6-2015

A holistic approach to child maltreatment

David Finkelhor
University of New Hampshire - Main Campus, David.Finkelhor@unh.edu

Corinna J. Tucker
University of New Hampshire, c.j.tucker@unh.edu

distress definition can be validly attained and is superior a categorical classification to identify poor outcomes.[9,10] With the release of the DSM-5, an anxious distress specifier was included to acknowledge the clinical significance of comorbid anxiety features in patients with depression. This specifier was based on five general anxiety symptoms: feeling keyed up or tense, feeling unusually restless, difficulty concentrating because of worry, fear that something awful might happen, and feeling loss of control. To establish how well such a dimension, which can be assessed with a short five-item measure, predicts clinical course and outcomes compared with a formal comorbid anxiety disorder diagnosis is of substantial importance. A dimensional approach to detect comorbid depression–anxiety features should not be restricted to the patient with depression, but should also be applied to the patient with anxiety. Because of the strong association between depression and anxiety, one disorder should not be considered alone; the focus should be on both partners in this insidious dance.

Brenda WJH Penninx
Department of Psychiatry, EMGO Institute of Health and Care Research and Neuroscience Campus Amsterdam, VU University Medical Center, Amsterdam 1081 HL, Netherlands
b.penninx@vumc.nl

BWJHP has received unrestricted research funding from Johnson & Johnson.

1 Lamers F, van Oppen P, Comijs HC, et al. Comorbidity patterns of anxiety and depressive disorders in a large cohort study: The Netherlands Study of Depression and Anxiety (NESDA). *J Clin Psychiatry* 2011; **72:** 341–48.
2 Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Arch Gen Psychiatry* 1994; **51:** 8–19.
3 de Graaf R, Bijl RV, Spijker J, Beekman AT, Vollebergh WA. Temporal sequencing of lifetime mood disorders in relation to comorbid anxiety and substance use disorders-findings from the Netherlands Mental Health Survey and Incidence Study. *Soc Psychiatry Psychiatr Epidemiol* 2003; **38:** 1–11.
4 Ionescu DF, Niciu MJ, Mathews DC, Richards EM, Zarate CA Jr. Neurobiology of anxious depression: a review. *Depress Anxiety* 2013; **30:** 374–85.
5 Hovens JG, Giltay EJ, Spinhoven P, van Hemert AM, Penninx BW. Impact of childhood life events and childhood trauma on the onset and recurrence of depressive and anxiety disorders. *J Clin Psychiatry* 2015; published online Feb 17. DOI:10.4088/JCP.14m09135.
6 Penninx BW, Nolen WA, Lamers F, et al. Two-year course of depressive and anxiety disorders: Results from the Netherlands Study of Depression and Anxiety (NESDA). *J Affect Disord* 2011; **133:** 76–85.
7 Fava M, Rush AJ, Alpert JE, et al. Difference in treatment outcome in out-patients with anxious versus nonanxious depression: a STAR*D report. *Am J Psychiatry* 2008; **165:** 342–351.
8 Meier SM, Petersen L, Mattheisen M, Mors O, Mortensen PB, Laursen TM. Secondary depression in severe anxiety disorders: a population-based cohort study in Denmark. *Lancet Psychiatry* 2015; published online May 15. http://dx.doi.org/10.1016/S2215-0366(15)00092-9.
9 Ionescu DF, Niciu MJ, Henter ID, Zarate CA. Defining anxious depression: a review of the literature. *CNS Spectr* 2013; **18:** 252–60.
10 Zimmerman M, Chelminski I, Young D, Dalrymple K, Walsh E, Rosenstein L. A clinically useful self-report measure of the DSM-5 anxious distress specifier for major depressive disorder. *J Clin Psychiatry* 2014; **75:** 601–17.

A holistic approach to child maltreatment

AJ Photo/Science Photo Library

Published Online
April 28, 2015
http://dx.doi.org/10.1016/S2215-0366(15)00173-X

See Articles page 524

Children and adolescents experience more violence, abuse, and criminal victimisation than do other segments of the population.[1] Proper public health attention to this vulnerability is hampered by many things, but one of the most remediable is the fragmentation of the response system. Separate institutions, researchers, and advocacy groups lobby and often compete on behalf of victims of child molestation, rape, exposure to domestic violence, corporal punishment, physical abuse, and bullying. Attention is also hampered by the description of abusive behaviours such as peer violence (including that among siblings) as being part of a "normal childhood",[2,3] and by viewing efforts to address such abuse as a sign of overwrought protectionism. The assault and abuse of children by their peers, often referenced by the term bullying has however gradually gained traction as a public health and child welfare issue. Bullying has been connected to high-profile criminal cases such as school shootings in the USA and the murder of James Bulger in 1993 in the UK.[4] These examples highlight that the peer problem can go far beyond just "bullying" and can include bald criminal acts committed by some young individuals against other young peers.

In *The Lancet Psychiatry*, Suzet Tanya Lereya and colleagues[5] report long-term consequences of peer victimisation by examining its association with negative adult mental health conditions (ie, depression, anxiety, and self-harm). Using cohorts from the Avon Longitudinal Study of Parents and Children in the UK and the Great Smoky Mountains Study in the USA, the authors showed that children who were maltreated by adults

were at increased risk for bullying, but that even being bullied without child maltreatment was associated with poorer adult mental health than that in non-bullied children. Their research could be seen as complementary to the Adverse Childhood Experiences study,[6] whose key assessment scale predicts cancer, heart, and liver disease as well as alcoholism, drug abuse, and depression in children. This scale counts sexual abuse, physical abuse, neglect, and domestic violence by adults as adverse childhood experiences but omits bullying or any form of peer abuse or rejection as one of its countable childhood adversities.[6]

Lereya and colleagues[5] directly contrasted the effects of peer bullying with those of child maltreatment by adults and concluded that being bullied by peers had worse effects than did being maltreated by adults. Compared with children maltreated by adults only, bullied children reported more depression (OR 1·7; 95% CI 1·1–2·7) and self-harm (1·7; 1·1–2·6) in the UK sample, and more anxiety (4·9; 2·0–12·0) in the US sample. Emphasising such a contrast unnecessarily aggravates the already intense rivalries among the fragmented child protection lobbies. But their findings are not that strong. Methodological factors might have influenced the comparison; for example, the bullying might be overall more proximal in time to the outcomes being measured than maltreatment by adults, and therefore stronger in association. The finding on the weak influence of adult-perpetrated maltreatment on mental health is contradicted by at least one other longitudinal and direct comparison with bullying[7] and by a large body of previous research on the enduring effects of caregiver abuse.[8]

Despite these shortcomings, Lereya and colleagues' assertion that bullying is another form of maltreatment should be applauded as a call to the fragmented child protection lobbies to join forces. A broader effort to tamp down the rivalries among those in the specialty of child protection is the concept of developmental victimology,[1] originally proposed by one of us (DF). This concept puts all the ways children are victimised, including such things as dating violence, property crime, and exposure to domestic violence, into an integrative developmental framework. In this framework, the key questions become not "Is it worse to be battered by your dad or bullied by your buddy?", but rather "How do children respond to or cope with violence and degradation at different stages of their development?", and "How can the negative impacts most effectively be mitigated with developmentally appropriate interventions?" The findings from Lereya and colleagues[5] justify the important concern from a children's rights and public health perspective, not only because of the long-term effects of maltreatment on health but also by the immediate injustice and suffering caused by such victimisations.

This new study[5] illustrates the growing consensus that children are entitled to grow up free from violence, denigration, and non-consented sexual activity at the hands of both adults and young peers. That growing consensus might be responsible for the fact that, if the epidemiological data are to be trusted, in spite of the fragmentations of response systems, the toll of some of these various scourges seems to have been on the decline in the past 20 years.[9,10]

*David Finkelhor, *Corinna Jenkins Tucker*
Department of Sociology, Crimes Against Children Research Center, Family Research Laboratory (DF), and Department of Human Development and Family Studies (CJT), University of New Hampshire, Durham, NH, USA
cjtucker@cisunix.unh.edu

We declare no competing interests.

1 Finkelhor D. Developmental victimology: the comprehensive study of childhood victimization. In: Davis RC, Lurigio AJ, Herman S, eds. Victims of crime. 3rd edn. Thousand Oaks, CA: Sage Publications, 2007: 9–34.
2 Caspi J. Sibling aggression: assessment and treatment. New York, NY: Springer Publishing Company, 2011.
3 Dodge KA. Mediation, moderation, and mechanisms in how parenting affects children's aggressive behavior. In: Borkowski JG, Ramey SL, Bristol-Power M, eds. Parenting and the child's world: Influences on academic, intellectual, and social-emotional development. Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers, 2002: 215–29.
4 Bazelon E. Sticks and stones: defeating the culture of bullying and rediscovering the power of character and empathy. New York: Random House Incorporated, 2013.
5 Lereya ST, Copeland WE, Costello EJ, Wolke D. Adult mental health consequences of peer bullying and maltreatment in childhood: two cohorts in two countries. *Lancet Psychiatry* 2015; published online April 28. http://dx.doi.org/10.1016/S2215-0366(15)00165-0.
6 Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 1998; **14:** 245–58.
7 Price-Robertson R, Higgins D, Vassallo S. Multi-type maltreatment and polyvictimisation: a comparison of two research frameworks. *Family Matters* 2013; **93:** 84–98.
8 Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. the long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS Med* 2012; **9:** e1001349.
9 Finkelhor D, Saito K, Jones LM. Updated trends in child maltreatment, 2013. Durham, NH: Crimes against Children Research Center, 2015.
10 Finkelhor D. Trends in bullying & peer victimization. Durham, NH: Crimes against Children Research Center, University of New Hampshire, 2013.