POLICY REPORT

Child Maltreatment
Policy Resource Center

INTRAFAMILIAL CHILD TORTURE:

VICTIM IMPACT AND PROFESSIONAL INTERVENTIONS

AUTHORS

Pamela J. Miller, JD, MSW, LISW-S
Judith S. Rycus, PhD, MSW
Victor Vieth, JD, MA

2022

The Child Maltreatment Policy Resource Center translates research into useable resources that promote evidence-informed policymaking and direct practice in the professions that serve maltreated children and their families. The Center's products include policy white papers, practice guidance, issues briefs and training opportunities for policy makers and practitioners. The Center was founded by and is operated by the Institute for Human Services (IHS) in Columbus, Ohio.

For more information, visit our web site at http://www.cmprc.org

INTRAFAMILIAL CHILD TORTURE:

Victim Impact and Professional Interventions

Pamela J. Miller, JD, MSW, LISW-S
Judith S. Rycus, PhD, MSW
Victor Vieth, JD, MA

INTRODUCTION

Child maltreatment has been the subject of considerable research and attention for the past few decades, but identifying and intervening in the most severe, complex cases is an evolving science. Much remains to be learned about the life altering developmental consequences of extreme child abuse in child victims and the most effective interventions to help them recover and grow. This is particularly relevant for child victims of intrafamilial child torture (ICT).

Clinical data confirm that children who have been tortured by their parents are among the most severely and pervasively harmed victims of child maltreatment (Miller et al., 2021; Miller, 2020). The severe developmental pathologies seen in victims of ICT can be attributed to a typically long term and ongoing exposure to severe child abuse, concurrent exposure to multiple forms of severe maltreatment, the extreme intensity and scope of the experienced harm, and being deprived of the nurturing and supportive family relationships that could potentially mediate some of the traumatic outcomes.

Perhaps because the child maltreatment field is still relatively new, there is no uniform diagnostic category that accurately describes survivors of extreme child maltreatment and intrafamilial child torture. Professionals from multiple disciplines have used different diagnoses for child victims – all with somewhat differing characteristics, and all viewed from slightly different perspectives. Some examples are Posttraumatic Stress Disorder (PTSD), Complex Posttraumatic Stress Disorder (C-PTSD), Developmental Trauma Disorder, and Disorders of Nonattachment. From a heuristic perspective, all these contribute to a deeper understanding of the identifiable outcomes of severe trauma in

children. But without a uniform and comprehensive diagnostic category, we cannot ensure consistency in identification, diagnosis, and treatment of severely maltreated and tortured children. In addition to mental health diagnosis and treatment, these children need identification and intervention from child protective services, child advocacy centers, law enforcement, and the court system.

A published letter to Bessel van der Kolk by the American Psychiatric Association (APA) in May 2011 reflects the lack of consensus around outcomes of severe child maltreatment. It reads, "The notion that early childhood adverse experiences lead to substantial developmental disruptions is more clinical intuition than a research based fact. There is no known evidence of developmental disruptions that were preceded in time in a causal fashion by any type of trauma syndrome" (see van der Kolk, 2015, p. 149).

Still, advocates who have done research or have clinical experience with severely maltreated or tortured children have proposed diagnostic categories to help professionals recognize these children's consistent developmental characteristics and challenges. Since the early 1990s, and as recently as 2012, Dr. Judith Herman has lobbied the APA to include a category of Complex-PTSD (C-PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which would more accurately reflect the unique presentation of outcomes seen in severely maltreated children and other severely abused and tortured persons. Dr. Bessel van der Kolk has spent much of his career advocating for the inclusion of Developmental Trauma Disorder in the DSM. In the early 1990s, Dr. Charles Zeanah and other early childhood mental health scholars opted to publish their own diagnostic manual: *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, or *DC:0–5.* The DC:0–5 includes categories with precise criteria that describe the presentation of PTSD, attachment disorders, and other "trauma, stress, and deprivation disorders" in infants, toddlers, and preschool age children (Zero to Three, 2016).

In our first paper on intrafamilial child torture (ICT), we advocated that it be considered a specialized category of child maltreatment. We proposed a working definition because it is impossible to consistently or accurately identify child victims of ICT without a common definition. Without consistency in definition and identification, a holistic and individualized approach to intervention and treatment for these children is compromised, creating a major deterrent to both immediate and long-term care and treatment.

Many pioneers in both research and clinical practice have worked to develop interventions for severely maltreated children. The purpose of this paper is to present the current best available evidence to help professionals identify and assess child survivors of ICT and to plan specialized interventions that meet children's needs, including their psychosocial, developmental, medical, and spiritual needs.

THE IMPACT OF EXTREME MALTREATMENT ON CHILDREN'S PSYCHOSOCIAL DEVELOPMENT

The conceptual framework for understanding the impact of intrafamilial child torture has evolved from decades of work by several key researchers, including Dr. Judith Herman, Dr. Bruce Perry, Dr. Bessel van der Kolk, and Dr. Charles Zeanah – presented here in alphabetical order to reflect their equally strong contributions to this field. In spite of differences in how they have approached their work, they identify very similar patterns of psychodevelopmental disruption in severely maltreated or tortured children, including problems with arousal, attachment, sensory integration, emotional regulation, and more complex cognitive constructs such as identity, values, and beliefs. Taken together, this body of work provides a more comprehensive and cohesive understanding of the scope, depth, and severity of the outcomes of severe child maltreatment and child torture – and a warning about the pervasive and often permanent deleterious impacts of extreme forms of maltreatment on children's health and well-being. A summary of each contributor's body of work follows.

Dr. Judith Herman began her career studying father-daughter incest, an early term for intrafamilial child sexual abuse (Herman, 1981). In 1992, she published a groundbreaking article (Herman, 1992a) and a book titled *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror* (Herman, 1992b). Herman argued that prolonged interpersonal trauma and violence can only occur in conditions of physical captivity, psychological captivity, or both. As such, it produces a profoundly different syndrome than single traumatic events or trauma that does not involve violence or captivity – hence a more "complex" form of PTSD, or C-PTSD. This diagnostic category does include symptoms of intrusion, hypervigilance, and avoidance as they are conceptualized in the DSM III's criteria for PTSD. But C-PTSD also includes symptoms of dissociation, poor affect regulation, poor relational skills, and pervasive states of terror, helplessness, and a longing for help or rescue, which are not typically part of a PTSD diagnosis. Herman identified the torture of prisoners of war, abuse of women by an

intimate partner, and severe child abuse or child torture as typical causes of Complex-PTSD.

In DSM-IV trials, Herman determined that approximately 14% of traumatized persons had Complex-PTSD (Herman, 2012). Many of her colleagues were coming to the same conclusions in the 1990s, but Herman's book was the first to introduce modern trauma theory to a broader public audience. Despite her insight and well-articulated argument for Complex-PTSD, the APA rejected it for inclusion in the DSM-IV. Nevertheless, Herman continued to advocate for the inclusion of Complex-PTSD in the DSM.

More recently, Herman has published works on self-compassion and emotional regulation (Scoglio et al., 2018) and STAIR Narrative Therapy (Cloitre et al., 2014). In 2009, in collaboration with Bessel van der Kolk and other colleagues, Herman published work specifically on a developmental approach to Complex-PTSD (Cloitre et al., 2009).

In her chapter on child abuse, Herman (1992b) discussed the existential (spiritual), somatic, relational, and developmental harms that are unique to survivors of very severe child maltreatment. She described child survivors as being in "a constant state of autonomic hyperarousal" (p. 100), which can lead to states of terror (pp. 96–98), fear of imminent death (p. 98), being minutely attuned to the abuser's inner states (p. 99), having "hysterical" psychogenic seizures (p. 99), and the use of self-harm to calm autonomic arousal (p. 109). Underarousal can also occur, such as a child becoming numb (p. 98) and adopting a position of complete surrender (p. 99).

Regarding attachment, Herman wrote that severely abused children face the formidable task of finding a way to "preserve trust in people who are untrustworthy" (p. 96). Ordinary caretaking relationships with parents are "profoundly disrupted," and children, desperate for connection, develop pathological attachments to their abusers (p. 98). This leads to longer-term problems such as disturbed intimate relationships, high numbers of sexual partners (p. 97), emotional disconnection from others (p. 133), and experiencing relationships as inauthentic (p. 100).

Herman also described pervasive problems with sensory integration experienced by survivors of severe child abuse. She described children who, in response to trauma cues, had convulsions, sore throats, nausea and vomiting, and shortness of breath (p. 97); children who self-harmed to dissociate from their bodies and experience anesthesia (p. 109); sexual dysfunction (p. 97), psychogenic amnesia (p. 97), and denied causation and control of their bodies (p. 99). Survivors perceived themselves as unable to influence the

world around them; they did not view themselves as causal agents, particularly when the abuse generated feelings of futility and helplessness. These symptoms, combined with a high level of autonomic arousal and a lack of protective attachments, can lead to the breakdown of sensory integration in severely maltreated children, or even prevent its development.

Herman also addressed children's inability to regulate their own emotional responses. She stated, "The normal regulation of emotional states is similarly disrupted by traumatic events that repeatedly evoke terror, rage, and grief.... [T]he emotional state of the chronically abused child ranges from a baseline of unease, through intermediate states of anxiety and dysphoria, to extremes of panic, fury, and despair" (p. 108).
Herman also explains that severe developmental trauma affects identity formation, particularly when the abuse or torture is intentional on the part of the parent. She explains that "the perpetrator seeks to destroy the victim's sense of autonomy.... [A]ssaults on the body shames and demoralizes her" (p. 77); that the child victim "takes the evil of the abuser into herself" and has "an innate sense of inner badness" (p. 105). Herman describes severe child abuse survivors as experiencing a "fragmented personality" (p. 97), a "disintegration of the self" (p. 108), and problems with identity into adulthood" (p. 110).

Regarding the development of a personal code of values and beliefs, Herman wrote, "the abused child's existential task is equally formidable. Though she perceives herself as abandoned to a power, without mercy, she must find a way to preserve hope and meaning. The alternative is utter despair, something no child can bear" (p. 101). To try and preserve an attachment with their parents, child victims conclude that their inner badness is the cause of abuse/torture, and that if they can just be good, they can make the abuse stop. Herman identified this belief pattern as normative for early childhood, "in which the self is taken as a reference point for all events" (p. 103).

In her descriptions of the dynamic between perpetrators and child victims, by using terms such as "evil," "doublethink," "pervasive terror," and the child as "a whore and a slave," Herman is often precisely describing the dynamics of intrafamilial child torture and is capturing what differentiates ICT from more typical forms of abuse or neglect. While most survivors of child abuse emphasize the chaotic and unpredictable enforcement of rules, some describe a highly organized pattern of punishment and coercion. These survivors often report punishments similar to those in political prisons. Many describe intrusive control of bodily fluids, such as forced feeding, starvation, use of

enemas, sleep deprivation, or prolonged exposure to heat or cold. Others describe actually being imprisoned: tied up or locked in closets or basements. (p. 99)

Herman made a strong case for use of the Complex-PTSD diagnosis to more precisely describe the syndrome experienced by child survivors of extreme maltreatment. Herman argued that Complex-PTSD had clinical significance and utility, suggesting that treatments proved to be effective for PTSD may be inadequate and potentially harmful for victims with C-PTSD (Herman, 2012b, p. 256; also see Hembree, 2004; Cloitre et al., 2010). Herman specifically referenced a poor response to Cognitive Behavioral Therapy and the potential harm of exposure treatments for children with Complex-PTSD. She recommended, instead, a five-phase course of psychotherapy, which must begin with a healing relationship: "The core experiences of [interpersonal] psychological trauma are disempowerment and disconnection from others.... [R]ecovery can only take place within the context of relationships" (p. 133). Other phases that should occur sequentially are establishing safety, remembrance and mourning, reconnection, and commonality (which includes reconnection with the community and society).

Beginning in the 1980s and continuing throughout her career, Dr. Herman collaborated with Dr. Bessel van der Kolk to co-author publications and to support each other's work. In 1994, van der Kolk published a seminal article titled "The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress." This article posited that trauma is stored in somatic (bodily) memory and expressed as changes in the biological stress response. Thus, traumatic memories are often experienced as physical sensations (p. 253).

Emphasizing the physiological brain that underlies the concept of mind, van der Kolk wrote, "Animal research suggests that intense emotional memories are processed outside of the hippocampally mediated memory system and are difficult to extinguish" (p. 253), and that "...excessive stimulation of the central nervous system (CNS) at the time of trauma may result in *permanent neuronal changes* that have a negative effect on learning, habituation, and stimulus discrimination" (emphasis added, p. 255). Van der Kolk's decades-long focus on the bodily experience of trauma, resulting from changes in the physical brain, has led to an array of recommended treatments as well as a certificate program in a "Trauma and Body-based Approach" to healing. In a week-long training program for mental health clinicians, van der Kolk teaches body-based treatment techniques focused on regulating autonomic arousal, achieving sensory integration, and regulating strong emotions. A special emphasis is placed on working with maltreated children, using van der Kolk's conception of Developmental Trauma Disorder.

In 2005, van der Kolk began advocating for a DSM category that better fit survivors of severe child maltreatment (van der Kolk, 2005; van der Kolk et al., 2005). He also published a paper titled "Developmental Trauma Disorder: A New, Rational Diagnosis for Children With Complex Trauma Histories," in which he called for a new DSM diagnosis to address the "developmental derailments secondary to complex trauma [in childhood]" (2005). He identified a pervasive and multifaceted symptom cluster (p. 401) and cited numerous research studies concluding that the majority of severely traumatized and maltreated children do not meet the criteria for the DSM's PTSD diagnosis (pp. 403–404), thus agreeing with and providing additional data to support Herman's contention that a new diagnostic category for these children was necessary.

In his 2005 paper, van der Kolk described numerous symptoms common to child survivors of severe abuse, including excessive anxiety, anger, a longing to be taken care of, being disoriented and disconnected, being hyperaroused, and feeling helpless (p. 402). He also explained that survivors of severe child maltreatment often lack any sense of cause and effect, not believing they can influence what happens to them (p. 403). He also explained that chronic childhood trauma "interferes with neurobiological development and the capacity to integrate sensory, emotional, and cognitive information into a cohesive whole" (p. 402). Moreover, child survivors typically have numerous physical illnesses and medical challenges, including cardiovascular, metabolic, immunological, and sexual disorders (p. 404). He expressed concern that these children were often labeled as oppositional, rebellious, unmotivated, and antisocial and are inaccurately diagnosed with Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), separation anxiety, and phobias (p. 403) without an accurate understanding of the underlying disorder that contributes to these behaviors.

Van der Kolk supported his conceptualization of Developmental Trauma Disorder with a list of 13 developmental effects of extreme forms of child maltreatment that are not accounted for in the diagnostic category of PTSD. They include the following:

- Complex disruption of affect regulation
- Disturbed attachment patterns
- Rapid behavior regressions and shifts in emotional states
- Loss of autonomous strivings
- Aggressive behavior against self and others
- Failure to achieve developmental competencies
- Loss of bodily regulation in the areas of sleep/food/self-care
- Altered schemas of the world

- Anticipatory behavior and traumatic expectations
- Multiple somatic problems, such as gastrointestinal distress and headaches
- Apparent lack of awareness of danger and resulting self-endangering behaviors
- Self-hatred and self-blame
- Chronic feelings of ineffectiveness (pp. 404–405).

In 2015, van der Kolk published his book *The Body Keeps the Score*, in which he reflected on his work on Developmental Trauma Disorder, saying,

> We published the first articles about our findings, developed a validated rating scale, and collected data on about 350 kids…to establish that this one diagnosis, Developmental Trauma Disorder, captured the full range of what was wrong with these children. It would enable us to give them a single diagnosis…and would firmly locate the origin of their problems in a combination of trauma and compromised attachment. (p. 158)

We find the case for a diagnostic category of Developmental Trauma Disorder highly compelling and helpful, as it describes the psychosocial and psychodevelopmental impacts on children who have experienced torture in their families. Based on clinical data, the symptoms listed by van der Kolk, especially in their most severe forms, are highly consistent with the documented clinical presentations of children who have been victims of ICT, and they are also congruent with the self-expressed lived experiences of ICT survivors.

Dr. Bruce Perry, a child psychiatrist, has spent much of his career researching the impact of interpersonal trauma on children. In the 1990s, he served as a consultant, expert witness, and advocate for traumatized children after the Columbine High School massacre, the Oklahoma City bombing, and the Waco siege (see generally, Perry & Szalavitz, 2006, 2017). His career has focused on creating a neurodevelopmental approach, which he calls the Neurosequential Model of Therapeutics (NMT), for assessing and treating severely traumatized children, with a focus on severe interpersonal trauma and child maltreatment. In 1990, Perry founded the Center for the Study of Childhood Trauma, now the ChildTrauma Academy, which researches and trains practitioners in the use of the NMT. His neurodevelopmental approach has now been adapted for use in schools (Neurosequential Model of Education, or NME) and in child care (Neurosequential Model of Caregiving, or NMC) (Barfield et al., 2012).

The Neurosequential Model of Therapeutics (NMT) creates a visual representation of child development, presented as 32 developmental tasks that must be achieved in a

specific chronological sequence as children develop. Perry teaches NMT trainees to assess the sequelae of child maltreatment by identifying "dysregulation" in any of the 32 developmental tasks. Treatment planning requires treating the earliest, most foundational developmental deficits first. The NMT visually represents this developmental progression.

Children who have been tortured or severely abused from a young age will typically have deficits in the earliest levels of development, such as autonomic regulation, attachment, and sensorimotor integration as well as in developmental tasks that occur later in the sequence (Hambrick et al., 2018). However, children must learn the earlier tasks before they can master the later ones. As one example, until healthy attachment is achieved, complex cognitions are not possible. Children who experience healthy early development before they experienced severe maltreatment may have a very different presentation, with fewer areas of deficit in foundational capacities and more of their deficits occurring at a higher level on the NMT scale. Treatments are designed to help children master the precise developmental functions that are dysregulated or not yet well developed. Perry expressed this approach as providing "precision medicine" for children with developmental trauma (Hambrick et al., 2019). The hope for all child survivors of ICT is to successfully transform areas of deficit to areas of competence, including, at the most advanced developmental levels, abstract thinking, complex problem solving, planning for the future, and developing a strong and positive identity, beliefs, and values.

Dr. Charles Zeanah, a child psychiatrist and professor at Tulane University College of Medicine, is a well-known researcher in infant/early childhood mental health and attachment disorders. He was the lead researcher and instrumental in designing and implementing the Bucharest Early Intervention Project in the early 2000s, which studied Romanian children who were being raised in seriously understaffed and underresourced congregate care settings (orphanages), and who displayed extremely severe pathology in all areas of development as a result. In one study, the project compared the development of these children with children who had been moved from institutions into foster care early in their lives, and with children who had never been institutionalized. The striking and severe pathology of the children raised solely in institutional care for their first 3 years led Zeanah and his colleagues, including Dr. Neil Boris, to develop the concept of Disorders of Nonattachment, as opposed to the categories of insecure attachment developed by earlier scholars (Zeanah & Boris, 2000).

Zeanah has published widely on the sequelae of extreme early deprivation – a level of neglect so profound that it bears little resemblance to the reports of neglect typically

received by Child Protective Service (CPS) agencies. A comparable level of profound deprivation can be seen in infants and very young children who have been victims of intrafamilial child torture (ICT), having experienced, at the most extreme level, chronic physical, emotional, and cognitive deprivation and long periods of solitary confinement during their earliest developmental stages (see generally, Miller et al., 2021).

In Disorders of Nonattachment, children have typically been deprived of the opportunity to develop any level of attachment to any caregiver. These children exhibit indiscriminate, "qualitatively inappropriate" social behavior, or total emotional and exploratory withdrawal (Zeanah & Boris, pp. 358, 360). These disturbed attachment behaviors are consistent across environments and relationships. Zeanah and Boris, recommend an update on alternative criteria for attachment disorders (p. 364), which would include two categories: Attachment Disorder: No Discriminated Attachment Figure, and Attachment Disorder: Secure-Base Distortions.

Zeanah has been active with the American Psychiatric Association in multiple revisions of the DSM's category of attachment disorders (DSM-V, 2013), and he was a key leader in the Zero to Three Project, originally founded in 1977 as the National Center for Clinical Infant Programs. Ultimately, the Zero to Three Project responded to perceived deficits in the DSM regarding the mental health of infants and young children by publishing a diagnostic manual specifically related to young children, called *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, which has been shortened to DC:0–5 (Zero to Three, 2016, most recent update). The DC:0–5 conceives of all mental health disorders in infancy and early childhood as not only developmental but also relational. The DC:0–5 provides a new diagnostic category of Relationship Specific Disorder of Infancy/Early Childhood (RSD) (p.135), based on the premise that a disturbed attachment resulting from an ineffective or damaging caregiver is a function of the relationship, and a child victim of extreme relational deprivation should not be stigmatized with a diagnosis of a mental disorder (Zero to Three, 2014: also see Zeanah & Lieberman, 2019.)

The Relationship Specific Disorder (RSD) and other alternative diagnostic categories in the DC:05 may be useful in assessing, intervening, and treating child survivors of intrafamilial child torture, particularly those who are below the age of 5. Child development research demonstrates that infants and younger children are especially vulnerable to the effects of severe maltreatment and are more likely to die from it (Rycus et al., 1998). Effectively intervening in cases of ICT will often mean working on behalf of infants, toddlers, and preschool age children to ensure their safety and well-being, and

prioritizing strategies to promote their healthy development. The DC:0–5 provides meaningful diagnostic categories that can lead to the "precision medicine" advocated by Perry, which is desperately needed by the youngest torture survivors.

Decades of work by prominent researchers and scholars have provided a consistent composite picture of the severe psychodevelopmental outcomes in young children who have experienced extreme maltreatment and chronic trauma. This body of work underpins our contention that children who are tortured in their families are extremely vulnerable to long-term and often permanent developmental damage. Early identification and appropriate protective and treatment interventions are essential to enable these children to heal and to develop into healthy and functioning adults.

TREATMENT INTERVENTIONS FOR CHILD VICTIMS OF ICT

Any discussion of potential treatment for severely maltreated children must begin with the caveat that no treatment will be effective until children are safe. Children must actually be safe, and they must also feel safe. Because of the egregious level of maltreatment and the unique family dynamics of ICT, child victims of torture will be at extremely high risk of continued harm if they remain in the custody of the parents who inflicted the torture. The first level of intervention must always be to ensure the child's physical and emotional safety, which is not possible if children remain in the physical care and custody of the parent(s) who inflicted or were complicit in the torture. All children will be subjected to additional trauma each time they are moved to another placement. Relationship permanence with healthy and nurturing caregivers is a prerequisite for children to feel emotionally safe and to begin the long process of healing.

The majority of interventions described in this section promote mastery of fundamental psychodevelopmental tasks, including emotional regulation, sensory integration, relationship development, and ultimately, strong and enduring positive attachments. Child survivors of torture often have serious, complex, and equally pressing health and medical problems that can result from both deprivation and inflicted injury. These children will need access to pediatricians who understand the medical consequences of extreme maltreatment and can provide consistent care over time. Most children will also need some form of special education, other developmental services, and often, spiritual care. Our purpose here is to focus primarily on empirically supported therapies that

promote development of early, fundamental capacities, with some attention given to other needed services.

The following interventions have been researched and shown to be effective for child victims of severe interpersonal trauma and severe child maltreatment, including ICT. Many of these interventions require no special certification. However, practitioners should be well trained and skilled in these methods before attempting to use them with child victims of severe maltreatment and torture, due to the fragility of these children and the possibility of causing unintended harm. Miller has used most of these techniques in her psychotherapy practice with child survivors of ICT and has collected clinical data on client response to these interventions. Her clinical practice insights will be described for each of the interventions discussed.

Body-Based Trauma Treatment *(van der Kolk, 2015; 2020)*

This approach is grounded in the premise that trauma is experienced in the body, not just in the mind, and therefore the initial point of intervention should be the effects of trauma on the body. Body-based interventions are indicated for trauma survivors of any age, and they are especially effective for young children who lack the cognitive and verbal skills to participate in "talk therapy." Body-based interventions can include deep breathing exercises, progressive muscle relaxation, yoga, neurofeedback therapy, sensory and body exploration exercises, and expressive therapies such as art, music, and dance that can help achieve biological homeostasis and stability. In clinical practice, body-based interventions also help children to master tasks of sensory integration and emotional regulation (van der Kolk, 2020; Miller, 2018, 2019). Training and certification are available through the Trauma Research Foundation, but no certification by the Foundation is required to use body-based approaches. Body-based treatments are appropriate for children and youth of all ages.

Yoga Therapy *(van der Kolk et al., 2014; van der Kolk, 2015)*

Dr. van der Kolk devoted an entire chapter of his book *The Body Keeps the Score* to explain and promote the use of yoga to help people heal from trauma. In randomized controlled trials, he found that yoga reduced symptoms of PTSD in people who had experienced interpersonal violence. These studies found yoga to be equally as helpful as evidence-based psychotherapies and psychopharmacologic approaches (van der Kolk et al., 2014).

Researchers assert that yoga helps people better tolerate physical and sensory experiences associated with fear and helplessness, and it increases emotional awareness and tolerance of painful feelings (van der Kolk et al., 2014), In clinical practice, yoga has been found to help child survivors of ICT learn to feel safe in their bodies, build strength and feelings of confidence in their bodies, and learn strategies to self-regulate, to release stress, and to achieve relaxation (Miller, 2018, 2019). Yoga is appropriate for children and youth of all ages.

Theraplay *(Booth & Jernberg, 2010; Wettig, 2006)*

Theraplay was created in the late 1960s as part of Chicago's Head Start program. The original goal was to improve and enhance mothers' relationships with their children. It has since been adapted for psychotherapeutic treatment, particularly for children with disordered attachments and histories of maltreatment or trauma. Theraplay has been widely researched and has a strong evidence base to support its validity. Its theoretical base includes attachment theory, developmental theory, a body-based approach to treatment, and neurosequential healing.

Theraplay consists of specially adapted activities, games, songs, and physical touch experiences that replicate an ideal infant-caregiver experience. The four main components are to provide children with structure, to engage them in playful interaction, to regularly nurture children, and to challenge them to grow. Many children participate in Theraplay with their foster or adoptive parents, and it has been used as part of reunification therapy for children returning to their biological families. Theraplay may still be provided even if there is no emotionally available caregiver to participate; the therapist or others who have a relationship with a child can substitute for the caregiver with some adaptations to the activities. The Theraplay Institute offers training and certification, and a book is available that teaches the theory and practice of Theraplay. It includes an appendix of Theraplay games, grouped by the age of the intended recipients. A certification is required to communicate that one is a Theraplay therapist, but no certification is required to use Theraplay activities/games in clinical practice. In clinical practice, Theraplay has been helpful to child survivors of ICT to learn to feel safe with other people and to experience others as a source of nurturing, pleasure, and attachment (Miller, 2018, 2019). The Theraplay program has specific adaptations for young children, school age children, and teens.

Attachment, Regulation, and Competency, or "ARC" *(Arvidson et al., 2011)*

This treatment approach was developed by Kinniburgh and Blaustein at the former Trauma Center, Justice Resource Institute. It was originally designed as a psychotherapy approach and has since been adapted for use in a variety of child serving settings. ARC focuses on three key areas of need in severely traumatized children: healthy attachment to a permanent caregiver; help in regulating arousal, mood, and emotions; and building a sense of competence instead of feeling helpless. There is a strong evidence base for ARC. It has been shown to decrease PTSD, symptoms of depression and anxiety, and problematic behaviors, and it also supports permanency for children in out-of-home care. In a study using ARC with very young foster children, researchers found that ARC increased placement stability (Arvidson et al., 2011).

Training is available for individuals and for agencies. While formal training is necessary to become an ARC provider, the program components and ideas can be used in other therapeutic interventions. In clinical practice, ARC has helped child survivors of ICT build protective and supportive relationships, experience co-regulation before they are expected to self-regulate, and build a sense of agency to affect the world around them (Miller, 2018, 2019). ARC was originally developed for use with adolescents but has been adapted for younger children by Arvidson and colleagues (2011).

Attachment and Biobehavioral Catch-Up, or "ABC" *(Dozier et al., 2006)*

ABC is a home visiting and parenting program created by Mary Dozier and colleagues at the University of Delaware. ABC teaches parents and caregivers to nurture and respond sensitively to their infants and toddlers to foster healthy development and strengthen primary attachments. In one study, ABC was provided to foster parents caring for children age birth to 36 months, and the result was an improvement in behavior for 1 to 3-year-olds and lowered cortisol levels in both infants and toddlers. It was hypothesized that the program strengthened the relationships between foster parents and their children, which improved co-regulation and the beginnings of self-regulation in the children. Numerous randomized controlled trials have demonstrated the effectiveness of the ABC program. Becoming certified to offer the ABC program involves 12 months of ongoing training and supervision. In clinical practice, providing ABC to foster parents, relative caregivers, and adoptive families has been helpful to child survivors of ICT to build strong, supportive relationships with their caregivers (Miller, 2018, 2019). ABC was developed for use with young children.

Trust-Based Relational Intervention (TBRI) *(Purvis et al., 2013; Howard et al., 2014)*

TBRI is a therapeutic model developed by Dr. Karyn Purvis, a developmental psychologist, and her colleagues at the Institute of Child Development at Texas Christian University. It was designed as a trauma-informed and attachment-based intervention to meet the needs of children and youth suffering from complex developmental trauma. While therapists can provide TBRI in a variety of settings, it was also designed for use by parents and caregivers to help children heal and develop in their own homes. Every interaction with a child is seen as an opportunity to help children learn different ways of experiencing and relating to the world. TBRI uses the child's primary relationships to foster connecting with others, communicating, and learning healthy behaviors.

TBRI has been widely implemented with children who have been in institutional care or foster care, most of whom have experienced severe maltreatment or other forms of psychodevelopmental trauma. TBRI has three core components: (1) Empowering Principles (meeting a child's ecological and physical needs), (2) Connecting Principles (meeting a child's attachment needs and promoting a child's capacity for awareness, engagement, and attunement), and (3) Correcting Principles (helping children master more effective self-regulation, learn appropriate boundaries, and develop healthy behaviors). TBRI is an evidence-based promising practice. Positive outcomes have been measured in traumatized children and youth living in a variety of settings, such as foster and adoptive families, residential treatment centers, group homes, or juvenile justice facilities, and in children participating in TBRI therapeutic camp programs (see Howard et al., 2014). TBRI has been shown to reduce symptoms of PTSD, depression, and problematic behaviors and to lower cortisol levels in children. An 8-hour introductory online training is available, as well as a practitioner training course, instructional videos, open-access articles, and a book titled *The Connected Child* by Purvis et al. (2007). No certification is required to learn and utilize TBRI components, but completion of the practitioner training course is expected for professionals claiming to be using principles of TBRI. The TCU Institute of Child Development maintains a list of all professionals who have completed the practitioner training. TCU also offers a second-level training to certify practitioners as TBRI trainers, who can then train other professionals and parents to use the interventions. TBRI was developed for use with children and youth of all ages.

Neurosequential Model of Therapeutics (NMT) *(Perry, 2006, 2017; Gaskill & Perry, 2013)*

NMT was created by child psychiatrist Bruce Perry. Practitioners are required to receive training and full certification through Dr. Perry's ChildTrauma Academy or satellite trainers before using the NMT resources. While NMT is not itself a specific therapeutic model, it provides empirically supported tools to assess children's neurodevelopment and to plan treatment to precisely target developmental needs and delays. NMT is grounded in attachment theory, developmental trauma theory, and most important, the theory of sequential neurodevelopment, which is a theme in many of the treatments helpful for severely maltreated children. The NMT model includes a visual representation of 32 areas of development that build on each other from simple to more complex developmental tasks. Therapists rate each developmental area to determine a child's level of regulation versus dysregulation in various domains. Children who have been severely maltreated or tortured often have significant deficits in the most basic developmental milestones, such as regulating heart rate and respiration.

NMT has been heavily researched through randomized controlled trials and provides significant evidence of its effectiveness. There are also many open-access journal articles on the ChildTrauma Academy website, videos of Dr. Perry speaking about NMT, and a book available publicly, titled *The Boy Who Was Raised As a Dog* (updated 2017). Perry also has published an article on adapting NMT for play therapy with very young children (2012), which is highly relevant for treating the youngest ICT survivors. In clinical practice, using the Neurosequential Model for assessment and treatment planning has allowed child survivors of ICT to receive developmentally appropriate interventions. Further, it has allowed these most fragile children to avoid interventions for which they are not developmentally ready or that may harm them (Miller, 2018, 2019). The NMT model can be used with children and youth of all ages.

Integrated Play Therapy or "IPT" *(Gil, 2016)*

In a 2016 book chapter, IPT's creator, Dr. Eliana Gil, makes the case for using play-based therapies with severely maltreated children, as play is uniquely suited to young children's natural mode of expression, learning, and dealing with stressful or painful events in their lives. Gil describes the integrative play approach as using "nondirective and directive techniques, and would focus simultaneously on relational, emotional, and cognitive mastery, as directed by the individual child's needs" (p. 98). In IPT, play is both the assessment and the intervention. The Gil Institute for Trauma Recovery and Education provides direct services as well as agency-level training on IPT and other play-based

approaches. There is no certification program for IPT. Gil has written numerous books, book chapters, and journal articles on childhood trauma, maltreatment, and the IPT approach. The Gil Institute also serves as a regional training center for Theraplay (see above). IPT is sometimes confused with another therapy that uses the label IPT, Interpersonal Psychotherapy, but the two are not connected. In clinical practice, IPT has helped child survivors of ICT express their memories, emotions, and concerns in a natural, organic manner without the limitations of highly structured methods largely controlled by adults (Miller, 2018, 2019). Gil recommends that children aged 8 and under should receive only play-based therapeutic interventions, including IPT, and children ages 9–12 should receive 50% play-based interventions. Teens and adults can benefit from occasional play-based interventions, particularly when they are functioning at a developmentally younger age.

Circle of Security (CoS) *(Hoffman et al., 2006; Circle of Security International, 2015)*

In 2006, the creators of CoS – Dr. Kent Hoffman, Mr. Glen Cooper, and Mr. Bert Powell – published the first major paper on CoS, which is a group treatment modality to provide parent education and psychotherapy based on attachment theory. Their paper described a 20-week long standardized intervention that used a pre- and post-test design to measure changes in the quality of attachment to their parents in children who had received the intervention. The study showed that CoS reduced insecure and disorganized attachment in high-risk toddlers and preschoolers. The Circle of Security is a visual illustration of attachment, a circular drawing showing a secure base from which to explore and return. The parent organization, Circle of Security International, provides resources for parents and professionals, including in-person, online, and self-study trainings. A book about CoS, *The Circle of Security Intervention*, is available to the public.

The CoS website encourages practitioners to read their materials and start providing the services in either group or one-on-one settings. A certification is not required to use CoS concepts. Dr. Neil Boris, Medical Director of CoS International, has recommended CoS for use with ICT child survivors and their permanent caregivers (personal communication, March 31, 2021). In clinical practice with child torture survivors, CoS has been used as a family intervention with children and their foster-to-adopt and adoptive parents. It appears to be helpful in increasing mutual attunement, healthy reciprocity, and strengthening supportive relationships (Miller, 2018, 2019). The CoS intervention is designed for use with infants, toddlers, and preschool age children.

Neurofeedback Therapy *(van der Kolk, 2015; Rogel et al., 2020)*

Dr. Bessel van der Kolk and his colleagues have developed the use of neurofeedback exercises for treating developmental trauma in children. Neurofeedback for maltreated children is supported by multiple randomized controlled trials. A study published in 2020 demonstrated that neurofeedback was effective for children who experienced early and chronic maltreatment (typically a highly treatment-resistant population). There are many commercial and nonprofit organizations that train professionals in various approaches to neurofeedback. Some approaches use electronic media, while some focus on diaphragmatic breathing. In clinical practice, diaphragmatic breathing has been helpful for ICT child survivors by building awareness of and mastery over the body and strengthening the mind-body connection (Miller, 2018, 2019). Some children may need to work on other body-based regulation techniques before they are ready for neurofeedback training. Neurofeedback therapy is appropriate for children and youth of all ages.

Expressive Therapies: art therapy, music therapy, animal therapy, drama therapy, narrative therapies *(van der Kolk, 2015; Klorer, 2008; Hillard, 2008; Loumeau-May, 2008; Malchiodi & Ginns-Gruenberg, 2008; Haen, 2008)*

Formerly conceptualized as alternative or adjunctive therapies (see generally, van der Kolk, 2015), expressive therapies are now recognized as key components of treatment for severely maltreated children. Art, music, drama, and storytelling can be used to help children express thoughts, feelings, beliefs, and concerns in a way that is more comfortable and perhaps more powerful than traditional talk therapy. Animal therapy can be used to help children with relational difficulties. Children may feel emotionally safer bonding with an animal than with a person. Animal therapy also teaches healthy boundaries, attunement, mutuality, reciprocity, and can increase feelings of calm and relaxation. It may be used to help children learn to express feelings of love and belonging. Common animal therapies are dog therapy and equine therapy, and some programs also use small animals such as rabbits or guinea pigs.

Expressive therapies have a strong evidence base, and some forms of therapy have a related educational program and certification. However, no certification is necessary to begin using expressive techniques in therapeutic settings, and training is widely available in these therapies. van der Kolk has applied them in Body-based Trauma Treatment, and Gil has applied them in Integrative Play Therapy. Expressive therapies have been effectively used with ICT child survivors (Miller, 2018, 2019). These therapies may be the

best way to begin treatment, while children are waiting for the safety and permanency necessary for readiness to engage in other more structured or directive interventions. Expressive therapies are appropriate for children and youth at all ages.

Trauma-Focused Cognitive Behavioral Therapy, or "TF-CBT" *(Cohen et al., 2017)*

TF-CBT is the most widely studied trauma treatment for children. It has been researched for decades and has a very strong empirical base to confirm its effectiveness. TF-CBT is an excellent treatment and the gold standard of trauma care when it is used at the right time and place in a child's life. However, TF-CBT is often inappropriate as a first-line treatment for severely maltreated or tortured children, because the therapeutic process itself requires the child to have a certain degree of behavioral control and affect regulation. Ideally, a permanent caregiver with a healthy attachment to the child should participate in TF-CBT, according to the model. TF-CBT's primary components include gradual exposure to the trauma memory and correcting inaccurate or unhelpful thoughts about it. Exposure and cognitive restructuring approaches to trauma treatment will be most effective when children are well regulated in early, fundamental neurodevelopmental tasks, can engage in complex cognitions, and can tolerate the emotional stress of re-exposure to memories of specific traumatic events. Herman has referenced studies that suggest exposure and cognitive-based treatments may be ineffective or even harmful to clients with more severe trauma histories (Herman, 2012, p. 256).

TF-CBT has been used successfully with ICT child survivors when used later in the therapeutic sequence (Miller, 2018, 2019). Training in TF-CBT is widely available. An online training is available and in-person trainings have been frequently held throughout the country. A certification in TF-CBT is available; however, it is not necessary to be certified to provide TF-CBT. TF-CBT trainings always teach adaptations for working with young children, older children, and teens.

OTHER THERAPEUTIC INTERVENTIONS

Educational Interventions

Child survivors of intrafamilial child torture (ICT) may benefit from a variety of specialized interventions to address developmental deficits, such as physical therapy, occupational

therapy, and/or speech therapy. School-age children may need special education and Individualized Education Plans (IEP), including learning activities adapted to meet their individual needs. Some children will be able to participate in a structured school setting only if they are given individualized help. Professionals and parents may need to advocate for an Evaluation Team Report (ETR) to determine a child's eligibility for an IEP. They will also need to participate in regular IEP meetings. Parents and professionals who know a child's history may need to educate school officials about the child's developmental limitations and need for special attention. Attorneys who practice education law can help when a school is not meeting the individual needs of a child or appears to be penalizing a child for behaviors related to their cognitive, emotional, and social delays. In some jurisdictions, Attorney-GALs can receive training in education law and then represent children both in their child protection and educational proceedings.

Child Protective Services (CPS) Interventions

Fundamental child protective services interventions, including accurately identifying children who are being tortured and ensuring their immediate and long-term safety, are critical for serving ICT survivors. Unless children are physically and emotionally safe, they cannot benefit from treatment interventions. Much of the work to help children develop strong, positive attachments requires the participation of a permanent, nurturing caregiver with a strong commitment to ensuring the child's best interests (Rycus et al., 1998). When child victims of ICT remain in a state of uncertainty, not knowing where they will live or if they will have to return to the parents who tortured them, it is very difficult for reparative, relationship-based interventions to be effective.

Child victims of ICT who remain in the custody of the parents who tortured them are at extreme risk of both imminent and long-term harm. They are at risk of serious physical, sexual, and psychological injury, which often causes permanent disabilities in all areas of development They are also at risk of death. Child protective services must rapidly address the many immediate threats to children's safety, while also ensuring their longer-term safety (Rycus et al., 1998). For most children, their felt or perceived safety is as important as their actual safety, and some children may not feel safe even in secure settings. If children are placed with families who do not believe the child, who don't fully understand what happened to the child, or who defend the parents who inflicted the torture, the children are going to feel chronically unsafe. The normal CPS requirement for visitation with birth parents, even if in a supervised setting, may be an unsafe environment for children, as parents can inflict significant emotional harm on their children by subtly asserting coercive control in a way that may be invisible to those monitoring a visit.

Reunification in situations of ICT will rarely be safe or in a child's best interest, because of the egregious maltreatment suffered by victims of ICT as well as the unique dynamics in families who torture. Reunification might be possible if there is a nonoffending parent who can develop the capacity to protect the child and keep the offending parent away from the child. However, in Knox and colleagues' (2014) sample of 51 perpetrators of ICT, all adults in the home knew about the extreme abuse being inflicted on the child and participated to some extent in the abusive acts (p. 39). This usually included one or both biological parents. We expect that children who have been tortured cannot and should not be reunited with the parent(s) who tortured them, whether these parents were directly involved or allowed it to happen without protest or protective intervention.

In most ICT cases, children will need to be immediately removed to prevent imminent harm. The ideal placement may be therapeutic foster care in a "foster-to-adopt" or kinship family that would consider adoption or permanent custody. These parents should be expected to participate in parent-child psychotherapies and support the necessary developmental, medical, and spiritual care to help the child heal. These parents must also be able to protect children from any contact with the parent(s) who inflicted the torture. The reunification bypass option created by the Adoption and Safe Families Act of 1997 was designed specifically for cases of extreme child abuse, such as torture, and it's a good option to protect vulnerable children in ICT cases (ASFA, Public Law 105-89). This federal law states that a child protective services agency may choose not to make reasonable efforts to prevent removal or pursue reunification in "aggravated circumstances" of extreme child maltreatment. Agencies are permitted to immediately remove a child, file for Termination of Parental Rights (TPR), and begin pursuing a permanent adoptive family for the child. Filing for TPR at the outset of the case speeds up the process of achieving permanency for child victims of torture, thereby strengthening their feelings of physical and emotional safety at an earlier age. This physical and emotional safety and a permanent relationship with a nurturing and committed caregiver are necessary prerequisites to maximize the effectiveness of other therapeutic interventions.

Medical Interventions

Clinical data indicate that child survivors of ICT often have both immediate, acute medical needs and long-term, chronic medical needs. Medical conditions can result from both physical and psychological maltreatment. According to torture expert Dr. Rona M. Fields,

> "Torture is speciously categorized as physical when it is evidenced in damaged tissues, impaired sensory organs, broken bones, and/or major organ failure; or as psychological. This is a distinction without a difference. Coercion of any type, in itself, implies threat, fear, powerlessness, all of which can and often does impact on brain, spinal cord, and organ integrity and therefore has medical consequences" (Fields, 2008, p. 139).

Fields further suggests that the experiences of fear, threat, or dread – nearly universal in victims of torture – changes the brain and other parts of the body. Fields (2008) indicates that "reduced oxygen in red blood cells, metabolic interruptions, nutritional deficiencies, and cardiovascular disorders are common medical outcomes of physical and psychological torture" (p. 142).

Acute medical care for child survivors of ICT should include a forensic medical exam at a hospital or Child Advocacy Center (CAC) immediately following identification or removal by CPS, or both. If a forensic medical exam is not available, children should be assessed and treated by a pediatrician with specialized training in child maltreatment. Medical documentation of injuries and illness can be helpful in criminal and child protection litigation, and it expedites providing treatment for acute medical conditions (see Knox et al., 2014; Rasmussen et al., 2006). Knox and colleagues (2014) created a description of the medical sequelae of child torture in families to help pediatricians accurately recognize and diagnose torture. Their work group noted several acute conditions that were prevalent in their sample of 28 child torture survivors. Some examples include the following:

- Starvation
- Dehydration
- Burns, including burns with infection
- Bleeding in the back part of the eye
- Bruising and lacerations (cuts) of the skin
- Broken bones
- Hair loss
- Dental trauma
- Laceration of the liver and pancreas
- Bruise of a lung or heart
- Abusive head trauma
- Genital injuries
- Medical neglect resulting in critical illness

Knox and colleagues (2014) recommended that pediatricians and other health care providers be trained to recognize signs of torture in children who are being seen for other reasons, and that doctors should not automatically accept parents' explanations for suspicious injuries. In their sample, some children, who were eventually identified as torture survivors, had been previously evaluated by pediatricians for injuries resulting from torture, but they had not been identified as victims of torture at the time (pp. 40–41).

Rasmussen and colleagues (2006) noted that in early medical work with survivors of torture, physicians focused primarily on the documentation of torture, but when physicians recognized the scope of serious medical problems in these children, their focus expanded to include treatment (p. 46). Appropriate acute medical care for victims of ICT should always include a forensic medical exam, documentation of injuries, medical care to address all acute medical issues, and referrals for management of chronic medical issues.

There is a broad range of possible medical outcomes from child torture. Many injuries evolve into chronic medical conditions because of prolonged exposure to extreme early life stress or from a direct traumatic injury (see generally, van der Kolk, 2015). Julie, an adolescent who had been tortured throughout childhood, developed epileptic seizures as a likely result of the head injuries inflicted by her parents (see Miller & Rycus, 2021). Julie also developed chronic migraines, irritable bowel syndrome, fibromyalgia, asthma, stomach ulcers, an autoimmune disorder, and kidney disease. When she was in solitary confinement and given inconsistent access to food and water, Julie learned to ignore her feelings of hunger and thirst. Eventually she no longer knew when her body needed food or water, and she ate and drank less than she needed. Chronic dehydration combined with a kidney reflux disorder resulted in severe kidney infections that required many hospitalizations and caused permanent scarring and damage to her kidneys. Julie was eventually diagnosed with chronic kidney disease.

Other authors have long recognized the physiological outcomes of torture. "Commonly occurring conditions included headache, impaired hearing, gastrointestinal distress, and joint pain" (Goldfeld et al., 1988, p. 2726). Herman (1992b) described one child survivor of severe abuse who had "banished" traumatic memories but regularly experienced convulsions, nausea, sore throat, and shortness of breath. van der Kolk's work (2015) on the bodily manifestations of trauma, particularly Developmental Trauma in Children, listed the following chronic medical conditions often seen in severe trauma survivors:

- Autoimmune disorders, including lupus (pp. 126, 291–292)

- Weakened immune system (pp. 126-127, 240, 291).
- Abdominal pain (p. 204)
- Epilepsy and seizures (pp. 172, 310, 315).
- Sleep disorders (p. 409)
- Heart disease and cancer (p. 267)
- Chronic fatigue syndrome (p. 330)
- Asthma and breathing difficulties (pp. 61, 97)
- Migraines (p. 97)
- Chronic pain and need for painkillers (pp. 97, 146)
- Inability to feel pain/blocking of pain (pp. 33, 291)
- High blood pressure (pp. 61, 66)
- Obesity (p. 144)
- Metabolic disorders (p. 404)
- Sexual disorders (p. 405)

Pediatricians treating ICT survivors should expect to encounter many of these conditions. Management of chronic medical problems is as important as management of chronic mental health problems. Pediatricians should collaborate with providers of psychosocial, developmental, and spiritual care to ensure that child victims receive truly integrated and holistic care.

Spiritual Impact of ICT and Spiritual Interventions

Most leading trauma scholars acknowledge the existential or spiritual crisis created by severe interpersonal trauma, especially ICT and other forms of torture. Herman (1992b) specifically used the term *existential* to describe the crisis faced by survivors of severe child abuse; she used the language "good versus evil" to describe the nature of a victim's fight for survival (p. 101). Herman (1992b) contended that child victims face formidable developmental tasks and equally formidable existential ones – finding a way to preserve hope and meaning in an environment of hopelessness and futility (p. 101). Herman described child torture survivors who believe their parent/torturer possesses supernatural powers, such as the power to read their minds (p. 100). Other survivors describe feeling as if they are possessed by the devil (p. 102). Herman stated that severe child maltreatment and torture create "a sense of internal badness" in the child victim (p. 103). Van der Kolk (2015) explained that victims experience "a sense of desertion by God and man"; he described child survivors as having feelings of "spiritual alienation and loneliness."

Julie, the adolescent ICT survivor discussed previously, was a very religious child and had attended church all her life. She interpreted her victimization in religious terms by thinking that God must have allowed her father to torture her to build her strength of character. She explained her rescue by believing that God – in a pang of guilt that He had let things go too far – had eventually sent Child Protective Services to save her. Not surprisingly, the torture Julie experienced had religious overtones, including having been told by her father that she was evil and possessed by the devil (Miller & Rycus, 2021). Once she was safe in a foster home, Julie benefitted from sensitive and supportive spiritual care from her church. She also benefitted from hospital-based chaplains when she was hospitalized for her many injuries. During adolescence, Julie used her religion and spirituality as a source of coping, comfort, and hope. As a young adult in college, Julie studied world religions, theology, and philosophy to help her reconcile her experiences and to determine which religious beliefs she would adopt as an adult.

There is a large and growing body of research on the spiritual impact of severe child maltreatment and the benefits of competent spiritual care for children and youth (see Vieth, 2017; Vieth & Singer, 2019; Russell, 2018; Walker et al., 2009). Vieth contends that since child torture involves several concurrent forms of extreme abuse and neglect, this body of research is highly applicable to [ICT]" (Vieth & Singer, 2019).

Vieth (2017) stated that child survivors may be more likely to have religious concerns if the adults who tortured them used religious or spiritual reasons to manipulate the child or to explain the abusive behavior. Children with a strongly religious worldview might feel angry at God for having allowed them to be tortured, or they may be confused about why God didn't answer their prayers to stop the abuse or prevent it from happening at all. In one study of 527 survivors of child maltreatment, researchers identified multiple forms of what they termed "spiritual injury," including feelings of guilt, anger, grief, despair, doubt, a fear of death, a fear of going to hell, and a belief that God is fundamentally unfair (Lawson et al., 1998). This study also found that having experienced severe child maltreatment was associated with higher levels of positive religiosity and spirituality in adulthood, suggesting that spirituality may be an important source of coping and resilience for survivors of ICT and other forms of severe maltreatment. Younger children could be more affected spirituality than older children, because their spirituality is still developing and evolving (Bottoms et al., 2004).

A number of studies document that spirituality and religiousness in children can moderate posttraumatic symptoms (Bryant-Davis et al., 2012). Vieth (2017) contends that spirituality is an intrinsic part of human development and thus may be particularly

important to helping child survivors of severe maltreatment to heal. In one study, 86% of 149 youth in an institutional care setting considered themselves to be very or somewhat spiritual. For these children, competent spiritual care and support of their spirituality and religious focus may support resilience and help them heal. Conversely, in the absence of spiritual counseling, children may remain permanently angry with God, or the Universe, which can impede their healing. Both the American Psychological Association and the American Academy of Pediatrics have published guidelines indicating that children's spiritual needs must be recognized and addressed in a holistic approach to treatment (see Vieth & Singer, 2019).

To be most effective, professionals who offer spiritual care to ICT survivors need to fully understand the profound impacts of ICT, as well as the roles and responsibilities of the organizations serving these children, including child advocacy centers (CACs), child protective service agencies (CPS), and juvenile or family courts. Providers of spiritual care should always coordinate their services with providers of mental health, physical health, and developmental therapies to ensure an integrated approach to helping child victims. Providers in other disciplines, such as pediatricians, psychotherapists, developmental therapists, and child welfare workers need to recognize the importance of including spiritual care in a child's treatment plan and refer children for these services, especially if the child raises spiritual questions related to their torture or healing.

Options for spiritual care may include therapists with specialized training in the spiritual impact of child maltreatment and torture, religious leaders (of the same faith tradition as the child – a pastor, priest, rabbi, or imam), or professional chaplains who have degrees in theology and chaplaincy. Professional chaplains may be from any faith community or religion, as they are trained to provide emotional, spiritual, religious, pastoral, ethical, and/or existential care in secular settings (Hoffman, 2016). Chaplains are trained to care for people of any faith or no faith. Their role is not to proselytize, convert, or recruit people to religion, but rather to listen, to understand the struggle to make meaning of suffering, and to support people as they wrestle with difficult questions related to their painful experiences (Hoffman, 2016). Some chaplains who specialize in working with children may be employed at a children's hospital, a children's psychiatric facility, or a child advocacy center (CAC). The Pediatric Chaplains Network (PCN) is a helpful resource to learn about spiritual care for children and how to locate competent help for individual children.

In 2013, leaders from several national child protection organizations proposed 12 potential roles for chaplains serving on a child advocacy center's (CAC) multidisciplinary

team (Vieth et al., 2013). This proposal was incorporated into the Julie Valentine Center, an accredited CAC in Greenville, South Carolina, and it has now been replicated in several other CACs in the United States (Vieth et al., 2020). The implementation of a chaplaincy or other spiritual care program is consistent with cultural competency standards required of all accredited CACs (see National Children's Alliance Standards for Accredited Members, 2017).

Although there is a sizable body of research documenting the importance and benefit of spiritual care to victims of severe child maltreatment, many professionals lack an understanding of the importance of spiritual care and don't adequately address the spiritual needs of the children they serve. They may be unaware of the existing research on spiritual care, they may be uncomfortable integrating religion with social services, or they may not understand the nature of chaplaincy care. A culturally responsive child protection community must understand the critical importance of spiritual care for many child survivors of ICT and integrate spiritual services into their treatment plans.

CONCLUSION

In this paper, we provide practical information and instruction to professionals who care for child survivors of intrafamilial child torture. We outline the utterly devastating impact of torture on children's development, including neurological and psychosocial development, drawing on the work of prominent scholars who have studied and served severely maltreated children. We suggest specific, evidence-based interventions for this particularly vulnerable group of child victims and identify interventions that could cause harm. We introduce and discuss 16 treatment programs for use in psychotherapy, including home-visiting and early intervention programs that have psychotherapeutic and psychodevelopmental efficacy for severely maltreated children. We also suggest best practices for serving tortured children in education, medical care, child protection, and spiritual care.

Our 2021 paper – "Intrafamilial Child Torture: Making the Case for a Distinct Category of Child Maltreatment"– answered the question "What is intrafamilial child torture?" (Miller et al., 2021). This paper answers the question "How do we best help child victims of ICT?" We are also providing two associated case studies as real-life examples of effective intervention and treatment (Melissa Case Study) and the consequences of poor, ineffective intervention and treatment (Kelsey Case Study.) Readers who are interested in learning more about ICT should contact the Center for Child Policy, operated by the Institute for Human Services, at www.centerforchildpolicy.org

References

Adoption and Safe Families Act (1997). 2 U.S.C. 901.

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C., & Blaustein, M. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC intervention model. *Journal of Child & Adolescent Trauma*, *4*, 34–51.

Barfield, S., Dobson, C., Gaskill, R., & Perry, B. D. (2012). Neurosequential model of therapeutics in a therapeutic preschool: Implications for work with children with complex neuropsychiatric problems. *International Journal of Play Therapy, 21*(1), 30–44.

Booth, P. B., & Jernberg, A. M. (2010). *Theraplay: Helping parents and children build better relationships through attachment-based play* (3rd ed.). Jossey-Bass.

Bottoms, B. L., Nielsen, M., Murray, R., & Filipas, H. (2004). Religion-related child physical abuse. *Journal of Aggression, Maltreatment, & Trauma, 8*(1–2).

Bryant-Davis, T., Ellis, M. U., Burke-Maynard, E., Moon, N., Counts, P. A., & Anderson, G. (2012). Religiosity, spirituality, and trauma recovery in the lives of children and adolescents. *Professional Psychology: Research and Practice, 43*(4), 306–314.

Circle of Security International. (n.d.). http://www.circleofsecurityinternational.com

Cloitre, M., Henn-Haase, C., Herman, J. L., Jackson, C., Kaslow, M., Klein, C., Mendelsohn, M., & Petkova, E. (2014). A multi-site single-blind clinical study to compare the effects of STAIR narrative therapy to treatment as usual among women with PTSD in public sector mental health settings: Study protocol for a randomized controlled trial. *Trials, 15*(197).

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399–408.

Cloitre, M., Stovall-McClough, K. C., Nooner, K., Zorbas, P., Cherry, S., Jackson, C.L., Gan, W., & Petkova, E. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry, 167*(8), 915–924.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). Guilford Press.

Dozier, M., Peloso, E., Lindheim, O., Gordon, M. K., Manni, M., Sepulveda, S., Ackerman, J., Bernier, A., & Levine, S. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. *Journal of Social Issues, 62*(4), 767–785.

Fields, R. M. (2008). The neurobiological consequences of psychological torture. In A. E. Ojeda (Ed.), *The trauma of psychological torture* (pp. 139–162). Praeger Publishers.

Gaskill, R., & Perry, B. D. (2013) The neurobiological power of play: Using the neurosequential model of therapeutics to guide play in the healing process. In C. Malchiodi & D. A. Crenshaw (Eds.), *Play and creative arts therapy for attachment problems*. Guilford Press.

Gil, E. M. (2016). Using integrated directive and non-directive play intervention for abused and traumatized children. In Reddy, L. A., Files-Hall, T. M., & Schaefer, C. E. (Eds.), *Empirically based play interventions for children* (2nd ed.) (pp. 95-113). American Psychological Association.

Goldfeld, A. E., Mollica, R. F., Pesavento, B. H., & Faraone, S. V. (1988). The physical and psychological sequelae of torture: Symptomatology and diagnosis. *JAMA, 259*(18), 2725–2729.

Haen, C. (2008). Vanquishing monsters: Drama therapy for treating childhood trauma in the group setting. In C. A. Malchiodi (Ed.), *Creative interventions with traumatized children* (pp. 225–246). Guilford Press.

Hambrick, E. P., Brawner, T. W., Perry, B. D., Brandt, K., Hofmeister, C., & Collins, J. (2018). Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health, and developmental outcomes in children. *Archives of Psychiatric Nursing, 33*(3), 238–247.

Hambrick, E. P., Brawner, T. W., & Perry, B. D. (2019). Timing of early-life stress and the development of brain-related capacities. *Frontiers in Behavioral Neuroscience, 13*(183).

Hembree, E. A., Street, G. P., Riggs, D. S., & Foa, E. B. (2004). Do assault-related variables predict response to cognitive behavioral treatment for PTSD? *Journal of Consulting and Clinical Psychology, 72*(3), 531–534.

Herman, J. L. (1981). *Father-daughter incest*. Harvard University Press.

Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5(*3), 377–391.

Herman, J. L. (1992b). *Trauma and recovery.* Basic Books.

Herman, J. L. (2012). C-PTSD is a distinct entity: Comment on Resick et al. *Journal of Traumatic Stress, 25*(3), 256–257.

Hillard, R. E. (2008). Music and grief work with children and adolescents. In Malchiodi, C. A (Ed.). *Creative interventions with traumatized children* (pp. 62-80). Guilford Press.

Hoffman, K. (2016, January 14). What Is a Professional Chaplain? *Medivizor.* Available at www.medivizor.com/blog/2016/01/14/professional-chaplain

Hoffman, K. T., Cooper, G., Powell, B., & Marvin, R. S. (2006). Changing toddlers' and preschoolers' attachment classifications: The circle of security intervention. *Journal of Consulting and Clinical Psychology, 74*(6), 1017–1026.

Howard, A. R., Parris, S. R., Nielson, L. E., Lusk, R., Bush, K., Purvis, K. B., & Cross, D. R. (2014). Trust-based relational intervention (TBRI) for adopted children receiving therapy in an outpatient setting. *Child Welfare, 93*(5), 47–64.

Klorer, P. G. (2008). Expressive therapy for severe maltreatment and attachment disorders: A neuroscience framework. In C. A. Malchiodi (Ed.), *Creative interventions with traumatized children* (pp. 43-61). Guilford Press.

Knox, B. L., Starling, S. P, Feldman, K. W., Kellogg, N. D., Frasier, L. D., & Tiapula, S. L. (2014). Child torture as a form of child abuse. *Journal of Child and Adolescent Trauma, 7*, 37–49.

Lawson, R., Drebing, C., Berg, G., Vincellette, A., & Penk, W. (1998). The long term impact of child abuse on religious behavior and spirituality in men. *Journal of Child Abuse and Neglect, 22*(5), pp. 369-380.

Loumeau-May, L.V. (2008). Grieving in the public eye: Art therapy for children who lost parents in the world trade center attacks. In C. A. Malchiodi (Ed.), *Creative interventions with traumatized children* (pp. 81-111). Guilford Press.

Malchiodi, C. A., & Ginns-Gruenberg, D. (2008). Trauma, loss, and bibliotherapy: The healing power of stories. In C. A. Malchiodi (Ed.), *Creative interventions with traumatized children* (pp. 167-188). Guilford Press.

Miller, P. J. (2018, November). *Child torture: A new category of child maltreatment.* Proceedings from the Annual Conference of the National Association of Social Workers Ohio, Columbus, Ohio.

Miller, P. J. (2019, February). *Violence intervention: Recognizing and responding to child torture.* Proceedings from the Gundersen National Child Protection Training Center, Violence Intervention and Prevention Summit, Orlando, Florida.

Miller, P. J. (2020). Intrafamilial child torture: Training mandated reporters. *APSAC Advisor, 32*(1), 3–8.

Miller, P. J., & Rycus, J. S. (2021). Case study of a child survivor of intrafamilial child torture. American Professional Society on the Abuse of Children, Center for Child Policy. Available at https://www.centerforchildpolicy.org/_files/ugd/7833cd_2a828859cf824aa79f50adae9cc2b85d.pdf

Miller, P. J., Rycus, J. S., & Hughes, R. C. (2021). Intrafamilial child torture: Making the case for a distinct category of child maltreatment. American Professional Society on the Abuse of Children, Center for Child Policy. Available at https://www.centerforchildpolicy.org/_files/ugd/7833cd_dec5135fa27649c195575ebf8204bf45.pdf

National Children's Alliance Standards for Accredited Members. (2017). Available at https://ovc.ojp.gov/sites/g/files/xyckuh226/files/media/document/os_nca_standards_child_advocacy_centers-508.pdf

Pediatric Chaplains Network. (n.d.) Available at https://pediatricchaplains.org/

Perry, B. D., & Szalavitz, M. (2006, 2017). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook* (2nd ed). Basic Books.

Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-based relational intervention (TBRI): A systemic approach to complex developmental trauma. *Child & Youth Services*, *34*, 360–386.

Purvis, K. B., Cross, D. R., & Sunshine, W. L. (2007). *The connected child*. McGraw-Hill.

Rasmussen, O. V., Amris, S., Blaauw, M., & Danielsen, L. (2006). Medical physical examination in connection with torture. *Torture, 16,* 48–55.

Rogel, A., Loomis, A. M., Hamlin, E., Hodgdon, H., Spinazzola, J., & van der Kolk, B. (2020). The impact of neurofeedback training on children with developmental trauma: A randomized controlled study. *Psychological Trauma: Theory, Research, Practice, and Policy.* [Advance online publication].

Russell, A. (2018). The spiritual impact of child abuse and exploitation: What research tells us. *Currents in Theology and Mission, 45*(3), 14–19.

Rycus, J. S., & Hughes, R. C. (1998). *Field guide to child welfare: Foundations of child protective services.* Child Welfare League of America Publications.

Scoglio, A. A., Rudat, D. A., Jarmolowski, M., Jackson, C., & Herman, J. L. (2018). Self-compassion and responses to trauma: The role of emotion regulation. *Journal of Interpersonal Violence, 33*(13), 2016–2036.

Van der Kolk, B. A. (1994). *The body keeps the score.* Author.

Van der Kolk, B.A. (2005). Developmental trauma disorder: A new rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401–408.

Van der Kolk, B. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Group.

Van der Kolk, B. (2020, September 9–12). *Experiencing the body keeps the score*. Proceedings of the Trauma Research Foundation.

Van der Kolk, B., Roth, S. Pelcovitz, D., Sunday, S., & Pinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389–399.

Van der Kolk, B., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. *The Journal of Clinical Psychiatry, 75*(6), e559–e565.

Vieth, V. (2017). *When faith hurts: The spiritual impact of child abuse*. The Zero Abuse Project. Available at https://www.zeroabuseproject.org/when-faith-hurts-the-spiritual-impact-of-child-abuse.

Vieth, V. I., Everson, M. D., Vaughan-Eden, V., & Tiapula, S. (2013). Chaplains for children: Twelve potential roles for a theologian on the MDT. *Centerpiece: The Peer-Reviewed Newsletter of the National Child Protection Training Center, 3*(6), 1–5.

Vieth, V. I., Everson, M. D., Vaughan-Eden, V., Tiapula, S., Galloway-Williams, S., & Nettles, C. (2020). Keeping faith: The potential role of a chaplain to address the spiritual needs of maltreated children and advise child abuse multi-disciplinary teams. *Liberty University Law Review, 14*(2), Article 5. Available at https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=1285&context=lu_law_review

Vieth, V., & Singer, P. (2019). Wounded souls: The need for child protection professionals and faith leaders to recognize and respond to the spiritual impact of child abuse. *45 Mitchell Hamline Law Review, 1213.*

Walker, D. F., Reid, H. W., O'Neill, T., & Brown, L. (2009). Changes in personal religion/spirituality during and after childhood abuse: A review and synthesis. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(2), 130– 145.

Wettig, H. H. G., Franke, U., & Fjordbak, B. S. (2006). Evaluating the effectiveness of Theraplay. In C. E. Schaefer & H. G. Kaduson (Eds.), *Contemporary play therapy: Theory, research, and practice* (pp 103-135.). Guildford Press.

Zeanah, C. H., & Boris, N. W. (2000). Disturbances and disorders of attachment in early Childhood. In C. H. Zeanah (Ed.), *Handbook of infant mental health: Second edition* (pp 353-368.). Guilford Press.

Zeanah, C. H., & Lieberman, A. F. (2019). Relationship specific disorder of early childhood. In C. H. Zeanah (Ed.), *Handbook of infant mental health: Fourth edition*. Guilford Press, pp. 467-484).

Zero to Three (1994, 2005, 2016). *DC:0–5: Diagnostic classification of mental health and developmental disorders of infancy and early childhood.* Author.