and domestic violence. Also, research will be carried out into the effectiveness of the integrated approach. The goal of this initiative is to create a multidisciplinary child abuse centre, modelled along the lines of the Chadwick Center in San Diego, California. There they have everything under one roof. When a report of

suspected abuse is received, testing, assessment and treatment all take place there. The forensic examination, too, is carried out at the centre. The advantages of this approach are: short lines of communication, fast turnaround times, and rapid assistance for children and parents.

During 2011, many agencies gave their backing to the plan, including the province of Friesland Youth Care Agency, the Friesland mental health care association, the Leeuwarden Medical Centre and Fier Fryslân. The chief constable and the chief public prosecutor in the province of Friesland are closely involved in the further development and discussion of various plans. The target date for launch is 15 September 2011. The pivotal points are primarily research and diagnosis, together with the establishment of a plan of action/treatment programme that facilitates multidisciplinary collaboration within a clear framework around the child and its system. The principle is that the plan of action/treatment programme be carried out within mainstream organisations, agencies and partnerships.[195]

It is worth noting that this is not the first such initiative for a multidisciplinary centre for the treatment of victims of child abuse. In the year 2000, various parties in Twente agreed a business plan for a centre for the treatment of victims of child abuse in that province. The plan came to nothing and was forgotten, a victim of unfortunate political timing, policy discussions about the new Youth Care Act, and of the fine-tuning of procedures for tackling child abuse and domestic violence.[196]

Finally, the Committee points to the Academic Collaborative Centre on Child Abuse (AWK) of the KJTC Haarlem (centre for traumatized children and young people) and the VU University Amsterdam (together, these two institutions represent a partnership of all care and judicial institutions in the Zuid Kennemerland area that deal with child abuse), plus the local authorities in Zuid Kennemerland and the university. The goal of this initiative is to promote collaboration between knowledge institutions, institutions involved in everyday practice, and government bodies in the Noord-Holland-Zuid region. It focuses specifically on knowledge development, knowledge transfer, and the implementation of science-based and best practice methods in the areas of child abuse and of the treatment of children who have experienced abuse (together with their parents/guardians). Three sub-projects are being set up within the AWK:[197]

- The creation of a Child Abuse Team to achieve improved collaboration and to deliver care more rapidly, plus research into the effectiveness of these

measures. This team consists of experts from the collaborative care and judicial institutions. It is similar to the *Fier Fryslân* multidisciplinary centre for the treatment of victims of child abuse (*KJTC* and *Fier Fryslân* are pooling their resources for research on this topic)
- Efficacy studies on interventions for the victims of sexual abuse or domestic violence
- Knowledge transfer and implementation within the *Landelijk Opleidingscentrum Aanpak Kindermishandeling* (National Training Centre for Tackling Child Abuse Issues, or LOAK). The treatment methods will be made transferable for professionals working in this area (both now and in the future). The *Fier Fryslân* MDC (multidisciplinary centre for the treatment of victims of child abuse) will also participate in LOAK.[198,199]

The Child Abuse MDC in Friesland and the Academic Collaborative Centre on Child Abuse in Noord-Holland-Zuid are the first to combine efficacy studies of interventions with research into the efficacy of the type of collaboration and integrated approach used in cases of child abuse.

4.7 Conclusions

When treating a victim of child abuse, it is necessary to involve the entire social system surrounding the child in question. The parents or guardians are enormously important in terms of providing safety and support. Treatment should be integrated, as simultaneous interventions in various domains are needed.

As yet, very few interventions for treating the effects of child abuse are adequately supported by scientific evidence. TF-CBT and EMDR are currently the best studied and most effective treatment for children with PTSD symptoms resulting from child abuse. PCIT has been shown to be the best evidence-supported intervention for improving the parent-child relationship after physical abuse. The evidence for the other available interventions for treatment is disappointing. Further studies of good quality and sufficient scope are required.

The infrastructure for assessment and treatment is highly complex in nature, and – sadly – does not always perform as it should. The main bottlenecks involve the need for specialised knowledge and experience, and the need for an integrated approach.

Chapter 5

Assessment and treatment of adults

This Chapter addresses the assessment and treatment of adults with a history of child abuse.

5.1 Assessment of adults

The assessment of adults who were abused during their childhood and who have now been taken into care, is – if anything – even more difficult than in the case of children. This is because, all too often, there is a failure to link the problems presented by the adult to past abuse. Occasionally, there are also problems with recovered memories.[200]

The assessment of adults is mainly guided by the disorders that have developed. Accordingly, this is largely confined to psychiatry. This section deals with the various elements of the assessment of adults.

5.1.1 Safety

This advisory report focuses on treating the effects of child abuse. The safety of adults during their childhood is, therefore, no longer relevant. However, if the effects of previous abuse are to be treated effectively, it is important that the individual in question be safe at the time of treatment. Individuals who were abused during childhood are at increased risk of insecure relationships in adulthood.[23,46] Accordingly, it is entirely possible that an adult may still be in a

situation where abuse is involved. In such cases, an attempt is made to motivate the individual in question to step out of that situation, by moving into sheltered accommodation, for example.

5.1.2 *Psychiatric diagnosis*

Enough instruments (at the level of the disorder) are available for the diagnosis of psychological problems in adults, depending on the problem in question. These include the structured clinical interview DSM-IV disorders – Axis I (SCID-I). The problem is that insufficient use is made of such instruments. In the absence of targeted, systematic questioning about the psychological problems themselves, disorders may be overlooked.

Aside from those used to diagnose PTSD, complex PTSD and dissociative disorders, few diagnostic tools are specific to trauma or child abuse. The drawback of this situation is that cases requiring a trauma-specific treatment can be missed. Conversely, extensive trauma-based diagnosis carries a risk of overdiagnosis and over-treatment. Moreover, it is by no means certain that information about youth traumas is always relevant to the treatment of psychological problems in adulthood.

Currently, however, patients are asked about sexual abuse as a matter of course. In the case of other forms of abuse and neglect, however, this either happens less often or is non-systematic in nature. Emotional abuse and physical abuse are the worst in this regard.[201]

In 2008, the Netherlands Centre for Chronic Childhood Traumatization (LCVT) published its Guidelines for influx, diagnosis, needs assessment, and evaluation diagnosis (measurement of effects) for adults with psychopathology resulting from early childhood traumatization.[202] The affiliated highly specialised (tertiary care) trauma centres operate in strict accordance with these guidelines. The professional practitioners employed by these centres are only permitted to deviate from these guidelines if they are able to supply adequate and well documented reasons for doing so.

The adult target group for such highly specialised (tertiary care) trauma centres consists of individuals with symptoms of trauma-related disorders. These centres therefore provide tertiary diagnosis for patients who are referred from primary or secondary health care. Self-report lists and a short, standard trauma list are used at intake and during the introductory phase.[203] The following diagnostic test uses SCID-I, CAPS, and SIDES, in addition to a psychiatric examination.[204-206]

People with complex trauma-related disorders almost always suffer from a combination of Axis I (clinical disorders) and Axis II (personality disorders), which makes diagnosis difficult. To reflect this overlap of Axis I and Axis II disorders, Draijer developed the "diagnostic square".[207-209] This tool is used to set out the diagnostic path and to better substantiate the individual-oriented needs assessment. Along the horizontal axis, the model indicates the severity of emotional neglect involved, which reflects the degree of insecurity of the early attachment relationship with the parents. This dimension is most fully expressed in the therapeutic relationship. The greater the number of problems associated with emotional neglect and attachment, the more difficult the therapeutic relationship. The vertical axis represents the severity of traumatisation and its cumulative effect. This dimension is mainly reflected by the severity of posttraumatic and dissociative problems, and by issues involving emotional regulation.

The above shows that the diagnosis of complex, stress-related disorders is an intricate process requiring a great deal of experience and expertise. Accordingly, this diagnostic procedure must be carried out by trained diagnosticians. This is not currently a priority for mainstream educational programmes in Psychology and Psychiatry.[209]

5.1.3 *Medical Diagnostics*

Adults who were abused during childhood may still exhibit the visible effects of such abuse. These include scars, old fractures, or brain damage.

In the case of chronic disorders such as obesity, cardiovascular diseases, diabetes and asthma it is important (but not yet common practice) to enquire about traumatic events in childhood. As described in Chapter 3, the ACE study in the U.S. was the first to demonstrate the existence of a relationship between a history of abuse and chronic disorders such as diabetes, asthma, obesity and cardiovascular diseases.[85,88,99] A recent study by the Netherlands Organisation for Applied Scientific Research (TNO) showed this also appears to be the case in the Netherlands.[106] Several prospective studies have now confirmed that there is indeed a link between abuse during childhood and a heightened risk of chronic disorders in adulthood.[101-105]

5.1.4 *Parenthood*

The risk that adults who were abused during childhood will go on to abuse their own children is greater than in the case of those who did not suffer such abuse.

This arises from impotence, because they themselves were given a bad example and are unaware that violence has no place within the family, due to impaired emotion regulation, or as a result of the stress caused by psychological problems. When conducting an assessment, it is therefore important to find out whether the individual in question has children of their own, and how they are faring. How does the individual feel about parenthood, are their own children being abused, or there is a substantial risk of future abuse?

Until recently, the adult mental health care association focused mainly on the psychological problems of those involved, without addressing the influence of parenting on the problems in question (and vice versa). The above-mentioned KOPP (children of parents with psychiatric problems) projects are one example of changing practices.[210]

One consideration pertaining to parenthood in adults with mental health problems (whether or not they themselves have a background of abuse) is that professionals treating these problems may find it difficult to decide whether or not to report any abuse of their patient's children. The parent might then opt to terminate their treatment, thereby putting the cart before the horse. However, a failure to report any abuse may cause it to continue, which is very harmful for the children in question. Specific communication skills are needed to facilitate a discussion about the abuse and about notifying a Child Abuse Reporting Agency (AMK). Experience shows that a conversation with the parents can be more productive than is sometimes thought. Various interventions targeting mother-child interaction are currently under development. These clearly meet a need to tackle the parenting role in combination with mental health problems, and to prevent the abuse or neglect of very young children (see also Chapter 4).[181,211]

If the treatment allows the parent to attach more securely and to desist from further abuse, this will facilitate the rebuilding of trust between parent and child. Reporting the abuse might well frustrate any restoration of trust. Nevertheless, due consideration must always be given to the parenthood of adult patients, while the health and safety of their children must be fully safeguarded.

5.2 Treatment

In this literature survey too, the Committee focused on reviews (including systematic reviews) and evidence-based guidelines. The list of research literature examined was not exhaustive.

Table 5 summarises the best researched interventions. Accordingly, this Table does not represent a comprehensive summary of all current interventions.

Table 5 Summary based on systematic reviews and guidelines regarding interventions for adults.

Intervention	Evidence
TF-CBT and EMDR are the obvious psychological treatments for PTSD. Research into various trauma groups is also needed, however. B[212,213]	Level 2
Any primary care treatment for chronic PTSD that exceeds three months must be trauma focused (TF-CBT or EMDR) B[214]	Level 2
There is no reason to believe that, in cases of PTSD resulting from childhood trauma, TF-CBT is any less effective than in adult trauma C[215]	Level 3
There is evidence that individual and group TF-CBT, EMDR and stress management are effective in treating cases of PTSD, including those resulting from childhood abuse. They are more effective than non-trauma-specific psychological interventions or than doing nothing at all (being on a waiting list). In view of the unexplained heterogeneity in the comparisons, the authors urge caution when interpreting the results of the review. B[216]	Level 3
Psychotherapeutic approaches to treating the psychological effects (PTSD, trauma symptoms, internalising and externalising symptoms, self-esteem, interpersonal functioning) of childhood sexual abuse generally have a beneficial effect. More specific studies are required to find out which approach works for whom. B[217]	Level 3
There are a range of psychotherapeutic treatment concepts for patients with personality disorders resulting from childhood trauma. These are based on CBT or on psychodynamic psychotherapeutic interventions. Given the heterogeneity of the patient population, none of these concepts is able to address the clinical problems of every single patient. B[218]	Level 3
There are effective interventions for patients with borderline personality disorder (often with a history of abuse), including therapies targeting abuse and other issues. B[219-222]	Level 2-3

As is the case with children, the literature contains strikingly few abuse-specific studies. Similarly, while there are sufficient good-quality studies into the treatment of PTSD, little or no research has been carried out into the treatment of more profound, complex trauma-related disorders.

TF-CBT and EMDR seem to be effective interventions for adults with PTSD resulting from child abuse. As a result, there is no doubt about what constitutes appropriate treatment for PTSD. A review that is due for publication later this year shows that the results of trauma-focused treatments for PTSD caused by chronic childhood trauma are clearly superior to those of therapies that lack this focus.[223] In the case of more complex problems (e.g. complex PTSD and dissociative disorders), however, there are very few relevant studies. This means that there is no empirical evidence for interventions. Nevertheless, in the field of dissociative disorders, an international cohort study has shown that psycho-

therapy holds out the prospect of progress.[224] The finishing touches are being added to a Dutch RCT (Randomized Controlled Trial) into the effect of a stabilising intervention in complex PTSD.[225,226]

There is sometimes a tendency to view a disorder (e.g. a psychosis) as a contraindication for the resolution of trauma, which is not necessarily the case. Trauma experience integration can actually help in treating the "main disorder".[215*] In the area of borderline personality disorders, there is currently a greater focus on trauma experience integration, although this is neither standard nor widely available.

A book by Courtois and Ford (Eds.) (2009), entitled "Treating complex traumatic stress disorders" confirms that the treatment of complex PTSD and dissociative disorders in particular is widespread, while the scientific and clinical validation of psychotherapeutic treatments is still at an early stage.[227] In the Netherlands too, this message is repeatedly being hammered home.[189,228] In the case of this severely affected group of patients, it is not clear whether they should be given trauma focused therapy (such as CBT) immediately or whether they should first be given preparatory treatment (stabilisation and emotional regulation). This issue is currently being investigated.[226,229,230] In this connection, Courtois and Ford identify three phases of treatment:

1 Safety and stabilisation
2 Integration of traumatic memories
3 Reintegration.

The authors consider the first phase, to be the most important, in terms of the treatment's chances of success. If they are not safe or do not feel safe, these individuals will retain their defensive, self-protective strategies, which precludes any chance of progress. In some cases, stabilisation is the only feasible goal.

This three-phase approach is also used in the Netherlands, in the treatment of patients with complex trauma-related clinical pictures.[228] The International Society for the Study of Trauma and Dissociation (ISSTD) provides international guidelines for those working with children, adolescents and adults with dissociative disorders.[231] Given the paucity of research-based evidence in this area, these guidelines are based on expert consensus. In the Netherlands, similar expert-based guidelines were developed by the LCVT (National Centre for Early Childhood Trauma).

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* This is a controversial position when it comes to complex trauma-related disorders, where initial stabilisation is the preferred approach (ISSTD guidelines).[231]

For adults, as for children, further studies of good quality and sufficient scope are required to identify the effectiveness of interventions. The more complex the disorder the less the amount of research into proven interventions.

A recent study by the Trimbos Institute into the implementation of guidelines clearly shows that a large majority of borderline patients do not receive the treatment indicated by the recent guidelines (specialised psychotherapy).[232,233] Other studies show that with PTSD too, if the disorder or the patient is assessed as being complex in nature, the treatment stipulated by the guideline is not administered (e.g. TF-CBT). While there are evidence-based treatments for these patient groups, in practice, the appropriate treatment is often not available.

In the case of various DSM-IV disorders, there is evidence to support the effectiveness of interventions. This has also been incorporated into various guidelines for treatment (e.g. depression, schizophrenia, eating disorders, anxiety disorders). However, many of these studies and guidelines fail to take account of the effects on diagnosis and treatment of a background of abuse. This sometimes seems less relevant to adults, as the issue of whether or not the patient has a background of abuse is not always relevant to the treatment outcome of the DSM-IV disorder. Given the continuing paucity of research it is not possible to draw definitive conclusions about the majority of psychiatric disorders. In the case of inadequate treatment outcomes it would seem worthwhile to consider a targeted diagnosis for any existing childhood traumas and, if confirmed, to treat them.

The Committee is also concerned about the lack of care provision for those suffering from the effects of child abuse, but whose symptoms are not clearly covered by a DSM-IV classification (or main category). Although a psychotherapeutic treatment based on trauma experience integration is indicated, the general impression is that many of these patients do not receive adequate help.

In the more complex patient groups, childhood experiences seem to affect the pathogenesis and persistence of the disorder. However, there is a lack of scientifically substantiated, well-tested treatments for the effects of child abuse in such individuals. This is particularly the case with dissociative disorders, psychotic disorders, various disorders in forensic contexts, and low intelligence.

5.3 Care infrastructure

Figure 6 is a diagrammatic representation of the care infrastructure for adults. In terms of the assessment and treatment of the effects of child abuse, the pivotal points are the diagnosis and treatment of psychological problems. The practitioners who operate in these areas are psychologists, psychotherapists and psychiatrists in mental health care associations and public mental health care. Although the parenting role is not included here, it will be addressed by mental health careservices.

An important issue in the infrastructure for the treatment of adults concerns the way in which they enter the care system. Again, careful assessment is important. Is the practitioner aware that there might be a link between the symptoms presented by the patient and a history of abuse? Do these practitioners make appropriate referrals, i.e. enabling a rapid and correct diagnosis to be made, and an appropriate course of treatment to be initiated?

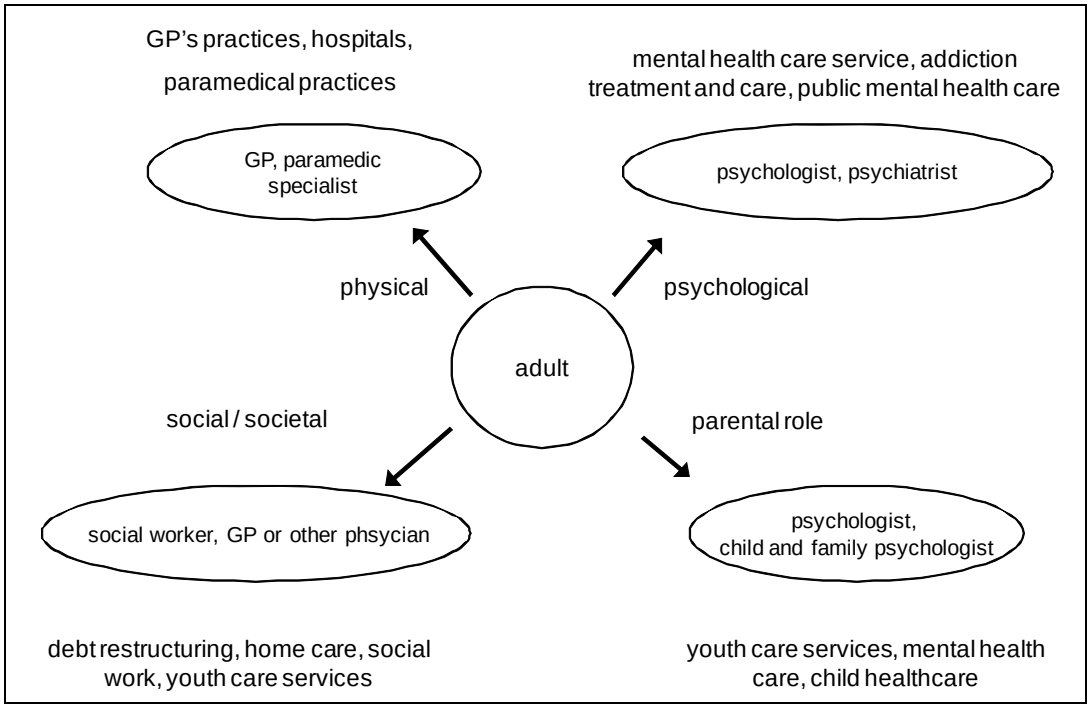

Figure 6 Care infrastructure for the assessment and treatment of adults who were abused during childhood.

One source of concern are those patients who have experienced problems since childhood and who, upon reaching adulthood, have to be transferred from youth care services to adult care services. When this happens, these individuals lose their regular treatment contact. This is hardly conducive to effective treatment. These vulnerable young people should have a permanent, fixed contact.

5.4 Care needs

In order to identify existing care needs, the Committee has met with the Hidden Violence Foundation, the Association Against Child Sexual Abuse, Caleidoscoop (a dissociative disorder patient association), STUK (support group for abused juveniles) and the Fier Fryslân centre for children and young people. One major limitation of this method is that it does not identify the care needs of children. The legal complexities involved in interviewing children meant that it was not possible to interview them specifically. Accordingly, the needs defined in this section relate solely to the adult perspective.

5.4.1 General

All of the interviews revealed that the subject of child abuse is still a taboo. The victims are reticent when it comes to talking about what happened to them. Care practitioners, too, find this a difficult subject. Those dealing with child abuse mainly focus on prevention and detection, and too little on teaching people how to live with the associated repercussions. There is scant recognition for these repercussions. If the abuse stops, the response of the outside world (including many care practitioners) is “OK, it’s over”. Accordingly, the victims have a great need for an acknowledgement of what happened and of the traces it leaves behind. It is essential that they feel that someone is really listening.

With children, too, when the issue of care is raised, it is necessary to talk to them about what has happened and what they need. If necessary, they could be given the opportunity to communicate this information by making drawings. In this way, young children can indicate their present or future needs, as a basis for the care response. Indeed, this course of action is explicitly required by the guidelines, but in practice it is often omitted.

5.4.2 Needs with respect to care practitioners

There is great need for care practitioners with the relevant expertise, who also know how to deal with victims both clinically and emotionally. It is very

important for care practitioners to demonstrate involvement (while maintaining an appropriate degree of professionalism), that victims are taken seriously, and that the treatment plan matches the victim's expressed needs. Care practitioners must also be able to apologise when they make mistakes, or if they have treated their clients unfairly.

In addition, care practitioners should also acquaint themselves with the ethnic background of the victim and their family, as this may affect the way these individuals are dealt with and the medical treatment they receive. The care given to these victims should be integrated and multidisciplinary in nature. That is not always the case.

One issue that was raised in every interview was that those involved were often slow (or unable) to link the victims' symptoms and problems to abuse. This relates both to the victims themselves and to the care practitioners.

Some interlocutors indicated that care practitioners are often perceived as being too young and as having too little life experience to carry out their professional duties in families with numerous problems, for example, with even a modicum of credibility. In a number of interviews, the lack of continuity in caregivers was identified as a problem. Customised training programmes should be created for young people with practical knowledge (based on their own experience) who have a desire to get involved in care work.

Another problem is that primary health care practitioners, particularly GPs, often do not know to whom they should refer their patients. The uncertainty surrounding capacity in youth care services was cited as a reason for this, though this also applies to care provision for adults.

5.4.3 *Treatment needs*

One important point put forward with regard to children, was that the child's needs should come first. This is now widely acknowledged, but in fact everything still revolves around the care system – not the child. It was also stated that practitioners should tailor their treatment to the strength and capabilities of victims, rather than trying to treat everyone the same way, in accordance with a rigid protocol.

All of the interviews underscored the importance of contact with fellow sufferers. It can serve as a springboard for bringing out what happened to a victim and thus provide an input for treatment. Moreover, according to many of the interlocutors, contact with fellow sufferers is an essential aspect of the treatment as it allows people to reflect and to share experiences. Contact with fellow sufferers enables victims to learn to live with the past and with any

resultant disorders. Yet it is by no means certain that victims will be referred to these patient groups.

In the same way, it was indicated that victims need training courses to learn to live with their past. By no means every aspect of care necessarily involves psychiatrists. There are some problems for which practitioners prescribe medication, almost as a matter of course.

It has long been the case that there are marked regional differences in the availability of specialist treatments. Following the opening of the Netherlands Centre for Chronic Childhood Traumatization (LCVT), the affiliated trauma centres formally consented to the standardisation of diagnosis and treatment. This greatly improved the situation in the LCVT centres, but things are still not ideal. Care should be accessible and easy to find.

One problem affecting the treatment of dissociative disorders, for example, are the long waiting lists involved. These are long-term treatments (lasting around eight years), for which there are too few therapists. In addition, there is no national coverage and expertise outside the trauma centres is too limited. This most severely affected group is often sent from pillar to post, and is even excluded from mental health care institutions due to a lack of in-house expertise and to the high cost of these treatments.

According to some interlocutors, the relatively new DTC system is not suited to funding the treatment of the effects of child abuse. Diagnosis is difficult, and patients often exhibit several concurrent problems. The treatments (which can be rather lengthy) need to be integrated, which makes them incompatible with the current system. For example, under the international expert based guidelines (International Society for the Study of Trauma and Dissociation; ISSTD) for the treatment of dissociative disorders, intensive individual psychotherapy is appropriate and a fixed treatment contact is preferable. In the event of crises, admission may be necessary, whereby it is appropriate for the individual treatment contact to be maintained.[231]

5.4.4 *Research needs*

With regard to dissociative disorders, there is a great need for research into diagnosis and treatment in adults and children. Given that this is a complex disorder requiring long-term treatment, it is very difficult to find adequate funding for such research.

Several interlocutors also expressed the view that greater use should be made of the victims' practical knowledge (based on their own experience) when developing new treatment methods.

The Committee would also like to draw attention to the difficulty of doing intervention research with adults who were abused during childhood, as well as with children. Here too, the emotionally charged nature of this subject makes it rather unpopular. It is also difficult to assemble sufficiently large and homogeneous experimental groups. Finally, it is often a complicated matter to obtain the permission of both (authoritative) parents and from the medical ethics review committees charged with assessing the ethical aspects of research proposals.

5.5 Conclusions

In practice, the diagnosis of psychiatric disorders is often not carried out systematically, as no use is made of structured (or semi-structured) interviews. As a result, there is a risk that some trauma-related problems, such as PTSD or borderline personality disorder, might be overlooked. Moreover, the sheer difficulty of diagnosing complex trauma-related disorders means that this should only be carried out by practitioners specifically trained for the purpose.

Some psychiatric disorders (and comorbid psychiatric disorders) such as psychosis, depression, and borderline can benefit if the previous history of child abuse is addressed. Indefensibly, that is often not the case.

There is consensus concerning the stages of treatment for adults with complex trauma-related disorders. The stages in question are stabilisation, trauma experience integration, and reintegration.

For adults too, TF-CBT and EMDR are the best researched and (for the moment) most effective interventions for treating the symptoms of PTSD, although the evidence base for this could be more robust. The situation for adults, also, is that these interventions are not widely available and accessible in the Netherlands. There are still too few evidence- supported interventions for the treatment of complex disorders such as complex PTSD, and dissociative disorders.

With regard to the nature of victims' care needs, one point of pivotal importance is the need to be listened to as a human being. Also, better use could be made of

the victims' practical knowledge (based on their own experience) to improve care, and of contact with fellow sufferers within a treatment context.

Although the care infrastructure for adults is less complex that for children, here too continuity and coordination between care practitioners could be better.

Chapter 6

Conclusions and recommendations

Child abuse is a serious, complex and widespread social problem with far-reaching, often life-long repercussions for the victims. The key to a solution is the development of a full appreciation of the seriousness, complexity and scope of this problem. In addition to spotlighting prevention, an emphasis on effective assessment and proper treatment is, and will continue to be, essential. In this Chapter, the Committee answers the questions contained in the request for advice, on the basis of the preceding chapters. It concludes with a number of recommendations.

6.1 The effects of child abuse

Do we have a clear understanding of the types of physical and psychological disorders that can develop as a result of child abuse?

This question was answered in Chapter 3.

Effects

Clearly, the effects can be far-reaching in nature and may persist into adulthood if no action is taken to remedy them.

The effects of child abuse can be both physical and psychological in nature.

The physical effects involve fractures and scars, as well as brain damage and an increased risk of chronic disorders such as cardiovascular diseases, asthma and obesity, in addition to psychosomatic disorders such as stomach aches and headaches. Given their physical vulnerability, very young children are at greater risk of permanent brain damage and death as a result of injuries sustained during abuse.

The psychological effects range from attachment problems, anxiety, depression and concentration problems, to behavioural problems, personality disorders, complex PTSD, and dissociative disorders.

The view that small children are less likely to suffer injury as their brains are still so plastic, is categorically incorrect. Very young children are actually more susceptible to injury, because of that very plasticity. If their carers fail to deal with traumatic events properly, or are unable to do so, this is likely to lead to permanent damage to the child's developing brain and to increased sensitivity of the stress system. Disruptions of the stress system, in turn, have an impact on the immune system, which also affects the individual’s susceptibility to infections. Neglect does not immediately result in trauma but it certainly has serious consequences.

The consequences of child abuse can be quite debilitating, inflicting significant economic damage both on the individual victims and on society at large.

Cause and effect

There are no obvious one-on-one cause-effect relationships between specific forms of abuse and specific problems or disorders. Nevertheless, there are indications that some forms of abuse are more strongly correlated with certain effects. Individuals with borderline personality disorder are more likely to have been sexually abused during childhood. Those with antisocial personality disorder were more likely to have encountered physical violence during childhood. Finally, people with a dissociative identity disorder are more likely to have suffered both physical and sexual abuse. One problem with research into specific causes and specific effects is that it is often the case that several forms of child abuse occurred concurrently, frequently in combination with emotional neglect.

6.2 Care needs

What are the needs of child abuse victims, in terms of psychiatric care and trauma care? Are these needs primarily clinical or social in nature?

The answer to these questions is mainly derived from the needs of adult victims, as indicated in interviews (Chapter 5). Here too, the Committee explores the potential scope of the care needs. This is based partly on the conclusions from Chapter 3, concerning the possible effects of child abuse. It is also based on Chapters 4 and 5, concerning the assessment and treatment of children and of adults who were abused during childhood.

Nature of care needs

Interviews conducted with organisations for adult victims who were abused during childhood revealed that there was a great need to break the taboo on talking about child abuse, particularly among care practitioners. It is important that victims are listened to and taken seriously for who they are, and that sensitive care is provided, based on their ability to cope.

Practitioners by no means always identify a link between abuse (or a history thereof) and the symptoms presented by victims. This often leads to many years of treatment and to misdiagnoses. Since the 1980s, various educational programmes and refresher courses for physicians, for example, have spotlighted this issue. Nevertheless, it seems unable to take root. To date, there has been no consistent interest in this subject.

Other important issues cited by these organisations are the lack of continuity of care resulting from frequent staff changes, and the lack of experienced care practitioners. There is a need for smooth and careful assessment, targeted referral, and evidence-supported treatment of the effects of child abuse in children and adults. Finally, the victims' organisations expressed the view that better use could be made of the victims' practical knowledge (based on their own experience), for instance in the area of contact with fellow sufferers, in support of other areas of treatment.

The Committee would like to add that, given the gravity of the effects of child abuse, it should be clearly understood that waiting lists are disastrous.

In the case of children, safety should be guaranteed immediately. Assessment and treatment must take place in various areas, within a few weeks of notification. In addition to providing immediate safety, this also involves an effective, integrated assessment to identify the requisite assistance and treatments. These must then be instigated immediately and concurrently.

This serves to illustrate that the care needs are both social and clinical in nature.

Indication of scope of care needs

Estimates of the scope of the problem vary widely. All available estimates show that this is a very significant problem. The group of Dutch people who were abused during childhood numbers in the hundreds of thousands, at the very least. Conservative estimates indicate that about 10% of adult women were sexually abused within the family, while a further 10% were physically abused. It is estimated that the various forms of abuse and neglect combined represent a figure of 10-30%, which equates to approximately 1.5 to 4 million adults.

The exact effects involved vary from one individual to another. Accordingly, the scope and nature of the requisite care cannot be calculated on the basis of estimates of the occurrence of abuse, something that to some extent is possible in the case of diabetes for example. Based on the available estimates, however, it is clear that this is a very large-scale problem. The Committee believes that, at the very least, all abused children should receive psycho-education.

6.3 Evidence-supported interventions for children and adults

What evidence-supported interventions are currently available in the area of treatment, both in clinical and social terms?

This question is answered in Chapter 4 for children, and in Chapter 5 for adults who were abused during childhood.

The importance of a good assessment

Before exploring the issue of what evidence-supported treatment interventions are available, the Committee would like to emphasise the crucial importance of a careful, integrated assessment. This must involve an accurate analysis of the situation in terms of safety, environmental factors, the role of parents as individuals and as those who are entrusted with the child's upbringing. Careful note is also taken of the child's development, and of its mental and physical condition. It is also important to take note of the positive aspects. In general, the assessment of adults who were abused during childhood involves the very same elements. The one exception is that, where appropriate, the parent's role relates to their own performance in terms of parenting. Given its multifaceted nature, assessment should be conducted along multidisciplinary lines.

Without good assessment, there is no basis for a proper decision about the types of care and treatment needed.

Evidence-supported clinical interventions

For both children and adults, there are only a small number of evidence-supported clinical interventions. For both groups, TF-CBT and EMDR are the best researched and, for the moment, the most effective interventions (at international level) for treating the symptoms of PTSD. Moreover, there is little literature specific to the treatment of abuse.

In the case of various DSM-IV disorders, there is evidence to support the effectiveness of interventions. This has also been incorporated into various guidelines for treatment. However, many of these studies and guidelines fail to take account of the effects on diagnosis and treatment of a background of abuse.

This seems less relevant to adults, as the issue of whether or not the patient has a background of abuse has no implications for the treatment outcomes of many DSM-IV disorders. In the case of borderline personality disorder, dissociative identity disorder, and complex PTSD, however, there are indications that it is better if unresolved issues from the past are involved in the treatment process. At international level, a three-stage model is used for these complex disorders. The first aim is stabilisation (1), then, if possible, exposure is used (2), while the final step involves a process of integration (3).

The effects in children are less likely to manifest as autonomic disorders. Also, the psychological problems are more closely related to the abuse. Accordingly, in the treatment of children, it is very important to make specific allowance for the nature and severity of the abuse in question.

Evidence-supported social interventions

In the social area, there are parenting support interventions for parents. PCIT is the best studied of these, and it also appears to be genuinely effective. Triple-P Level 4/5, Functional family therapy (FFT), Parent Management Training Oregon (PMTO), and Multi System Therapy - Child abuse and neglect (MST-CAN) can be described as promising. However, these interventions have not been adequately tested for effectiveness in the specific setting of child abuse. There are also many general, non abuse-specific parenting support interventions whose effectiveness is supported by little or no research. Several studies are currently being carried out in this area. Many are funded by the Netherlands

Organisation for Health Research and Development's Youth Programmes, although these are nearing the end of their term, and there is uncertainty about future follow-up.

When a parenting intervention is used, it is important that it be abuse-specific, and that it be embedded in the wider context of treatment.

Preconditions for treatment

A number of preconditions for good-quality treatment have been identified, based on the current level of knowledge, and on the Committee's knowledge and experience.

For children and adults who were abused during childhood, an integrated, multidisciplinary approach to assessment and treatment is essential.

In children, assessment must be carried out by a multidisciplinary team, so that all aspects of the child's development (physical, social, emotional, etc.) and possible variations thereof can be identified. The victim's entire system should also be involved in their assessment and treatment. Is important to continually assess who needs what, where, and when. It is inefficient to use a single intervention without considering the context and development over time.

In the course of their educational training programmes, practitioners must learn to converse with their patients about sensitive issues such as child abuse and sexual abuse. This is an essential skill in the treatment of adults. The educational programme should focus on recognising the effects of abuse. Instruction should also be given in the associated diagnosis of trauma-related disorders such as complex PTSD and dissociative disorders.

The treatment available to children and adults is, wherever possible, of proven efficacy, is administered in accordance with protocol, and the results are monitored. Care practitioners should be well trained in assessment and in intervention methods.

In the case of children, assessment and, where necessary assistance and treatment must take place in various areas, within a few weeks of notification. In addition to an examination of the immediate safety level, a determination is made (based on a sound assessment) about whether assistance or treatment is required (and if so, what type) as well as rapid action in this regard.

Available evidence-based guidelines merit implementation and compliance. This is the responsibility of the professional groups involved. Where such guidelines are unavailable or outdated, it is important to develop or update them.

All things considered, the Committee concludes that - given the specific knowledge and experience required - the role of caring for the victims of child abuse should be reserved for specialised professionals.

6.4 Availability and accessibility of evidence-supported interventions

Are the requisite interventions available throughout the country, and are they accessible to all victims (both children and adults)? If not, how can availability and accessibility be improved?

These questions are answered in Chapters 4 and 5.

Without accurate assessment it is not possible to provide adequate treatment. This applies to both children and adults. However, there is a major gap here, because the components of the assessment are currently carried out by a range of different professionals/agencies. In addition, transfer and cooperation often do not proceed smoothly.

In the Netherlands, interventions in the area of child abuse are provided by numerous agencies. The problem is that the vast majority of these interventions are not abuse specific. This is particularly true of many parenting support interventions, for example.

Furthermore, an integrated approach to treatment is essential, both for children and adults. This means that the support provided in different areas for different stakeholders (the child in question, brothers, sisters, parents, partner) should be offered concurrently. Moreover, the various lines of support should be prioritised, coordinated and reconsidered. Given the way in which youth care services, as well as youth and adult mental health care services, are organised in the Netherlands, this kind of integrated approach and coordination is not a foregone conclusion. Accordingly, the provision of care is not as efficient as it could be. As a result, there are often delays before victims get the assistance they need. The impending change in the youth care services system will have profound implications for cooperation and coordination between various agencies. Under the new system, local authorities will be given a range of tasks, including organising youth care and parenting support.

The availability of TF-CBT and EMDR for PTSD in children and adults is not evenly distributed across the country. The use of TF-CBT and EMDR requires proper training and supervision The *de Bascule* trauma centre (academic centre for child and adolescent psychiatry in Amsterdam) introduced TF-CBT to the

Netherlands, and will be staging training sessions throughout the country this year. The Horizon method, which was developed in Haarlem, also has a CBT component. The effectiveness of the full method will be investigated over the next four years. The eye movement desensitisation and reprocessing (EMDR) training and supervision programmes are provided by the Dutch EMDR Association. The proper implementation and national roll out of evidence-supported interventions requires a national implementation structure, especially in light of the upcoming changes to the youth care system, which will involve a marked shift towards the decentralisation of amenities.

The area of care infrastructure involved in treating the effects of child abuse in children, and in adults who were abused during childhood, is very complex and fragmented. This is mainly a result of the multiplicity of related care domains involved, the numerous agencies operating in these fields, and the many professionals working in these areas.

6.5 Scientific gaps in the area of treatment

Is it possible to identify any scientific gaps in the area of treatment?

This question is mainly answered in Chapters 4 and 5.

Firstly, the Committee would like to draw attention to the fact that many of the tools and checklists used in the assessment process lack any kind of scientific basis.

The field of social treatment interventions lacks an evidence base. In clinical interventions (both somatic and psychiatric) too little consideration is given to abuse as a major underlying factor in physical and psychological symptoms. There are also gaps in our knowledge regarding the effectiveness of child-abuse-specific interventions for both children and adults.

In the more complex adult patient groups there is a lack of scientifically substantiated and well-tested treatments for the effects of child abuse. In such patients, childhood experiences seem to affect the pathogenesis and persistence of the disorder. This is particularly the case with complex PTSD, dissociative disorders, psychotic disorders and various disorders in forensic contexts.

6.6 Recommendations

The general conclusion of this advisory report is that, as yet, we have only a limited understanding of how to treat the late effects of child abuse. This is a very dynamic area, yet few treatments are based on sound scientific evidence. This is reflected in the recommendations formulated below.

6.6.1 Integrated approach to assessment and treatment

In Section 6.3, the Committee indicated that treatment of the effects of child abuse requires an integrated, multidisciplinary approach. This applies to both children and adults.

As indicated in Section 4.6 above, this calendar year the Academic Collaborative Centre on Child Abuse of the *KJTC Haarlem* (centre for traumatized children and young people) and the *Fier Fryslân* multidisciplinary centre for the treatment of victims of child abuse will be the first to launch this approach across a range of domains.

The Committee recommends that the two initiatives in Haarlem / VU Amsterdam and Friesland be used as a testing ground. With this in mind, it is appropriate to offer additional support to monitor and record their experiences, as well as facilitating the development of coherent intersectoral care provision within the framework of these initiatives.

As these two initiatives mainly target children, the Committee recommends that an academic collaborative centre be set up for adults who were abused during childhood. This would be complementary to the activities of the Netherlands Centre for Chronic Childhood Traumatization (LCVT). The study should primarily focus on the diagnosis and treatment of complex disorders such as complex PTSD and dissociative disorders, beginning with a systematic review of these areas.

6.6.2 Care infrastructure

The Committee noted that there are currently few evidence-supported interventions for treating the effects of child abuse in children and adults. The Committee

believes that, given the extremely limited nature of the evidence base, it would be unwise to make far-reaching recommendations concerning possible adjustments to the existing, highly complex infrastructure. Before the health care infrastructure can be tackled, care provision needs to be brought up to scratch. This requires that the field be properly prepared for evidence-based working and for conducting well designed and documented research.

However, the Committee does recommend that efforts be made to ensure that TF-CBT and EMDR for the treatment of PTSD in children and in adults who were abused during childhood are available and accessible at well distributed points throughout the Netherlands. Here too, it important that there be a national coordination and implementation structure, especially in light of the impending decentralisation the youth care services system.

In line with this, the Committee recommends that initiatives and national coordination associated with the implementation of coherent and coordinated intersectoral care provision be encouraged. This should incorporate the results obtained from the testing grounds.

6.6.3 *Preparing care provision for evidence-based working*

Evidence-based working is not yet being used as a matter of course at all levels of care provision for the victims of child abuse. This issue is not restricted to the Netherlands, it is a worldwide problem. However, the first indications of a trend in that direction are now visible in youth care services. In addition, psychiatry for children and adults already involves the use of evidence-based guidelines.

Incidentally, evidence-based working is not the same as working in accordance with a fixed, unchanging set of procedures and fixed interventions. Evidence-based working involves work that is based on the current level of knowledge.* Given that science is in a state of continuous development, evidence-based working is essentially a dynamic process.

The guidelines for diagnosis and treatment in the various domains of care (mental health care services, youth mental health care, youth care services, child healthcare) for the various professional groups are important tools for evidence-based working.

* In the U.S., in the context of child abuse, the term research-based working is also used, as hard evidence for the effectiveness of interventions is still limited.

In the U.S., the State of South Carolina has obtained good results with community-based learning as a way of convincing all kinds of regional support agencies of the added value of training courses in evidence-based working. [192]

> The Committee recommends that where evidence-based guidelines are still lacking, they be developed. Such guidelines should take into account the effects of child abuse (past or present) on diagnosis and treatment. Existing guidelines should be kept up to date, implemented, and used. This is a job for professionals.
>
> The Committee also recommends that people's experiences with community-based learning in South Carolina and in the BEST project be studied, to see how they might be translated into a Dutch project.

The Committee also found that care provision for the victims of child abuse is a specialist area, in the sense that care practitioners need to be specifically trained in this area. This applies to care provision for children and for adults who were abused during childhood.

The National Training Centre for Tackling Child Abuse Issues (LOAK), (which is an initiative of the *KJTC Haarlem* (centre for traumatized children and young people) and the *Fier Fryslân* multidisciplinary centre for the treatment of victims of child abuse) will work on delivering nationwide professional development in dealing with the effects of child abuse. In this endeavour, the centre will cooperate with other national and international organisations that provide training courses in this field. It will also focus on delivering services that are not yet available. The centre focuses on all professionals who work (or might foreseeably work) in the area of child abuse, in relation to children and their parents.

In 2012, the National Training Centre for Tackling Child Abuse Issues (LOAK) will launch a training course for therapists in the field of abuse-focused and trauma-focused treatments. The course will be at higher vocational and university level. The Netherlands Centre for Chronic Childhood Traumatization

(LCVT)* has specialised courses for professionals working with adults who were traumatized during childhood.

> The Committee recommends that the National Training Centre for Tackling Child Abuse Issues (LOAK) be charged with the establishment, development and structured provision of this specific, specialised training programme for the Netherlands. The Netherlands Centre for Chronic Childhood Traumatisation's (LCVT) programme of courses for the provision of care to adults merits support.
>
> LOAK could also take on a national coordinating role for this range of courses, if appropriate assistance is provided.

6.6.4 *Preparing care provision for scientific research*

Robust scientific research is not carried out as a matter of course in those areas of care in which the victims of child abuse are cared for and treated. It is unrealistic to think that, in the current situation, measures such as a research programme could trigger immediate change. The ground must first be "prepared" by refining the systematic and structural monitoring of the "why" and "how" aspects, as well as the results of treatment and other procedures. In theory this is already an aspect of psychiatric practice, in the form of routine outcome monitoring. Youth care services in particular also need a system of this kind In addition, the Academic Collaborative Centre on Child Abuse will help link trauma centre workers in everyday practice to academic research. The experiences of those in the workplace can later be translated into a broader palette.

> The Committee recommends that a system be developed for the systematic and structured monitoring of the reasons and results of procedures and treatments. The practice-based evidence collected in this way can provide a foundation for scientific research, which in turn can lead to evidence-based practice.

* As of 1 January 2012 the LCVT will cease to exist as a separate organisation. The affiliated centres will continue to collaborate in two new networks on child & adolescent and adult traumatisation, respectively. The collaborations will in principle continue to make use of the instruments and guidelines developed within the LCVT framework.

Based in part on the results obtained by the Academic Collaborative Centre on Child Abuse, a feasibility study could be conducted into a form of research support analogous to that provided by the National Institute of Public Health and Environmental Protection (RIVM) for infectious disease research at municipal medical and health services. For youth care services, this could involve a possible role for the Netherlands Youth Institute (NJi).

Finally, the Committee recommends that the major scientific gaps be filled by commissioning research. This would primarily involve research into the validation of assessment instruments, efficacy studies into parenting and treatment interventions specific to the effects of child abuse, and research into new interventions for the most complex groups of adult patients with complex PTSD and dissociative disorders.

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A Request for advice

B The Committee

C Justification for approach adopted

D Experts consulted

E Abbreviations

Annexes

Annex **A**

The request for advice

On 18 February 2010, the President of the Health Council received a request from the Minister for Youth and Families for an advisory report on child abuse. The Minister wrote (letter JZ/LJ-2983817):

It is estimated that over 107,000 children in the Netherlands are neglected or abused each year.* A number of these children will suffer serious psychological damage as a result of trauma which, in some cases, may have continued for many years.** The Youth Care Act, defines child abuse as “any form of interaction that is violent or threatening towards a minor, whether physical, psychological or sexual in nature, which may be actively or passively imposed upon the minor by a parent or other person with whom the minor has a dependent or constraining relationship, and which causes or is liable to cause serious physical or psychological harm to the minor”.*** Child abuse involves both physical and sexual violence, as well as physical and emotional neglect.

Child abuse undermines the child's trust in others and in themselves. Abuse of the child by a parent is particularly harmful, because of the special attachment between parent and child. If that trust is violated, as a result of abuse, this can produce enormous adverse effects.

* Van IJzendoorn, M.H. et al. (2007) Child Abuse in the Netherlands in 2005, National Prevalence study on the Abuse of Children and Adolescents (NPM-2005).
** Article 1, sub p.
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The NEMESIS study showed that emotional neglect is the most common form of neglect in the Netherlands (23% of the general population), followed by psychological abuse (12%), physical abuse (7%) and sexual abuse (7%). Child abuse is more common in girls than in boys. This is especially true for sexual abuse.*

The repercussions of child abuse are many and varied. They include various types of physical injury and psychological problems. Child abuse can produce effects such as acute trauma, post-traumatic stress disorder, anxiety disorders and depression.

To some extent, the effects of abuse on the child are immediately noticeable, but in many cases the damage does not become apparent until the child reaches adulthood. People who have been abused during childhood are at increased risk of chronic disorders and psychological problems in adulthood, such as mood or anxiety disorders and addiction problems. There is also a greater risk of social exclusion in the form of disability, unemployment, or delinquent behaviour.

In 2007, I used the launch of the Child Abuse Action Plan “Keeping children safe at home” to take strong measures to improve the detection, reporting and prevention of child abuse. My goal is to have this plan of action fully implemented by 2011.

Action on prevention is both necessary and effective. There have been recent improvements in the identification and reporting of child abuse. However, the exact care needs of the victims of child abuse are still too poorly understood. Nor is it known whether the currently available options are sufficient.

In view of these considerations, and in compliance with a request from the Lower House of the Dutch parliament, I would like to submit the following questions to the Health Council:

1 Do we have a clear understanding of the types of physical and psychological disorders that can develop as a result of child abuse?
2 What are the needs of child abuse victims, in terms of psychiatric care and trauma care? Are these needs primarily clinical or social in nature?
3 What evidence-supported interventions are currently available in the area of treatment, both in clinical and social terms?
4 What scientific gaps can be identified in the area of treatment?
5 Are the requisite interventions available throughout the country and are they accessible to all victims (children and adults)?
6 If not, then can you advise on ways of improving their availability and accessibility?

* The psychological effects of child abuse in adulthood. Results of the Netherlands Mental Health Survey and Incidence Study (NEMESIS) J. Verdurmen et al, Trimbos Institute, Utrecht (2007).

Please base your response to these questions on the forms of child abuse defined in the Youth Care Act. Also, please frame your reply with reference both to abused children and to adults who were abused in their youth and who are still affected by this experience.

If possible, please submit your advisory report to me in the spring of 2011.

Yours sincerely,
The Minister for Youth and Families,
(signed)
A. Rouvoet

Annex **B**

The Committee

- Prof. E. Schadé, *chairman*
  Professor of General Practice and Family Medicine, Academic Medical Center Amsterdam
- Prof. M.A.G. van Aken
  Professor of Developmental Psychology, Utrecht University
- Prof. A.R. Arntz
  Professor of Clinical Psychology, Maastricht University
- Dr. I.J. ten Berge
  Senior Associate for youth care services and parenting support, Netherlands Youth Institute, Utrecht
- Dr. P.J. Draijer
  Associate Professor, Department of Psychiatry, VU University Medical Center, Amsterdam
- Prof. F. Lamers-Winkelman
  Emeritus Professor of Prevention and Care Provision in Child Abuse, VU University Amsterdam
- Dr. R.J.L. Lindauer
  Child and adolescent psychiatrist / philosopher, Head of Child and Adolescent Psychiatry, Academic Medical Centre, Amsterdam, and the substantive divisional director O4, *de Bascule*, Amsterdam
- Dr. S. Lo Fo Wong
  GP, St. Radboud University Medical Centre, Nijmegen/ Rotterdam

- M.H. van de Merwe
  Medical counsellor, Maasstad Hospital, Rotterdam
- Prof. S.A. Reijneveld
  Professor of Social Medicine, University Medical Center, Groningen
- A.C. van der Tuin, *observer*
  Senior Policy Officer dealing with child abuse, Youth and Family Division, Ministry of Health, Welfare and Sport, The Hague
- Dr. V.W.T. Ruiz van Haperen, *scientific secretary*
  Health Council of the Netherlands, The Hague

The Health Council and interests

Members of Health Council Committees are appointed in a personal capacity because of their special expertise in the matters to be addressed. Nonetheless, it is precisely because of this expertise that they may also have interests. This in itself does not necessarily present an obstacle for membership of a Health Council Committee. Transparency regarding possible conflicts of interest is nonetheless important, both for the chairperson and members of a Committee and for the President of the Health Council. On being invited to join a Committee, members are asked to submit a form detailing the functions they hold and any other material and immaterial interests which could be relevant for the Committee's work. It is the responsibility of the President of the Health Council to assess whether the interests indicated constitute grounds for non-appointment. An advisorship will then sometimes make it possible to exploit the expertise of the specialist involved. During the inaugural meeting the declarations issued are discussed, so that all members of the Committee are aware of each other's possible interests.

Annex **C**

Justification for approach adopted

Search period

The selection of grey literature was carried out intermittently from March 2010 to May 2011.

The systematic literature search for systematic reviews and large-scale studies covers all literature included in the cited databases up until March 2011. Either in full or in part, the literature is supplemented with articles published between March and May 2011.

Databases

- PubMed/Medline
- Cochrane Database of Systematic Reviews
- PsychLit
- National Guideline Clearinghouse
- Guidelines Finder

Search strategy filters: child abuse and systematic review

Child abuse:
Search string: ((child abuse) OR (child maltreatment))
(Searching for individual forms of child abuse, then pooling the literature hits

found, proved to be no more fruitful than searching for the general terms “child abuse” and “child maltreatment”.)

Systematic review:
(Source: University of Rochester): Filter: ((((((((((“Meta-Analysis”[MeSH Terms] OR meta-analysis[pt]) OR medline[tiab]) OR ((((metaanalyses[tiab] OR metaanalysis[tiab]) OR metaanalytic[tiab]) OR metaanalytical[tiab]) OR metaanalytically [tiab])) OR “meta analysis”[All Fields]) OR (((((overview[tiab] OR overview/literature[tiab]) OR overviewed[tiab]) OR overviewer[tiab]) OR overviewing[tiab]) OR overviews[tiab])) OR clinical trial[pt]) OR multicenter study[pt]) OR evaluation studies[pt]) OR validation studies [pt]) OR review[pt]) OR (systematic review[All Fields] OR systematic reviews[All Fields]))

Level of evidence in the literature (chapters 4 and 5 assessment and treatment)

	For articles on: Intervention (prevention or therapy) (types of evidence)
A1	Systematic review of at least two independently conducted, A2-level studies
A2	Randomised, double-blind, comparative clinical trial of good quality and sufficient scope
B	Comparative trial, but not including all of the features listed under A2 (includes cohort studies, case-control studies)
C	Non-comparative trial
D	Opinion of experts, such as the members of the Committee

Source: CBO: Levels of Evidence (http://www.cbo.nl/Downloads/632/bijlage_A.pdf).

Formulating conclusions from the literature

Conclusions were then formulated on the basis of the available evidence, together with an indication of the degree of cogency of the evidence, in accordance with the following categories:

Degree of cogency of the evidence supporting the conclusions	
Level 1	Based on one systematic review (A1) or at least two independently conducted studies of A2 level
Level 2	Based on one A2-level study or at least two independently conducted B-level studies
Level 3	Based on one B-level or C-level study
Level 4	Based on the opinion of experts, e.g. the members of the Committee

Note: A conclusion is as firm as the study with the most cogent evidence. Accordingly, a systematic review (SR) can only lead to a level-1 conclusion if it

is based on at least two independently conducted, randomised, controlled clinical trials. If the best study discussed in a systematic review is level B or C, then any conclusions drawn on the basis of that systematic review can never be stronger than level 2 or 3. The latter applies to most systematic reviews in the area of interventions for child abuse.

Digital references

Use was also made of information derived from websites. On 1 June 2011, all of the web references were verified by checking that they were still active in the designated form, and that they contained the information in question.

Annex **D**

Experts consulted

- E. van Amersfoort, the Association Against Child Sexual Abuse, Utrecht
- J. van Bavel, clinical psychologist, manager of the *KJTC Haarlem* (centre for traumatized children and young people) and project manager of the Academic Collaborative Centre for tackling child abuse issues.
- Dr. M. Dekker, programme director, Augeo Foundation, Zeist
- A. van Dijke, Director, *Fier Fryslân* multidisciplinary centre for the treatment of victims of child abuse, Leeuwarden
- Dr. A.M. van Dijke, Head of knowledge development, LCVT (National Centre for Early Childhood Trauma), Utrecht/clinical neuropsychologist, Delta Psychiatric Centre, Poortugaal
- Dr. M. Donkers, Youth policy advisor, Marjon Donkers Coaching & Consultancy, Amsterdam
- Prof. V.J. Felitti, Kaiser Permanente, San Diego, United States
- Dr. I. de Graaf, Senior research assistant, Mental health, Trimbos Institute, Utrecht
- T. van Haaren-Paulus, Regional Coordinator Approach to Child Abuse, Programmes/Social care, Housing and Social Support Department, Amsterdam
- M. Hovingh, the Association Against Child Sexual Abuse, Amersfoort
- Professor M.H. van IJzendoorn, Centre for Child and Family Studies, Leiden University
- Dr. H.P.M. Kreemers, Secretary of the Deetman Commission, The Hague

- H. Lakho, Hidden Violence Foundation, The Hague
- Dr. M.P. Lambregts-van den Berg psychiatrist (and child & adolescent psychiatrist), Poli Combined Psychiatry / Child & Adolescent Psychiatry, Erasmus Medical Centre, Rotterdam
- N. Landsmeer, paediatrician, Dutch Paediatric Association
- Dr. F.J.M. van Leerdam, Senior Inspector, Dutch Health Care Inspectorate, Amsterdam
- A. van Leeuwen, Child Abuse Reporting Agency (AMK), Gouda
- G.M. Rensen, LCVT (National Centre for Early Childhood Trauma), Utrecht
- C. Ruppert, Secretary, Samson Commission, The Hague
- Dr. A.R. Teeuw, social paediatrician, Academic Medical Centre, Amsterdam
- M. Visser, Trauma team coordinator, clinical psychologist, *Haarlem KJTC* (centre for traumatized children and young people)
- A.P. van der Zanden, Research assistant, Department of Child & Adolescent Mental Health, Trimbos Institute, Utrecht
- Child Abuse Team, Academic Medical Centre, Amsterdam
- Initiative group, multidisciplinary centre for the treatment of victims of child abuse, Friesland
- STUK
- Haarlem centre for traumatized children and young people
- *Fier Fryslân* multidisciplinary centre for the treatment of victims of child abuse, Leeuwarden
- Child Abuse Reporting Agency (AMK), Gouda
- Caleidoscoop board, national association for people with a dissociative disorder, Amersfoort

Annex **E**

Abbreviations

ACE	Adverse childhood experiences
ARC model	Attachment, self-regulation and competency model
AMK	Child Abuse Reporting Agency
AWK	Academic Collaborative Centre on Child Abuse
BVA	Child Abuse Medical Counselling Centre
CAPS	Clinician-Administered PTSD Scale
CAPS-CA	Clinician-administered PTSD scale for children and adolescents
CARE-NL	Child abuse risk evaluation – Dutch version
CBLC	Child behaviour checklist
CDC	Centers for Disease Control and Prevention
CFRA	California family risk assessment
CBT	Cognitive behavioural therapy
CJG	Youth and Families Centre
COPD	Chronic Obstructive Pulmonary Disease
CPP	Child Parent Psychotherapy
DTC	Diagnosis-treatment combination
DSM	Diagnostic and statistical manual of mental disorders
EMDR	Eye movement desensitisation and reprocessing
FFT	Functional Family Therapy

FHG	Domestic violence in families
GGZ	Mental health care association
HPA axis	Hypothalamic-pituitary-adrenal axis
Jeugd-GGZ	Youth mental health care
KJTC	Centre for traumatized children and young people
KOPP	Children of parents with mental health problems
LCVT	National Centre for Early Childhood Trauma
LIRIK	Light Risk Assessment Instrument for Child Abuse
LOAK	National Training Centre for Tackling Child Abuse Issues
LVG	Mildly mentally handicapped
MCD	Multidisciplinary Child Abuse Center
MeMoSa	Mentor mothers for support and advice
MST-CAN	Multi system therapy – child abuse and neglect
NCPC	National child protection clearing house
NEMESIS	Netherlands Mental Health Survey and Incidence Study
NJI	Netherlands Youth Institute
NPM	National prevalence study on the abuse of children and adolescents
OGGZ	Public mental health care
PCIT	Parent Child Interaction Therapy
PMTO	Parent Management Training Oregon
POP	Psychiatry, obstetrics and paediatrics
Project BEST	Bringing Evidence Supported Treatments to South Carolina Children and Families
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Controlled Trial
RAK	Regional approach to child abuse
RIVM	National Institute of Public Health and the Environment
RMPI	Rotterdam Medisch Pedagogisch Instituut
ROM-CAP	Routine outcome monitoring child and adolescent psychiatry
SCID-I	Structured Clinical Interview DSM-IV disorders – Axis I
SDQ	Strengths and Difficulties Questionnaire
SEV	Social Emotional Questionnaire
SIDES	Structured interview for disorders of extreme stress
SOM	Schoolchildren On Abuse study

TAP model	Treatment assessment pathway-model
TF-CBT	Trauma focused cognitive behavioural therapy
TRF	Teacher's report form
TRTC	Highly specialised trauma centre
TSC	Trauma symptoms checklist
UMC	University Medical Centre
UNICEF	United Nations Children's Fund
VWS	Ministry of Health, Welfare and Sport
WHO	World Health Organization
ZonMw	Netherlands Organisation for Health Research and Development