Doctoral Thesis

Outcomes of Psychological Maltreatment in Children

Ariadna de la Vega Castelo

Thesis supervisors:

Dra. Lourdes Ezpeleta Ascaso

Nuria de la Osa Chaparro

Doctorat en Psicologia Clínica i de la Salut

Unitat d' Epidemiologia i Diagnòstic en Psicopatologia del Desenvolupament

Departament de Psicología Clínica i de la Salut

Universitat Autònoma de Barcelona

Factultat de Psicologia

Bellaterra (Barcelona) - 2012

Acknowledgements

This thesis has been carried out thanks to the grants by the Science and Education Ministry of Spain for the project *"Effects of Domestic Violence in Children"* SEJ2005-01786 and the program for the university staff training (Formación del Profesorado Universitario, FPU) reference AP2007-01614, also funded by the Science and Education Ministry (Spain), with the goal of fulfilling my Ph D thesis, teaching and doing research.

Agradecimientos:

En primer lugar un especial agradecimiento a mis directoras de Tesis, Lourdes Ezpeleta y Nuria de la Osa, por todo su trabajo y experiencia, sin cuyo apoyo este trabajo no hubiera sido posible. Mi mayor gratitud a Antonia Bifulco, mi tutora en el *Center of Abuse and Trauma Studies*, por su paciencia y generosidad. A Roser Granero, por su inestimable ayuda en los análisis de datos y su cariño. A mis compañeros de la *Unidad de Epidemiología y Diagnóstico* y de la *Universidad Autónoma de Barcelona*, especialmente a los que se han convertido en una segunda familia para mí; Beatriz, Gemma y Virginia. A los hermanos Sesma por resolver incidencias de sincronización. A Chuck, por sus revisiones de inglés y su amistad. A todo el personal Administrativo (*PAS*) del departamento: Jose, Silvia, Esperanza y especialmente Cristina, que me ha ayudado a sobrevivir a trámites y plazos. A mis amigos, especialmente Celia, Valentina y Marina, que saben de primera mano qué significa la aventura de ser doctorando, por sus ánimos. A mi familia, especialmente a mis padres, mi hermano y mi abuelo Javier. Y a Carlos, mi gran apoyo incondicional.

List of Contents

ACKNOWLEDGEMENTS 1

LIST OF CONTENTS 3

PRESENTATION 5

INTRODUCTION 7

1.1 Definition of Psychological Maltreatment 7

1.2 Incidence and Prevalence of Psychological Maltreatment 18

1.3 Psychological Maltreatment and Other Forms of Child Maltreatment 20

1.4 The Assessment of Psychological Maltreatment 24

1.5 Negative Outcomes of Psychological Maltreatment 29

1.6 Vulnerability of Suffering Psychological Maltreatment 40

DIFFERENTIAL OUTCOMES OF PSYCHOLOGICAL MALTREATMENT SUBTYPES 45

2.1 Paper: Differential Effects of Psychological Maltreatment on Children Exposed to Intimate Partner Violence 47

ACCUMULATIVE RISK OF PSYCHOLOGICAL MALTREATMENT SUBTYPES 57

3.1 Paper: Severity of Psychological Maltreatments and Accumulative Risk for Psychopathology in Children of Mothers Exposed to Intimate Partner Violence 59

DISCUSSION 79

4.1 Importance of the Type and Number of Subtypes of Psychological Maltreatment Suffered by the Child 79

4.2 Recommendations and Clinical Implications 80

4.3 Limitations 81

4.4 Further Direction for Research 82

CONCLUSIONS 87

BIBLIOGRAPHY 89

ANNEX 110

7.1 Manuscript: Psychological Abuse in Childhood: III. Long-term Effects and Relation to Attachment Styles 110

Presentation

This thesis, presented in the European Ph D framework, is a part of a major project, "Effects of Domestic Violence in Children" (SEJ2005-01786), funded by the Science and Education Ministry (Spain). Data and sample collection for this thesis have been performed during the period of my FPU grant (AP2007-01614). The general goal of this thesis is to study different relevant topics related to how exposure to Psychological Maltreatment (PM) in childhood could lead to different negative outcomes, in order to improve the welfare of children. Despite the great complexity of this issue, this study tries to address three fundamental questions. In order to allow a greater diffusion of the results, each research question lead to a scientific manuscript: 1) **Differential Effects of Psychological Maltreatments on Children of Mothers Exposed to Intimate Partner Violence,** published at Children Abuse and Neglect, study how the exposure to different types of PM affect differentially in a child's mental health, in order to explore the particular contribution of each PM subtype; 2) **Severity of Psychological Maltreatments and Accumulative Risk for Psychopathology in Children of Mothers Exposed to Intimate Partner Violence**, accepted at Journal of Family Violence, study if suffering a greater number of PM subtypes leads to greater levels of psychopathology and poorer functioning, in order to explore accumulative risk and severity of PM and 3) **Exploring Psychological Abuse in Childhood: III. Long-term Effects and Relation to Attachment Styles** addressed the question of long-term consequences of PM and it is attached as an annex due to these results is not published jet. This last topic has been studied thanks to a brief stay of three months, since the first of June to the 31st of August of 2010, in the *Department of Health and Social Care*, of the *Royal Holloway University of London* in the *Lifespan Research Group* of the *Centre for Abuse and Trauma Studies* of London, UK. A stay and collaboration in a foreign European country is a requirement of the European Ph D. My person in charge of the Host institution was Antonia Bifulco. The sample of adult women necessary to answer the third research question of the long-term consequences of PM was provided for this center.

Introduction

1.1 Definition of Psychological Maltreatment

The term Psychological Maltreatment (PM) refers to *affective and cognitive* aspects of child maltreatment. Hart, Germain & Brassard (1987) highlight that PM includes both acts of *omission and commission,* which are judged on the basis of a combination of community standards and professional expertise to be psychologically damaging. This thesis is focused on PM against children; in this field, their definition also refers to the perpetrator's characteristics and state that such acts are committed by individuals, singly or collectively, who by their characteristics (e.g., age, status, knowledge, organizational form) are in a *position of differential power* that renders the child vulnerable. And, also, they point to the consequences of such acts, which *damage immediately or ultimately* the behavioral, cognitive, affective, social and psychological functioning of the child.

Since the second National Conference on Child Abuse and Neglect (1978), there have been several attempts to describe PM. In 1987 Rosenberg suggested that research in the area of psychological abuse had been hindered by a lack of consensus regarding an operational definition. Currently, the present status of defining and conceptualizing PM is best represented in the Guidelines of the American Professional Society on the Abuse of Children (APSAC), which states that PM means a *repeated pattern* of caregiver behavior or *extreme incident*(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs (APSAC, 1995). This definition highlights the *meaning that such acts transmit* to the child and the negative messages that conveys to the child about him or herself.

The Modified Maltreatment Classification System (MMCS; English & LONGSCAN, 1997, pg. 27) highlights the *non-satisfaction of needs*, its definition states that Emotional Maltreatment involves persistent or extreme thwarting of children's basic emotional needs. This category also includes parental acts that are harmful because they are *insensitive to the child's developmental level*. These needs include, but are not limited to, the following: 1) *Psychological safety and security*: the need for a family environment free of excessive hostility and violence, and the need for an available and stable attachment figure. Note that this category refers to the interpersonal climate of the

home, whereas Lack of Supervision (LOS) refers to cases in which the physical environment is unsafe; 2) *Acceptance and self-esteem*: the need for positive regard and the absence of excessively negative or unrealistic evaluation, given the child's particular developmental level, and 3) *Age-appropriate autonomy*: the need to explore the environment and extra familial relationships, to individualize within the bounds of parental acceptance, structure, and limit setting, without developmentally inappropriate responsibility or constraints placed on the child.

Other definitions highlight the importance of the developmental level of the battered child, for instance, for McGee and Wolfe (1991), PM is conceptualized as the interaction between maltreating parent behaviors and the special vulnerabilities of a child, particularly his or her developmental level.

In the process of finding a consensus concerning the definition of PM there have been different criticisms about classifications, and some authors suggest that it would be necessary to conduct more in-depth research into this issue since the theoretical and conceptual bases for these forms of maltreatment are not evident. Some of the most frequent criticisms are that the term PM has some delimitation problems (Socolar, Runyan & Amaya-Jackson, 1995), that some types could be subsumed under other subtypes (Glaser, 2002), or that various behaviors may be classified simultaneously in different subtypes (categories) at the same time (McGree & Wolfe, 1991). In other cases, PM's definition refers to the effect rather than to the acts; "Emotional abuse is the persistent emotional ill-treatment of a child such as *to cause severe and persistent adverse effects* on the child's emotional development..." *(*Department of Health et al., 1999, pgs.5-6), and as stated by Hart and Brassard, (1990) this problem could lead to less specific or tautological definitions of the term PM, where the term is included in its definition (psychological maltreatment is whatever causes psychological harm). There is also much debate concerning the significance of the *intentions* of perpetrators. McGee and Wolf (1991) and O'Hagan (1993) recommend that PM should be defined independently of the perpetrator's intentions or motives.

Besides the debate on the definition of the term, there is also some debate about which term is the best to use. There are several similar terms used in the scientific literature that sometimes could be synonymous. For instance, in some of the literature the term "*emotional abuse*" is used interchangeably with "*psychological abuse*", along with other terms such as "*mental cruelty*" (Navarre, 1987), "*mental injury*" (Kavanagh, 1982), and "*psychological battering*" (Garbarino, Guttman & Sheeley, 1986). At other

times it depends on the geographic and idiomatic area: The use of the term "*emotional* abuse" is more common in UK literature, whilst American literature tends to refer to "*psychological* abuse" (Cawson, Wattam, Brooker & Kelly, 2000, pg.53; Edmuson & Colier, 1993). But some other authors argue that these terms are not exactly the same; O' Hagan (1993) has proposed a distinction between "*emotional*" and "*psychological*" abuse, arguing that the child's psychological (mental) development is not the same as emotional development. He contends that they are not the same, but are not entirely separate experiences since both may be occur at different points in an abusive relationship (O'Hagan, 1995). Other authors have grouped emotional and psychological *abuse* together and employ the broader term of "*psychological maltreatment*" (Garbarino et al., 1986; McGee & Wolfe, 1991), and this is also the term used in this thesis. All of these complications in defining PM render its measurement and assessment difficult, and therefore a gap in detecting and really understanding its prevalence (Kinard, 1994; Manly, 2005) turns into a hidden obstacle.

1.1.1 Types of Psychological Maltreatment

PM is an extremely heterogeneous phenomenon, occurring in a wide variety of contexts. No two cases of PM will contain exactly the same elements, and many will be quite different from one another (Binggeli, Hart & Brassard, 2001).

In this section the most common classifications of PM are described. In the first place, the definitional framework published by the APSAC, as the *Guidelines for Suspected Psychological Maltreatment of Children and Youth* (APSAC, 1995), was chosen because it was developed with input from many of the leading researchers in the field and has been refined empirically, and it has been used repeatedly in forensic settings. Following the APSAC framework, PM includes spurning, terrorizing, isolating, exploiting/corrupting, denying emotional responsiveness, mental health, medical and educational neglect (APSAC, 1995). A definition of each PM subtypes is further included in Table 1. This is the framework used in this thesis for classifying PM subtypes because it is one of the most important classifications and is used in research. Table 2 shows the principal classifications of PM subtypes in chronological order in order to shows how the classifications and the concept of PM are evolving. All of them have similarities, even when some use different terms.

Table 1

APSAC Psychological Maltreatment Forms.

1. Spurning (hostile rejecting/degrading), it is a rejection by commission acts. It includes verbal and non-verbal caregiver acts that reject and degrade a child. Spurning includes the following: – Belittling, degrading, and other non-physical forms of overly hostile or rejecting treatment. – Shaming and /or ridiculing the child for showing normal emotions such as affection, grief or sorrow. – Consistently singling out one child to criticize and punish, to perform most of the household chores, or to receive fewer rewards. – Public humiliation.
2. Terrorizing includes caregiver behavior that threatens or is likely to physically hurt, kill, abandon or place the child or child's loved one or objects in recognizably dangerous situations. Terrorizing includes the following: – Placing a child in unpredictable or chaotic circumstances. – Placing a child in recognizably dangerous situations. – Setting rigid or unrealistic expectations with the threat of loss, harm, or danger if they are not met. – Threatening or perpetrating violence against the child. – Threatening or perpetrating violence against a child's loved ones or objects.
3. Isolation includes caregiver acts that consistently deny the child opportunities to meet needs for interacting or communicating with peers or adults inside or outside the home. Isolation includes the following: – Confining the child or placing unreasonable limitations on the child's freedom of movement within his or her environment. – Placing unreasonable limitations or restrictions on social interactions with peers or adults in the community.
4. Exploiting/Corrupting includes caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, anti-social, criminal, deviant or other mal-adaptive behaviors). Exploiting/corrupting includes the following: – Modeling, permitting, or encouraging antisocial behavior (e.g., prostitution,

performance in pornographic media, initiation of criminal activities, substance abuse, violence to or corruption of others).

- Modeling, permitting, or encouraging developmentally inappropriate behaviors (e.g., parentification, infantalization, living the parent's unfulfilled dreams). *Parentification* refers to children or adolescents assuming adult roles before they are emotionally or developmentally ready to manage those roles successfully. *Infantalization* is any action that equates or subverts a person's knowledge, authority, or any other form of power.
- Encouraging or coercing abandonment of developmentally appropriate autonomy through extreme over-involvement, intrusiveness, and/or dominance (e.g., allowing little or no opportunity or support for the child's views, feelings and wishes; micromanaging the child's life).
- Restricting or interfering with cognitive development.

5. Denying Emotional Responsiveness (Ignoring) rejection by acts of omission. It includes caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring, and love for the child) and that show no emotion in interaction with the child. Denying emotional responsiveness includes the following:

- Being detached and uninvolved through either incapacity or lack of motivation.
- Interacting only when absolutely necessary.
- Failing to express affection, caring and love for the child.

6. Mental health, medical, and educational neglect includes unwarranted caregiver acts that ignore, refuse to allow or fail to provide the necessary treatment for the mental health, medical, needs and educational problems.

(From APSAC, 1995, pgs. 7-8).

Table 2

Psychological Maltreatment Subtypes in the Principal Classifications:

National Center for Child Abuse and Neglect, NCCAN	1980	Verbal and emotional assault, close confinement, inadequate nurturing and affection and knowingly permitting maladaptive behavior.
Garbarino, Guttman & Sheeley	1986	Rejecting, isolating, terrorizing, ignoring and corrupting a child or youth.
Baily & Baily	1986	The same subtypes as Garbarino and: excessive threats, refusal of psychological treatment, sexual exposure and exploitation, denial of opportunities to grow socially and emotionally, singling out one child in the family to punish/criticize and unrealistic expectations.
McGee & Wolfe	1991	Rejecting, degrading, terrorizing, isolating, missocializing, exploiting and denying emotional responsiveness.
Barnett, Manly& Cicchetti	1993	Confining to a small space, public humiliation, Cinderella syndrome, severe verbal abuse, coercing to delinquency, threatening a child, refusal of psychiatric treatment, not allowing social and emotional growth and not providing a loving home.
National Incidence Study (NIS) Sedlack & Broadhurst (1996)	1996	*Close Confinement: Tying/Binding*, *Close Confinement: Other* (confinement in a closet for instance), and *Verbal or Emotional Assault (06.0*) attempted or potential physical or sexual assault or exploitation.
Glaser	2002	Persistent negative attributions or misattributions to the child, failure to recognize the child's individuality and inconsistent developmental expectations.
Moran, Bifulco, Ball, Jacobs & Benaim	2002	Humiliation/degradation, terrorizing, cognitive disorientation, deprivation of basic needs, deprivation of valued objects, extreme rejection, inflicting marked distress or discomfort, emotional blackmail, corruption/exploitation. Others: complex psychological abuse, parental antipathy and role reversal.

AAP American Academy of Pediatrics (Kairys & Johnson)	2002	Spurning, terrorizing, exploiting or corrupting that encourages a child to develop inappropriate behaviors, denying emotional responsiveness, rejecting, isolating, unreliable or inconsistent parenting, neglecting mental health, medical and educational needs and witnessing intimate partner violence

1.1.2 Comparing APSAC Classification with Other Classifications

As Table 3 shows, the APSAC framework is used to organize the subtypes of the major definitions for purposes of comparison. This table organizes nine definitional systems reviewed which are relative to the presence or absence of contents included in the APSAC definition (1995). As Table 3 shows, APSAC classification was chosen because it includes components of the other principal classifications of PM subtypes.

Table 3

Contents of Major Maltreatment Definitions Organized by APSAC Definitions

(pgs. 156-157)

APSAC Categories	Subcategories of parental/ caregiver behavior toward child	NIS Sedlack and Broadhurst (1996)	Barnett, Manly and Cicchetti (1993)	Baily and Baily (1986)	Glaser (2002)	McGree and Wolfe (1991)	Garbarino, Guttman and Seely (1986)	Moran, Bifulco, Ball, Jacobs, and Benai, (2002)	Giovanni and Becerra (1979)	AAP Kairys, Johnson, and AAP committee on Child Abuse and Neglect (2002)
Spurning	Belittling, denigrating, or other rejection	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ridiculing for showing normal emotions	✓		?	✓	✓				✓
	Singling out	✓		✓	✓	✓	✓	✓	✓	✓
	Humiliating in public	✓			✓	✓	✓	✓		✓
Terrorizing	Placing in unpredictable/chaotic circumstances	*	✓	✓	✓	✓	✓		*	✓
	Placing in recognizably dangerous situations	*	*						*	
	Having rigid/		?	✓	?	✓	✓			✓

	unrealistic expectations accompanied by threats if not met									
	Threatening /perpetrating violence against child	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Threatening/ perpetrating violence against child's loved ones/ objects – includes exposure to domestic violence	✓	✓		✓	✓		✓	✓	✓
Isolating	Confiding within environment	✓	✓						*	✓
	Restricting social interactions in community		✓	✓	✓		✓	✓	?	✓
Exploiting/ corrupting	Modeling, permitting, or encouraging antisocial behavior	✓	*	✓	✓	✓	✓	✓	*	✓
	Modeling, permitting, or encouraging antisocial behavior	✓	✓	✓	✓	✓	✓		✓	✓
	Restricting/ undermining psychological autonomy	✓	✓	✓	✓	?		?		✓
	Restricting/ interfering with cognitive development	*	*	✓	✓	*	✓		*	✓
Denying emotional responsive -ness	Being detached from child or uninvolved due to parent's incapacity or lack of motivation	✓	✓	✓	✓	?	✓			✓
	Interacting only when necessary	✓	?	?	✓	?				✓
	Failing to show affection, caring, love	✓	✓	✓	✓	*	✓		✓	✓
Mental health/ Medical/ Educational Neglect	Parent/ caregiver ignores or refuses to allow/ provide treatment for child's…									
	… serious emotional/behavioral problems/needs	✓	*	✓					*	✓
	…serious physical health problems/needs	*	*			*			*	✓
	…serious educational problems/needs	*		✓						✓

Table from Feerick, Knutson, Trickett & Flanzer, (2006, pgs.156-157). Contents of major maltreatment definitions organized by APSAC definitions for suspected PM.

✓= in system and called psychological maltreatment (abuse or neglect)

* = in system but not called psychological maltreatment

? = not conclusive/partially covered.

1.1.3 Levels of Severity of Psychological Maltreatment

The data reviewed indicate that of all people that have suffered PM in childhood (30% of all of the adult population of the US), it is estimated that from 10% to 15% of them have experienced the more severe and chronic forms of PM (Binggeli, et al., 2001).

In determining the level of severity of PM, the APSAC Guidelines (1995, pg. 8) give some consideration that should be taken into account:

- ✓ *Intensity*/extremeness, *frequency*, chronicity.
- ✓ The degree to which PM pervades the *caregiver-child relationship*.
- ✓ *Number of forms* of psychological maltreatment which have been or are being perpetrated.
- ✓ Influences in the child's life that may *buffer* the child from PM.
- ✓ Salience of the maltreatment given the *developmental period(s)* in which it occurs and the developmental periods that will follow.
- ✓ *Extent* to which negative child developmental outcomes exist, are developing or are predicted.

In others cases, the classification of PM subtypes also implies a classification in order of severity; for instance, the classification system of the Consortium for Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) considers a list of more than twenty behaviors ranging from *lower to higher severity* (English & LOGSCAN Investigators, 1997, pgs. 28-30) to define PM, and this classification implies a code from eleven to fifty-five. In this code the kind of caregiver behavior and its length (two hours, eight hours, twenty-four hours…) is taken into account to evaluate severity.

- ✓ 11 Requires the child to assume an *inappropriate level of responsibility*.
- ✓ 12 The caregiver *undermines the child's relationships* with other people.
- ✓ 13 The caregiver often *belittles or ridicules the child*.
- ✓ 14 The caregiver *ignores or refuses to acknowledge* the child's bids for attention.
- ✓ 15 The caregiver *uses fear or intimidation* as a method of disciplining. Include here pressuring a child to keep secret(s) about a family situation.
- ✓ 21 The caregiver does not permit *age-appropriate socialization*.
- ✓ 22 The caregiver places the child in a *role-reversal*.
- ✓ 23 Thwarts the child's developing sense of maturity and responsibility.

- ✓ 24 *Reject/ inattentive/*unaware of the child's needs for affection and positive regard.
- ✓ 25 Allow the child to be exposed extreme but *nonviolent marital conflict*.
- ✓ 31 The caregiver *blames the children for marital or family problems*.
- ✓ 32 The caregiver sets up the child to fail or to feel inadequate by *having inappropriate or excessive expectations* for the child.
- ✓ 33 The caregiver makes a serious and convincing *threat to injure* the child.
- ✓ 34 The caregiver calls the child *derogatory names* (e.g., "slut", "whore").
- ✓ 35 The caregiver *binds* the child's hands and feet for moderate periods of time (e.g., approximately two to five hours), the child is not attended.
- ✓ 36 The caregiver exposes the child to *extreme, unpredictable, and/or inappropriate behavior* (e.g. violence *toward other family members*).
- ✓ 37 The caregiver demonstrates a pattern of *negativity or hostility* toward the child (e.g. the caregiver screams at the children that they can never do anything right).
- ✓ 41 The caregiver threatens *suicide or abandonment* in front of the child.
- ✓ 42 The caregiver allows the child to be exposed to *extreme marital violence* in which serious injuries occur to the caregiver.
- ✓ 43 The caregiver *blames* the child for the *suicide or death* of another family member.
- ✓ 44 The caregiver *confines and isolates the child* (e.g., locks the child in his or her room), and the confinement is between five and eight hours.
- ✓ 45 The caregiver uses *restrictive methods to bind* a child or places the child in close confinement for less than two hours.
- ✓ 51 The caregiver makes a *suicidal attempt* in the presence of the child.
- ✓ 52 The caregiver makes a *homicidal attempt* or *realistic homicidal threat* against the child without actual physical harm to the child.
- ✓ 53 The primary caregiver *abandons the child* for 24 hours or longer without any indication of when or if he or she will return.
- ✓ 54 The caregiver uses *extremely restrictive methods* (e.g., child tightly tied to a chair).
- ✓ 55 The caregiver *confines the child to an enclosed space* (e.g. locks the child in a closet or small space) for extended periods (e.g., more than eight hours).

Finally, the classification system of Moran et al. (2002) uses a licker scale for rating severity. Instances of psychological abuse are rated in terms of overall severity

using the same 4-point scale used for the majority of the CECA scales (i.e., 1, marked; 2, moderate; 3, some/mild, or 4, little/none). The overall severity was influenced by the *number* of subcategories of psychological abuse rated, but equally, by the *intensity* and *frequency* of single forms of such abuse. Judgments are made by considering a number of features of the abuse in the child's particular context, consistent with predefined rating criteria. As with other CECA scales, severity ratings reflect the *potential* for long-term psychological and emotional damage rather than actual damage to the subject.

1.1.4 Importance of Psychological Maltreatment

The PM of children and youth may be one of the single greatest contributors to human suffering. Its major role in the formation of childhood and adult mental disorders and disturbed interpersonal relationships is becoming more evident (Binggeli, et al., 2001). The term PM has been used to refer to the underlying destructive elements that connect all forms of abuse and neglect (Garbarino et al., 1986), because virtually all acts of maltreatment, abuse and neglect carry negative emotional/psychological messages to their victims. Consequently, it may be argued that every act of maltreatment constitutes Emotional Maltreatment (English & LOGSCAN Investigators, 1997). Moreover, PM also significantly exists independently of the other forms of abuse and neglect (Glaser, 2002) and due to its importance should not be considerate as a supplementary topic to other forms of abuse and neglect, but rather as the centrepiece of the efforts to understand family functioning and protect the children (Gabarino et al., 1986).

PM has been conceptualized and proposed as being the core component of all forms of child abuse and neglect (Gabarino et al., 1986). This perspective is supported by the facts that: (a) PM is embedded in nearly all other acts of abuse and neglect as the psychological meaning of those acts, (b) it appears to have the strongest predictors of the impact of child maltreatment and (c) PM may have the longest-lasting and strongest negative effects on survivors of child abuse and neglect. This is explained by the vast majority of abuse and neglect cases not resulting in death or permanent injury and the most significant and lasting effects of abuse and neglect tending to be psychological. Physical pain cannot be re-experienced from memory, but psychological context and distress, associated with both physical and psychological trauma, can be re-experienced (Beese & Morley, 1993).

1.2 Incidence and Prevalence of Psychological Maltreatment

PM is the most prevalent form of child abuse (Brassard, Germani, & Hart, 1987), but it has been the last form of child abuse and neglect to receive full attention from child protection services (CPS) and researchers (Feerick et al., 2006), even when PM should be easy to observe and identify, since many parents make few attempts to hide their behaviors. Thus, PM is often observed in public, unlike sexual and physical abuse (Davis, 1996). Despite the relative ease of observation, PM often goes unidentified and, therefore, comes to the attention of CPS less frequently than other forms of maltreatment (Claussen & Crittenden, 1991). The official statistics are widely considered to be underestimates of the true incidence of child maltreatment, and this is particularly true for PM, which is likely to be unreported unless it co-occurs with other forms of abuse or neglect (Binggeli et al., 2001).

The true incidence of PM is not known. The National Incidence Study, funded by the National Center on Child Abuse and Neglect (NCCAN), has two standards or two definitions of child maltreatment, depending on the consequences of this maltreatment. They distinguish whether the maltreatment has already caused harm to the child (called the "harm standard"), which is a more restrictive definition, and, on the other hand, the maltreatment that could cause future harm to the child but that has not yet caused harm (called the "endangerment standard"). Under these standards, the NCCAN Report states that 1.5 million children were estimated to be abused or neglected in The United States in 1993 under the "harm standard" (the more restrictive definition that implies that children are considered to be maltreated only if they had *already experienced harm* from abuse or neglect) and nearly 3 million under the "endangerment standard" (that includes those children who experienced abuse or neglect that put them *at risk of harm*). The latter standard also resulted in an estimate of approximately 532,200 children being emotionally abused and 585,100 being emotionally neglected in 1993.

Although incidence statistics are cited more frequently, prevalence statistics permit the estimation of the percentage of people in the general population who experience abuse or neglect during childhood. It appears that PM may have been a significant presence in the childhoods of more than one-third (about 30%) of the general adult population of the United States (Binggeli et al., 2001). This could be even more if we take into account that, collectively, these adults were not exaggerating their negative

experiences, because the most common human tendency seems to be to minimize one's own maltreatment history (Varia, Abidin, & Dass, 1996).

National Reports on Child Abuse in the US reported a *prevalence* of PM of 6.1% (National Center of Child Abuse & Neglect, 1997), and this prevalence is underestimated since often PM is only detected if it comes together with other non-psychological maltreatments isolated of the child's other maltreatments, PM has had the lowest rate of substantiation or verification of any type of maltreatment (Kairys & Johnson, 2002). According to the National Committee to Prevent Child Abuse (NCPCA), in 1997, 3,195,000 children (4.6% of all children) were reported for child abuse and neglect to CPS agencies in The United States (Wang & Daro, 1998). CPS confirmed 1,054,000 (or 1.5% of all children) as being victims of child maltreatment. Of these confirmed cases, only 4% (or 42,160) represented specifically identified emotional maltreatment. These data report that PM is often forgotten and not encoded by CPS.

The prevalence studies also demonstrate that PM occurs at a substantial rate in all socio-economic classes, cultural backgrounds and family structures (Binggeli et al., 2001).

1.3 Psychological Maltreatment and Other Forms of Child Maltreatment

Child Maltreatment is a complex, heterogeneous and multidimensional phenomenon (Cicchetti & Barnett, 1991). It is important to take into account the high rate of comorbidity among various forms of maltreatment (Dong et al., 2004; Knutson, DeGarmo, Koeppl & Reid, 2005). The data reviewed indicate that among people that had suffered PM in their childhood, only between 15% to 20% experienced PM occurring alone, and more than one-third experienced it in combination with other forms of abuse, so it is more frequent to suffer PM and other maltreatments at the same time, (Binggeli, et al., 2001).

Hart (1992) has proposed a conceptual model to guide the setting of research priorities for clarifying the relationship between psychological maltreatment and other forms of child abuse. In equation form, the model is:

CDQ = (PA/SA/PN) x (PM1, 2 or 3) x MC

CDQ= Child Developmental Consequences
PA= Physical Abuse
SA= Sexual Abuse
PN= Physical Neglect
PM1= the psychological meaning of the abuse or neglect (PA/SA/PN)
PM2= discrete acts of psychological maltreatment that occur simultaneously with or are temporally close and/or meaningfully specific in their connection to physical or sexual abuse or physical neglect (PA/SA/PN)
PM3= discrete acts of PM not temporally or meaningfully specific in their relationship to ongoing physical or sexual abuse or physical neglect (PA/SA/PN)
MC= Mediation Conditions

This equation states that physical abuse (PA), sexual abuse (SA) and physical neglect (PN) experienced by a child interacts with the psychological meaning of this abuse (PM1) and/or associated psychological maltreatment (PM2 and/or PM3), all of which are associated whit mediation conditions (MC) to produce child developmental consequences (CDQ). Experiences of PM2 or PM3 are likely to increase the power of PA/SA/PN.

1.3.1 Poly-victimization and Re-victimization

The concept of poly-victimization implies suffering more than one type of victimization. Exposure to multiple forms of victimizations is common. Children who suffer one type of victimization are also likely to experience other types. Focusing on only one, or a few types, of the large spectrum of victimizations that children experience has several important limitations such as underestimating the full burden of victimization exposure and overestimating the impact of individual victimizations. Furthermore, a fragmented approach hampers the identification of the most highly victimized children. Experiencing many different forms of victimization is more highly related to trauma symptoms than is experiencing repeated victimization of a single type; and lifetime exposure to multiple victimizations substantially accounts for the effects of individual victimization types. It seems likely that exposure to many different forms of victimization reflects substantial adversity across multiple contexts of children's lives. Thus, poly-victims are likely to experience victimization by peers at school, by family members at home, and by a variety of individuals within neighborhoods and communities. For such children, victimization represents more of a life condition than a set of events (Turner, Finkelhor & Ormrod, 2010b).

The concept of re-victimization, or repeated victimization, is increasingly of interest to researches who study maltreatment and crime due to the evidence that persons who experience one victimization (an assault, a burglary, sexual abuse, etc.) are at risk for subsequent victimizations, so it is also relevant to interrupt this pattern. The issue of re-victimization has been addressed in different ways: It has meant a connection between childhood victimization and adult victimization (Arata & Lindman, 2002), two victimizations occurring in closer proximity (Outlaw, Ruback, & Britt, 2002) and the recurrence of an episode of child maltreatment, typically at the hands of the same perpetrators, after a first episode was identified (Depanfilis & Zuravin, 1999). Typically, studies have examined the recurrence of only one or a few kinds of victimizations, for example sexual abuse or violent crime, but the possibility also exists that victimizations of one sort, such as child maltreatment, may create vulnerability for other different kinds of victimization. A limitation of re-victimization literature is that it has tended to view victimization as an event rather than as a condition, but much victimization is ongoing, as the literature on bullying, child abuse, and intimate partner violence have made clear. Indeed the persistence of victimization may suggest that victimization may be a

condition, rather than a recurrence of certain kinds of victimization events. In this direction, Finkelhor, Omrod and Turner (2007) found that children victimized in one year are two to seven times more likely than non-victimized children to be victimized again in the following year; re-victimization vulnerability extended to a very broad range of victimizations, so victimization of one sort creates vulnerability for victimization of another sort, and the group most intensively victimized, with highs levels of different kinds of victimizations, identified as “poly-victims”, were to very likely to remain so, and also had high levels of vulnerability to every kind of victimization. Poly-victimization had a high risk of persistence and a strong association with all other future types of victimizations as well.

1.3.2 Children Exposed to Intimate Partner Violence

Intimate Partner Violence (IPV) can be defined as the violence, physical, psychological or sexual, within an intimate relationship. Most authors agree that the impact of IPV is greater on women (Walby & Allen, 2004; Women’s Aid & the Child and Women Abuse Studies Unit, 2001), and women are more likely to suffer severe or lethal abuse from their male partners (Campbell, Sharp, & Glass, 2001; Jaffe, Lemon & Poisson, 2003: Walby & Allen, 2004: World Health Organization, 2002).

It has been estimated that between 25% and 30% of all American women are beaten at least once during the course of an intimate relationship (Pagelow, 1984). Severe violence may be a chronic feature of almost 13% of all marriages in The United States (Straus, 1977). The seriousness of this violence is demonstrated by the fact that women are more likely to be killed by their husbands or boyfriends than by anyone else (Jaffee, Wolfe, & Wilson, 1990), and more women are physically injured by their partners than are injured in car accidents, muggings or rapes (Toufexis, 1987).

The large proportion of abused women is at ages between 21 and 40 years old, and they are married or have stable relationships (Centro Reina Sofía para el estudio de la violencia, 2008). Families suffering IPV have a greater number of children at home, especially pre-schoolers (Fantuzzo, Boruch, Beriama, Atkins & Marcus, 1997). Fantuzzo and Mohr (1999), in their review of databases in the U.S., found that families with IPV were twice as likely to have children at home, compared to families without IPV. Approximately 10 million children are exposed to violence between their parents in countries like the U.S. (Straus & Gelles, 1990), and these data are similar in Europe

(Kury, Obergefell-Fuchs & Woessner, 2004). It is likely that children are present in many of these instances of spousal violence. Leighton (1989) reported 68% of 2,910 wife-assault cases had children present. Children are aware of IPV presence more than mothers report: In 75% of the cases, children are present at home when an IPV incident occurs (Hutchison & Hirschel, 2001).

UNICEF informs about statistics of children exposed to IPV around the world, according the United Nations sources. In Spain, at least 118,000 children are exposed to violence between parents, while in countries such as the UK, the rates range from 240,000 to 963,000; in France from 240,000 to 802,000; and in Germany, 22,000 (UNICEF, 2006). This problem is increasing. In Spain Queen Sofia for the Study of Violence (2007) reported an increase up to $0.84/^{000}$ in the prevalence of children who are victims of family violence, revealing an increase of 133.33% between 2001 and 2005. The cumulative incidence increased to 146.29% during the same period of time. Despite the high prevalence of children exposed to IPV, many cases remain in anonymity: Osofsky (1995) called these children the "invisible victims".

Children exposed to IPV are more likely to suffer other forms of maltreatment (Appel & Holden, 1998; Osofsky, 1999). Partner violence and child abuse share many common features and often occur together (Bourassa, 2007). Indeed, in many cases the same perpetrator is guilty of assaulting multiple family members, the assaulted family member is not necessarily the only victim in the situation, and children may be doubly victimized in such families: first, by being maltreated themselves and, second, by witnessing the victimization of a parent (Hamby, Finkelhor, Turner & Ormrod, 2010). Child PM and IPV are two closely related phenomena. Domestic violence is a feature of many families in which emotional abuse occurs (Cawson et al., 2000; Mitchell, 2005; Mullender & Morley, 1994), and exposure to family violence is increasingly believed to be emotionally abusive (Butler-Sloss, 2001). Accumulative research evidence indicates that children who observe spousal abuse are being psychologically abused (they are being terrorized, corrupted, and perhaps isolated) and they suffer psychological harm as a result of this experience (Holden, Geffener & Jouriles, 1998). The current trend is to consider exposure to IPV as a form of abuse because witnessing an assault may terrify the children and significantly alter their socialization (McGee & Wolfe, 1991). For instance, the APSAC includes 'witnessing IPV' as an example of the PM subtype '*Corrupting*'. And The American Academy of Pediatrics (AAP) (Kairys & Johnson,

2002) uses the same PM types as does APSAC and also adds '*unreliable or inconsistent parenting'* and '*witnessing* IPV' as a type of PM itself.

1.4 The Assessment of Psychological Maltreatment

Due to PM being a complex phenomenon, and very often remaining undetected, currently there is not complete agreement in the scientific community about the best way or instrument of assessing. A summary of the principal instruments is shown in Table 4. Some of the more frequently used are:

1.4.1 Observational Measures

The Assessment of PM could be accomplished by observational measures like:

- ✓ Psychological Maltreatment Rating Scales (PMRS) (Brassard, Hart & Hardy, 1993: Hart & Brassard, 1990): This instrument uses global rating scales of actual parent-child interaction relevant to PM. It contains four scales that assess subclinical psychological abuse and neglect and nine scales that assess pro-social parenting.
- ✓ The Mother and Child Risk Observation (MACRO) (Louis, Condon, Shute & Elzinga, 1997). This is an observational rating form for mother-infant (Form 1) and mother-toddler (Form 2) interaction. Using a 5-point Likert scale, raters respond to 10 items on each of five scales (these scales assess safety, care, emotional responsiveness, mother's mental state and infant characteristics that might contribute to parenting difficulties).
- ✓ The Child-Adult Relational Experimental Index (CARE Index) (Crittenden, 1988). This is a 52-'items behavioral rating system that assesses the quality of caregiver-child interaction during a 3-minute play episode. The quality of caregiver behaviour is rated on its level of sensitivity, controllingness and unresponsiveness, Child behaviour is rated in four styles of conduct (cooperative, difficult, passive, and compulsively compliant).
- ✓ The Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell & Bradley, 1984) is designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment and the child as a recipient of inputs from objects,

events, and transactions occurring in connection with the family surroundings. There are four versions: IT (Infant/Toddler) birth to age 3, 45 items; Early Childhood (EC) 3-6 years, 55 items; Middle Childhood (MC) 6-10 years, 59 items, and Early Adolescent (EA) ages 10 to 15, 60 items.

- ✓ The Childhood Level of Living Scale, CLL (Polansky, Chambers, Butternweiser and Williams, 1981) is a checklist of features related to both physical and emotional care being produced, and it provides a measure of the child's standard of living.
- ✓ The Child Well-Being Scales CWBS (Magura & Moses, 1986) were developed as an outcome measure for evaluating programs in child welfare services. They consist of 43 scales covering 4 areas: parenting role performance, familial capacities, child role performance, and child capacities.

1.4.2 Self- report Questionnaires

There are also self-report questionnaires like:

- ✓ The Psychological Abuse Index of the Conflict Tactics Scales (CTS) (Straus, 1990). This self-report questionnaire is a screening measure and it is the only nationally normed measure of PM in the USA. The primary form in use is Form R, which takes 3 minutes to administer and provides data on the incidence, prevalence and chronicity of physical and psychological maltreatment.
- ✓ The Conflict Tactics Scale-Parent-Child (CTSPC) (Straus, Hamby, Finkelhor, Moore & Runyan, 1998). The core scales covert non-violent discipline, psychological aggression, and physical assault. The CTSPC, with the supplemental scales would allow researchers to obtain self-report data on physical, psychological, and sexual abuse and neglect from both parental figures in the home. It is a useful screening tool.
- ✓ The Picture Card Version of CTS (Mebert & Straus, 2002) (6-9 years old) present 22 items in the form of pictures depicting acts of maltreatment, accompanied by a verbal statement. It provides scores for less and more severe physical and psychological maltreatment, and also parents' use of non-violent discipline strategies. Testing time is about 15 minutes.

1.4.3 Interviews/Rating Scale and Systems for Rating Case Records and Integrating Other Data

Although direct observation is desirable, it is not always necessary in order to form an opinion regarding whether or not PM has occurred. There are also Rating Scales used to assess PM, like the Record of Maltreatment Experiences (ROME) (McGee, Wolfe & Wilson, 1990) and systems for rating case records and integrating data like the Maltreatment Classification Scheme (MCS) and the Multiple Informants Rating Systems (MIRS) (Kaufman, Jones, Stieglitz, Vitulano & Mannarino, 1994). Inside the category of interviews is one of the instruments used in this thesis: the *Childhood Experience of Care and Abuse (CECA)* (Bifulco, Brown & Harris, 1994). It is a retrospective, semi-structured interview measure that is used to assess a range of negative childhood experiences prior to age 17. The categories of psychological abuse are *humiliation/degradation; terrorizing*; *cognitive disorientation, deprivation of basic needs, deprivation of valued objects, extreme inflicting marked distress or discomfort, emotional blackmail* and *corruption/exploitation*. This instrument also assesses parental *antipathy* (dislike, rejection, irritation and coldness, which could be like a less-severe kind of PM), *parental neglect, role reversal, parental discipline, parental supervision, physical abuse, sexual abuse*, and *felt shame*. The PM level of severity is assessed using a four-point scale; 1 marked, 2 moderate, 3 some, 4 little/none.

Table 4

Measures of Psychological Maltreatment

		Observational					Self-report					Record Rev.		Rating Scale		Interview
APSAC Categories	**Subcategories of parental/ caregiver behavior toward child**	CARE-Index (birth to 24 months) Crittenden (2001)	PMRS (3-8 years old) Brassard, Hard and Hardy (1993)	HOME (birth to 15 years old) Caldwell and Bradley (1984)	CLL (4-7 Years) Polansky, Chamers, Buttenweiser and Williams (1981)	CWBS (families with children) Magura and Moses (1986)	Multi-dimensional Neglectful Behavior Scale (6 years to adult) Straus (1979), Straus &Hamby (1997)	CTS9 adult version, used with children) Straus, Kinard and Williams (2001)	CTSPC (child/adolescent) Straus, Hamby, Finkelhor, Moore and Runyan (1998)	Picture Card Version of CTS (6-9 years old) Merbert and Straus (2002)	PARQ (7-12 years old) Rohner, Saavedra & Granum (1978)	Child Maltreatment Log (<18 years old) Sternberg, Knutson, Lamb, Baradaran, Nolan and Flanzer (2004)	MCS (child/adolescent) Barnett, Manly and Cicchetti (1993)	Ontario CNI (child/adolescent) Trocme (1992,1996)	ROME (birth to 16 years old) Wolfe and McGee(1994) McGee, Wolfe and Wilson (1990)	Herrenkohl, (child and adolescent) Herrenkohl, Herrenkohl and Egolf (1991) Herrenkohl, Herrenkohl and Toedter (1982)
Spurning	Belittling, denigrating, or other rejection	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓
	Ridiculing for showing normal emotions	✓	✓	✓		✓										
	Singling out					✓					✓		✓		✓	✓
	Humiliating in public										✓				✓	✓
Terrorizing	Placing in unpredictable/chaotic circumstances					✓						✓	✓	?	✓	
	Placing in recognizably dangerous situations			✓		✓	P					✓	✓	✓	✓	
	Having rigid/ unrealistic expectations accompanied by threats if not met		✓			✓									✓	
	Threatening /perpetrating violence against child	✓	✓	?	✓	✓		✓	✓	✓	✓		✓		✓	✓

	Threatening/ perpetrating violence against child's loved ones/ objects – includes exposure to domestic violence					✓	P				✓		✓		✓	✓
Isolating	Confiding within environment		✓	✓		✓						✓	✓		✓	✓
	Restricting social interactions in community		✓	✓		?							✓		✓	
Exploiting/ corrupting	Modeling, permitting, or encouraging antisocial behavior	✓	✓			✓	✓					✓	✓		✓	
	Modeling, permitting, or encouraging antisocial behavior	✓	✓			✓					✓	✓	✓		✓	
	Restricting/ undermining psychological autonomy	✓	✓	✓		?					✓		?			
	Restricting/ interfering with cognitive development	✓	✓	✓	✓	✓						✓			✓	
Denying emotional responsive-ness	Being detached from child or uninvolved due to parent's incapacity or lack of motivation	✓	✓	✓		✓	✓				?					
	Interacting only when necessary	✓	✓	✓		✓					✓					
	Failing to show affection, caring, love	✓	✓	✓	✓	✓	✓	✓			✓		✓		✓	
Mental health/ Medical/ Educational neglect	Parent/ caregiver ignores or refuses to allow/ provide treatment for child's…															
	… serious emotional/behavior problems/needs					✓						✓		✓		
	…serious physical health problems/needs			✓		✓	✓					✓	✓	✓	✓	
	…serious educational problems/needs					✓						✓		✓		

Table from Feerick, Knutson, Trickett & Flanzer, (2006, pgs.170-171).
P= Parent version; ✓= covered by measure; ? = not conclusive/ partially covered.

1.5 Negative Outcomes of Psychological Maltreatment

For more than 30 years, expert opinion, research and clinical findings have identified serious consequences associated with and probable consequences of PM. The American Human Association (Wald, 1961) and the National Center on Child Abuse and Neglect (Broadhurst, 1984) both published the following list of disorders as being representative of possible psychological maltreatment consequences: habit disorders, conduct disorders, neurotic trails, psychoneurotic reactions, behavior extremes, overly adaptive behaviors, lags in development and attempted suicide. It is also important to take into account that negative outcomes of PM are affected by a broad class of variables that determine the consequences of abuse in children: the nature of the abuse, frequency, intensity and duration; individual characteristics of the victim; the nature of the relationship between the child and the abuser and the response of others to the abuse and factors associated with the abuse that might exacerbate its effects (Emery & Laumann-Billings, 2002). A summary of PM negative-effects research is included below and in Table 5:

- **Mental health problems**: anxiety, depression, conduct disorders, withdrawal and enuresis, substance abuse, eating disorder problems, post-traumatic symptoms, suicidal ideation, enhanced risk for attempting suicide, emotional instability, impulse control problems, borderline instability, unresponsiveness, (See Braver, Bumberry, Green & Rawson, 1992; Briere & Runtz, 1988, 1990; Claussen & Crittenden, 1991; Crittenden, Claussen & Sugarman, 1994; Egeland & Erikson, 1987; Engels & Moisan, 1994; Gross & Keller, 1992; Herrenkohl, Herrenkohl & Egolf, 1983, 1991; Ney, Fung & Wickertt, 1994; Mc Cord, 1983; Mullen, Martin, Anderson, Romans & Herbison, 1996; Rohner & Rohner, 1980; Rorty, Yager & Rossotto, 1994). Children and young people appear to internalize the critical voice of the abusive caregiver, which lays the foundation for low self-esteem and mood disorders (Iwaniec, 2006).

- **Physical problems:** high likelihood to be smaller in stature, weigh less than same-age peers and fail to meet expected developmental milestones (Cleaver, Unell & Aldgate 1999; Iwaniec, 2004), allergies, (Miller & Baruch, 1948, 1950), asthma and other respiratory ailments (Jacobs, Spilken & Noeman, 1972), hypertension (McGinn,

1963), somatic complaints (Hughes, 1992; Krugman & Krugman, 1984), high mortality rates (McCord, 1983), dramatic negative physical health, infant mortality (Spitz, 1945, 1946), serious growth failure despite adequate nutrition or “non-organic failures to thrive”, cause of damage to brain structure related to memory, significant reduction in the size of hippocampus (Joseph, 1999), more hospitalizations for illnesses, a greater number of physical and psychological problems (Johnson, 1993), lower rating of overall health, and the greater number of types of childhood abuse, the poorer the woman’s adult health tended to be (Moeller, Bachman & Moeller, 1993). There also appears to be a significant neurological component to emotional abuse linked to hyperactivity, sleep disturbance, anxiety, and learning and memory problems (Glaser, 2000).

- **Interpersonal, social and antisocial functioning:** self-isolating behavior, low social competence, low empathy, non-compliance, dependency, sexual maladjustment, aggression and violent behavior, antisocial functioning and delinquency/criminality (See Briere & Runtz, 1988, 1990; Brown, 1984; Claussen & Crittenden, 1991; Crittenden et al. 1994; Egeland & Erikson, 1987; Herrenkohl et al., 1983, 1984, 1991, 1997; Hughes & Graham-Bermann, 1986; Main & Goldwyn, 1984; Main & George, 1985; McCarthy, 1974; McCord, 1983; Mullen et al., 1996; Rohner & Rohner 1980; Rorty et al., 1994; Vissing et al., 1991). Also, it is most probable to be abusive: Mothers who physically assaulted their children were more likely to have had childhood histories of being terrorized, spurned and denied emotional responsiveness (DeLozier, 1982). Men who battered women were characterized by memories of cold, rejecting and abusive fathers (Dutton, 1995).

- **Cognitive, learning and educational problems:** decline in mental health competence, lower measured intelligence, non-compliance, lack of impulse control, negative life views, impaired learning, academic problems and lower achievement-test results, impaired development of moral reasoning, poor performance in intelligence tests, do less well in school, school-related problems in ability and academic achievement (See Bilbro, Boni, Johnson & Roe, 1979; Hoffman, 1970; Claussen & Crittenden, 1991; Crittenden et al. 1994; Egeland & Erikson, 1987; Hughes & Graham-Bermann, 1998; Main & Goldwyn, 1984; Main & George, 1985; Rohner & Rohner, 1980; Chan, 1981; Manley, 1977; Sheintuch & Lewin, 1981; Starkey, 1980); Difficulties to adapt to the demands of school and to attend ti tasks requiring cognitive skills (Kurtz, Gaudin,

Wodarski & Howin, 1993; Oates, 1996), low educational and vocational aspirations, more disruptive behavior at school, discipline problems and repeat years (Kelly, Thornberry & Smith, 1997). They were more likely to finish school without any qualifications, thus limiting economic opportunities and prospects for financial security (Kendall-Tackett & Eckernrode, 1996).

1.5.1 Negative Outcomes of Different Types of Psychological Maltreatment

Several studies like the Minnesota Mother Child Interaction Project (Egeland & Erickson, 1987; Egeland, Sroufe & Erickson, 1983; Erickson, Egeland & Pianta, 1989) have found that different forms of PM lead to different outcomes. For instance, spurning (children of a hostile/verbally abusive mother) has been related to negative outcomes such as an angry and non-compliant behavior, negative emotion, lack of impulse control, hyperactivity and distractibility, difficulties in learning and solving problems, lack of enthusiasm and persistence, and low creativity (Egeland & Erikson, 1987), and it also predicted features of borderline personality disorder (Allen, 2008).

Denying emotional responsiveness (psychologically unavailable mothers) has been judged to be the most devastating subtype, and can lead to anxious avoidant attachment, non-compliance, lack of impulse control, decline in competence from infancy through pre-school years, low self-esteem, negative emotion, lack of enthusiasm, high dependence, self-abusive behavior, serious psychopathology (Egeland & Erikson, 1987), depression and borderline personality-disorder features (Allen, 2008). Terrorizing significantly predicted somatic complaints and anxiety in early adulthood (Allen, 2008).

Table 5.

Subtypes of Psychological Maltreatment and Negative Outcomes.

Spurning	Angry and non-compliant behavior Negative emotion Lack of impulsive control Hyperactivity and distractibility Difficulty learning and solving problems Lack of enthusiasm and persistence Low creativity Predicted current features of BPD.

Denying Emotional Responsiveness	Was judged to be the most devastating Anxious avoidant attachment Non-compliance Lack of impulse control Decline in competence from infancy through pre-school years Low self-esteem, negative emotion, lack of enthusiasm High dependence Self-abusive behavior Serious psychopathology Depression and borderline personality-disorder features.
Terrorizing	Significantly predicted somatic complaints and anxiety in early adulthood.

1.5.2 Theoretical Explanations for the Impact of Emotional Abuse

The negative outcomes of PM are unquestionable, but how does PM exert its impact? Some useful theoretical perspectives have been proposed and incorporated in research specific to PM:

- **The Human Need Theory.** Although all humanistic theories have relevance to child abuse and neglect, the Human Need Theory (Maslow, 1970) has been recognized to have particularly strong explanatory and heuristic value for PM. It proposed that the human organism has certain needs to be met if one is to develop properly. The first fit includes *basic or physiological needs* (food, clothing, and shelter), the *psychological need* (such as safety, love, belongingness and esteem), and the *growth needs* (self-actualization). This theory states that humans will develop in healthy ways if the physical, and, in particular the social environments in which they are raised support fulfillment of natural human needs. If children are thwarted in their efforts to satisfy their basic needs, such as love and safety, they are forced to meet these needs in unhealthy ways, thus distorting development.

- **The Psychological Stage Theory.** Erick Erikson (1959) proposed that human development proceeds in a series of stages, each of which has its own set of tasks or conflicts. The stages for infancy are: 1) *trust versus mistrust* (0-1 years), which depends on the relationship with the mother, and 2) *autonomy versus shame and doubt* (1-3 years), based on cognitive and motor development. In this stage the child take consciousness of itself as being independent of parents and he wants to do everything by himself. Failures and ridicule can create doubt and shame. The stages for childhood are:

1) *initiative versus guilt* (critical years 3-6), in which it is favorable to stimulate activity and curiosity. If parents react negatively to children's questions, they generate guilt; and 2) *industry versus inferiority* (critical years 7-12). It consists of an interest in how things work and their own efforts to make things. The stimulation of the school and peer group is important. Unfavourable comparisons and failures contribute to inferiority. For adolescents, the principle stage is *identity versus identity confusion* (critical years, 13-17); in this stage, the adolescent is looking for his/her own identity. Each stage refers to two opposite results, one adaptive and one maladaptive. These two results are not alternative but complementary, good resolution means that the adaptive quality exceeds the maladaptive. There are optimal times to achieve each quality; however, it is possible to compensate for early dissatisfaction at a later stage, but it becomes more difficult. From this theoretical orientation PM can be viewed as undermining the individual's efforts to successfully master the tasks of the developmental stage.

- **The Attachment Theory.** According to the Attachment Theory (Ainsworth, 1989, Bowlby, 1988a, 1988b), the human infant enters the world programmed with a set of behaviors designed to elicit appropriate responses from a caregiver. Between 6 to 12 months of age, the infant begins forming attachments with one or a few individuals. The development of secure attachment with a primary caregiver is the stage-salient task during this period. A growing body of evidence strongly suggests that the quality of attachment has profound implications for emotional health and interpersonal functioning.

Four attachment patterns have been identified: secure attachment, ambivalent-resistant attachment, avoidant attachment and disorganized-disoriented attachment. Infant attachment patterns have been found to be systematically related to specific patterns of maternal caretaking behavior.

✓ Mothers of children with *secure attachment* provide good psychological care, they tend to be responsive, accessible, and sensitive to their needs (the opposite of PM).

✓ The mothers of infants with *ambivalent-resistant attachment* have been found to be inconsistent in their responsiveness and accessibility and too often give insensitive care characterized by withdrawal and uninvolvement, a behavior that fits the *denying emotional responsiveness* category of PM.

✓ The mothers of infants with *avoidant attachment* have been found to be insensitive to their infant's needs and to alternate between being rejecting, neglecting

and interfering- behaviors that fit the *spurning, denying emotional responsiveness, and exploiting/corrupting* categories of PM.

✓ The mothers of infants with *disorganized-disoriented attachment* display diverse and contradictory behavior patterns, including the three types previously described. Mothers of these infants generally have been consistent for an extended period of time, followed by period of inconsistency, conditions that may, as a pattern, include *spurning, terrorizing, isolating and denying emotional responsiveness* characteristics. Many abused children display disorganized-disoriented attachment patterns.

- **The Parental Acceptance-Rejection Theory.** Rohner and Rohner (1980) have developed this theory specifically to clarify the nature of emotional maltreatment and to guide cross-cultural research on rejection. In their theory, *acceptance* means parental warmth and affection, and *rejection* means emotional abuse, which comes in two principal ways: (a) *parental hostility and aggression* and (b) *parental indifference and neglect*. Those two forms of rejection are, to a large extent, the equivalent of the spurning and denying emotional responsiveness categories of APSAC. The Acceptance-rejection theory predicts that rejected children everywhere tend more than accepted children to be: hostile, aggressive, passive-aggressive, or to have problems with management of hostility and aggression; to be dependent or "defensively independent" depending on the degree of rejection, to have an impaired sense of self-esteem and self-adequacy; to be emotionally unstable, emotionally unresponsive, and to have a negative world view. The more recent research suggests that rejection may be embedded in every type of PM.

- **The Coercion Model.** The coercion model of interpersonal problems (Patterson, 1986) posits that interpersonal relations involve interactions between persons through which the negative action of one person stimulates a negative response by the other person, which then stimulates another, possibly more severe, negative response by the first person; and this goes on in an *escalating fashion*. Many of the negative actions and responses would fall within PM categories.

1.5.3 Accumulative and Multiplicative Effects

APSAC (1995) indicates that the number of subtypes suffered by the child is an indicator of the severity of the PM. Previous research has not focused on the multiplicative effects that different forms of PM might have in a population of risk, such as that of children exposed to IPV. The study of this topic in this population is especially important, because PM of children and IPV are closely related phenomena (Appel & Holden, 1998; Osofsky, 1999). IPV is a feature of many families in which emotional abuse co-occurs (Butler-Sloss, 2001).

According to previous literature, different types of PM lead to specific and differential negative outcomes. Also, a high rate of co-occurrence among various forms of maltreatment is observed (Dong et al., 2004; Knutson et al., 2005), which results in multiplicative effects between the number of different maltreatments and developmental consequences in the child.

Furthermore, experiences of PM are likely to increase the effects of other types of abuse or neglect, as proposed by Hart (1992). This idea is in line with the classic model of additive main effects proposed by Rutter (1985, 2006), according to which it is important to take into account the accumulated risk factors, given that the sum of the number of different types of maltreatment has poorer outcomes than each factor individually. Hahm, Lee, Ozonoff and Wert (2010) reported that experiencing different kinds of maltreatment during childhood led to an extensive range of risk behaviors in domains such as sexual risk behavior, delinquency and suicidality. Boxer and Terranova (2008) found an association between the number of different types of maltreatment and high psychopathology.

1.5.4 Negative Effects of Combinations of Psychological Maltreatment Subtypes

Furthermore, some combinations of PM subtypes have poorer outcomes than others; for instance, the combination of spurning and denying emotional responsiveness frequently appeared in the combinations of abuse that tended to produce the most devastating outcomes in both children and young adults (Lefkowitz, Eron, Walder & Huesmann, 1977; Loeber & Strouthamer-Loeber, 1986; Ney et al., 1994).

The Lehigh Longitudinal Study (Herrenkohl, Egolf & Herrenkohl, 1997: Herrenkohl et al., 1983; Herrenkohl, Herrenkohl, Egolf & Wu, 1991; Herremkohl,

Herrenkohl, Toedter & Yanushefski, 1984) found that children suffering *spurning* (critizing and rejecting the child verbally) in combination with *terrorizing* (threatening the child with punishment and physical abuse) are more likely to become school-age children who feel unloved, inadequate, angry, low self-esteem and aggressive. When *spurning* (critizing mother being hostile and irritable) is combined with *corrupting* (impeding child's performance), this influences the level of assaultive behavior in adolescents.

Loeber and Strouthamer-Loeber (1986), in a meta-analysis of longitudinal research on delinquency, found that *spurning* (parental rejection) + denying emotional responsiveness (lack of parent-child involvement and supervision) is the most powerful predictor of juvenile delinquency.

The Cambridge-Somerville Youth Study (McCord, 1983; McCord, McCord & Zola, 1959) found that the combination of terrorizing, spurning, isolating and denying emotional responsiveness predisposes children to crime. Their definitions of precipitating parenting/home conditions correspond to all of these forms of PM because they include discipline that is erratic and punitive or lax, parental rejection, neglectful and cruel. Ney et al. (1994) found that *spurning* (verbal abuse) in combination with emotional responsiveness (emotional neglect) appeared frequently in the combinations of abuse that tended to produce the most devastating outcomes and also have negative effects on feelings and perspectives about enjoyment of living, purpose in life, prospects for future life, chance of having a happy marriage or expectation for being a good parent.

Table 6

Combination of Types of Psychological Maltreatment and Negative Outcomes.

Spurning (critizing and rejecting the child verbally) + **Terrorizing** (threatening the child with punishment and physical abuse)	**The Lehigh Longitudinal Study** (Herrenkohl, Egolf & Herrenkohl, 1997; Herrenkohl, Herrenkohl & Egolf, 1983; Herrenkohl, Herrenkohl, Egolf &Wu, 1991; Herremkohl, Herrenkohl, Toedter & Yanushefski, 1984)	Children are more likely to become school-age children who feel unloved, inadequate, angry, low self-esteem and aggressive.
Spurning (critizing mother being hostile and irritable) + **Corrupting**	**The Lehigh Longitudinal Study** (Herrenkohl, Egolf & Herrenkohl, 1997; Herrenkohl, Herrenkohl & Egolf, 1983; Herrenkohl, Herrenkohl, Egolf	Influence the level of assaultive behavior in adolescents.

(impeding child's performance)	& Wu, 1991; Herremkohl, Herrenkohl, Toedter & Yanushefski, 1984)	
Spurning (parental rejection) + **Denying Emotional Responsiveness** (lack of parent-child involvement and supervision)	**Lefkowitz, Eron, Walder and Huesmann (1977)**	The strongest predictors of aggression in both children and young adults.
	Loeber and Strouthamer-Loeber (1986)	The most powerful predictor of juvenile delinquency.
	Ney, Fug and Wickett (1994)	Appeared frequently in the combinations of abuse that tended to produce the most devastating outcomes. Negative effect on feelings and perspectives about enjoyment of living, purpose in life, prospects for future life and chance of having a happy marriage.

1.5.5 Longitudinal Research: Long-Term Effects of Psychological Maltreatment

PM produces both acute and long-term negative effects. Among the survivors of other kinds of maltreatment, PM is also the most destructive type in terms of its impact (Brassard et al., 1987; Garbarino et al., 1986), and its harm does indeed extend into adult life (Hart, Binggeli & Brassard, 1998). It increases the risk for psychiatric disorders in adulthood like anxiety, depression, obsessive-compulsive disorder, dissociation and suicidal ideation (Briere & Runtz, 1990), and it increases the likelihood of lifetime comorbid axis I disorders and personality disorders (Rorty et al., 1994), for instance, borderline personality disorder (Park, Imboden, Park, Hulse & Unger, 1992). Although many of the children's difficulties remit when they are removed from the abusive environment (Keiley, Howe, Dodge, Bates & Petit, 2001), a considerable number of children still show signs of dysfunction many years after the abuse has terminated (Iwaniec, 2000). Among the most important longitudinal studies are the *Minnesota Mother Child Interaction Project*, which followed form birth to adulthood the care and development of children; The *Lehigh Longitudinal Study*, and the *Cambridge-Somerville Youth Study*, which is a 40-year investigation. Among long-term effects personality disorders are found in adulthood (Gibb, Wheeler, Alloy & Abramson, 2001; Grover et al., 2007).

1.5.6 The Circle of Risk

As a result of the fact that PM affects social and antisocial functioning and that PM effects also extends into adult life, the subject that has been abused is both more probable for being abused again, and also more probable to be abusive. Among interpersonal difficulties found of PM, it is frequent that the abused subject adopted insecure attachment styles owing to the child's cognitive and emotional capacity being insufficiently developed to cope with contradictory models of care generated by parents, who are a source of both protection and harm (Tomison & Tucci, 1997), and this disadaptative pattern of relationships is generalized to the relations with others (Doyle, 2001). The capacity of emotion management and stressful situations is affected (O'Hagan, 1995), and the abused child is more likely to select relationships and social situations which replicate and confirm the abusive experience (Bowlby, 1973) -more probable to be abused again- and there is also a limited capacity to empathize with others, difficulties in relationships with peers and partners and inappropriate parenting skills (Briggs & Hawkins, 1996) –more probable to abuse others. These difficulties appear to perpetuate the cycle of risk.

1.5.7 Psychological Maltreatment and Attachment

A relevant theoretical orientation about the relationship of PM and the attachment style was proposed by Binggeli et al. (2001). This theoretical approach states that, through their ongoing iterations with attachment figures, the children forms internal working models, or sets of expectations about their own roles and the roles of others in social interactions. For instance, ambivalent-resistant attachment (high level of stress at mother's departures and ambivalent behaviors toward her, alternatively seeking closeness, and angrily pushing her away when she returns) are associated with insensitive care characterized by withdrawal and uninvolvement (that fits the denying emotional responsiveness category of PM). The mother of the infants that have avoidant attachment (this child shows little stress when mother leaves and they avoid their mothers by looking away, ignoring her in the meeting), have been found to be insensitive to their infant's needs and to alternate between being rejected, neglected and interfering (behavior that fits the spurning, denying emotional responsiveness, and

exploiting/corrupting categories of PM). And, finally, the mother of the infant with the disorganized/disoriented attachment (diverse and contradictory behavior patterns and bizarre and stereotypic behavior) generally has been consistent for an extended period of time followed by a period of inconsistency, conditions that may, as a pattern, include spurning, terrorizing, isolating, and denying emotional responsiveness characteristics.

Morton and Browne (1998) review the literature on attachment and child maltreatment in relation to the intergenerational transmission of maltreatment, with a descriptive analysis of 13 studies. The majority of studies demonstrate that, on average, maltreated children are lees securely attached to their mothers than non maltreated children. They found that the primary process by which maltreatment continues from one generation to the next is that this early mother-infant relationship is internalized by the child and consequently forms a prototype of which all future relationships are assimilated. Thus, maltreated children may have problems forming relationships with peers, partners and their own children.

Baer and Martinez (2006), in a meta-analysis of eight studies about child maltreatment and insecure attachment, found that maltreated infants were significantly more likely to have an insecure attachment than were the controls, and different types of maltreatment affect the magnitude of the effect, and they conclude that child maltreatment is considered one of the most important causes of insecure/disorganized attachment.

Bailey, Moran and Pederson (2007) studied the relationship between childhood maltreatment, complex trauma symptoms and unresolved attachment in an at-risk sample of adolescent mothers. They found that childhood physical abuse, sexual abuse and general maltreatment were associated with unresolved attachment. And a sexual abuse history and general maltreatment predicted unresolved loss that adversely affected the integration of the other emotional and/or traumatic experiences.

Taussig and Culhane (2010) examined the impact of emotional maltreatment on the psychological functioning in a prospective design in a sample of maltreated children with a recent entry into out-of-home care. Findings show that some emotional maltreatment subtypes are positively associated with psychosocial problems. After controlling for other abuses, emotional maltreatment was associated with higher self-reported anxiety and post-traumatic stress symptoms, and less social acceptance, self-esteem and levels-of-life satisfaction. Riggs (2010) reviewed the theoretical and empirical literature regarding the normative development of the attachment system from

infancy through adulthood, and then discussed deviations from the normal developmental pathways that occur in response to emotionally abusive parenting. His theoretical models propose that early emotional abuse engenders insecure attachment, which impairs emotional regulation, fosters negative views of self and others that support maladaptive coping responses, interferes with social functioning and the capacity for intimate adult attachments, contributes to poor mental health and, consequently, shapes the quality of romantic relationships.

1.6 Vulnerability of Suffering Psychological Maltreatment

Previous research had studied the vulnerability of suffering PM. Previous research has found that there are three main groups of risk variables for suffering PM:

1.6.1 Family Factors

It has not been possible to identify a clear profile of the types of families that are particularly at risk for PM. While PM is found in a broad range of families, it is more prominent in families where stressors exceed supports and where risks are greater than protective factors (Belsky, 1993). Doyle (1997) found that a combination of multiple family variables was a better predictor of PM than any single family variable. However, it is important to point out that PM can also occur in families that are free of obvious stress and interpersonal problems.

PM has been associated with parents' own histories of maltreatment and experiences of less than optimal relationships with carers (Doyle, 2001; Iwaniec & Sneddon, 2001, 2002). The experience of emotional abuse affects the ability to cope with and manage stressful situations in the family home and with the development of insecure attachment and poor relationships with partners and children. In addition, parents who have been verbally abused as children have been found to be more likely to yell at their own children (Hemenway, Solnick & Carter, 1994) and to be more susceptible to employing emotionally abusive and neglectful behavior in response to crisis situations (Crittenden & Ainsworth, 1989). The quality of family relationships has also been linked to emotional abuse. Mothers classified as being psychologically abusive have been found to have less affectionate relationships with their husbands and parents and to report

greater levels of verbal and physical aggression (Lesnik-Oberstein, Koers & Cohen, 1995). On a related note, domestic violence is a feature of many families in which emotional abuse occurs (Cawson et al., 2000; Mitchell 2005; Mullender & Morley, 1994). As described earlier, exposure to family violence is increasingly believed to be emotionally abusive. Butler-Sloss (2001), for example, highlights a growing body of knowledge as to the short-term and long-term effects of domestic violence upon children's mental health and stability. Family breakdown is a further factor that has been linked to an increased potential for emotional abuse (Mitchell, 2005). It has been observed that children are at increased risk of suffering emotional harm if involved inappropriately in the divorce process and subsequent disputes regarding residence and contact arrangements with the non-custodial parent (Iwaniec, 2006). Additionally certain parental personality factors increases the risk for PM, like physical and mental illness, disability, learning difficulties, parental preoccupation, substance misuse, early parenthood, larger families (Chaffin, Kelleher & Hollenberg, 1996; Mitchell, 2005; Iwaniec, 2006; Thoburn et al., 2000) and emotional disturbances, aggression, hostility, lower self-esteem, social anxiety, less engagement in social activities, dysthymic symptoms, lower verbal reasoning and more illness (Lesnik-Oberstein et al., 1995).

1.6.2 Child Factors

Just as there appears to be no one type of family which is more vulnerable to emotional abuse, there appears to be no one type of child who is more likely to experience this form of maltreatment, in terms of age, gender, ordinal position in family, or health status. It is generally found that both boys and girls are equally vulnerable to experience psychological maltreatment (US Department of Health and Human Services, Children's Bureau, 2004). However, some research (e.g., Manion & Wilson, 1995) has indicated that girls report significantly more emotional abuse than do boys. It is now apparent that children with a wide variety of disabilities are several times more likely to have a history of maltreatment as are children without disabilities. Almost one-third of children with special needs have substantiated maltreatment, and it is extremely likely that many others have experienced unreported or un-sustained maltreatment.

Children with birth defects, premature babies, temperamentally difficult children and those with a physical or intellectual disability are disproportionately vulnerable to experience a type of care-giving which disregards their emotional and social

development. Reports exploring prevalence rates in child protection services indicate that children with registered disabilities are up to three times more likely to experience emotional abuse and neglect than are children without any registered impairments (e.g., Sullivan & Knutson, 2000). It is possible that these particular groups are more vulnerable to emotional abuse because of the greater potential for disruptions in the parent–infant bonding process and for greater parenting stress (Doyle, 1997; Tomison, 1996). Current research suggests three categories of relation between maltreatment and disability: a) maltreatments cause many disabilities, b) children with disabilities are more vulnerable to maltreatment and c) some other primary causal factors increase the risk for both violence and disability (like parental substance abuse, spousal abuse during pregnancy, poverty, disorganized parental behaviour, and a number of other factors) (Sobsey, 2002). It is also important to take into account the type of disability, because specific disabilities can lead to different types of victimization. A study of Turner, Vanderminden, Finkelhor, Hamby and Shattuck (2011), about associations between several different types of disability and past-year exposure to multiple forms of child victimization, has found that attention-deficit disorder/attention-deficit with hyperactivity disorder elevates the risk for peer victimization and property crime, internalizing psychological disorders increases the risk for both child maltreatment and sexual victimization, and developmental/learning disorders heighten risk only for property crime. In contrast, physical disability did not increase the risk for any type of victimization, once confounding factors and co-occurring disabilities were controlled. It appears that disabilities associated with interpersonal and behavioral difficulties are most strongly associated with victimization risks. Mental health problems in childhood and adolescence appear to represent important risk factors for increased victimization. High levels of co-occurring internalizing and externalizing symptoms were particularly likely to experience increased exposure to several forms of victimization, including peer victimization, maltreatment and sexual victimization, controlling for earlier victimization and adversity. The relationship of symptoms to victimization exposure differed across developmental stages. Elementary-school-age children with high levels of symptoms were especially vulnerable to victimization by peers, whereas distressed youth in early adolescence were particularly vulnerable to sexual victimization (Turner, Finkelhor & Ormrod, 2010a).

1.6.3 Environment and Community Factors

There are also some environmental variables that can increase the risk for PM, like neighborhood variables and life events. Sedlak (1997) suggested an increased risk for PM for children from lower-income families, or children whose race was described as ‘other’ (ethnic minorities). Further factors such as poverty and social exclusion may also increase the potential for emotionally abusive behavior (Chaffin et al., 1996; Iwaniec, 2006; Mitchell, 2005; Thoburn, Wilding & Watson, 2000).

Differential Outcomes of Psychological Maltreatment Subtypes

The first goal of this thesis is to study the differential adverse outcomes in mental health and the functioning of different types of PM in children of mothers suffering from IPV, and it was addressed through the paper *Differential Effects of Psychological Maltreatments on Children of Mothers Exposed to Intimate Partner Violence* published in *Child Abuse & Neglect*. Although previous research has studied negative outcomes of PM and also specific outcomes related to each subtype of PM, PM has not been specifically studied in relation to IPV. The study of this topic in this population is especially important because child PM and IPV are closely related phenomena, as previously explained in the Introduction.

The *hypothesis* is that different types of PM will lead to different outcomes in children living in a home where IPV exists. This information is relevant because it could enable us to identify the particular effects of each PM experience in this population and to develop specific interventions and treatments.

2.1 Paper: Differential Effects of Psychological Maltreatment on Children Exposed to Intimate Partner Violence

de la Vega, A., de la Osa, N., Ezpeleta, L., Granero, R., & Domènech, J. (2011). Differential effects of psychological maltreatment on children of mothers exposed to intimate partner violence. *Child Abuse & Neglect, 35*, 524-531. doi:10.1016/j.chiabu.2011.03.006

Country of Publication: EEUU

ISSN: 0145-2134

Editorial: PERGAMON-ELSEVIER SCIENCE LTD

Data Base: Social Science Citation Index

Area: Family Studies

Impact Index: 2.471

Ranking of the Journal in this area: 6

Total of Journals in this area: 39

Quartile: Q1

Child Abuse & Neglect 35 (2011) 524–531

Contents lists available at ScienceDirect

Child Abuse & Neglect

Differential effects of psychological maltreatment on children of mothers exposed to intimate partner violence☆

Ariadna de la Vega[a,b,*], Nuria de la Osa[a,b], Lourdes Ezpeleta[a,b], Roser Granero[a,c], Josep María Domènech[a,c]

[a] Unit of Epidemiology and Diagnosis in Developmental Psychopathology, Universitat Autònoma de Barcelona, Spain
[b] Department of Clinical and Health Psychology, Universitat Autònoma de Barcelona, Spain
[c] Department of Psychobiology and Methodology of Health Sciences, Universitat Autònoma de Barcelona, Spain

ARTICLE INFO

Article history:
Received 14 October 2009
Received in revised form 19 March 2011
Accepted 22 March 2011
Available online 6 August 2011

Keywords:
Children
Intimate partner violence
Psychological maltreatment

ABSTRACT

Objective: Psychological maltreatment (PM) is the most prevalent form of child abuse, and is the core component of most of what is considered as child maltreatment. The aim of this work was to explore differential adverse outcomes of the different types of PM in the mental health and functioning of children living in homes in which they are exposed to intimate partner violence (IPV).

Method: Participants were 168 children, aged between 4 and 17, whose mothers experienced IPV. They were assessed using different measures of psychopathology and functioning: Diagnostic Interview for Children and Adolescents-IV, Child Behavior Checklists and Child and Adolescent Functioning Assessment Scale. Furthermore, IPV was assessed with the Schedule for Assessment of Intimate Partner Violence Exposure in Children and the Index of Spouse Abuse. Statistical analyses were carried out with regression models adjusted by means of Generalized Estimating Equations.

Results: Spurning was the PM subtype with the greatest global effect on the children, as it was significantly associated with internalizing and externalizing problems. Denying emotional responsiveness specifically increased the risk of internalizing psychopathology and impairment in the emotional area. Terrorizing was not significantly associated with a greater number of negative outcomes in children's psychopathology or functioning in this population.

Implications: The results suggest the importance of taking PM types into account in order to fully understand the problems of children exposed to IPV at home, and for the design of effective treatment and prevention programs.

The Guidelines from the American Professional Society on the Abuse of Children (APSAC, 1995) state that psychological maltreatment involves a repeated pattern of caregiver behavior or extreme incident(s) that conveys to the child that s/he is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs. Major categories of Psychological Maltreatment (PM) considered are: spurning, terrorizing, exploiting or corrupting, denying emotional responsiveness, isolation and (mental health, medical, and educational) neglect (APSAC, 1995). The term PM has also been used to refer to the underlying destructive elements that connect all forms of abuse and neglect, and due

☆ This work was supported by grant SEJ2005-01786 and by a grant from the Research Training Program of the Ministry of Education and Science (Spain).
* Corresponding author at: Universitat Autònoma de Barcelona, Departament de Psicologia Clínica i de la Salut - Edifici B, 08193 Bellaterra (Barcelona), Spain.

to its importance, their study should not be considered as a supplementary topic to other forms of maltreatment but as the centerpiece of the efforts to understand family functioning and protect children (Garbarino, Guttmann, & Seeley, 1986).

PM is more prevalent than other forms of maltreatment (Brassard, Germain, & Hart, 1987; Garbarino et al., 1986). National Reports on Child Abuse in the US reported a prevalence of PM of 6.1% (National Center of Child Abuse & Neglect, 1997), though "isolated PM has had the lowest rate of substantiation of any type of maltreatment" (Kairys & Johnson, 2002, p. 2). In 1997, the National Committee to Prevent Child Abuse (NCPCA) confirmed 1,054,000 victims of child maltreatment. Of these confirmed cases only 4% represented specifically identified emotional maltreatment. These official statistics are widely considered to underestimate the true incidence of child maltreatment, and specifically psychological maltreatment, which is likely to be unreported unless it co-occurs with other forms of abuse or neglect (Binggeli, Hart, & Brassard, 2001).

PM is also the most destructive type in terms of its impact (Brassard et al., 1987; Garbarino et al., 1986), and its harm indeed extends into adult life (Hart, Binggeli, & Brassard, 1998). Brassard and Donovan (2006) reviewed 52 studies evaluating the effect of different subtypes of PM, finding negative outcomes in the cognitive/achievement, internalizing, externalizing, medical and social domains. Hart et al. (1998), in a review of 35 studies, found that PM had been involved in—and in some cases established as producing—29 types of negative developmental consequences. The negative outcomes of PM affect different areas: interpersonal thoughts, feelings and behaviors such as low mood, a feeling of hopelessness and low self-esteem (Brown, Cohen, Johnson, & Smailes, 1999; Kaufman, 1991); symptoms of emotional problems, such as substance abuse (Widom & White, 1997) or eating disorders (Hund & Espelage, 2006); social and antisocial functioning, such as illegal behavior (Widom & White, 1997); learning, such as academic (Oates, 1996) or learning and memory problems (Perry, 2001); and physical health, such as growth delay and failing to meet expected developmental milestones (Iwaniec, 2004). PM is also related to increased use of mental health services (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996).

Although many of the children's difficulties decrease when they are removed from the abusive environment (Keiley, Howe, Dodge, Bates, & Petit, 2001), a considerable number of children continue to show signs of dysfunction for many years after the abuse has ended (Yates & Wekerle, 2009); for instance, PM has been associated with personality disorders (Grover, 2007). Moreover, the abused individual is believed to be more likely to choose relationships and social situations which replicate and confirm the abusive experience, so that PM leads to a risk of suffering further abuse (Crawford & Wright, 2007). Adults with a childhood history of PM frequently display a limited capacity to empathize with others, difficulties in relationships with peers and partners and inadequate and often inappropriate parenting skills (Briggs & Hawkins, 1996). As a result, the risk cycle is perpetuated.

Some studies have also found specific outcomes related to each subtype of PM. Allen (2008) found that terrorizing children significantly led to somatic complaints and anxiety in early adulthood; depression was significantly predicted by the frequency of denying emotional responsiveness, and spurning led to features of Borderline Personality Disorder. In the Minnesota Mother Child Interaction Project (Egeland & Erikson, 1987), the outcomes of children of psychologically unavailable mothers were judged to be the most devastating. The Lehigh longitudinal study (Herrenkohl, Herrenkohl, Egolf, & Wu, 1991) found that threatening the child with punishment and physical abuse increased the likelihood of school-age children presenting low self-esteem and aggressive behavior). Loeber and Strouthamer-Loeber (1986) found that spurning and denying emotional responsiveness were some of the most powerful predictors of juvenile delinquency. Ney, Fung, and Wickett (1994) found that verbal abuse and emotional neglect appeared frequently in the combinations of abuse which tended to produce the most devastating outcomes. As a conclusion, different PM subtypes lead to different outcomes, affecting both psychopathology (anxiety, depression) and functioning areas; however, more research is necessary in this field.

Apart from PM outcomes in psychopathology, it is important to study the impact of PM subtypes on the different areas of child life functioning (school, community, mood, social area). Several researchers (Mannassis & Hood, 1998; Steinhausen, 1987) advocate the use of impairment measures in the diagnostic assessment. Functional impairment is defined as reduced functions caused by a psychological disorder. The symptoms assessment should not be included in the measure of damage, being rather an independent measure (Ezpeleta, Granero, & de la Osa, 1999).

Although previous research has studied outcomes related to each subtype of PM, PM has not been specifically studied in relation to IPV. The study of this topic in this population is especially important because child PM and IPV are closely related phenomena. For instance, the APSAC includes "witnessing IPV" as an example of the PM subtype "Corrupting", and The American Academy of Pediatrics (AAP, 2002) adds to the APSAC definitions "unreliable or inconsistent parenting" and "witnessing IPV" as actual types of PM. The Queen Sofia Center for the Study of Violence in Spain (2007) reported an increase up to 0.84/^{000} in the prevalence of children who are victims of family violence, revealing an rise of 133.33% between 2001 and 2005. The cumulative incidence increased to 146.29% during the same period of time. Children exposed to IPV are also more likely to suffer from other forms of maltreatment (Appel & Holden, 1998; Osofsky, 1999). Therefore, in order to treat exposed children correctly it is important to know to what other forms of PM they have been exposed.

In this framework the goal was to study the different adverse outcomes in mental health and functioning of different types of PM in children of mothers suffering IPV. Our hypothesis is that different types of PM will lead to different outcomes in children living in a home where IPV exists. This information could enable us to identify the particular effects of each PM experience in this population and to develop more specific interventions and treatments.

Table 1
Sample characteristics.

	Total (N = 168)	Terrorizing		Spurning		Denying emotional responsiveness	
		Yes (N = 64) 38.1%	No (N = 104) 61.9%	Yes (N = 46) 27.4%	No (N = 122) 72.6%	Yes (N = 60) 35.7%	No (N = 108) 64.3%
Child age; mean (SD)	8.5 (3.5)	9.3 (3.7)	8.0 (3.2)	10.1 (3.7)	7.9 (3.3)	8.4 (3.5)	8.6 (3.5)
Years of exposure to IPV; mean (SD)	7.7 (9.2)	9.1 (10.7)	6.9 (8.1)	10.2 (12.2)	6.8 (7.6)	8.2 (12.5)	7.5 (6.7)
SES (%)[a]							
High/medium-high	22.7	14.5	27.7	22.7	22.7	28.1	19.8
Medium/medium-low	50.9	59.7	45.5	50.0	51.3	50.9	50.9
Low	26.4	25.8	26.7	27.3	26.1	21.1	29.2
Sex male (%)	60.7	65.6	57.7	71.1	56.6	65.3	59.3
Other forms of maltreatment (%)[b]	25.0	46.9	11.5	58.7	12.3	36.7	18.5

SD: statistical deviation.
[a] Socio-economic status (Hollingshead, 1975).
[b] Physical, sexual maltreatment or neglect.

Method

Participants

One hundred and thirty one mothers attending a Gender Violence Center for women in the area of Barcelona were invited to participate with their children in this research. One hundred and sixteen mothers and 168 children aged 4–17 accepted. The admission criteria were having been exposed to IPV at least in the last year.

No differences emerged in the children for sex (p = .944), age (p = .777), ethnicity (p = .070) or socioeconomic status (SES; Hollingshead, 1975; p = 133) in the comparison between participants and refusals. The mothers' mean Index of Spouse Abuse (Hudson & Rau, 1981) scores were also similar for participants and non-participants (p = .115 for physical abuse scale, and p = .817 for non-physical abuse scale). Table 1 shows the socio-demographic features and characteristics for the sample.

Measures

Schedule for the Assessment of Intimate Partner Violence Exposure in Children (SAIPVEC) (Unit of Epidemiology and Diagnosis in Developmental Psychopathology, 2005): The different types of PM suffered by children were assessed using this instrument, created ad hoc based on Holden (2003). It is a rating scale with an interview format, and collects information from the mother about the degree of the child's exposure to IPV, the type and degree of aggression against the mother, the age of the child when the maltreatment began, and the type of maltreatment the child has suffered (physical abuse, sexual abuse, and the APSAC subtypes of psychological maltreatment). In 93% of the cases the aggressor was the biological father of the child, in 3.5% it was the stepfather, and in 3.5% it was the mother's male partner. The types of child maltreatment are assessed with 8 dichotomous items, and each type is defined in the schedule: (a) Terrorizing, meaning behavior such as threatening to injure, kill, or abandon the child or someone he/she cares about (or his/her pets), and seeing or hearing traumatic or violent episodes between their parents; (b) Corrupting, that is, allowing or encouraging antisocial or inappropriate behavior, misogyny, violent behavior, verbal or physical aggression, or substance abuse; (c) Spurning, including rejecting, scorning, ridiculing, or criticizing the child; (d) Denying emotional responsiveness, that is, ignoring the emotional needs of the child and his/her attempts to interact, or not showing positive emotions towards the child, not getting involved or being unable to display affection; (e) Isolation is described as unreasonably restricting contact with other children, not providing opportunities for socialization; and (f) Neglect is a lack of attention to the physical and educational needs of the child. Children from the sample could be simultaneously exposed to more than one subtype of PM. Neglect has not been studied as one of the types of PM because the APSAC Guidelines define neglect as mental health, medical and educational neglect, and the focus of interest in this study was strictly psychological maltreatment. Some authors also place neglect in a category separate from PM, for instance in the Consortium for Longitudinal Studies of Child Abuse and Neglect classification (English & LONGSCAN Investigators, 1997), or the Childhood Experience of Care and Abuse instrument (Moran, Bifulco, Ball, Jacobs, & Benaim, 2002). However mental health, medical and educational neglect have been included in the analyses as a control variable, and of course psychological neglect has been included as psychological maltreatment, since Denying Emotional Responsiveness is considered.

From the information obtained from mothers, the clinician working at the Gender Violence Center, who is handling that case and is acquainted with the particular problems of each family, asked and rated whether or not the child received each type of abuse. The internal consistency is good (Cronbach's alpha of 0.70 in the section used for this study) and it has good convergent validity with other standardized instruments (Ezpeleta et al., 2007 May).

The Diagnostic Interview for Children and Adolescents-IV (DICA-IV) (Reich, 2000), a semi-structured diagnostic interview that covers the most common DSM-IV (American Psychiatric Association, 1994) diagnostic categories in children and

adolescents, was used to assess child psychopathology. There are 4 versions: 1 for children aged 8–12, 1 for adolescents aged 13–17, and 2 for parents (1 regarding children aged 8–17, and another regarding children aged 4–7). It was adapted and validated for the Spanish population with satisfactory psychometric properties (Ezpeleta, de la Osa, Domènech, Navarro, & Losilla, 1997). The agreement obtained between interviewers was good to excellent (kappa values of between 0.65 and 1) (Ezpeleta, de la Osa, Domènech, 1997; Ezpeleta, de la Osa, Júdez, Domènech, Navarro, & Losilla, 1997). The interview was carried out by trained psychologists. Diagnoses were derived, where applicable, combining the information from the mothers and the children. Different psychologists interviewed the mother and the child separately. A symptom was considered to be present if any of the 2 informants reported it positively. For children aged 4–7, the information was obtained from the mothers only.

Child Behavior Checklists (CBCL) (Achenbach & Rescorla, 2000, 2001), were used as dimensional measures of psychopathology. The CBCL is a scale with 3 response options, and covers a wide range of emotional and behavioral problems in children and adolescents. The CBCL/1½–5, for ages 1½ to 5, has 100 items, and the CBCL/6–18, for ages 6–18, has 113 items. Both questionnaires were completed by the mother. As the number of items included on each scale is not the same in each version of the instrument, typical scores (*T*) were used for analyzing scales common to the 2 versions. Scales specific to each version were analyzed separately using *T*-scores.

The Child and Adolescent Functioning Assessment Scale (CAFAS/PECFAS) (Hodges, 1997, 1999a) was used to assess functional impairment in children aged over 7 in 8 different areas: performance at school, home, community, behavior towards others, mood/emotions, self-harming behavior, substance use, and cognition. The PECFAS (Hodges, 1999a) is the version used with children aged 3–7 years, the information being provided by mothers. The PECFAS scales are the same as those of the CAFAS, except for the fact that substance abuse is not included in the pre-school version. The scores for each scale indicate 4 levels of impairment (0 no impairment, 10 mild, 20 moderate, and 30 severe impairment). The instrument also provides a total score, which is the sum of the sub-scales. It can be used with children aged 8–17 and their parents. The score reflects the clinician's appraisal of the information from mothers and children obtained in the interview. The trained psychologist that carried out the interview rated the CAFAS/PECFAS. In this study the impairment was defined by choosing the most dysfunctional score of the child or the mother on each scale. Due to the fact that the original ordinal distribution of CAFAS/PECFAS scores was highly asymmetrical, making their analysis difficult, scores were dichotomized into 0 (no impairment) versus 10-20-30 (any impairment). The psychometric properties are good in the original version of the instrument (Hodges, 1999b) and also in the Spanish population (Ezpeleta, Granero, de la Osa, Domènech, & Bonillo, 2006).

Procedure

This study was approved by the Ethics Review Board of the author's university. Women whose children had been exposed to IPV during the last year were informed and invited to participate in the research. Informed written consent to participate was obtained from the mothers, and oral consent from the children. Confidentiality was guaranteed.

The SAIPVEC was completed by a trained clinical psychologist when the women arrived at the Gender Violence Center. The DICA interview, which lasts approximately 1 h, was carried out by trained personnel, simultaneously and separately with mothers and children (older than 8). After the interviews, the interviewers filled out the CAFAS/PECFAS. Lastly, the mothers filled out the CBCL questionnaire. After their participation, the women received an oral report about the mental health of their children and the possible need for referral to treatment.

Statistical analysis

The statistical analysis was carried out with SPSS 15 for Windows. Two APSAC PM subtypes were excluded from the analysis: isolation, due to the low prevalence (4.8%), and corrupting because it was constant for all participants, given that all the children were exposed to IPV. Terrorizing was not a constant because not all those in the sample witnessed traumatic or violent episodes. Different analyses evaluated the effect of the 3 different types of PM (independent variables of this study, with binary format: present–absent) on children's functional impairment and psychopathology (dependent variables).

This research refers to a nested structure data (some siblings had the same parents), but a low level of hierarchy was observed (58% of families had only 1 child, 38% had 2 children and 4% had 3 children; mean number of children per family was 1.47), so that multi-level models were inadequate because they did not allow a satisfactory adjustment (Hox, 2002). To account for data dependency at the lower data level and prevent possible estimation bias, the random factor "family" was included in multiple mixed models using Generalized Estimating Equations (GEE procedure in SPSS system). Family is considered a random factor in the GEE models because our study includes children belonging to different families. The point of this study is to generalize the results for all the families of the larger population of families exposed to domestic violence, and to consider the specific families included in the research as a random sample of that population. These models were adjusted in accordance with the Binomial distribution and the Logit link-function for binary criteria, with the Normal distribution and the Identity link-function for quantitative outcomes and with the Negative-Binomial distribution and Log link-function for counting criteria such as number of DSM-IV disorders. The models' overall predictive capacity was assessed using Nagelkerke's *R*-square for binary responses and adjusted *R*-squared for metric criteria.

Table 2
Effect of different types of psychological maltreatment on DSM-IV diagnoses.

	Terrorizing			Spurning			Denying emotional responsiveness			Percentage in total sample
	Percentages		OR	Percentages		OR	Percentages		OR	
	Yes	No		Yes	No		Yes	No		
Any DSM disorder	84.4	71.2	1.69	82.6	73.8	1.05	78.3	75.0	1.09	76.2
Disruptive behavior disorders	42.2	37.5	0.77	45.7	36.9	0.99	35.0	41.7	0.57	39.3
Mood disorders	31.1	17.3	0.31	47.8	13.1	9.99*	35.0	15.7	3.40	22.6
Major depression	26.6	10.6	0.68	39.1	8.2	7.67	30.0	9.3	7.11*	16.7
Anxiety disorders	62.5	43.3	1.66	63.0	45.9	1.35	61.7	44.4	1.61	50.6
Elimination disorders	20.3	12.5	1.64	19.6	13.9	0.54	18.3	13.9	1.10	15.5

	Terrorizing			Spurning			Denying emotional responsiveness			Percentage in total sample
	Means		MD	Means		MD	Means		MD	
	Yes	No		Yes	No		Yes	No		
N DSM disorders	2.83	2.48	0.35	3.26	2.05	1.21*	2.88	2.43	0.46	2.24
N Externalizing	10.4	10.5	0.13	12.8	8.14	4.64*	9.34	11.6	2.24	9.83
N Internalizing	19.9	17.5	2.36	21.5	15.9	5.56*	21.8	15.6	6.18*	16.0
N Total symptoms	30.3	28.0	2.23	34.3	24.1	10.2*	31.1	27.2	3.94	25.8

MD: mean differences.
* Significant OR (0.05, with Bonferroni–Finner correction). All the comparisons (OR coefficients and mean differences) were adjusted according to sex, age, other comorbid disorders, type, severity and duration of exposure to IPV, and other forms of maltreatment.

In order to obtain the adjusted contribution of each abuse subtype, all PMs were simultaneously entered into GEE models (ENTER procedure). All the regressions were adjusted according to the children's sex and age, the number of comorbid disorders, the duration of exposure to IPV, the presence of other forms of maltreatment (physical abuse, sexual abuse or physical neglect), and type and severity of IPV. In view of the multiple comparisons in the study, Bonferroni–Finner's correction (Finner, 1993) was used to control type-I error through SPSS macros (Domènech, 2007), in order to avoid spurious results.

Results

The percentage of children subject to each of the PM types studied is shown in Table 1. Table also includes some descriptive data for the total sample and for each PM group; sex, age, socioeconomic level, duration of exposure to IPV, and percentage of children suffering from other types of maltreatment. Prevalence of the terrorizing PM was 28.1%, for spurning it was 27.4%, and for denying emotional responsiveness it was 35.7%.

DSM-IV diagnoses

Table 2 shows the percentage of children suffering each type of DSM disorder in the total sample and in subsamples according to each type of PM. The table also includes the adjusted OR to observe whether suffering from each type of PM compared to not experiencing it significantly increases the risk of each disorder. Spurning is associated with increases in Mood disorders (adjusted OR = 9.99). The results suggest that denying emotional responsiveness increases the risk of suffering from major depression (adjusted OR = 7.11).

Table 2 also shows the number of disorders and symptoms (on average) according to the subtype of PM. Children subject to spurning have on average one more DSM disorder, 4.6 externalizing symptoms, 5.6 internalizing symptoms and 10 total symptoms of DSM disorders than children who are not exposed to spurning. Children being Denied emotional responsiveness have on average 6.2 times as many internalizing symptoms as children not suffering from that type of PM.

Dimensional psychopathology (CBCL)

Table 3 shows the average score on each scale of the Achenbach questionnaires in both the total sample and according to PM subtypes. Children suffering from spurning present a significantly higher mean score (more pathology) for withdrawal, aggressive behavior, social problems and rule-breaking behavior, internalizing, externalizing and total CBCL scales. The results suggest that denying emotional responsiveness significantly increases CBCL withdrawal and internalizing problems scores. No significant differences were noted between children subject to terrorizing and those not subject to it on any CBC scale.

Table 3
Effect of different types of psychological maltreatment on CBCL results.

CBCL overall (*T*-scores)[a]	Terrorizing			Spurning			Denying emotional responsiveness			Scale mean in total sample
	Means		MD	Means		MD	Means		MD	
	Yes	No		Yes	No		Yes	No		
Anxiety-depression	75.0	77.3	2.33	74.4	78.0	3.58	74.9	77.5	2.60	64.3
Withdrawal	64.4	65.8	1.37	71.3	58.9	12.5*	68.9	61.3	7.65*	61.2
Somatic complains	63.2	64.3	1.10	66.4	61.1	5.35	65.9	61.5	4.41	61.5
Attention problems	63.6	59.5	4.04	64.4	58.7	5.64	64.1	59.0	5.14	59.1
Aggressive behavior	67.5	64.4	3.17	70.6	61.4	9.20*	66.4	65.5	0.96	63.3
Social problems[b]	60.6	58.9	1.66	63.8	55.7	8.11*	60.1	59.4	0.70	57.9
Thought problems[b]	60.3	62.3	1.95	65.2	57.4	7.81	61.3	61.3	0.01	59.4
Rule-breaking behavior[b]	60.2	59.7	0.51	66.1	53.9	12.2*	58.2	61.7	3.49	58.0
Internalizing	69.9	70.7	0.78	76.7	63.9	12.8*	75.2	65.5	9.69*	65.5
Externalizing	66.4	63.4	3.03	69.8	60.0	9.78*	65.0	64.8	0.23	62.3
Total CBC score	68.8	67.0	1.81	73.2	62.6	10.7*	70.6	65.2	5.45	64.1

MD: mean differences.
[a] CBCL 6–18 and CBCL 1–5 years old variables.
[b] Specific CBCL 6–18 years old variables.
* Significant difference (0.05, with Bonferroni–Finner correction). All the MD comparisons were adjusted according to sex, age, other comorbid disorders, type, severity and duration of exposure to IPV and other forms of maltreatment.

Table 4
Effects of different types of psychological maltreatment on functional impairment.

CAFAS/PECFAS[a]	Terrorizing			Spurning			Denying emotional responsiveness		
	Percentages (%)		OR	Percentages (%)		OR	Percentages (%)		OR
	Yes	No		Yes	No		Yes	No	
School	65.0	51.9	0.73	72.7	49.2	3.00	61.3	55.7	0.95
Home	70.3	70.9	0.93	63.0	73.6	0.73	64.4	74.1	0.59
Community	12.5	5.8	1.28	15.2	5.8	2.26	8.5	8.3	0.38
Behavior towards others	56.3	43.7	1.43	60.9	43.8	1.45	57.6	43.5	1.66
Mood/emotions	87.5	68.0	2.40	82.6	72.7	0.82	86.4	69.4	4.58*
Self-harm	15.6	8.7	1.31	23.9	6.6	4.77	13.6	10.2	0.742
Thinking/communication	12.5	10.7	1.19	10.9	11.6	0.70	11.9	11.1	1.02

[a] Binary scale 0: minimum/1: low – moderate – severe impairment.
* Significant OR (0.05, with Bonferroni–Finner correction). All the comparisons (OR coefficients and mean differences) were adjusted according to sex, age, duration of exposure to IPV, other forms of maltreatment and type and severity of IPV.

Functional impairment

Table 4 shows the percentage of patients showing impairment in each area depending on the PM type. The results suggest that denying emotional responsiveness is significantly associated with functional impairment because increases the risk of functional impairment in the emotional area by a factor of four, according to the information from the CAFAS.

Discussion

According to our hypothesis, the results show that there are some differences in the influence of different types of PM on children's psychopathology and functioning. The subtype with the most negative outcomes is spurning, since it is related to both internalizing and externalizing psychopathology. A possible explanation for such a global effect is that this type of abuse affects one's self-perception. A significantly higher CBCL score on the scale of withdrawal/depression in children who suffer from spurning could be related to the fact that this form of PM directly affects self-esteem due to the criticism and scorn the child suffers, and through withdrawal the child would avoid the feeling of being exposed to such treatment. This scale also assesses aspects such as lack of amusement, preferring to be alone, refusing to speak, shyness, lack of energy, and feeling sad and isolated. Other authors have already found a relationship between psychological abuse and low mood, hopelessness and low self-esteem (Brown et al., 1999; Kaufman, 1991). Regarding externalizing problems, in the same way that Loeber and Strouthamer-Loeber (1986) found that spurning is related to juvenile delinquency, we found spurning to be related to aggressive and rule-breaking behavior and to social problems. This may be because when a person is "put down" it can create hostility. Other studies have found that emotional abuse in early childhood is associated with high levels of aggression and social withdrawal (Shaffer, Yattes, & Egeland, 2009).

The PM subtype denying emotional responsiveness was related to internalizing psychopathology (major depression, CBCL internalizing scales, and mood/emotion area in CAFAS/PECFAS). This effect on mood could be explained by the fact that this type of abuse involves a lack of emotional support. Other studies have found that depression is related to a lack of psychosocial resources and social support (Allen, 2008; Bifulco, Brown, & Harris, 1987) and to the absence of parents in childhood and lack of adequate parental care (Zunzunegui, LlácerCentro, & Béland, 2002). As Ney et al. (1994) found, spurning (verbal abuse) and denying emotional responsiveness tend to produce the most devastating outcomes. In the present study these are the PM subtypes with worst outcomes.

The PM subtype with least effect in this sample seems to be terrorizing, as it is the only one not related to a significantly greater number of negative outcomes compared to those who do not suffer from terrorizing. These results are different from those found by Allen (2008). We should take into account that in this sample all the children are subject to at least one other type of maltreatment (corrupting, as they are exposed to IPV), so that the results could mean that children exposed to terrorizing do not have significantly poorer outcomes than children not exposed to it, but they may have poorer outcomes than children from the general population, as opposed to a population of children whose mothers have been exposed to IPV. Another possible explanation is that fear of being physically hurt seems to have fewer consequences in psychopathology and functioning than other PM subtypes such as spurning, in which one's psychological integrity is threatened (as it concerns self-concept), and this is precisely when the effects are more adverse and global. Other authors have also found that PM has a more destructive impact than other forms of maltreatment (Brassard et al., 1987; Garbarino et al., 1986).

These results suggest the importance of taking into account the different types of PM, as this could help produce specific prevention and treatment solutions. Regarding prevention, the presence of other types of PM apart from those involving the witnessing of IPV should also be systematically assessed. It is necessary to take into account the psychopathology that is associated with each specific type of PM in order to prevent these disorders, through the introduction, for example, of programs to improve self-esteem, or anger management programs for children subject to spurning.

In general, psychopathological differences are greater if we assess them dimensionally (CBC scales) rather than by the number of DSM disorders (quantitative vs. dichotomy assessment). This implies that the effects of PM are not noticed as much in the increased risk of a particular mental disorder (dichotomous measures) as they are in dimensional measurements (averages on different scales that assess areas of psychopathology). It is important to take this into account in order to improve the assessment of the negative outcomes of PM. Other studies found a preference for dimensional assessments because the associations of predictors with psychological distress syndromes are most accurately dealt with through the use of dimensional measures (Kessler, 2002).

On interpreting the results, some limitations should be taken into account. The results can only be generalized and applied to children of mothers seeking help due to having been exposed to IPV. Another limitation is that the size of the sample of some PM subtypes such as isolation rendered it impossible to include them in the analysis. Furthermore, models for some disorders could not be considered due to the low prevalence of response in the sample, as is the case for Eating Disorders or some preschool-age disorders. Other limitations include the wide age range (4–17 years); the outcomes of PM may differ across age ranges, though age was an adjusted variable in this study. Therefore, in future research it would be interesting to study the differential impact of PM at different ages. Also, the perpetrator in our study was always the father, and it would be advantageous to explore the outcomes when mothers are also engaged in the PM and whether there is a sex of parent by sex of child interaction. In this paper, corruption was used as a constant, this type of PM being applied to all IPV-environment participants, but the possibility cannot be ruled out that they have differentially experienced some of the non-IPV components of corruption (such as parents' substance abuse and others negative models). Finally, as far as the limitations are concerned, there is room for more comparison between suffering PM in IPV environments and experiencing it in non-IPV environments.

Despite these limitations, this research has important clinical applications as regards the process of assessing children living in circumstances of IPV. The use of this instrument constitutes one of the first systematic approaches to the assessment of PM types in IPV. We have provided evidence in support of the need to consider different types of PM on assessing children exposed to IPV. As we mentioned, IPV and child PM are very closely related. There is a need to replicate these results in other populations and to study risk variables that lead to children suffering from the different types of PM, as well as the cumulative risk involved of each one of them.

References

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA preschool-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth & Families.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth & Families.

Allen, B. (2008). An analysis of the impact of diverse forms of childhood psychological maltreatment on emotional adjustment in early adulthood. *Child Maltreatment, 13*, 307–312.

American Academy of Pediatrics (AAP). (2002). The psychological maltreatment of children. Technical report. *Pediatrics, 109*, 1–3.

American Professional Society on the Abuse of Children (APSAC). (1995). Psychosocial evaluation of suspected psychological maltreatment in children and adolescents. *Cultic Studies Journal, 13*, 153–170.

American Psychiatric Association. (1994). *DSM-IV diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal Family Psychology, 12*, 578–599.

Bifulco, A. T., Brown, G. W., & Harris, T. O. (1987). Childhood loss of parents, lack of adequate parental care and adult depression: A replication. *Journal of Affective Disorders, 12*, 115–128.

Binggeli, N. J., Hart, S. N., & Brassard, M. R. (2001). *Psychological maltreatment of children. The APSAC study guides 4*. Thousand Oaks, California: Sage Publications.
Brassard, M. R., & Donovan, K. L. (2006). Defining psychological maltreatment. In M. M. Feerick, J. F. Knutson, P. K. Trickett, & S. M. Flanzer (Eds.), *Child abuse and neglect: Definitions, classifications, and a framework for research* (pp. 151–197). Baltimore, MD: Paul H. Brookes.
Brassard, M. R., Germain, R., & Hart, S. N. (1987). *Psychological maltreatment of children and youth*. New York: Pergamon.
Briggs, F., & Hawkins, R. M. F. (1996). *Child protection: A guide for teachers and child care professionals*. St Leonards, NSW: Allen & Unwin.
Brown, J., Cohen, P., Johnson, J. G., & Smailes, E. M. (1999). Childhood abuse and neglect: Specificity of effects on adolescent and young adult depression and suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 1490–1496.
Crawford, E., & Wright, M. (2007). The impact of childhood psychological maltreatment on interpersonal schemas and subsequent experiences of relationship aggression. *Journal of Emotional Abuse, 7*, 93–116.
Domènech, J. M. (2007). *SPSS Macro !BONFE. Bonferroni procedures for multiple significance test (V2007.02.19) [Computer software]*. Bellaterra: Universitat Autònoma de Barcelona. Available from: http://www.metodo.uab.cat/macros.htm
Egeland, B., & Erikson, M. (1987). Psychological unavailable caregiving. In M. R. Brassard, R. Germanin, & S. N. Hart (Eds.), *Psychological maltreatment of children and youth* (pp. 110–120). New York: Pergamon.
English, D. J., & LONGSCAN Investigators. (1997). *Modified maltreatment classification system (MMCS)*.
Ezpeleta, L., de la Osa, N., Domènech, J. M., Navarro, J. M., & Losilla, J. M. (1997). Fiabilidad test–retest de la adaptación española de la diagnostic interview for children and adolescents – DICA-R. *Psicothema, 9*, 529–539.
Ezpeleta, L., de la Osa, N., Júdez, J., Domènech, J. M., Navarro, J. B., & Losilla, J. M. (1997). Diagnostic agreement between clinician and the diagnostic interview for children and adolescents – DICA-R in a Spanish outpatient sample. *Journal of Child Psychology and Psychiatry, 38*, 431–440.
Ezpeleta, L., de la Osa, N., Tarragona, M. J., Granero, R., Olaya, B., & Domènech, J. M. (2007 May). Domestic violence exposure profiles and risk of psychopathology in children. Individual invited paper on the symposium psychological assessment of domestic violence. In *9th European conference on psychological assessment* Thessaloniki, Grecia.
Ezpeleta, L., Granero, R., & de la Osa, N. (1999). Evaluación del deterioro en niños y adolescentes a través de la children's global assessment scale (CGAS). *Revista De Psiquiatría Infanto-Juvenil, 1*, 18–26.
Ezpeleta, L., Granero, R., de la Osa, N., Domènech, J. M., & Bonillo, A. (2006). Assessment of functional impairment in Spanish children. *Applied Psychology, An International Review, 55*, 130–143.
Finner, H. (1993). On a monotonicity problem in step-down multiple test procedures. *Journal of the American Statistical Association, 88*, 920–923.
Garbarino, J., Guttmann, E., & Seeley, J. W. (1986). *The psychologically battered child: Strategies for identification, assessment, and intervention*. San Francisco, CA: Jossey-Bass, Inc.
Garland, A. F., Landsverk, J. L., Hough, R. L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20*(8), 675–688.
Grover, K. E. (2007). The relationship between childhood abuse and adult personality disorder symptoms. *Journal of Personality Disorders, 21*, 442–447.
Hart, S. N., Binggeli, N. J., & Brassard, M. R. (1998). Evidence of the effects of psychological maltreatment. *Journal of Emotional Abuse, 1*, 27–58.
Herrenkohl, R. C., Herrenkohl, E. C., Egolf, V., & Wu, P. (1991). The developmental consequences of child abuse: The Lehigh longitudinal study. In R. H. Starr, & D. A. Wolfe (Eds.), *The effects of child abuse and neglect: Issues and research* (pp. 55–80). New York: Guilford.
Hodges, K. (1997). *CAFAS manual for training coordinators, clinical administrators and data managers*. Ann Arbor, MI: Author.
Hodges, K. (1999a). *PECFAS self-training manual and blank scoring form*. Ann Arbor, MI: Author.
Hodges, K. (1999b). Child and adolescent functional assessment scale. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment* (pp. 631–664). Mahwah, NJ: Lawrence Erlbaum Associates.
Holden, G. W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical Child and Family Psychology Review, 6*, 151–160.

Hollingshead, A. B. (1975). *Four factor index of social status*. New Haven, CT: Yale University, Department of Sociology., unpublished manuscript.
Hox, J. J. (2002). *Multilevel Analysis, Techniques and Applications*. Mahwah, NJ: Erlbaum.
Hudson, W., & Rau, S. (1981). The assessment of spouse abuse: Two quantifiable dimensions. *Journal of Marriage and the Family, 43*, 883–885.
Hund, A. R., & Espelage, D. L. (2006). Childhood emotional abuse and disordered eating among undergraduate females: Mediating influence of alexithymia and distress. *Child Abuse & Neglect, 30*, 393–407.
Iwaniec, D. (2004). *Children who fail to thrive: A practical guide*. Chichester: John Wiley & Sons.
Kairys, S. W., & Johnson, C. F. (2002). Committee on child abuse and neglect: The psychological maltreatment of children-technical report. *Pediatrics, 109*, 68–70, 26 July 2006.
Kaufman, J. (1991). Depressive disorders in maltreated children. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*, 257–265.
Keiley, M. K., Howe, T. R., Dodge, K. A., Bates, J. E., & Petit, G. S. (2001). The timing of child physical maltreatment: A cross-domain growth analysis of impact on adolescent externalizing and internalizing problems. *Development and Psychopathology, 13*, 912–981.
Kessler, R. C. (2002). The categorical versus dimensional assessment controversy in the sociology of mental illness. *Journal of Health and Social Behavior, 43*, 171–188.
Loeber, R., & Strouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency. In M. Tonry, & N. Morrys (Eds.), *Crime and justice. An annual review of the research* (pp. 29–149). Chicago: University of Chicago Press.
Mannassis, K., & Hood, J. (1998). Individual and familiar predictors of impairment in childhood anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 428–434.
Moran, P., Bifulco, A., Ball, C., Jacobs, C., & Benaim, K. (2002). Exploring psychological abuse in childhood. I. Developing a new interview scale. *Bulletin of the Menninger Clinic, 66*, 213–240.
National Center of Child Abuse and Neglect. (1997). *Child maltreatment*. Washington: National Center of Child Abuse and Neglect.
Ney, P. G., Fung, T., & Wickertt, A. R. (1994). The worst combinations of child abuse and neglect. *Child Abuse & Neglect, 18*, 705–714.
Oates, R. K. (1996). *The spectrum of child abuse: Assessment, treatment, and prevention*. New York: Brunner/Mazel Inc.
Osofsky, J. D. (1999). The impact of violence on children. *The Future of Children, 9*, 33–49.
Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. In D. Schetky, & E. Benedek (Eds.), *Textbook of child and adolescent forensic psychiatry* (pp. 221–238). Washington, DC: American Psychiatric Press.
Queen Sofia Center for the Study of Violence. (2007). *Menores víctimas de violencia en el ámbito familiar*. http://www.centroreinasofia.es/paneldecontrol/est/pdf/EST009-3270.pdf
Reich, W. (2000). Diagnostic interview for children and adolescents (DICA). *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 59–66.
Shaffer, A., Yattes, T. M., & Egeland, B. R. (2009). The relation of emotional maltreatment to early adolescent competence: Developmental processes in a prospective study. *Child Abuse & Neglect, 33*, 36–44.
Steinhausen, H. C. (1987). Global assessment of child psychopathology. *Journal of American Academy of Child Adolescent Psychiatry, 26*, 203–206.
Unit of Epidemiology and Diagnostic in Developmental Psychopathology. (2005). *Schedule for the assessment of intimate partner violence exposure in children (SAIPVEC)*. Unpublished manuscript.
Widom, C. S., & White, H. R. (1997). Problem behaviours in abused and neglected children grown up: Prevalence and co-occurrence of substance abuse, crime and violence. *Criminal Behaviour and Mental Health, 7*, 287–310.
Yates, T. M., & Wekerle, C. (2009). The long-term consequences of childhood emotional maltreatment on development: (mal)adaptation in adolescence and young adulthood. *Child Abuse & Neglect, 33*, 19–21.
Zunzunegui, M. V., Llácer-Centro, A., & Béland, F. (2002). The role of social and psychological resources in the evolution of depression in caregivers. *Canadian Journal on Aging, 21*, 357–369.

Accumulative Risk of Psychological Maltreatment Subtypes

The second goal of this thesis is to study the *accumulative risk* of the different types of PM in the mental health and functioning of children exposed to IPV and it is addressed to the paper *Severity of Psychological Maltreatments and Accumulative Risk for Psychopathology in Children of Mothers Exposed to Intimate Partner Violence* accepted in the *Journal of Family Violence*. Little research about this topic has been carried out in this IPV population.

In accordance with the evidence from research carried out in different populations, the *hypothesis* is that suffering a greater number of PM types will increase the negative consequences for the psychopathology and functioning of children living in an IPV context. Studying the relationships between the number of PM subtypes and the risk for psychopathology has relevant clinical applications for the prevention of the appearance of different PM subtypes and the detection and treatment of populations at risk.

3.1 Paper: Severity of Psychological Maltreatments and Accumulative Risk for Psychopathology in Children of Mothers Exposed to Intimate Partner Violence

de la Vega, A., de la Osa, N., Ezpeleta, L. & Granero, R. (2012). Severity of Psychological Maltreatment and Accumulative Risk for Psychopathology in Children of Mother Exposed to Intimate Partner Violence. *Journal of Family Violence.* In press.

Country: EEUU

Editorial: SPRINGER/PLENUM PUBLISHERS

ISSN: 0885-7482

Data Base: ISI Web of Knowledge

Area: Family Studies

Impact Index: 1.167

Ranking of the Journal in this area: 16

Total of Journal in this area: 38

Quartile: Q2

Abstract

Psychological maltreatment (PM) is an extremely heterogeneous phenomenon that includes several subtypes. The aim of this work is to explore whether the accumulation of different subtypes of PM has a greater impact on the child's psychopathology and functional impairment. One hundred and sixty-eight children and adolescents aged between 4 and 17 whose mothers had been exposed to intimate partner violence (IPV) participated. Psychopathology was assessed through a rating scale and a diagnostic interview. Polynomial contrasts by means of Generalized Estimated Equations explored linear and quadratic trends. The greater the number of PM subtypes suffered by children, the greater the adverse effects in psychopathology and functioning. The number of DSM disorders doubles from suffering one PM subtype to suffering four. Each type of PM matters. Linear trends were mainly found in internalizing problems. The importance of accurately assessing characteristics and severity of PM, and design efficient programs of prevention and treatment, is highlighted.

Keywords: accumulative risk, children, intimate partner violence, psychological maltreatment.

Severity of Psychological Maltreatment and Accumulative Risk for Psychopathology in Children of Mothers Exposed to Intimate Partner Violence.

The American Professional Society on the Abuse of Children guidelines (APSAC; 1995) states that psychological maltreatment (PM) involves a repeated pattern of caregiver behavior or a serious incident which transmits to the child that s/he is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs. PM has also been conceptualized and proposed as the core component of all forms of child abuse and neglect (Garbarino, Guttmann, & Seeley, 1986). This perspective is supported by the facts that: (a) PM is embedded in nearly all other acts of abuse and neglect as the psychological meaning of those acts; (b) it appears to be the strongest predictor of the impact of child maltreatment; and (c) PM may have the longest-lasting and strongest negative effects on survivors of child abuse and neglect (Binggeli, Hart, & Brassard, 2001). PM is an extremely heterogeneous phenomenon, occurring in a wide variety of contexts. No two cases of PM will contain exactly the same elements, and many will be quite different from one another (Binggeli et al., 2001).

The APSAC (1995) proposes 6 PM subtypes: *spurning, terrorizing, exploiting or corrupting, denying emotional responsiveness, isolation* and *neglect*. Several studies have found that different forms of PM lead to different outcomes. For instance, *spurning* has been related to negative outcomes such as an angry and non-compliant behavior, negative emotion, lack of impulse control, hyperactivity and distractibility, difficulties in learning and solving problems, lack of enthusiasm and persistence, and low creativity (Egeland & Erikson, 1987), and also predicted features of borderline personality disorder (Allen, 2008). *Denying emotional responsiveness* has been judged the most devastating subtype, and can lead to anxious avoidant attachment, non-compliance, lack of impulse control, decline in competence from infancy through preschool years, low self-esteem, negative emotion, lack of enthusiasm, high dependence, self-abusive behavior, serious psychopathology (Egeland & Erikson, 1987), depression and borderline personality disorder features (Allen, 2008). *Terrorizing* significantly predicted somatic complains and anxiety in early adulthood (Allen, 2008). A high rate of co-occurrence among various forms of maltreatment is observed (Dong et al., 2004; Knutson, DeGarmo, Koeppl, & Reid, 2005), which results in multiplicative effects between the number of different maltreatments and developmental consequences in the child.

Furthermore, experiences of PM are likely to increase the effect of other types of abuse or neglect, as proposed by Hart (1992). A revision of the second Canadian Incidence Study found that cases of co-occurrence of maltreatment present more negative effect, and more risk factors are observed (e.g., emotional harm, alcohol abuse, housing problems, chronicity, and referral to other services) when substantiated psychological maltreatment are also observed (Chamberland, Fallon, Black, Trocmé, & Chabot, 2012). This idea is in line with the classic model of additive main effects proposed by Rutter (1985; 2006), according to which it is important to take into account the accumulated risk factors, given that the sum of the number of different types of maltreatment has poorer outcomes than each factor individually. Hahm, Lee, Ozonoff and Wert (2010) reported that experiencing different kinds of maltreatment during childhood led to an extensive range of risk behaviors in domains such as sexual risk behavior, delinquency and suicidality. Boxer and Terranova (2008) found an association between the number of different types of maltreatment and high psychopathology. Furthermore, some combinations of PM subtypes have poorer outcomes than others; for instance, the combination of *spurning* and *denying emotional responsiveness* frequently appeared in the combinations of abuse that tended to produce the most devastating outcomes (Loeber & Strouthamer-Loeber, 1986; Ney, Fung, & Wickertt, 1994).

The APSAC (1995) indicates that the number of subtypes suffered by the child is an indicator of the severity of the PM. Previous research has not focused on the multiplicative effects that different forms of PM might have in a risk population, such as that of children exposed to IPV. The study of this topic in this population is especially important, because PM of children and IPV are closely related phenomena (Appel & Holden, 1998; Osofsky, 1999). IPV is a feature of many families in which emotional abuse co-occurs (Butler-Sloss, 2001). The current trend is to consider exposure to IPV as a form of abuse, because witnessing an assault can terrify children and significantly alter their socialization (McGee & Wolfe, 1991). As defined in the APSAC, 'witnessing IPV' is a form of '*Corrupting'*. Given the high prevalence of children exposed to IPV, it is relevant to study the accumulative effect of suffering different types of maltreatment in this population.

Little research has been carried out in this population. *Spurning* has been the PM subtype with the greatest global effect on the children exposed to domestic violence, as it was significantly associated with internalizing and externalizing problems, and *denying emotional responsiveness* specifically increased the risk of internalizing

psychopathology and impairment in the emotional area (de la Vega, de la Osa, Ezpeleta, Granero & Domènech, 2011). The aim of this work is to study the accumulative risk of the different types of PM in the mental health and functioning of children exposed to IPV. In accordance with the evidence from research carried out in different populations, the hypothesis of this work is that suffering a larger number of PM types will increase the negative consequences for the psychopathology and functioning of children living in an IPV context. Studying the relationships between the number of PM subtypes and the risk for psychopathology has relevant clinical applications for the prevention of appearance of different PM subtypes and the detection and treatment of populations at risk. The present study is an original contribution to the field beyond previous knowledge. Unlike previous research, which is focused in the accumulation of risk factors or types of maltreatments, the present study focuses in the accumulation of a specific type of maltreatment: PM, and in the total amount of PM. It also contributes to the modeling of trends of the accumulation of PM (linear, quadratic or cubic) and to report on the different associations of each trend. These objectives pretend to fill the gap that exists in the study of a high risk population such as children exposed to IPV, which is poorly studied regarding to psychological maltreatment.

Method

Participants

One hundred and sixty eight children and adolescents aged between 4 and 17 years, whose mothers were battered women attending an outpatient Gender Violence Centre for Women in the Barcelona area participated in the study. The inclusion criterion was that they were exposed to intimate partner violence, at least, in the last year. Of the 131 mothers invited to participate, 116 accepted. No statistical differences emerged for the comparison between participants and refusals by children's sex ($p=.944$), age ($p=.777$), ethnicity ($p=.070$) or socioeconomic status (Hollingshead, 1975) ($p=.133$). Mothers' mean scores on the physical and non-physical scales in the Index of Spouse Abuse (Hudson & Rau, 1981) were also similar for participant and non-participants ($p=.115$ and $p=.817$).

Different groups were created according to the number of PM types suffered by the child. Numbers of participants in each group and socio-demographic characteristics are shown in Table 1, as the socioeconomic level of the sample (22.7% high or medium-high level, 50.9% medium or medium-low and 26.4% low). The ethnic distribution was

predominantly Caucasian (85.1%), followed by American-Hispanic (9.5%) and other groups (5.4%). At the moment of the interview 15.5% of the women had already abandoned the house as a result of the violence. Mothers of the sample were aged 24 to 51. The average age of the mothers was 36.8 (statistical deviation 5.3). The number of mono-parental families was 8.93% (N=15). The average time of exposure to violence was six years (statistical deviation 3.4). The 60.7% of the children were males.

Measures

Schedule for the Assessment of Intimate Partner Violence Exposure in Children (SAIPVEC) (Developmental Psychopathology Epidemiological and Diagnostic Unit, 2005). The different types of PM suffered by children were assessed using this instrument, designed following Holden (2003). It is a rating scale with interview format for collecting information with 5 sections: 1) child's degree of exposure to IPV assesses dichotomously (yes/no) through 11 non-exclusive items (prenatal exposure, victim, participation, eyewitness, auditory /not visual witness, seeing the initial effects, experiencing the consequences, hearing about it, unaware of the situation, provided with some explanation about what happens). 2) Type and degree of aggression against the mother, dichotomously (yes/no) through 3 non-exclusive items (sexual, psychological, and physical) and the degree (1= slight, 2= moderate, 3= severe) of the exposure; and also child age at the beginning of each kind of violence. 3) characteristics of the aggressor as reported by the mother (yes/no) (aggressive only in the family environment, antisocial, dysphoric/ limit, substance abuse, impulsive, extremely jealous, inhibited / explosive, male chauvinist/ dominant, psychopathic, other), the aggressor's age and the relationship of the aggressor with the child. 4) The role of the mother in the aggression (0= passive, 1= Mother defends himself by attacking the aggressor, 2= mother calms the aggressor, 3= escape, 4= assertive behavior), and the resolution (mother says sorry, aggressor is sorry, denial of conflict, minimization of conflict, acceptation, conflict goes on, submission/compliance, mother leaves family home). 5) The last section, which is the mainly used in this study, registers the types of child maltreatment with 8 dichotomous items (physical maltreatment, sexual maltreatment, physical neglect, ant the APSAC subtypes of PM: terrorizing, corrupting/bad socialization, spurning, lack of emotional responsiveness and isolation). Each type of child maltreatment has a definition that the clinician must follow in order to assess if this condition is present or absent: a) *Terrorizing*, meaning behavior such as threatening to injure, kill or abandon the child or

someone he/she cares about, or his/her pets; b) *Corrupting*, that is, allowing or encouraging antisocial or inappropriate behavior, misogyny, violent behavior, verbal or physical aggression or substance abuse; c) *Spurning*, including rejecting, scorning, ridiculing or criticizing the child; d) *Denying emotional responsiveness*, ignoring the emotional needs of the child and his/her attempts to interact, or not showing positive emotions towards the child, being detached and uninvolved or being unable to display affection; e) *Isolation*, described as unreasonably restricting contact with other children, not providing opportunities for socialization; and f) *Physical Neglect*, which is lack of attention to the physical and educational needs of the child. Children from the sample could be simultaneously exposed to more than one subtype of PM. Physical Neglect was included in the analyses as a control variable, since it is not a form of PM. This instrument showed good internal consistency (Cronbach's alpha equal to 0.70 in the section used for this study, in his case the last section of the instrument) and convergent validity with other standardized instruments (Ezpeleta et al., 2007).

Child Behavior Checklists (CBCL/1½-5; CBCL/6-18) (Achenbach & Rescorla, 2001) were used as dimensional measures of psychopathology answered by mothers. They contain 100 and 113 items, respectively, with three response options, and cover a wide range of emotional and behavioral problems in children and adolescents. These two instruments have 8 scales in common: Anxiety- Depression, Withdrawal, Somatic Complains, Attention Problems, Aggressive Behavior, Internalizing Problems, Externalizing Problems and Total Score. There are 3 scales specific for the 6-18 version: Social Problems, Though Problems, Breaking Rules Behavior, and 2 scales are specific for the 1 ½-5 version: emotional problems and sleep problems. Standardized T-scores were analyzed in order to include in the analysis the common scales for young (4 and 5 years) and older (6 to 17) children. T-scores are chosen because allowed comparison by sex and age. Specific scales of the CBCL/6-18 version were analyzed separately (but not of the CBCL/1½-5, due to the small sample size for this range of ages). The reliability coefficients (Cronbachs' alpha) of the CBCL scales in this sample are good, the lower is the alpha is 0.647 from the CBCL/1½ -5 somatic complains scale 0.647 and the higher is 0.936 form the CBCL/1½-5 total scale.

The *Diagnostic Interview for Children and Adolescents-IV (DICA-IV)* (Reich, 2000), a semi-structured diagnostic interview that covers the most common DSM-IV (American Psychiatric Association, 1994) diagnostic categories in children and adolescents, was used to assess child psychopathology. It was adapted and validated for

the Spanish population with satisfactory psychometric properties (Ezpeleta, de la Osa, Domènech, Navarro, & Losilla, 1997). Agreement obtained between interviewers was good to excellent (kappa values of between 0.65 and 1) (Ezpeleta, de la Osa, Júdez, et al., 1997). There are three versions: one for children aged 8 to 12, one for adolescents aged 13 to 17, and one for parents (assessing children aged 8 to 17). Also the *Diagnostic Interview for Children and Adolescents for Parents of Preschool and Young Children* (DICA-PPYC) was answered by mothers of children aged 4 to 7. It was considered as a different instrument, rather than a version of the DICA, and has good statistical properties (Ezpeleta, de la Osa, Granero, Domènech, & Reich, 2011). The interview was carried out by trained psychologists. Diagnoses were derived, where applicable, by combining the information from the mothers and the children. Different psychologists interviewed the mother and the child separately. A symptom was considered to be present if any of the two informants reported it positively. For children aged 4 to 7, the information was obtained from the mothers only.

Children's Global Assessment Scale (CGAS; Shaffer et al., 1983), adapted for Spanish population (Ezpeleta, Granero, & de la Osa, 1999), was used to measure functional impairment during the last year of life. Scale scores were in a range between 1 (maximum impairment) and 100 (best performance). The lowest score combining the information from the child and the mother was chosen.

Procedure

The study was approved by the Ethics Review Board of the authors' institution. Women attending to center for battered women, whose children were exposed to IPV at least in the last year, were informed and invited to participate in the research. Informed written consent to participate was obtained from the mother and oral consent from the children. Confidentiality was guaranteed.

The SAIPVEC was completed by a trained clinical psychologist at intake of women to the Gender Violence Centre. After an interview with the mother, the clinician handling her case rated whether or not the child met each type of abuse. The DICA interview, which lasts approximately 1 hour, was carried out by trained personnel, simultaneously and separately with mothers and children (aged over 8). After the interviews, clinicians rated the degree of impairment (CGAS) associated with the psychological symptoms identified through a semi-structured diagnostic interview (DICA). Lastly, mothers completed the CBCL questionnaire. After their participation,

women received an oral report about the mental state of their children. The return of information was done with care and sensitivity, supporting and orienting the mothers, in order to avoid distress in this sensitive group.

Statistical Analysis

The statistical analysis was carried out with SPSS 19 for Windows. All PM subtypes proposed by APSAC were assessed, but one subtype was excluded from the analysis: *isolation*, due to the low prevalence in the sample (4.8%).

This research refers to nested structure data (some siblings had the same mother), but a low level of hierarchy was observed (58% of mothers included only one child, 38% two children and 4% three children: mean number of children per family was 1.47), so that multi-level models were inadequate because they did not permit satisfactory adjustment (Hox, 2002). To account for data dependency at the lower data level and prevent some estimation bias, the random factor "family" was included in multiple mixed models through GEE (Generalized Estimating Equations). Family was considered as a random factor in the GEE models because our study includes children pertaining to different families, and its aim was to generalize the results to all the families of the larger population of families exposed to domestic violence: the specific families included in the research were considered as a random sample of that population.

Linear, quadratic and cubic trends of number of maltreatments in the impact on psychopathology and functioning were explored though polynomial contrasts in GEE analysis. Number of PMs was the independent variable, and mean scores on the CBCL, CGAS and diagnostic interview the outcomes. Linear trends rated the global increase-decrease of mean scores, quadratic trends explored whether the change comparing children with 1 and 2 PM was statistically equal to the change comparing children with 2 and 3 PM, and cubic trends did the same for changes between 2-3 PM and 3-4 PM.

All the analyses were adjusted for the covariates children's sex and age, duration of exposure to IPV, presence of other forms of maltreatment (physical, sexual abuse or physical neglect), and type and severity of IPV suffered by the mother. Given the multiple comparisons in the study, the Bonferroni-Finner correction (Finner, 1993) was used to control type-I error and to avoid spurious results. Bonferroni's corrections were applied to adjust to .05 the level of significance for the set of comparisons.

Results

Regards prevalence of PM in the sample, 38.1% (N=64) of the children were exposed to *terrorizing*, 27.4% (N=46) to *spurning*, and 35.7% (N= 60) to *denying emotional responsiveness*. All the children in the sample were exposed to PM subtype *corrupting* because they all were exposed to IPV. In 38.1%, *corrupting* was the only type of PM suffered. Those suffering *only* corrupting (38.1%; N= 64) are the group of number of PM =1. A total of 32.1% (N= 54) of the children suffered two type of PM (N=54), 20.2% (N=34) suffered three types (group of number of PM=3) and 9.5% four types (terrorizing, spurning and denying emotional responsiveness, plus corrupting).

Table 1

Sample Characteristics

		Number of PMs suffered			
	TOTAL (N=168)	One N= 64	Two N= 54	Three N=34	Four N=16
Child's age (years); Mean (SD)	8.5 (3.5)	8.0 (3.4)	8.0 (3.0)	9.8 (4.1)	9.8 (3.5)
Years of exposure to IPV; mean (SD)	6.0 (3.4)	6.0 (2.8)	6.9 (3.1)	8.1 (4.5)	8.0 (4.1)
SES (%) *High/ medium-high*	22.7	25.8	18.9	23.5	21.4
Medium/Medium-Low	50.9	46.8	52.9	52.9	57.1
Low	26.4	27.4	28.3	23.5	21.4
Sex: male (%)	60.7	57.8	53.7	70.6	75.0
Other forms of maltreatment (%)[a]	25.0	3.1	24.1	44.1	75.0

Note: SES = Socio-economic status (Hollingshead, 1975); SD = Standard Deviation.

[a] Physical, sexual maltreatment or neglect.

Dimensional Psychopathology (CBCL). Table 2 shows the results of GEE rating the association between number of PMs and mean scores on the CBCL scales. A positive linear trend was found for anxiety-depression, withdrawal, attention problems,

aggressive behavior, social problems, internalizing problems, and total problems, indicating that the greater the number of PMs, the higher the mean scores (more psychopathology). There were no significant squared or cubic trends on any of the CBCL scales, indicating that increases were statistically constant across the different numbers of PMs.

Table 2

Linear, Squared, and Cubic trends of number of forms of Psychological Maltreatment and CBCL psychopathology

	CBCL Means							
	Number of PM suffered					Trends[a] (p)		
CBCL Scales	Total N= 168	One N= 64	Two N= 54	Three N=34	Four N=16	Linear	Quadratic	Cubic
Anxiety- Depression	67.9	59.2	61.6	73.4	77.4	0.003*	0.873	0.345
Withdrawal	65.0	56.6	59.2	64.9	79.7	<0.001*	0.637	0.670
Somatic Complaints	63.4	59.7	60.7	64.3	69.8	0.142	0.813	0.947
Attention Problems	61.4	54.4	57.8	65.9	67.6	<0.001*	0.873	0.345
Aggressive Behavior	65.3	59.8	61.3	70.5	69.6	0.039*	0.873	0.309
Internalizing	70.1	60.4	62.7	73.6	83.9	<0.001*	0.770	0.654
Externalizing	64.0	58.7	60.3	70.1	67.0	0.051	0.786	0.309
Total Score	67.1	59.3	62.1	73.1	74.0	0.003*	0.873	0.309
Only CBC6-18 scales	Total N= 134	One N= 48	Two N= 44	Three N=27	Four N=15			
Social Problems	59.7	55.5	54.7	63.8	64.9	0.004*	0.873	0.654
Thought Problems	60.9	58.3	58.7	63.6	63.3	0.396	0.919	0.657
Breaking-Rules Behavior	58.8	55.0	56.1	66.2	58.0	0.238	0.637	0.172

Note: PM = Psychological Maltreatments.

[a]Comparison adjusted by sex, age, time of exposure, other forms of maltreatment and type and degree of IPV.

* p>.05 significant difference including Bonferroni-Finner's correction

Functional impairment and DSM variables. Table 3 shows the GEE models for the functional impairment score (CGAS) and the results obtained in the diagnostic interview. A negative linear trend was found for the CGAS score: the increase in number of PMs was associated with the decrease in CGAS means (that is, the greater the number of PMs, the higher the impairment score).

A positive linear trend was also found for the number of internalizing and total symptoms, as well as for the total number of DSM disorders: children with greater numbers of PMs attained the highest means for symptoms/disorders. No significant trends emerged for the number of externalizing symptoms.

Table 3

Linear, Squared, and Cubic trends of number of Psychological Maltreatments and Functional impairment, and DSM symptoms and disorders

	Means for different number of PM					Trends[a] (p)		
	Total N=168	One N= 64	Two N= 54	Three N=34	Four N=16	Linear	Quadratic	Cubic
CGAS (mean score)	61.9	67.0	65.3	61.4	53.9	<0.001*	0.099	0.862
N of Externalized Symptoms	9.71	8.93	9.56	12.7	7.61	0.909	0.104	0.188
N of Internalized Symptoms	18.9	12.0	15.9	18.6	28.9	<0.001*	0.197	0.402
N of Total Symptoms	28.6	20.95	25.4	31.3	36.5	0.001*	0.903	0.846
N of DSM Disorders	2.78	1.81	2.33	3.18	3.81	0.015*	0.908	0.747

Note: PM = Psychological Maltreatments.

[a]Comparison adjusted by sex, age, time of exposure, other forms of maltreatment and type and degree of IPV.

* p>.05 significant difference including Bonferroni-Finner's correction.

Discussion

According to the hypothesis, a larger number of PMs suffered by a child exposed to IPV increases linearly the severity of psychopathology and functional impairment. These results are in agreement with those of previous models indicating that accumulated risk factors, such as the different forms of PM, lead to poorer outcomes (Boxer & Terranova, 2008; Hahm et al., 2010; Hart, 1992; Rutter, 1985). These results are especially relevant given the high prevalence of children exposed to IPV (Queen Sofia Center for the Study of Violence, 2007) and the multiple exposures to maltreatment that they suffer (Appel & Holden, 1998; Cawson, Wattam, Brooker, & Kelley, 2000; Mitchell, 2005; Mullender & Morley, 1994; Osofsky, 1999). These results indicate that each form of psychological maltreatment is relevant, and permit to identify children exposed to IPV as a target group for risk reduction.

Although the area of problems in which this increase mostly occurs is internalizing (anxiety-depression, withdrawal), accumulative risk of different forms of PM affects different areas of psychopathology, and also increases the likelihood of attention and social problems, as well as externalizing problems (aggressive behavior). Different forms of PM have an unspecific effect (Binggeli et al., 2001; Brassard & Donovan, 2006; Iwaniec, 2006), so that the prevention of PM in IPV must include components directed towards emotion, mood, and also behavior.

Accumulative risk of PM also affected global functioning in daily life. As the number of PM increases, the level of functioning of children exposed to IPV is increasingly poorer. Briere (2004) also reported in an abused population that more severe and prolonged abuse increases subsequent mental health impairment. Glaser (2002) linked emotional abuse and neglect to impairment of the child's development in all domains of functioning.

The fact that all the significant trends were linear implies that as the child is exposed to an increasing number of maltreatments, child's psychopathology also increases and child's functioning decreases. Therefore, prevention programs for children exposed to domestic violence must be directed to decrease the number of psychological maltreatments they suffer.

This research has important clinical applications for the design of prevention and treatment programs, and also for the assessment of children living in circumstances of IPV. IPV and child PM are closely associated. This is the first approach to assessing the accumulative risk of PM in a Spanish population exposed to IPV. However some limitations must be considered on interpreting the results of the study. The size of some maltreatment groups (*isolation*) made it impossible to include this form of PM in the analysis. The voices of children under eight year are missing from this study and the data from mothers speaking for these younger children under eight could be subjective and may not mirror what the children think or feel, but interview schedules are not appropriate for children under age eight (Ezpeleta, 2001). Also, the results can be generalized only to children of mothers exposed to IPV seeking help.

In conclusion, the results show that the more abuse suffered, the greater the adverse effects. This paper highlights the relevance of taking into account the different forms of PM, given that each type is important in considerations of child psychopathology and functioning. Each PM that clinicians might prevent will mean a significantly smaller number of DSM symptoms and disorders. It is important to assess

the presence of the different components of PM and to use instruments that enable us to do so. The careful assessment of PM in IPV will permit the accurate identification of exposed cases and the application of prevention programs that help to avoid the appearance of new PM subtypes.

References

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth & Families.

Allen, B. (2008). An analysis of the impact of diverse forms of childhood psychological maltreatment on emotional adjustment in early adulthood. *Child Maltreatment, 13*, 307-312. doi:10.1177/1077559508318394

American Professional Society on the Abuse of Children (APSAC). (1995). *Psychosocial evaluation of suspected psychological maltreatment in children and adolescents.* Chicago: Author.

American Psychiatric Association. (1994). *DSM-IV diagnostic and statistical manual of mental disorder*s (4th ed.). Washington, DC: Author.

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal Family Psychology, 12*, 578-599. doi:10.1037/0893-3200.12.4.578

Binggeli, N. J., Hart, S. N., & Brassard, M. R. (2001). *Psychological maltreatment of children. The APSAC study guides 4*. Thousand Oaks, CA: Sage Publications.

Boxer, P., & Terranova, A. (2008). Effects of multiple maltreatment experiences among psychiatrically hospitalized youth. *Child Abuse & Neglect, 32*, 637-647. doi:10.1016/j.chiabu.2008.02.003

Brassard, M. R., & Donovan, K. L. (2006). Defining psychological maltreatment. In M. M. Feerick, J. F. Knutson, P. K. Trickett & S. M. Flanzer (Eds.), *Child abuse and neglect: Definitions, classifications, and a framework for research* (pp. 151-197). Baltimore, MD: Paul H. Brookes.

Briere, J. (2004). Psychological assessment of child abuse effects in adults. In T. M. Wilson, & J. P. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 538-564). New York: Guildford Press.

Butler-Sloss, E. (2001). Contact and domestic violence. *Family Law, 31*, 355-358.

Cawson, P., Wattam, C., Brooker, S., & Kelley, G. (2000). *Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect*. London: National Society for the Prevention of Cruelty to Children.

Chamberland, C., Fallon, B., Black, T., Trocmé, N., & Chabot, M. (2012). Correlates of substantiated emotional maltreatment in the second Canadian incidence study. *Journal Of Family Violence, 27*(3), 201-213. doi:10.1007/s10896-012-9414-8

de la Vega, A., de la Osa, N., Ezpeleta, L., Granero, R., & Domènech, J. (2011). Differential effects of psychological maltreatment on children of mothers exposed to intimate partner violence. *Child Abuse & Neglect, 35*, 524-531. doi:10.1016/j.chiabu.2011.03.006

Developmental Psychopathology Epidemiological and Diagnostic Unit. (2005). *Schedule for the assessment of intimate partner violence exposure in children (SAIPVEC).* Unpublished manuscript. Unitat d'Epidemiologia i de Diagnòstic en Psicopatologia del Desenvolupament, Universitat Autònoma de Barcelona, Spain.

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., & Thompson, T. J. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 28*, 771-784. doi:10.1016/j.chiabu.2004.01.008

Egeland, B., & Erikson, M. (1987). Psychological unavailable caregiving. In M. R. Brassard, R. Germanin, & S. N. Hart (Eds.), *Psychological maltreatment of children and youth* (pp. 110-120). New York: Pergamon.

Ezpeleta, L. (2001). *La entrevista diagnóstica con niños y adolescentes* [the diagnostic interview with children and adolescents]. Madrid: Síntesis.

Ezpeleta, L., de la Osa, N., Domènech, J. M., Navarro, J. M., & Losilla, J. M. (1997). Fiabilidad test-retest de la adaptación española de la diagnostic interview for children and adolescents- DICA-R [Test-retest reliability of the Spanish adaptation of the Diagnostic Interview for Children and Adolescents-DICA-R]. *Psicothema, 9*, 529-539.

Ezpeleta, L., Osa, N. de la, Granero, R., Doménech, J.M., & Reich, W. (2011). *The Diagnostic Interview for Children and Adolescents for Parents of Preschool Children*: Psychometric properties in the general population. Psychiatry Research, 190, 137-144. doi:10.1016/j.psychres.2011.04.034

Ezpeleta, L., de la Osa, N., Júdez, J., Domènech, J. M., Navarro, J. B., & Losilla, J. M. (1997). Diagnostic agreement between clinician and the diagnostic interview for children and adolescents – DICA-R in a Spanish outpatient sample. *Journal of Child Psychology and Psychiatry, 38*, 431–440.

Ezpeleta, L., de la Osa, N., Tarragona, M.J., Granero, R., Olaya, B., & Domènech, J.M. (2007, May). Domestic violence exposure profiles and risk of psychopathology in children**.** In N. de la Osa (Chair), *Psychological Assessment of Domestic Violence***.** Symposium conducted at the 9 European Conference on Psychological Assessment, of the European Association on Psychological Assessment, Thessaloniki, Grecia.

Ezpeleta, L., Granero, R., & de la Osa, N. (1999). Evaluación del deterioro en niños y adolescentes a través de la children's global assessment scale (CGAS) [Assessment of impairment in children and adolescents through the children's Global Assessment] Scale. *Revista De Psiquiatría Infanto-Juvenil, 1*, 18-26.

Finner, H. (1993). On a monotonicity problem in step-down multiple test procedures. *Journal of the American Statistical Association, 88*, 920-923.

Garbarino, J., Guttmann, E., & Seeley, J. W. (1986). *The psychologically battered child: Strategies for identification, assessment, and intervention*. San Francisco, CA: Jossey-Bass, Inc.

Glaser, D. (2002). Emotional abuse and neglect (psychological maltreatment): A conceptual framework. *Child Abuse & Neglect, 26*, 697-714. doi:10.1016/S0145-2134(02)00342-3

Hahm, H., Lee, Y., Ozonoff, A., & Wert, M. (2010). The impact of multiple types of child maltreatment on subsequent risk behaviors among women during the transition from adolescence to young adulthood. *Journal of Youth and Adolescence, 39*, 528-540. doi:10.1007/s10964-009-9490-0

Hart, S.N. (1992). *Psychological meaning and maltreatment factors relevant to consequences and treatment* (Letter to the Subpanel on Consequences and Treatment, Panel on Research on Child Abuse and Neglect, National Research Panel, National Academy of Sciences, Washington, DC). Indianapolis: Indiana University-Purdue University at Indianapolis, Office of the Study of the Psychological Rights of the Child.

Holden, G. W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical Child and Family Psychology Review, 6,* 151-160. doi:10.1023/A:1024906315255

Hollingshead, A. B. (1975). *Four factor index of social status.* Unpublished manuscript.

Hox, J. J. (2002). *Multilevel analysis, techniques and applications*. Mahwah, NJ: Erlbaum.

Hudson, W., & Rau, S. (1981). The assessment of spouse abuse: Two quantifiable dimensions. *Journal of Marriage and the Family, 43,* 883-885. doi:10.2307/351344

Iwaniec, D. (2006). Research review: Risk and resilience in cases of emotional abuse. *Child and Family Social Work, 11,* 73-82. doi:10.1111/j.1365-2206.2006.00398.x

Knutson, J. F., DeGarmo, D. S., Koeppl, G., & Reid, J. B. (2005). Care neglect, supervisory neglect and harsh parenting in the development of children's aggression: A replication and extension. *Child Maltreatment, 10,* 92-107. doi:10.1177/1077559504273684

Loeber, R., & Strouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency In M. Tonry, & N. Morrys (Eds.), *Crime and justice. an annual review of the research* (pp. 29-149). Chicago: University of Chicago Press.

McGee, R. A., & Wolfe, D. A. (1991). Psychological maltreatment: Toward an operational definition. *Development & Psychopathology, 3,* 3-18. doi:10.1017/S0954579400005034

Mitchell, G. (2005). Emotional abuse and neglect: An overview. part II. *Representing Children, 17*, 252-262.

Mullender , A., & Morley, R. (1994). Context and content of a new agenda. In A. Mullender, & R. Morley (Eds.), *Children living with domestic violence*. London: Whiting and Birch. il

Ney, P. G., Fung, T., & Wickertt, A. R. (1994). The worst combinations of child abuse and neglect. *Child Abuse & Neglect, 18,* 705-714. doi:10.1016/0145-2134(94)00037-9

Osofsky, J. D. (1999). The impact of violence on children. *The Future of Children, 9,* 33-49. doi:10.2307/1602780

Queen Sofia Center for the Study of Violence. (2007). *Menores víctimas de violencia en el ámbito familiar* [*Child victims of violence in the family]* Retrieved from Centro

Reina Sofía website: http://www.centroreinasofia.es/paneldecontrol/est/pdf/EST009-3270.pdf

Reich, W. (2000). Diagnostic interview for children and adolescents (DICA). *Journal of the American Academy of Child & Adolescent Psychiatry, 39,* 59-66.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorders. *British Journal of Psychiatry, 147,* 598-611. doi:10.1192/bjp.147.6.598

Rutter, M. (2006). In Clarke-Stewart A., Dunn J., Clarke-Stewart A. and Dunn J. (Eds.), *Families count: Effects on child and adolescent development*. New York: Cambridge University Press.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., et al. (1983). A Children's global assessment scale (CGAS). *Archives of General Psychiatry, 40*, 1228-1231.

Discussion

The papers which have been included in this thesis highlight the importance of identifying PM on children exposed to IPV and their consequences on the emotional and behavioral well-being of children and adolescents.

4.1 Importance of the Type and Number of Subtypes of Psychological Maltreatment Suffered by the Child

Due to the fact that the specific effect of each type of PM has not been explored before in this population, the paper *Differential Effects of Psychological Maltreatments on Children of Mothers Exposed to Intimate Partner Violence* tries to clarify which areas should be the target of the prevention and treatment programs, depending on the kind of PM subtypes that the child has suffered. The aim is to help both professionals from the mental health field and researchers who work with this type of population. Children suffering *spurning* have ten times more risk of suffering mood disorders; they have, on average, ten DSM symptoms and one DSM disorder more, and a significantly increased average in withdrawal, aggressive behavior, social problems, rule-breaking behavior, and internalizing problems and total problems scales of the $CBCL^{6-18}$. So the intervention in these cases must be addressed to programs that improve, for example, communicational and social skills, anger and aggression control, impulse control, depression, anxiety, self-esteem, and both internalizing and externalizing behavior problems. On the other hand, children suffering from *denying emotional responsiveness* have seven times more risk of suffering DSM depression disorder, a significantly increased average in withdrawal and internalizing problems scales of CBCL and a higher impairment in the mood/emotions scales of CAFAS. Intervention in these cases must intensify self-esteem, social skills and prevent or treat depression. Secondly, the importance of assessing several effects of the exposure is noted, both functioning and psychopathology must be assessed. Psychopathology was assessed through DSM symptoms and diagnosis, but also quantitative measures like CBCL, because some areas can be affected even when the symptoms are not enough to make a DSM diagnosis. This suggests the importance to

accurately assess all PM subtypes in order to make a personalized intervention according to the type and number of PM suffered by the child.

The second question raised was to establish the importance of the number of PM suffered by the child. The paper *Severity of Psychological Maltreatments and Accumulative Risk for Psychopathology in Children of Mothers Exposed to Intimate Partner Violence,* points out that every single subtype added matters. The more the number of PM suffered by the child, the function score significantly decreases linearly and psychopathology increases in a positive linear trend. Efforts must be made in order to prevent each new PM subtype suffered by the child because each new PM subtype suffered could mean one DM disorder and five DSM symptoms more, on average.

4.2 Recommendations and Clinical Implications

The exposure to IPV and to PM has a negative impact on mental health, functioning and the child's well-being. Due to the fact that children and adolescents exposed to IPV are more than six to eight times likely to attend mental health centers (Campbell & Lewandowski, 1997), public agencies should be aware of the importance of detecting and treating this vulnerable population. For instance, guidelines for professionals who work with battered women and their children should be established. These guidelines should provide detection and evaluation of violence exposure, both against the mother and the child. When a woman is suffering IPV, it is also important to assess the child's degree of awareness of this situation and also the abuse (psychological or not) that the child himself could also be suffering in this context. IPV and child PM are two related phenomena; both are a very complex and heterogeneous risk factor for child psychopathology. This work provides a summary of the variables which should be taken into account, such as type and degree of violence against the mother, time of exposure, types and number of maltreatments suffered by the child, and also the different areas of intervention that should be targeted in an IPV situation, which can include interiorizing and exteriorizing areas depending on the kind of PM subtype suffered by the child. On the other hand, some abused children may accept violence and abuse as a way to interact in relationships and to solve problems (Jaffe, Hurley, & Wolfe, 1990). Detecting and modifying these erroneous patterns should be part of the intervention for

abused children, which may help to prevent the risk circle and the generational perpetuation of violence. The therapeutic programs for exposed children should consider a developmental and multidisciplinary framework, including closer collaboration among several professionals (psychologists, psychiatrics, physicians, social workers, lawyers and teachers). The child is a unit that is constantly connected with several functioning systems, such as family, school and society. When approaching the IPV issue, a bio-psycho-social perspective should be maintained, considering the participation of diverse people of the child's context. According to this perspective, the first step to eradicate IPV and child abuse in our society is to increase awareness of this kind of violence and their harmful outcomes, and the need to detect and report abuses to the justice agencies. Currently, some efforts have been made by public agencies with the goal of preventing and eradicating IPV. For instance, in 2012 there is one of the most recent public awareness campaigns, developed by the Ministry of Equality of the Spanish government, called "Elige vivir" (choose life), (http://www.msc.es/campannas/campanas12/eligeVivir.htm). Also some efforts have been addressed to prevent child maltreatment, for instance, the public awareness campaign against corporal punishment in the family, promoted by the Ombudsman for Minors of the Autonomous Community of Madrid in collaboration with some Non-Governmental Organizations like Unicef, Ceapa, Concapa and Save the Children (Calderon, Berzal, Garcia, Gonzalez & Oven, 2001).

4.3 Limitations

On interpreting the results, some limitations should be taken into account. The results can only be generalized and applied to children of mothers seeking help due to having been exposed to IPV. The voices of children under eight years old are missing and the data from mothers speaking for these younger children under eight could be subjective and may not mirror what the children think or feel, but interview schedules are not appropriate for children under age eight (Ezpeleta, 2001). Another limitation is that the size of the sample of some PM subtypes such as isolation rendered it impossible to include them in the analysis. Furthermore, models for some disorders could not be considered due to the low prevalence of response in the sample, as is the case for Eating Disorders or some preschool-age disorders. Other limitations include the wide age-range (4–17 years); the outcomes of PM may differ across age-ranges, though age was an

adjusted variable in this study. Therefore, in future research it would be interesting to study the differential impact of PM at different ages. Also, the perpetrator in the child sample study was always the father, and it would be useful to explore the outcomes when mothers are also engaged in PM and whether there is a sex-of-parent by sex-of-child interaction. Corruption was used as a constant, this type of PM being applied to all IPV-environment participants, but the possibility cannot be ruled out that they have differentially experienced some of the non-IPV components of corruption (such as parents' substance abuse and others negative models). Finally, as far as the limitations are concerned, there is room for more comparison between suffering PM in IPV environments and experiencing it in non-IPV environments.

Despite these limitations, this research has important clinical applications as regards the process of assessing children living in circumstances of IPV. The use of this instrument constitutes one of the first systematic approaches to the assessment of PM types in IPV. The work has provided evidence in support of the need to consider different types of PM when assessing children exposed to IPV.

4.4 Further Direction for Research

4.4.1 Vulnerability of Suffering Psychological Maltreatment

This research is currently involved in the objective of studying which variables are related to suffering from PM subtypes. The objective is to detect risk factors that could increase the risk of suffering from each different type of PM and protective factors that could decrease the risk of suffering from each type of PM. Previous literature has highlighted the promising buffering role of friendship; Finkelhor et al. (2007) found that youth with more friends had a lower risk of repeated poly-victimizations. Therefore, the aim is to know if the risk factor of suffering from each subtype is different or if, on the contrary, the risk factor for suffering from PM is unspecific and increases the risk of suffering from any of the different PM subtypes. Previous research has studied vulnerability of suffering from PM, (including family factors, child factors and environmental factors), but the present aim is relevant because further research has not studied the vulnerability of suffering from each subtype of PM. Other possible paths of further research are stated below.

4.4.2 Prevention of Psychological Maltreatment

Employing the **ecological model** (Belsky, 1980; Garbarino, 1977) as their framework, Fortin and Chamberland (1995) have developed a *prevention strategy* based on a "qualitative" equation that attempts to elucidate the person-situation-environment interactions. Both risk and protective factors have been empirically related to maltreatment.

$$\text{Degree of Psychological Maltreatment} = \frac{\text{Cultural expectations} + \text{Lack of opportunities} + \text{Stress factors} + \text{Organic dysfunction} + \text{Familial dysfunction}}{\text{Positive self-concept} + \text{Social skills} + \text{Level of awareness} + \text{Support}}$$

The numerator consists of the **risk factors**: cultural expectations, lack of opportunities, stress factors, organic dysfunction and familial dysfunction. The denominator consists of **protective factors**: positive self-concept, social skills, level of awareness and support. As the equation postulates, developmental problems in children are typically associated with many risk factors, not simply one: risk factors have an accumulative risk, are *culturally mediated* and are *developmentally relative* in that they may predict dysfunction at one developmental stage but not at others. This suggests that the efforts to *prevent* psychological programs should be embedded in *comprehensive programs* designed to prevent a variety of problems. Even though there are some programs of intervention like Chamberland's, more research should be done in order to develop and test the efficacy of intervention programs.

Two-tier systems for helping families include:

- **Educational and prevention efforts** (first tier) that imply sensitization campaigns such as "*Word Can Hurt Like a Fist*" (Giovannoni, 1991) or "*Words Can Hurt*" (Brassard & Hart, 1987) and socio-political action to ensure the legal protection of rights of children.

- **Child welfare/protection services** (second tier) include parent-support services like the *Nurse-staffed prenatal and early childhood home visitation program* (Olds et al., 1997).

4.4.3 Treatment of Psychological Maltreatment

There is no empirically supported treatment literature specific only to psychological maltreatment, so research must be done in this direction. However, recent research on the effects of PM and other forms of abuse and neglect provide a guidepost for the development of such a treatment program.

The subsequent psychosocial outcomes of maltreatment it has identified can be conceptualized as consisting of three interrelated domains:

- The first concerns *identity*, self-esteem and dysfunctional attributions regarding the self.
- The second domain includes problems related to *relationships*, working models of relationships, and insecure attachment to caregivers and significant others.
- And the third domain consists of problems of *internalizing* and *externalizing* behaviors, including acting out, impulse control, aggression and depression.

The three domains provide appropriate treatment targets for psychologically maltreated children and their parents. PM can be defined as a *relationship disorder* between a child and his or her parent. The parent's ability to provide a secure and close relationship for the child is essential to that child's optimal development and should constitute a *primary focus for the treatment* of abusive and neglectful parents (Biggenli et al., 2001).

4.4.4 Cross-Cultural Research

Finally, other fields for future research could be studied if PM also has negative outcomes in other cultures. Rohner and Rohner (1980) investigated the impact of rejection in dozens of anthropological studies conducted in a wide variety of the world's cultures. Their research revealed that rejection produces negative effects in children in every culture studied. Rejected children tended to have an impaired sense of self-esteem and self adequacy, to be emotionally unstable, emotionally unresponsive, and aggressive

and to have a negative worldview. But other PM subtypes, besides rejection, must be studied.

4.4.5 Intimate Partner Violence against Men

Intimate Partner Violence used by women against men is a phenomenon that has received little attention, both within the scholarly literature and the popular media (Hines & Douglas, 2009). Estimates from national family violence surveys show that within a given year, at least 12% of men are the target of some sort of physical aggression from their female partners; 4% (over 2.4 million men in the United States) sustain severe violence (Straus, 1995), and sometimes they are even killed as a result of IPV (Mann, 1996). Rates of IPV suffered by men could be underestimated. Men are commonly expected to be physically dominant, consequently, admitting to sustaining IPV from a woman may be viewed as emasculating (Steinmetz, 1977); indeed, men are not only reluctant to report assaults by women, they are also unlikely to report assaults by other men, even when severe injuries result (Henman, 1996). Additionally, rates of sexual and psychological IPV by women toward male partners are harder to obtain because they have rarely been systematically investigated. Among the possible psychological outcomes on men who sustain *physical IPV*, they report anger, emotional hurt, shame and fear (Morse, 1995) and greater levels of depression, stress, psychological distress and psychosomatic symptoms (Simonelli & Ingram, 1998). Men who experienced *psychological* maltreatment from a partner have been shown to display depressive symptoms and psychological distress (Simonelli & Ingram, 1998). Little work has been done on the mental health status of men who sustained *sexual* aggression from a female intimate partner.

Conclusions

As a conclusion, the importance of taking into account PM must be highlighted. Children exposed to IPV are a high-risk population to suffer different types of PM and, in fact, they are suffering at least the corrupting or bad socialization PM subtype. PM is the core component of child abuse and neglect, it is the most frequent of child maltreatments and leads to the worst outcomes. Negative outcomes of PM have been proved and this effect can be acute or long-term. PM is a very heterogeneous phenomenon and there are different types of PM. Each different type of PM leads to a concrete, specific and differential outcome. Also, the effects of PM subtypes are multiplicative, and suffering a higher number of PM leads to worse outcomes in psychopathology and functioning in a linear trend. The sum of different types is a measure of severity. Each PM that clinicians might prevent will mean a significantly smaller number of DSM symptoms and disorders. It is important to assess the presence of the different components of PM and to use instruments that enable us to do so. The careful assessment of PM in IPV will permit the accurate identification of exposed cases and the application of prevention programs that help to prevent the appearance of new PM subtypes. The results suggest the importance of taking PM types into account in order to fully understand the problems of children exposed to IPV at home, and for the design of effective treatment and prevention programs.

Bibliography

Ainsworth, M.D.S. (1989). Attachment beyond infancy. *American Psychologist, 44*, 709-716.

Allen, B. (2008). An analysis of the Impact of Diverse Forms of Childhood Psychological Maltreatment on Emotional Adjustment in Early Adulthood. *Child Maltreatment, 13*, 3 (307-312).

American Professional Society on the Abuse of Children (APSAC). (1995). *Psychosocial evaluation of suspected psychological maltreatment in children and adolescents*. Chicago: Author.

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal Family Psychology, 12*, 578-599.

Arata, C.M., & Lindman, L. (2002). Marriage, child abuse, and sexual revictimization. *Journal of Interpersonal Violence 17*, 953-971.

Baer, J.C., & Martinez C.D. (2006). Child maltreatment and insecure attachment: a meta-analysis. *Journal of Reproductive and Infant Psychology, 24*, 187-197.

Bailey, H.N., Moran, G., & Pederson, D.R. (2007). Childhood maltreatment, complex trauma symptoms, and unresolved attachment in an at-risk sample of adolescent mothers. *Attachment & Human Development, 9,* 139-161.

Baily, R.T., & Baily, W.H. (1986). *Operational definitions of child emotional maltreatment*. Augusta, ME: Department of Social Services.

Barnett, D., Manly, J.T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S. Toth (Eds.), *Child abuse, child development, and social policy* (pp. 7-74). Norwood, NJ; Ablex.

Beese, A., & Morley, S. (1993). Memory for acute pain experience is specifically inaccurate but generally reliable. *Pain, 53,* 183-527.

Belsky, J. (1980). Child Maltreatment. An ecological integration. *American Psychologist, 35,* 320-335.

Belsky, J. (1993). Etiology of Child Maltreatment: a developmental-ecological analysis. *Psychological Bulletin, 114,* 413-434.

Bifulco, A., Brown, G.W., & Harris, T.O. (1994). Childhood Experience of Care and Abuse (CECA): A retrospective interview measure. *Journal of Child Psychology and Psychiatry, 35,* 1419-1435.

Bifulco, A., Lillie, A., Ball, B., & Moran, P. (1998). *Attachment Style Interview (ASI). Training Manual.* Royal Holloway, University of London.

Bilbro, T., Boni, M., Johnson, B., & Roe, S. (1979). *The relationship of parental acceptance-rejection to the development of moral reasoning*. Unpublished manuscript, University of Connecticut, Center for the Study of Parental Acceptance-Rejection.

Binggeli, N. J., Hart, S. N., & Brassard, M. R. (2001). *Psychological maltreatment of children. The APSAC study guides 4.* Thousand Oaks, A: Sage Publications.

Bourassa, C. (2007). Co-occurrence of interparental violence and child physical abuse and it's effect on the adolescents' behavior. *Journal of Family Violence, 22*, 691-701.

Bowlby, J. (1973). *Attachment and Loss:* Vol. 2. Separation. Basic Books, New York.

Bowlby, J. (1988a). *A secure base: Clinical applications of attachment theory*. London: Routhledge.

Bowlby, J. (1988b). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Boxer, P., & Terranova, A. (2008). Effects of multiple maltreatment experiences among psychiatrically hospitalized youth. *Child Abuse & Neglect, 32*, 637-647.

Brassard, M. R., & Donovan, K. L. (2006). Defining psychological maltreatment. In M. M. Feerick, J. F. Knutson, P. K. Trickett & S. M. Flanzer (Eds.), *Child abuse and neglect: Definitions, classifications, and a framework for research* (pp. 151-197). Baltimore, MD: Paul H. Brookes.

Brassard, M. R., Germain, R., & Hart, S. N. (1987*). Psychological maltreatment of children and youth.* New York: Pergamon.

Brassard, M.R., & Hart, S.N., (1987). *Emotional abuse: Words can hurt*. Chicago: National Committee for the Prevention of Child Abuse.

Brassard, M.R., Hart, S.N., & Hardy, D. (1993). The Psychological Maltreatment Rating Scales. *Child Abuse & Neglect, 17,* 715-729.

Braver, M., Bumberry, J., Green K., & Rawson, R. (1992). Childhood abuse and current psychological functioning in a university counseling center population. *Journal of Counseling Psychology, 39*, 252-257.

Briere, J. (2004). Psychological assessment of child abuse effects in adults. In T. M. Wilson, & J. P. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 538-564). New York: Guildford Press.

Briere, J., & Runtz, M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse & Neglect, 12,* 331-341.

Briere, J., & Runtz, M. (1990). Differential adult symptomology associated with three types of child abuse histories. *Child Abuse & Neglect, 14,* 357-364.

Briggs, F., & Hawkins, R. M. F. (1996). *Child protection: A guide for teachers and child care professionals*. St Leonards, NSW: Allen & Unwin.

Broadhurst, D.D. (1984). *The educator's role in the prevention and treatment of child abuse and neglect.* Washington, DC: US. Department of Health and Humans Services, National Center on Child Abuse and Neglect.

Brown, S.E. (1984). Social class, child maltreatment, and delinquent behavior. *Criminology, 22*, 257-274.

Butler-Sloss, E. (2001). Contact and Domestic Violence. *Family Law, 31*, 355-358.

Calderón, B., García, L., González, R., & Horno, P. (2001). *Educa y no pegues*. Campaña para la sensibilización contra el castigo físico en la familia. [Do teach and do not hit] Madrid. Save the Children. Top Publisim, S.L.

Caldwell, B., & Bradley, R. (1984). *Home Observation for Measurement of the Environment: Administration manual*. Little Rock: University of Arkansas at Little Rock.

Campbell, J.C., & Lewanowski, L.A. (1997). Mental and physical health effects on intimate partner violence on women and children. *Psychiatric Clinics of North America, 20,* 353-374.

Campbell, J. C., Sharps, P., & Glass, N. (2001). Risk assessment for intimate partner homicide. In G. F. Pinard, & L. Pagani (Eds.), *Clinical assessment of dangerousness* (pp.136-157) Cambridge: Cambridge University Press.

Cawson, P., Wattam, C., Brooker, S., & Kelley, G. (2000). *Child Maltreatment in the Unit Kingdom: A Study of the prevalence of Child Abuse and Neglect*. National Society for the prevention of Cruelty to Children, London.

Centro Reina Sofía para el estudio de la violencia. (2008). Mujeres maltratadas por su pareja. Retrieved June/22, 2009, from http://www.centroreinasofia.es/paneldecontrol/est/pdf/EST007-3271.pdf

Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: psychiatric substances abuse and social risk factors from prospective community samples. *Child Abuse & Neglect, 20*, 191-203.

Chan, J. (1981). Correlates of parent-child interaction and certain psychological variables among adolescents in Hong Kong. In J.L- M. Dawson et al (Eds.), *Perspectives in Asian psychology*. Lisse: Swets & Zeitlinger.

Cicchetti, D., & Barnett, D. (1991). Toward the development of a scientific nosology of child maltreatment. En W. M. Grove y D. Cicchetti (Eds.), Thinking clearly about psychology: Essays in honor of Paul E. Meehl. Vol. 2. *Personality and Psychopathology* (pp. 346-377). Minneapolis: University of Minnesota Press.

Claussen, A.H., & Crittenden, P.M. (1991). Physical and psychological maltreatment: Relations among types of maltreatment. *Child Abuse and Neglect, 15*, 5-18.

Cleaver, H., Unell, I., & Aldgate, J. (1999). *Children's Needs - Parenting Capacity*. Department of Health, London.

Crittenden, P. (1988). Family and dyadic patterns of functioning in maltreating families. In K. Brown, C. Davies, & P. Stratton (Eds.), *Early prediction and prevention of child abuse* (pp. 161-189). New York: John Wiley.

Crittenden, P. (2001). CARE-Index: Coding Manual. Miami, FL: Family Relations Institute.

Crittenden, P.M., & Ainsworth, M.D. (1989) Child maltreatment and attachment. In *Handbook of Child Maltreatment: Clinical and Theoretical Perspectives* (Eds. D. Cicchetti & V. Carlson), pp. 432-463. Cambridge, New York.

Crittenden, P. M., Claussen, A.H., & Sugarman, D.B. (1994). Physical and psychological maltreatment in *middle childhood and adolescence*. *Development* and Psychopathology, 6, 145-164.

Davis, P.W. (1996). Threats of corporal punishment as verbal aggression: A naturalistic study. *Child Abuse & Neglect, 20*, 286-304.

Depanfilis, D., & Zuravin, S.J. (1999). Epidemiology of child maltreatment recurrences. *Social Service Review, 73*, 218-239.

Department of Health, Home Office, and Department for Education and Employment (1999). *Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children*. London: The Stationery Office.

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., & Thompson, T. J. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 28*, 771-784.

Doyle, C. (1997). Emotional abuse of Children: issues for intervention. *Child Abuse Review, 6*, 330-342.

Doyle, C. (2001). Surviving and coping with emotional abuse in childhood. *Clinical Child Psychology and Psychiatry, 31*, 387-402.

Edmunson, S. E., & Collier, P. (1993). Child protection and emotional abuse: Definition, identification and usefulness within an educational setting. *Educational Psychology in Practice, 8,* 198-206.

Egeland, B., & Erickson, M. (1987). Psychologically unavailable caregiving. In M.R. Brassard, R. Germain, & S.N. Hart (Eds.), *Psychological maltreatment of children and youth* (pp.110-120). New York: Pergamon.

Egeland, B., Sroufe, L.A., & Erickson, M. (1983). The developmental consequences of different patterns of maltreatment. *Child Abuse & Neglect, 7*, 459-469.

Emery, R.E., & Laumann-Billings, L. (2002). Child abuse. In M. Rutter & E. Taylor (Eds.); *Child and Adolescent Psychiatry* (pp. 325-339). Blackwell Science, Oxford.

Engels, M.L., & Moisan, D. (1994). The Psychological Maltreatment Inventory: Development of a measure of psychological maltreatment in childhood for use in adult clinical settings. *Psychological Reports, 74,* 595-604.

English, D. J., & LONGSCAN Investigators (1997). *Modified Maltreatment Classification System* (MMCS). Available from LONGSCAN website: http://www.ipex.unc.edu/longscan

Erickson, M.F., Egeland, B., & Pianta, R. (1989). The effects of maltreatment on the development of young children. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 647-684). New York: Cambridge University Press.

Erikson, E.H. (1959). *Identity and the life cycle: Selected papers* (Psychological Issue Monograph Series No.1). New York: International Universities Press.

Ezpeleta, L. (2001). *La entrevista diagnóstica con niños y adolescentes* [the diagnostic interview with children and adolescents]. Madrid: Síntesis.

Fantuzzo, J. W., Boruch, R., Beriama, A., Atkins, M., & Marcus, S. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 116-122.

Fantuzzo, J. W., & Mohr, W. K. (1999). Prevalence and effects of child exposure to domestic violence. *The Future of Children, 9,* 21-32.

Feerick, M.M., Knutson, J. F., Trickett, P. K., & Flanzer S. M . (2006) *Child abuse and neglect: Definitions, classifications, and a framework for research.* Baltimore, MD: Paul H. Brookes.

Finkelhor, D., Ormrod, R.K., & Turner, H. A. (2007). *Child Abuse & Neglect 31,* 479-502. doi:10.1016/j.chiabu.2006.03.012

Fortin, A., & Chamberland, C. (1995). Preventing psychological maltreatment in children. *Journal of Interpersonal Violence, 10,* 275-295.

Garbarino, J. (1977). The human ecology of child maltreatment: A conceptual model for research. *Journal of Marriage and the Family, 39,* 721-734.

Garbarino, J., Guttmann, E., & Seeley, J. W. (1986). *The psychologically battered child: Strategies for identification, assessment, and intervention.* San Francisco, CA: Jossey-Bass, Inc.

Gibb, B.E., Wheeler, R., Alloy, L.B., & Abramson, L.Y. (2001). Emotional, physical, and sexual maltreatment in childhood versus adolescence and personality dysfunction in young adulthood. *Journal of Personality Disorders, 15,* 505-511

Giovanni, J. M., (1991). *Defining child abuse*. New York: Free Press.

Giovanni, J. M., & Becerra, R. (1979). *Defining child abuse*. New York: Free Press.

Glaser, D. (2000). Child abuse and neglect and the brain: a review. *Journal of Psychology and Psychiatry, 41,* 97-116.

Glaser, D. (2002). Emotional abuse and neglect (psychological maltreatment): A conceptual framework. *Child Abuse & Neglect, 26,* 697-714.

Gross, A.B., & Keller, H.R. (1992). Long-term consequences of childhood physical and psychological maltreatment. *Aggressive Behaviour, 18*, 171-185.

Grover, K.E., Carpenter, L.L.M Price, L.H., Gagne, G.G., Mello, A.F., Mello, M.F., & Tyrka A.R. (2007) The Relationship Between Childhood Abuse and Adult Personality Disorder Symptoms. *Journal of Personality Disorders*: Vol. 21, No. 4, pp. 442-447. doi: 10.1521/pedi.2007.21.4.442

Hahm, H., Lee, Y., Ozonoff, A., & Wert, M. (2010). The impact of multiple types of child maltreatment on subsequent risk behaviors among women during the transition from adolescence to young adulthood. *Journal of Youth and Adolescence, 39,* 528-540.

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse & Neglect, 34,* 734-741.

Hart, S. N., Binggeli, N. J., & Brassard, M. R. (1998). Evidence of the effects of psychological maltreatment. *Journal of Emotional Abuse, 1*, 27-58.

Hart, S.N. (1992). *Psychological meaning and maltreatment factors relevant to consequences and treatment* (Letter to the Subpanel on Consequences and Treatment, Panel on Research on Child Abuse and Neglect, National Research Panel, National Academy of Sciences, Washington, DC). Indianapolis: Indiana University-Purdue University at Indianapolis, Office of the Study of the Psychological Rights of the Child.

Hart, S.N., & Brassard, M.R. (1990). Final report (stages one and two): *Developing and validating operationally defined measures of emotional maltreatment: A multimodal study of the relationships between caretaker behaviors and child characteristics*

across three developmental levels (Stage 1; Grant No. DHHS 90CA1216). Washington, DC: US Department of Health and Human Services and National Clearinghouse on Child Abuse and Neglect.

Hart, S.N., Germain, R.B., & Brassard, M. (1987). The challenge: To better understand and combat psychological maltreatment of children and youth. In M. R. Brassard, R. Germain, & S.N. Hart (Eds.), *Psychological maltreatment of children and* youth (pp.3.24). New York: Pergamon.

Hemenway, D., Solnick, S., & Carter, J. (1994) Child rearing violence. *Child Abuse & Neglect, 18,* 1011-1020.

Henman, M. (1996). Domestic violence: Do men under report? *Forensic Update, 47,* 3-8.

Herrenkohl, R.C., Egolf, B.P., & Herrenkohl, E.C. (1997). Preschool age antecedents of adolescent assaultive behavior: Results from a longitudinal study. *American Journal of Orthopsychiatry, 67,* 422-432.

Herrenkohl, R.C., Herrenkohl, E.C., & Egolf, B.P. (1983). Circumstances surrounding the occurrence of child maltreatment. J*ournal of Consulting and Clinical Psychology, 51,* 424-431.

Herrenkohl, R.C., Herrenkohl, E.C., & Egolf, B.P. (1991). *Methods of disciplining children Revised.* Unpublished instrument available from R.C. Herrenkohl, Center for Social Research, Lehigh University, 10 West Fourth Street, Bethlehem, PA 18015.

Herrenkohl, R.C., Herrenkohl, E.C., Egolf, V., & Wu, P. (1991). The developmental consequences of child abuse: The Lehigh Longitudinal Study. In R.H. Starr & D.A. Wolfe (Eds.). *The effects of child abuse and neglect: Issues and research* (pp-57-80). New York: Guilford.

Herrenkohl, E.C., Herrenkohl, E.C., & Toedter, L. (1982). *Procedures for interviewing families about their child discipline practices.* Unpublished instrument available

from R.C. Herrenkohl, Center for Social Research, Lehigh University, 10 West Fourth Street, Bethlehem, PA 18015.

Herrenkohl, E.C., Herrenkohl, E.C., Toedter, L., & Yanushefki, A.M. (1984). Parent-child interactions in abusive and nonabusive families. *Journal of the American Academy of Child Psychiatry, 23,* 641-648.

Hines, D.A., & Douglas, EM. (2009). Women's use of Intimate Partner Violence against Men: Prevalence, implications and consequences. *Journal of Aggression, Maltreatment & Trauma, 19,* 572-586. doi: 10.1080/109267709031033099

Hoffman, M.L. (1970). Moral development. In P. H. Mussen (Ed.), *Carmichael's manual of child psychology* (Vol.2). New York: John Wiley.

Holden, G. W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical Child and Family Psychology Review, 6,* 151-160.

Holden, G.W., Geffner, R., & Jouriles, E.N. (Eds.). (1998). *Children exposed to marital violence.* Washington, DC: American Psychological Association.

Hollingshead, A. B. (1975). *Four factor index of social status*. Unpublished manuscript.

Hughes, H.M. (1992). Impact of spouse abuse on children of battered women. *Violence Update, 2,* 8-11.

Hughes, H.M., & Graham-Bermann, S.A. (1998). Children of Battered women: Impact of emotional abuse on adjustment and development. *Journal of Emotional Abuse, 1,* 23-50.

Hutchison, I. W., & Hirschel, J. D. (2001). The effects of children's presence on woman abuse. *Violence and Victims, 16,* 3-18.

Iwaniec, D. (2000). From childhood to adulthood: the outcomes of a 20-year follow-up of children who failed to thrive. In Iwaniec, D. & Hill, M. (Eds.), *Child Welfare Policy and Practice: Current Issues in Child Care Research* (pp. 203-223). Jessica Kingsley, London.

Iwaniec, D. (2004). *Children who fail to Thrive: A Practice Guide*. John Wiley & Sons, Chichester.

Iwaniec, D. (2006). Research review: Risk and resilience in cases of emotional abuse. *Child and Family Social Work, 11,* 73-82.

Iwaniec, D., & Sneddon, H. (2001). *Failure to Thrive Children and Their Families: Outcomes of a 20-Year Longitudinal Study*. Institute of Child Care Research, Belfast.

Iwaniec, D., & Sneddon, H. (2002). The quality of parenting of individuals who had failed to thrive as children. *British Journal of Social Work, 32,* 283-292.

Jacobs, M., Spilken, A., & Noeman, M. (1972). Perception of faulty parent-child relationships and illness behavior. *Journal of Consulting and Clinical Psychology, 39,* 49-55.

Jaffe, P.G., Hurley, D., & Wolfe, D. A. (1991). Children's observations of violence: I. Critical issues in child development and intervention planning. Canadian *Journal of Psychiatry, 35,* 466-470.

Jaffe, P. G., Lemon, N. K. D., & Poisson, S. E. (2003). *Child custody & domestic violence: A call for safety and accountability*. Thousand Oaks: Sage Publications.

Jaffee, P. G., Wolfe, D. A., & Wilson, S. K. (1990). *Children of battered women*. Newbury Park, CA: Sage.

Johnson, A.K. (1993). Foster care and adoption policy in Romania: Suggestions for international intervention. *Child Welfare, 72,* 489-506.

Joseph, R. (1999). The neurology of traumatic "dissociative" amnesia: Commentary and literature review. *Child Abuse & Neglect, 23,* 715-727.

Kairys, S. W., Johnson, C.F., & American Academy of Pediatrics Committee on Child Abuse and Neglect. (2002). The psychological maltreatment of children-technical report. *Pediatrics, 109,* 1-3.

Kaufman, J., Jones, B., Stieglietz, E., Vitulano, L., & Mannarino, A.P. (1994). The use of multiple informants to assesses children's maltreatment experiences. *Journal of Family Violence, 9,* 227-248.

Kavanagh, Ch. (1982). Emotional Abuse and Mental Injury: A critique of the concepts a recommendation for practice. *Journal of Academy of Child Psychiatry, 21*, 171-177.

Kelly, B., Thornberry, T., & Smith, C. (1997). *In the Wake of Childhood Maltreatment.* National Institute of Justice, Washington, DC.

Kendall-Tackett, K.A., & Eckenrode, J. (1996). The effects of Neglect on academic achievement and disciplinary problems: a developmental perspective. *Child Abuse & Neglect, 20,* 161-169.

Kinard, E.M. (1994). Methodological issues and practical problems in conducting research on maltreated children. *Child Abuse & Neglect, 18,* 645-656.

Knutson, J.F., DeGarmo, D. S., Koeppl, G., & Reid, J. B. (2005). Care neglect, supervisory neglect and harsh parenting in the development of children's aggression: A replication and extension. *Child Maltreatment, 10,* 92-107.

Krugman, R.D., & Krugman, M.K. (1984). Emotional abuse in the classroom. American *Journal of Diseases of Children, 138,* 284-286.

Kurtz, P.D., Gaudin, J.M., Wodarski, J.S., & Howing, P.T. (1993) Maltreatment and the school-aged child: school performance consequences. *Child Abuse & Neglect, 17,* 581-589.

Kury, H., Obergefell-Fuchs, J., & Woessner, G. (2004). The extent of family violence in Europe: Comparison of national surveys. *Violence Against Women, 10,* 749-769.

Lefkowitz, M., Eron, L., Walder, L., & Huesmann, L. (1977). *Growing up to be violent: A longitudinal study of the development of aggression.* New York: Pergammon.

Leighton, B. (1989). *Spousal abuse in metropolitan Toronto: Research report on the response of the criminal justice system* (Report No. 1989-02). Ottawa: Solicitor General of Canada.

Lesnik-Oberstein, M., Koers, A.J., & Cohen, L. (1995). Parental hostility and its sources in psychologically abusive mothers: a test of the three factor theory. *Child Abuse & Neglect, 19,* 33-49.

Loeber, R., & Strouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency In M. Tonry, & N. Morrys (Eds.), *Crime and justice. an annual review of the research* (pp. 29-149). Chicago: University of Chicago Press.

Louis, A., Condon, J., Shute, R., & Elzinga, R. (1997). The development of the Louis MACRO (mother and child risk observation) forms: Assessing parent-infant-child risk in the presence of maternal mental illness. *Child Abuse & Neglect, 21,* 589-606.

Lourie, M.D., & Stefano, L. (1978). On defining emotional abuse. Child abuse and neglect: Issues in innovation and implementation. *Proceeding of the Second Annual National Conference on Child Abuse and Neglect* (pp.201-208). Washington, DC: Government Printing Office.

Magura, S., & Moses, B.S. (1986). *Outcome Measures for Child Welfare Services*. Washington, D.C.: Child Welfare League of America.

Main, M., & George, C. (1985). Responses of abused and disadvantaged toddlers to distress in agemates: A study in the day care setting. *Developmental Psychology, 21*, 407-412.

Main, M., & Goldwyn, R. (1984). Predicting rejection of her infant from mother's representation of her own experience: Implications for the abuse-abusing intergenerational cycle. *Child Abuse & Neglect, 8,* 203-217.

Manion, I.G., & Wilson, S. (1995). *An Examination of the Association between Histories of Maltreatment and Adolescent Risk Behaviours*. Catalogue No. H72-21/ 139-1995E. National Clearinghouse on Family Violence, Health Canada, Ottawa.

Manly, J.T. (2005). Advances in research definitions of child maltreatment. *Child Abuse & Neglect 29,* 425-439.

Mann, C.R. (1996). *When women kill.* New York: State University of New York Press.

Maslow, A.H. (1970). *A theory of human motivation.* New York: Harper & Row.

McCord, J. (1983). A forty-year perspective on effects of child abuse and neglect. *Child Abuse & Neglect, 7*. 265-270.

McCord, W., Mc Cord, J., & Zola, I.K. (1959). *Origins of crime: A new evaluation of the Cambridge-Somerville youth study.* New York: Columbia University Press.

McGee, R. A., & Wolfe, D. A. (1991). Psychological maltreatment: Toward an operational definition. *Development & Psychopathology, 3*, 3-18.

McGee, R.A., Wolfe, D.A., & Wilson, S.K. (1990). A *record of maltreatment experiences.* Unpublished manuscript. (Available from D.A. Wolfe, Institute for the Prevention of Child Abuse, 25 Spadina Road, Toronto, Ontario M5R259).

McGinn, N.F. (1963). *Perception of parents and blood pressure.* Dissertation Abstracts, 24, 872.

Mebert. C., & Straus, M.A. (2002). Picture-Card Version for Young Children Conflict Tactics Scale. In J. Touliatos, B.F. Perlmutter, & M. Straus (Eds.), *Handbooks of family measurement techniques*. Newbury Park, CA: Sage.

Miller, H., & Baruch, D.W. (1948). Psychosomatic studies of children with allergic manifestations: I. Maternal rejection: A study of 63 cases. *Psychosomatic Medicine, 10*, 275-278.

Miller, H., & Baruch, D.W. (1950). A study of hostility in allergic children. *American Journal of Orthopsychiatry, 20,* 275-278.

Mitchell, G. (2005). Emotional abuse and neglect: an overview. Part II. *Representing Children, 17(4),* 252-262.

Moeller, T.P., Bachman, G.A., & Moeller, J.R. (1993). The combined effects of physical, sexual and emotional abuse during childhood: Long-term health consequences for women. *Child Abuse & Neglect, 17*, 623-640.

Moran, P.M., Bifulco, A., Ball, C., Jacobs, C., & Benaim, K. (2002). Exploring psychological abuse in childhood: I. Developing a new interview scale. *Bulleting of the Menninger Clinic, 66,* 213-240.

Morse, B.J. 81995) Beyond the Conflict Tactics Scales: Assessing gender differences in partner violence. *Violence and Victims, 10,* 251-272.

Morton, N., & Browne, K.D. (1998). Theory and Observation of Attachment and its relation to Child Maltreatment: a review. *Child Abuse & Neglect, 22,* 1093-1104.

Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse & Neglect, 20,* 7-21.

Mullender, A., & Morley, R. (1994). Context and content of a new agenda. In A. Mullender, & R. Morley (Eds.), *Children living with domestic violence*. London: Whiting and Birch.

National Center for Child Abuse and Neglect. (1980). *National study of the incidence and severity of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services.

National Center of Child Abuse and Neglect, (1997). *Child Maltreatment*. National Center of Child Abuse and Neglect. Washington, DC.

Navarre, E. L. (1987). Psychological Maltreatment: the core component of child abuse, In M.R. Brassard, *R. Germain, & S.N. Hart (Eds.),* Psychological Maltreatment of children and youth (pp.45-56). New York: Pergammon Press.

Ney, P. G., Fung, T., & Wickertt, A. R. (1994). The worst combinations of child abuse and neglect. *Child Abuse & Neglect, 18,* 705-714.

O'Hagan, K.P. (1993). *Emotional and psychological abuse of children*. Buckingham, UK: Open University Press.

O'Hagan, K.P. (1995). Emotional and psychological abuse: problems of definition. *Child Abuse & Neglect, 19,* 449-4611.

Oates, R.K. (1996). *The Spectrum of Child Abuse: Assessment, Treatment, and Prevention*. Brunner/Mazel Inc, New York.

Olds, D., Eckenrode, J., Henderson, C. R., Kitman, H., Powers, J., Cole, R., Sidora, K., Morris, P. & Pettit, L. (1997) Long-term effects of home visitation on maternal life course, child abuse and neglect, and children's arrests: 15-years follow-up a randomized trial. *Journal of the American Medical Association, 278* (8), 637-643.

Osofsky, J.D. (1995). Children who witness domestic violence: The invisible victims. Social Policy Reports: Society for Research. *Child Development, 9,* 1-16.

Osofsky, J. D. (1999). The impact of violence on children. *The Future of Children, 9,* 33-49.

Outlaw, M. Ruback, B., & Britt, C. (2002). Repeat and multiple victimizations: The role of individual and contextual factors. *Violence and Victims, 17,* 187-204.

Pagelow, M.D. (1984). *Family violence.* New York: Praeger.

Park, L., Imboden, J., Park, T., Hulse, S., & Unger, T. (1992). Giftedness and psychological abuse in borderline personality disorder: Their relevance to genesis and treatment. *Journal of Personality Disorders, 6,* 226-240.

Patterson, G.R. (1986). Performance models for antisocial boys. *American Psychologist, 41,* 432-444.

Polansky, N., Chalmers, M.A., Buttenweiser, E., & Williams, D.P. (1981). *Damaged parents: An anatomy of child neglect.* Chicago, IL: University of Chicago Press.

Queen Sofia Center for the Study of Violence (2007). *Menores víctimas de violencia en el ámbito familiar* (2007). [Child victims of violence in the family] Retrieved from Centro Reina Sofía website: Accessed 15 April 2009. http://www.centroreinasofia.es/paneldecontrol/est/pdf/EST009-3270.pdf

Riggs, S. A. (2010), Childhood Emotional Abuse and the Attachment System Across the Life Cycle: What Theory and Research Tell Us. *Journal of Aggression, Maltreatment & Trauma, 19,* 5-51.

Rohner, R.P., & Rohner, E.C. (1980). Antecedents and consequences of parental rejection: A theory of emotional abuse. *Child, Abuse & Neglect, 4,* 189-198.

Rohner, R.P., Saavedra, J.M., & Granum, E.O., (1978). Development and validation of the Parental Acceptance-Rejection Questionnaire. *Catalog of Selected Documents in Psychology (MS 1635), 8,* 7-8.

Rorty, M. Yager, J., & Rossotto, E. (1994). Childhood sexual, physical, and psychological abuse in bulimia nervosa. *American Journal of Psychiatry, 151*, 1122-1126.

Rosenberg, M.S. (1987). New directions for research on the psychological maltreatment of children. *American Psychology,* 42, 166-171.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistence to psychiatric disorders. *British Journal of Psychiatry, 147*, 598-611.

Rutter, M. (2006). In Clarke-Stewart A., Dunn J., Clarke-Stewart A. and Dunn J. (Eds.), *Families count: Effects on child and adolescent development*. New York: Cambridge University Press.

Sedlack , A.J., & Broadhurst, D.D. (1996). *Third national incidence study of child abuse and neglect: Final report.* Washington, DC: Department of Health and Human Services.

Sedlak, A.J. (1997). Risk factors for the occurrence of child abuse and neglect. *Journal of Aggression, Maltreatment and Trauma, 1*, 149-187.

Sheintuch, G., & Lewin, G. (1981). Parents' attitudes and children's deprivation: Child rearing attitudes of parents as a key to the advantaged-disadvantaged distinction in pre-school children. *International Journal of Behavioral Development, 4,* 125-142. , 10 (1), 29-46. doi: 10.1207/S15327035EX1001_3

Simonelli, C.J., & Ingram, K.M. (1998). Psychological distress among men experiencing physical and emotional abuse in heterosexual dating relationships. *Journal of Interpersonal Violence, 13*, 667-681.

Sobsey, D. (2002). Exceptionality, Education and Maltreatment. *Exceptionality, 10* (1), 29-46.

Socolar, R. R. S., Runyan, D.K., & Amaya-Jackson, l. (1995). Methodological and ethical issues related to studying child maltreatment. *Journal of Family Issues, 16,* 565-586.

Spitz, R.A. (1945). Hospitalism: An inquiry into genesis of psychiatric conditions in early childhood. *The Psychoanalytic Study of the Child, 1,* 53-74.

Spitz, R.A. (1946). Hospitalism: A follow-up report. *The Psychoanalytic Study of the Child, 2,* 113-117.

Starkey, S.L. (1980). The relationship between parental acceptance-rejection and the academic performance of fourth and fifth graders. *Behavior Science Research, 15,* 67-80.

Steinmetz, S.K. (1997). Wifebeating, husbandbeating: A comparison of the use of physical violence between spouses to resolve marital fights. In M. Roy (Ed.), *Battered women: A psycho-sociological study of domestic violence* (pp.63-72). New York: Van Nostrand Reinold Co., Inc.

Sternberg, K.J., Knutson, J.K., Lamb, M.E., Baradaran, L.P., Nolan, C., & Flanzer, S. (2004). The Child Maltreatment Log: A computer-based program for describing research samples. *Child Maltreatment, 9,* 30-48.

Straus, M.A. (1977, March). *Normative and behavioral aspects of violence between spouses: Preliminary data on a nationally representative USA sample*. Paper presented to Symposium on Violence in Canadian Society, Simon Frasier University, Burnaby, British Columbia.

Straus, M. A. (1979). Measuring intra-family conflict and violence: The Conflict Tactics Scales. *Journal of Marriage and the Family, 41,* 75-88.

Straus, M.A. (1990). Conflict tactics scales (CTS). In J. Touliatos, B.F. Perlmutter, & M. Straus (Eds.), *Handbooks of family measurement techniques*. Newbury Park, CA: Sage.

Straus, M. A. (1995). Trends in cultural norms and rates of partner violence: An update to 1992. In National Council on Family Relations (Series Ed.) & S. Stith & M.A. Straus (Vol. Eds.), *Families in Focus, Vol. 2. Understanding partner violence: Prevalence, causes, consequences and solutions* (pp-30-33). Minneapolis, MN: National Council in Family Relations.

Straus, M. A., & Gelles, R. J. (1990). *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families.* New Brunswick, NJ: Transaction.

Straus, M.A., & Hamby, S.L. (1997). Measuring physical and psychological maltreatment of children with the Conflict Tactics Scales. In G. Kaufman Kantor & J.L. Jasinski (Eds.*), Out of the darkness: Contemporary perspective on family violence.* Thousand Oaks, CA: Sage Publications.

Straus, M.A., Hamby, S.L., Boney-Coy, S., & Sugarman, D.B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 283-316.

Straus, M.A., Hamby, S.L., Finkelhor, D., Moore, D.W., & Runyan, D. (1998). Identification of child maltreatment with parent-child Conflict Tactics Scales; Development and psychometric data for a notional sample of American parents. *Child Abuse & Neglect, 22,* 249-270.

Straus, M.A., Kinard, E.M., & Williams, L.M. (2001). *The Multidimensional Neglectful Behavior Scale, Form A: Adolescent and Adult-Recall Version.* Retrieved June 10, 2011, from http://pubpages.unh.edu/~mas2/Mul.htm

Sullivan, P.M., & Knutson, J.F. (2000). Maltreatment and disabilities: a population-based epidemiological study. *Child Abuse & Neglect, 24*, 1257-1274.

Taussig, H.N., & Culhane, S. E. (2010), Emotional Maltreatment and Psychosocial Functioning in Preadolescent Youth Paced in Out-of-Home Care. *Journal of Aggression, Maltreatment & Trauma, 19,* 52-74.

Thoburn, J., Wilding, J., & Watson, J. (2000) *Family Support in Cases of Emotional Maltreatment and Neglect*. The Stationery Office, London.

Tomison, A.M. (1996). *Child Maltreatment and Disability*. National Child Protection Clearing House Issues Paper no.7, Australian Institute of Family Studies, Melbourne.

Tomison, A., & Tucci, J. (1997). *Emotional Abuse: The hidden form of Maltreatment. Issues in Child Abuse Prevention*, Paper no. 8, National Child Protection Clearinghouse, Melbourne.

Toufexis, A. (1987, December 21). Home is where the hurt is: Wife beating among the well-to-do is no longer secret. *Time, 130*, 25-68.

Trocme, N. (1992). Focus on neglect: *Development of an expert-based index of child neglect*. Paper present at the IPSACN Conference, Chicago.

Trocme, N. (1996). Development and preliminary evaluation of the Ontario Child Neglect Index. *Child Maltreatment, 1*, 145-155.

Turner, H.A., Finkelhor, D., & Ormrod, R. (2010a). Child Mental Health Problems as Risk Factors for Victimization. *Child Maltreatment, 15*(2), 132-143. doi: 10.1177/1077559509349450

Turner, H.A., Finkelhor, D., & Ormrod, R. (2010b). Poly-victimization in a National Sample of Children and Youth. *American Journal of Preventive Medicine, 38*, 323-330. doi: 10.1016/j.amepre.2009.11.012

Turner, H.A., Vanderminden, J., Finkelhor, D., Hamby, S., & Shattuck, A. (2011) Disability and Victimization in a National Sample of Children and Youth. *Child Maltreat 16(4).* 275-286. doi: 10.1177/1077559511427178

US Department of Health and Human Services, Children's Bureau (2004). *Child Maltreatment, 2002*. US Government Printing Office, Washington, DC.

UNICEF (2006). Behind closed doors. *The impact of domestic violence on children*. Retrieved June/22, 2009, from www.unicef.org/media/files/BehindClosedDoors.pdf

Varia, R., Abidin, R.R., & Dass, P. (1996) Perception of abuse: Effects on adults psychological and social adjustment. *Child Abuse & Neglect, 20(6),* 511-526.

Walby, S., & Allen, J. (2004). *Domestic violence, sexual assault & stalking: Findings from the British crime survey.* London: Home Office Research Study, 276.

Wald, M. (1961). *Protective services and emotional neglect.* Denver, CO: American Humane Association.

Wang, C.T., & Daro, D. (1998). *Current trends in child abuse reporting and fatalities: The results of the 1997 Annual Fifty State Survey*. Chicago: National Committee to Prevent Child Abuse.

Women's Aid & and the Child and Women Abuse Studies Unit, London. (2001). *Teenage tolerance: The hidden lives of young Irish people*. Dublin: Women's Aid.

World Health Organization. (2002). *World report on violence and health*. Geneva: World Health Organization.

Annex

7.1 Manuscript: Psychological Abuse in Childhood: III. Long-Term Effects and Relation to Attachment Styles

Abstract

Objective: Psychological maltreatment (PM) is the core component of most of what is considered as child maltreatment. The aim of this work is to explore differential adverse outcomes of childhood PM in different functional areas like adult attachment, psychopathology, and quality of social relationships, in a high-risk community sample of women.

Method: Participants were 302 women, aged between 18 and 55 (mean 34.8, and statistical deviation of 7.05). The psychopathology was assessed using the Present State Examination (PSE), and attachment was assessed by the Attachment Style Interview (ASI). Furthermore, childhood abuse was assessed with the Childhood Experience of Care and Abuse (CECA). Statistical analyses were carried out with regression models adjusted by means of Generalized Estimating Equations.

Results: PM during childhood significantly increases the risk of some psychopathologies (like anxiety and suicide plans), several subscales of insecure attachment (fear of rejection and anger) and poor social relationships in adulthood (lack of a true close support figure).

Implications: These results could be useful in order to design prevention programs in childhood against PM, and for treatment in different areas of functioning in adulthood.

Key Words: attachment, psychopathology, psychological maltreatment, social function.

Among the survivors of other kinds of maltreatment, PM is also the most destructive type in terms of its impact (Brassard et al., 1987; Garbarino et al., 1986), and its harm does indeed extend into adult life (Hart, Binggeli, & Brassard, 1998). PM has been related to many problems Binggeli et al., (2001), reviewed 35 studies (including longitudinal studies, cross-cultural research and comparative studies), and have identified serious problems associated with and probable consequences of PM: interpersonal thoughts, feelings and behaviors (like low self-esteem, negative emotions, anxiety symptoms, depression, suicide/suicidal); emotional problems symptoms (like emotional instability, borderline personality, emotional unresponsiveness, impulse control problems, anger, physical self-abuse, eating disorders and substance abuse); social and anti-social functioning (attachment problems, low social competency, low sympathy/empathy, sexual maladjustment, dependency, aggression/violence and delinquency/criminality), learning problems (low academic achievement, impairments to learning and impaired moral reasoning); and physical health problems (failure to thrive, somatic complaints, poor adult health and high mortality).

Although many of the children's difficulties decrease when they are removed from the abusive environment (Keiley, Howe, Dodge, Bates, & Petit, 2001), a considerable number of children continue to show signs of dysfunction for many years after the abuse has ended (Yates & Wekerle, 2009). Moreover, psychological maltreatment can be defined as a relationship disorder between a child and his or her parent (Binggeli et al., 2001), so the abused individual is believed to be more likely to choose relationships and social situations which replicate and confirm the abusive experience, thus PM leads to a risk of suffering further abuse (Crawford & Wright, 2007). Adults with a childhood history of PM frequently display a limited capacity to empathize with others, difficulties

in relationships with peers and partners and inadequate and often inappropriate parenting skills (Briggs & Hawkins, 1996). As a result, the risk cycle is perpetuated.

A relevant theoretical orientation about the relationship of PM and the attachment style was proposed by Binggeli et al., (2001). This theoretical approach states that, through their ongoing iterations with attachment figures, the children form internal working models, or sets of expectations about their own roles and the roles of others in social interactions. For instance, ambivalent-resistant attachment (high level of stress at mother's departure and ambivalent behaviors toward her, alternatively seeking closeness, and angrily pushing her away when she returns) are associated with insensitive care characterized by withdrawal and uninvolvement (that fits the denying emotional responsiveness category of PM). The mothers of the infants that have avoidance attachment (this child shows little stress when their mother leaves and they avoid their mothers by looking away, ignoring her in the reunion), have been found to be insensitive to their infant's needs and to alternate between rejection, neglecting and interfering (behavior that fits the spurning, denying emotional responsiveness, and exploiting/corrupting categories of PM). And finally the mothers of the infant with the disorganized/disoriented attachment (diverse and contradictory behavior patterns and bizarre and stereotypic behavior) generally have been consistent for an extended period of time followed by a period of inconsistency, conditions that may, as a pattern, include spurning, terrorizing, isolating, and denying emotional responsiveness characteristics.

Morton and Browne (1998) review the literature on attachment and child maltreatment in relation to the intergenerational transmission of maltreatment, with a descriptive analysis of 13 studies. The majority of studies demonstrate that, on average, maltreated children are less securely attached to their mothers than non-maltreated children. They found that the primary process by which maltreatment continues from one

generation to the next is that this early mother-infant relationship is internalized by the child and consequently forms a prototype of which all future relationships are assimilated. Thus, maltreated children may have problems forming relationships with peers, partners and their own children.

Baer and Martinez (2006), in a meta-analysis of eight studies about child maltreatment and insecure attachment, found that maltreated infants were significantly more likely to have an insecure attachment than were the controls, and different types of maltreatment affect the magnitude of the effect, and they conclude that child maltreatment is considered to be one of the most important causes of insecure/disorganized attachment.

Bailey, Moran and Pederson (2007) studied the relationship between childhood maltreatment, complex trauma symptoms and unresolved attachment in an at-risk sample of adolescent mothers. They found that childhood physical abuse, sexual abuse and general maltreatment were associated with unresolved attachment. And a sexual abuse history and general maltreatment predicted unresolved loss that adversely affected the integration of the other emotional and/or traumatic experiences.

Taussig and Culhane (2010) examine the impact of emotional maltreatment on the psychological functioning in a prospective design in a sample of maltreated children with a recent entry into out-of-home care. Findings show that some emotional maltreatment subtypes are positively associated with psychosocial problems. After controlling for other abuses, emotional maltreatment was associated with higher self-reported anxiety and post-traumatic stress symptoms, and less social acceptance, self-esteem and levels of life satisfaction. Riggs (2010) reviews the theoretical and empirical literature regarding the normative development of the attachment system from infancy through adulthood, and then discusses deviations from the normal developmental

pathways that occur in response to emotionally abusive parenting. His theoretical model proposes that early emotional abuse engenders insecure attachment, which impairs emotional regulation, fosters negative views of self and others that support maladaptive coping responses, interferes with social functioning and the capacity for intimate adult attachments, contributes to poor mental health and consequently shapes the quality of romantic relationships.

In this framework the goal is to study the different, adverse long-term outcomes of childhood maltreatment, specifically PM, in adult attachment, social functioning and mental health, in a high-risk community sample of adult women. Our hypothesis, according to the literature, is that childhood PM leads to a worse social functioning, insecure attachment and higher psychopathology in adulthood. This information could enable us to identify the particular effects of PM experienced in this population and to develop more specific interventions and treatments. This study is relevant because, although the relationship between maltreatment and social function, psychopathology and attachment have been studied before, the specific contribution of PM was less studied than other types of maltreatment.

Method

Participants

The sample was taken from a research program investigating vulnerability to depression in community women. The high-risk series was selected by extensive questionnaire screening of general practitioners' registers of patients in Islington, North London. Screening questionnaires were sent out to 7,500 women. Three-quarters of the final series were selected for psycho-social vulnerability for depression, the remainder forming a comparison series. The sample incorporated two series investigating different

elements of psychosocial vulnerability and they were selected on the basis of motherhood and sister roles.

A series of 104 mothers with ongoing interpersonal problems (conflict with partner or child or lack of a close confidant) or low self-esteem, but free from clinical depression at first contact. These were seen twice prospectively over 12 months to gauge the impact of vulnerability on the onset of disorder.

A series of sister pairs, comprising one group, was selected for having experienced neglect or abuse in childhood (n=118), and a consecutive comparison series (n=80) was also selected. This is a total of 198 women (118 +80). Each had an available sister within 5 years of age, the sisters being brought up together in childhood. Each of the pair was interviewed independently about childhood to establish aspects of non-shared environment in relation to disorder.

Overall, 60% of suitable responders agreed to the interview (with sisters where appropriate) and 23% refused. A further 19% were unobtainable (mainly sisters of originally screened subjects) or those who had moved away for follow-up.

The final sample used in this study included three-hundred and two women of a high-risk community sample (104 + 198). Demographic characteristics of the final series showed 32% were working-class, 61% were married or cohabiting and 69% had children. The women are aged between 18 and 55. The average age was 34.8 (statistical deviation 7.0).

Table 1

Sample Characteristics

			Child PM	
		TOTAL (N=302)	**Yes** N= 49	**No** N= 253
Current age (years); Mean (SD)		34.8 (7.0)	33.7 (7.0)	35.0 (7.0)
SES (%)	*Middle-high*	44.8	35	46.4
	Middle-low	23.3	25	23
	Working-class high	12.5	12.5	12.6
	Working-class low	19.4	27.5	18
Sex: female (%)		100	100	100
Parenthood (%)		68.5	75.5	56.3
Single parent (%)		20.2	24.5	19.4
Early parenthood (%)		21.5	24.4	20.9
Marital status: cohabiting/married (%)		60.9	63.3	60.5
Marital status: separated (%)		51.7	51	51.8

SD: Standard Deviation.

PM: Psychological Maltreatment

Measures

Childhood Experienced of Care and Abuse (CECA) (Bifulco, 1994). The different types of PM suffered by women in their childhood were assessed using this instrument. It is a retrospective semi-structured interview measure that was used to assess a range of negative childhood experiences prior to age 17. The categories of psychological abuse are *humiliation/degradation;* (equivalent to the APSA subtype spurning), *terrorizing*; (with the same name in the APSA subtype), *cognitive disorientation, deprivation of basic needs, deprivation of valued objects, extreme*

rejection (similar to the APSA subtype denying emotional responsiveness), *inflicting marked distress or discomfort, emotional blackmail* and *corruption/exploitation* (with the same name in the APSA subtype). This instrument also assesses parental *antipathy* (dislike, rejection, irritation and coldness, which could be like a less-severe kind of PM), *parental neglect, role reversal, parental discipline, parental supervision, physical abuse, sexual abuse,* and *felt shame*. The maltreatment information collected using CECA is carefully rated by the clinician after the interview using an standardized manual rather than relying on the participant's subjective report. PM was assessed using a four-point scale; 1 marked, 2 moderate, 3 some, 4 little/none. The PM variable was dichotomized into PM (marked, moderate or some) versus no PM.

The *Attachment Style Interview (ASI)* (Bifulco et al., 1998) is a semi-structured diagnostic interview that covers the most common attachment styles, i.e. *secure attachment* and different insecure attachments: *enmeshed, fearful, angry/dismissive* and *withdraw* style, as well as the degree to which attachment styles were insecure or 'non-standard'. The styles are assessed using a scale of four points that assesses the degree, (1 high, 2 mild, 3 moderate, 4 none); the style was dichotomized: high and mild are considered 'non-standard', and moderate or none are considered 'standard'. The overall attachment style was a global judgment of style based on the *ability of making intimate relationships* and eight attitudinal scales like *mistrust, attitudinal constraints on closeness, self-reliance* and *anger* (reflecting avoidance /distance in maintaining relationships) and *fear of rejection, fear of sexual intimacy, fear of separation* and *desire of company* (reflecting anxious/ambivalent). The *mistrust, constraints on closeness, fear of rejection, fear of separation* and *anger* scales were assessed by a four-point ordinal scale (1 marked, 2 moderate, 3 some and 4 little/none), the low points are more psychopathological and the best, or standard, is the highest punctuation. The *ability to*

make and maintain relationships scale was assessed using the same ordinal scale, but in this case the best is the lowest point. Finally the scales *self-reliance* and *desire of company* were assessed by a four-point ordinal scale (1 high, 2 moderate/average, 3 low and 4 contradictory); in this case the highest and the lowest are bad and the average is best. The *enmeshed style* is characterized by a low or contradictory *self-reliance*, high or contradictory *desire of company*, high *fear of separation*, low *constraints on closeness* and *fear of rejection*, and any punctuation in *mistrust* and *anger*. The *fearful style* includes high *mistrust*, *constraints on closeness*, and *fear of rejection*; low *anger*, and any point in *self-reliance*, *desire of* company, and *fear of separation*. The *angry-dismissive style* is formed by high *mistrust*, *constraints on closeness*, *self-reliance* and *anger*, and low *fear of rejection*, *desire of company* and *fear of separation*. The *withdraw style* includes high *constraints on closeness* and *self-reliance*; and low *fear of rejection*, *desire of company*, *fear of separation* and *angry*, and any *mistrust*. Finally, the *secure style* includes a low punctuation in all of the subscales, and moderate *self-reliance* and *desire of company*. The *enmeshed* and the *fearful* styles could be considered anxious/ambivalent styles, while the *angry-dismissive* and the *withdrawn* styles are considered avoidant styles. All of them are non-standard styles.

The *Present State Examination* (Wing et al., 1974). This is a structured interview schedule that assesses psychopathology and it was used only for the adult female sample. This structured interview has passed through several editions and has found acceptance in several research programs. The Present State Examination (PSE) is not a questionnaire, and the examiner is not merely recording the patient's answers to the questions contained in this schedule. Rather, it is a clinical guide for the examiner, enabling him to thoroughly examine the psychopathological features of a patient and adhere to clear definitions of his clinical terms. It contains approximately 500 questions

or items, each representing a test for a specific symptom or psychological phenomenon. The examiner must determine whether the patient has or does not have a given symptom. The examination questions provide the examiner with a sequence and a wording for his tests, but he may question the patient in any manner he deems fit and he may observe as much spontaneous speech and behavior as he desires. However, the examiner must eventually make a judgment on the symptoms and adhere to particular definitions in deciding on their presence or absence. The PSE is thorough in that it not only tests for specific symptoms that are recorded during the interview, but it also calls for judgments of the patient's behavior observed during the interview and recorded immediately afterwards. The PSE has been divided by Wing into sections of clinically related phenomena. The mental status examination using the PSE generally took from 45 minutes to 1 ½ hours, depending primarily on the quantity of the patient's symptomatology, and, in particular, if there were many delusions, hallucinations, or markedly disordered thought present. The high reliability of the overall psychopathological profile, as well as the high reliability of the majority of the phenomenological sections, is strong evidence that the PSE provides not only a thorough, but a very reliable measure of psychopathology (Luria & McHugh, 1974).

Procedure

This study was approved by the Ethics Review Board of the author's university and confidentiality was guaranteed. The interviews were completed by a trained clinical psychologist. The women were interviewed in-depth about their childhood experience, ongoing supportive relationships, self-esteem, attachment style and psychopathology. The mental status examination was used to assess psychopathology over a 12-month recent period, it took from 45 minutes to 1 ½ hours, depending primarily on the quantity

of the patient's symptomatology. The Attachment Style Interview was used to assess her attachment style; it took between 30 min to 40 min to administer and around double that time to rate and score. The different types of PM and a wide range of negative childhood experiences prior to age 17 suffered by children were assessed retrospectively, using the semi-structured CECA interview.

Statistical Analysis

The statistical analysis was carried out with SPSS 17 for Windows. Different analyses evaluated the effect of childhood PM and antipathy (independent variables of this study, with a binary format: present-absent, on adult functional impairment, attachment and psychopathology (dependent variables). The PM variable was dichotomized, and it is considered present when the PM is marked, moderate or mild vs. PM being absent.

This research refers to nested structure data (some siblings had the same parents), but a low level of hierarchy was observed (67.2% of families had only one child, 29.1% had two children, 2.3% had three children, 0.7% had four and 0.3% had five; mean number of children per family was 1.03, SD= 0.925), so that multi-level models were inadequate because they did not allow for a satisfactory adjustment (Hox, 2002). To account for data dependency at the lower data level and prevent possible estimation bias, the random factor "family" was included in multiple mixed models using Generalized Estimating Equations (GEE procedure in the SPSS system). Family is considered a random factor in the GEE models because our study includes children belonging to different families. The point of this study is to generalize the results for all families of the larger population of at risk families, and to consider the specific families included in the research as a random sample of that population. These models were adjusted in

accordance with the Binomial distribution and the Logit link-function for binary criteria, and with the Poisson distribution and Log link-function for ordinal variables such as degree of mistrust and other subscales of attachment. The models' overall predictive capacity was assessed using Nagelkerke's R-square for binary responses and adjusted R-squared for metric criteria. B coefficients are provided for ordinal measures: Odds ratios (OR) and 95% confidence intervals (CIs) are provided for dichotomous functioning measures.

Subsequent analyses have been carried out. In the first step we included the demographic variable only if one of them had a significantly different distribution between the groups (psychological maltreatment and no psychological maltreatment); otherwise, the analyses in this step show the unadjusted association. In Block Two, the model is adjusted for the same variables rather than in the Step One and also for the antipathy variable. In order to obtain the adjusted contribution of each abuse subtype, all maltreatments were simultaneously entered into GEE models (ENTER procedure) in the last step, so in Block Three the analyses are adjusted by the same control variables as in the previous steps, and also other types of maltreatment (sexual, physical and neglect).

Results

As stated previously, participants with and without PM in childhood were compared on demographic characteristics like age, socio-economic level, and marital status (married, separated) and to be a parent at the first interview, (also difficult parenting, single parent or early pregnancy before age 20).

Results show that PM was not significantly associated with Socio-Economical Status (SES). Difference in SES between the PM and no-PM group is not significant ($\chi 2 = 2.66$, $p<.447$).

Psychological maltreatments were not associated with age, parenthood, single parent, early parenthood, marital status, or to be separated. Difference in these variables between the PM and no-PM group are not significant ($\chi 2 = 2.66$, $p<.447$). Thus, subsequent analyses are not controlled for any demographic variable.

Table 2

Descriptive statistics of the sample: adult psychopathology, attachment, social function measures and psychological maltreatment in childhood.

	Psychological maltreatment in childhood					
	Yes (n= 49)			No (n=253)		
	M	*SD*	*%*	*M*	*SD*	*%*
Psychopathology						
Depression			75.5			58.1
Suicide plan			36.7			17.4
Eating Disorders			4.1			6.3
Substance abuse/Borderline			26.5			11.9
Conduct Disorder			10.3			7.1
Anxiety			40.8			23.7
Negative Self-esteem			49.0			44.0
Attachment subscales						
Degree of insecurity attachment	1.6	.98		1.2	.96	
Mistrust	2.3	1.2		2.6	1.1	
Constraints closeness	2.3	1.3		2.7	.96	
Fear of rejection	2.7	1.2		3.2	1.0	
Fear of sexual intimacy	2.9	1.8		3.3	1.2	
Self-reliance	1.7	.68		1.8	.75	
Fear of separation	2.8	1.5		3.2	1.0	
Desire for company	2.5	1.0		2.4	.71	
Anger	2.6	1.4		3.1	1.2	
Ability to make/maintain a relationship	2.7	.62		2.4	.75	
Insecurity styles (any)			79.6			67.2
Enmeshed			8.2			6.7
Fearful			22.4			16.6
Angry/Dismissive			22.4			8.7
Withdrawn			8.2			9.9
Social relationship						
Poor support			49.0			50.6
Poor partner relationship			71.4			75.1
Lack of true close support figure			42.9			30.4

M= Mean
SD= Statistical Deviation.

Participants with and without PM in childhood were compared using the dependent variables of the sample: measures of psychopathology, attachment and social function.

Table 1 presents unadjusted rates of adult functioning (psychopathology, attachment measures and social relationships) as a function of childhood PM. Table 1 shows the mean and statistical deviation of different quantitative-ordinal dependent variables in each group (PM and no PM), and the percentage of women in each group if the variable was dichotomy.

In almost all of the ordinal variables (like the subscale of attachment where 1 was severe and 4 is low) the group with PM has an average which is slightly low (and low means worse or severe). And, also, in almost all of the binary variables the percentage was higher (more psychopathology, more insecure attachment or poor social relationship) in the PM group than in the group without PM. But these results are simply descriptive.

The associations between PM in childhood and functioning in adulthood are shown in Table 2. The first column corresponds to the first block and shows the unadjusted analysis, due to the fact that controlling for demographics variables was not necessary because the distribution of these variables between the two groups (PM vs. no-PM) was significantly homogeneous. Block Two included the covariate antipathy from either parent at childhood. The third block includes the previous covariate and other types of maltreatment during childhood (neglect, physical or sexual abuse).

Table 3. *Associations between psychological maltreatment during childhood and psychosocial functioning in adult women*

	Block 1[a]		Block 2 [a,b]		Block 3 [a,b,c]	
	b	OR (95% CI)	*b*	OR (95% CI)	*b*	OR (95% CI)
Psychopathology						
Depression		2.2 (1.3-3.8)**		1.6 (0.9-2.9)		1.3 (0.7-2.4)
Suicide plan		2.8 (2.2-3.5)***		1.9 (1.4-2.5)***		1.7 (1.1-2.4)*
Eating Disorders		0.6 (0.2-2.3)		0.5 (0.2-1.3)		0.5 (0.2-1.8)
Substance abuse/Borderline		2.7 (1.5-4.9)		1.8 (0.9-3.7)		1.6 (0.9-2.8)
Conduct Disorder		1.5 (0.4-6.1)		1.3 (0.3-5.0)		1.1 (0.2-4.9)
Anxiety		2.2 (1.9-2.6)***		1.6 (1.2-2.1)**		1.5 (1.1-2.0)**
Negative Self-esteem		1.3 (0.8-2.1)		1.04 (0.7-1.6)		0.96 (0.7-1.4)
Attachment subscales						
Degree of insecurity	0.30***		0.20*		0.12	
Mistrust	-0.11**		-0.05		-0.03	
Constraints closeness	-0.11*		-0.07		-0.05	
Fear of rejection	-0.12***		-0.10***		-0.09***	
Fear of sexual intimacy	-0.03		-0.01		-0.002	
Self-reliance	-0.08		-0.05		-0.06	
Fear of separation	-0.07**		-0.06		-0.06	
Desire for company	0.09*		0.08*		0.07	
Anger	-0.2***		-0.11**		-0.1*	
Ability to make/maintain relationship	0.11***		0.06**		0.02	
Insecure styles						
Any Insecure Style		1.9 (1.1-3.4)*		1.6 (0.8-3.0)		1.3 (0.7-2.6)
Enmeshed		1.2 (0.3-5.5)		0.9 (0.2-3.7)		0.8 (0.2-3.2)
Fearful		1.5 (1.04-2.0)*		1.26 (0.8-2.0)		1.1 (0.7-1.7)
Angry/Dismissive		3.0 (1.4-6.5)**		2.6 (0.9-7.3)		2.2 (0.64-7.8)
Withdrawn		0.8 (0.4-1.6)		0.8 (0.3- 3.0)		0.7 (0.3-1.7)
Social relationship						
Poor support		0.9 (0.6-1.4)		1.6 (0.8-3.0)		1.3 (0.7-2.6)
Poor partner relationship		0.8 (0.5-1.5)		1.6 (0.8-3.0)		1.3 (0.7-2.6)
Lack of true close support figure		1.7 (1.4-2.1)***		1.6 (1.1-2.3)*		1.5 (1.0-2.3)*

B coefficients are provided for ordinal measures; Odds ratios (OR) and 95% confidential intervals (ICs) are provided for dichotomous functioning measures.
[a] Unadjusted associations. [b] Adjusted for antipathy from either parent in childhood. [c] Adjusted for other types of maltreatment during childhood (neglect, physical or sexual abuse).
*p<.05; **p<.01; ***p<.001

Psychopathology

In the first block (unadjusted), PM in childhood was associated with four of the seven adult psychopathology measures: depression, suicide plan, substance abuse (borderline), and anxiety. In the second block, after controlling for antipathy, of the seven psychopathology measures, two remained significant after controlling for antipathy: suicide plans and anxiety. These results remain significant also in the third block, even after also controlling for other maltreatments like sexual or physical abuse and neglect. Suffering from PM in childhood increases the risk of ever suicide plans by 1.7, and it multiplies the risk of anxiety in adulthood by 1.5.

Attachment

In the *first block* (unadjusted), PM in childhood was associated with the variable of any insecure styles, specifically, PM was associated with two of the four adult insecure attachment styles: *fearful style* and *angry/dismissive* style. Suffering PM in childhood increases the risk of a *fearful* style in adulthood by 1.5 (OR=odd ratio), and it multiply by three (OR= 3.03) the risk of having an *angry/dismissive* style in adulthood. Also, PM was significantly associated with the variable *degree of insecurity of the style* and seven of the nine subscales of attachment: *mistrust, constraints closeness, fear of rejection, fear of separation, desire for company, anger* and *ability to make or maintain relationships*. In the *second block*, after controlling for antipathy, degree of insecurity and five of the seven subscales remained significant after controlling for antipathy: *fear of rejection, desire of company, anger* and *ability of making or maintain relationships*. In *Block Three* none of the attachment styles remains significant. Two of the attachment subscales also remain significant in the third block (*fear of rejection* and *anger*) even after also controlling for other maltreatment like sexual, physical and

neglect. Suffering from PM compared with not suffering from PM, significantly decreases almost 0.1 the punctuation of *fear of rejection* (*b*= - 0.90), and the punctuation of *anger* (*b*= - 0.96), which is worse, due to in the four-point scales 1 meaning severe.

Social Function

In no block, was PM in childhood associated with a *lack of true close support* figure in adulthood. Suffering from PM in childhood comparing with not suffering from PM in childhood significantly increases the risk by 1.5 of the *lack of true close support* figure. And even if analysis controls for physical, sexual maltreatment, neglect and antipathy, the contribution of PM is significant, as we can see in *Block Three*.

Discussion

According to our hypothesis, the results show that suffering from PM in childhood is associated with poorer functioning in adulthood. It increases the risk of psychopathology and poor social support, and it is related, if not with a concrete insecure style, with several subscales of attachment measures. And these associations are significant even when controlling for others maltreatments and antipathy, so the contribution is due specifically to PM.

Regarding psychopathology, PM in childhood is associated with anxiety and suicide plans. Those results are according to the previous literature. Other studies found the relationship between PM and anxiety symptoms (Claussen & Crittenden, 1991; Crittenden et al., 1994, and Hughes & Graham-Bermann, 1998).

Suffering from PM in childhood is not significantly associated with any concrete insecure attachment style in adulthood, after controlling for antipathy and other maltreatments, but it is significantly associated with some components of attachment.

PM in childhood significantly increases *anger* and *fear of rejection*. High *anger* is a component of the *angry-dismissive style*, and high *fear of rejection* is a component of the *fearful style*. Other authors have found the relationship between maltreatment and insecure attachment (Bailey et al., 2007; Bear & Martinez, 2006, and Morton & Browne, 1998), and specifically with PM (Binggeli et al., 2001; Mullen et al., 1996; Riggs, 2010, and Taussig & Culhane, 2010). The relationship between PM and anger was also found before (Egeland &Erickson, 1987). The insecure attachment style was found to be predictive of new episodes of anxiety disorders and, specifically, fearful and angry-dismissive styles were the two insecure attachments most consistently related to disorder (Bifulco, et al., 2006).

Results indicate that PM is related to a lack of a close support figure in adulthood. This could be related to the fact that PM is also significantly associated with *anger* (which could make other people go away, and because of this it also makes it difficult to have a secure, confident and reliable relationship), and with *fear of rejection* (which could make the person who has suffered from PM reject being involved in a relationship for the fear of be being hurt again). Other studies have also found that PM could be related to low social competence (Claussen & Crittenden, 1991). The presence of confident relationships and having a good social support network is a protective factor because it could buffer the impact of adversity and stressful life events. Other authors found that social support from friends, spouse or relatives was associated with significantly reduced odds of psychopathology (like panic disorder and psychological distress) after experiencing specific life events. So, the *lack of a close support figure* is a risk factor and it could perpetuate the risk cycle, which is known by the name of re-victimization. The relationships between childhood PM, interpersonal schemes, and

adult relationship aggression were explored by other authors (Crawford & Wright, (2007); childhood PM predicted both perpetration and re-victimization experiences.

On interpreting the results, some limitations should be taken into account. Results can only be generalized and applied to women, because the sample does not include men. Additionally, there are limitations that arise from employing retrospective accounts of childhood maltreatment.

Other limitations include the wide age range (18 to 55 years of age); the outcomes of PM may differ across age ranges. Another limitation is that the size of the sample of PM subtypes makes it impossible to take into account the subtype of the PM, so the PM variable is used in analysis, which includes very different phenomena.

Despite these limitations, this research has important clinical applications as regards childhood PM. These results suggest the importance of taking into account the long-term consequences of PM in adult functioning in order to design appropriate and accurate intervention in prevention and treatment. Adult attachment style seems to be a mediator between childhood neglect/abuse and adult psychopathology like anxiety. Programs addressed to people suffering form childhood PM will benefit if careful evaluation of the adult attachment style and of the interaction patterns of these people is included, due to insecure attachment, specifically fearful and angry/dismissive styles, which are risk factors for disorders and psychopathology. This fact provides a potential screening instrument for preventative interventions. Some areas that could also be targets in these programs are strategies for anxiety reduction, improvement of social skills and anger management. There is also important to detect suicidal ideation, and to make a comprehensive approach that includes a bio-psycho-social perspective, considering the participation of diverse people of the child's context, in order to improve resources and support figures or the environment.

References

American Professional Society on the Abuse of Children (APSAC). (1995). Psychosocial evaluation of suspected psychological maltreatment in children and adolescents. *Cultic Studies Journal, 13,* 153-170.

Baer, J.C., & Martinez C.D. (2006). Child maltreatment and insecure attachment: a meta-analysis. *Journal of Reproductive and Infant Psychology, 24,* 187-197.

Bailey, H.N., Moran, G., & Pederson, D.R. (2007). Childhood maltreatment, complex trauma symptoms, and unresolved attachment in an at-risk sample of adolescent mothers. *Attachment & Human Development, 9,* 139-161.

Bifulco, A., Brown, G.W., & Harris, T.O. (1994). Childhood Experience of Care and Abuse (CECA): A retrospective interview measure. *Journal of Child Psychology and Psychiatry, 35,* 1419-1435.

Bifulco, A., Kwon, J., Jacobs, C., Moran, P. M., Buun, A., & Beer, N. (2006). Adult attachment style as mediator between childhood neglect/abuse and adult depression and anxiety. Social Psychiatry and Psychiatric Epidemiology, 41, 796-805. doi: 10.1007/s00127-006-0101-z

Bifulco, A., Lillie, A., Ball, B., & Moran, P. (1998). *Attachment Style Interview (ASI). Training Manual*. Royal Holloway, University of London.

Binggeli, N. J., Hart, S. N., & Brassard, M. R. (2001). *Psychological maltreatment of children. The APSAC study guides 4*. Thousand Oaks, California: Sage Publications.

Brassard, M. R., Germain, R., & Hart, S. N. (1987). *Psychological maltreatment of children and youth*. New York: Pergamon.

Briere, J., & Runtz, M. (1990). Differential adult symptomology associated with three types of child abuse histories. *Child Abuse & Neglect, 14*, 357-364.

Briggs, F., & Hawkins, R. M. F. (1996). *Child protection: A guide for teachers and child care professionals*. St Leonards, NSW: Allen & Unwin.

Claussen, A.H., & Crittenden, P.M. (1991). Physical and psychological maltreatment: Relations among types of maltreatment. *Child Abuse and Neglect, 15*, 172-183.

Crawford, E., & Wright, M. (2007). The impact of childhood psychological maltreatment on interpersonal schemas and subsequent experiences of relationship aggression. *Journal of Emotional Abuse, 7,* 93-116. doi:10.1300/J135v07n02_06

Crittenden, P. M., Claussen, A.H., & Sugarman, D.B. (1994). Physical and psychological maltreatment in middle childhood and adolescence. *Development and Psychopathology, 6,* 145-164.

Egeland, B., & Erickson, M. (1987). Psychologically unavailable caregiving. In M.R. Brassard, R. Germain, & S. N. Hart (Eds.), Psychological maltreatment of children and youth (pp. 110-120). New York: Pergamon.

Garbarino, J., Guttmann, E., & Seeley, J. W. (1986). *The psychologically battered child: Strategies for identification, assessment, and intervention*. San Francisco, CA: Jossey-Bass, Inc.

Hart, S.N. (1992). Psychological meaning and maltreatment factors relevant to consequences and treatment (Letter to the Subpanel on Consequences and Treatment, Panel of Research on Child Abuse and Neglect, National Research Panel, National Academy of Sciences, Washington, DC). Indianapolis: Indiana

University-Purdue University at Indianapolis, Office for the Study f the Psychological Rights of the Child.

Hart, S. N., Binggeli, N. J., & Brassard, M. R. (1998). Evidence of the effects of psychological maltreatment. *Journal of Emotional Abuse, 1,* 27-58.

Hughes, H.M., & Graham-Bermann, S.A. (1998). Children of battered women: Impact of emotional abuse on adjustment and development. *Journal of Emotional Abuse, 1*, 13-50.

Keiley, M. K., Howe, T. R., Dodge, K. A., Bates, J. E., & Petit, G. S. (2001). The timing of child physical maltreatment: A cross-domain growth analysis of impact on adolescent externalizing and internalizing problems. *Development and Psychopathology, 13,* 981-912.

Maulik, P. K., Eaton, W. W., & Bradshaw, C. P. (2010). The effect of social networks and social support on common mental disorders following specific life events. *Acta Psychiatrica Scandinavica, 122,* 118-128. doi:10.1111/j.1600-0447.2009.01511.x

Morton, N., & Browne, K.D. (1998). Theory and Observation of Attachment and its relation to Child Maltreatment: a review. *Child Abuse & Neglect, 22,* 1093-1104.

Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse & Neglect, 20,* 7-21.

Riggs, S. A. (2010), Childhood Emotional Abuse and the Attachment System Across the Life Cycle: What Theory and Research Tell Us. *Journal of Aggression, Maltreatment & Trauma, 19,* 5-51.

Taussig, H.N., & Culhane, S. E. (2010), Emotional Maltreatment and Psychosocial Functioning in Preadolescent Youth Paced in Out-of-Home Care. *Journal of Aggression, Maltreatment & Trauma, 19,* 52-74.

Wing, J.K., Cooper, J.E., & Sartorius, N. (1974). *The measurement and classification of psych iatric symptoms: an instruction manual for the Present Status Examination and CATGO Programme*. Cambridge University Press, Cambridge.

Yates, T. M., & Wekerle, C. (2009). The long-term consequences of childhood emotional maltreatment on development: (mal)adaptation in adolescence and young adulthood. *Child Abuse & Neglect, 33,* 19-21.