

# Unseen Wounds: The Contribution of Psychological Maltreatment to Child and Adolescent Mental Health and Risk Outcomes

Joseph Spinazzola and Hilary Hodgdon  
The Trauma Center at Justice Resource Institute,  
Brookline, Massachusetts

Li-Jung Liang  
University of California, Los Angeles School of Medicine

Julian D. Ford  
University of Connecticut Medical School

Christopher M. Layne and Robert Pynoos  
National Center for Child Traumatic Stress, Los Angeles,  
California and University of California, Los Angeles

Ernestine C. Briggs  
National Center for Child Traumatic Stress, Durham, North  
Carolina and Duke University School of Medicine

Bradley Stolbach  
University of Chicago Pritzker School of Medicine

Cassandra Kisiel  
Northwestern University Medical School

For this study, we evaluated the independent and additive predictive effects of psychological maltreatment on an array of behavioral problems, symptoms, and disorders in a large national sample of clinic-referred children and adolescents drawn from the National Child Traumatic Stress Network Core Data Set (CDS; see Layne, Briggs-King, & Courtois, 2014). We analyzed a subsample of 5,616 youth with lifetime histories of 1 or more of 3 forms of maltreatment: psychological maltreatment (emotional abuse or emotional neglect), physical abuse, and sexual abuse. Measures included the University of California, Los Angeles Posttraumatic Stress Disorder–Reaction Index (Steinberg et al., 2004), Child Behavior Checklist (Achenbach & Rescorla, 2004), and 27 diagnostic and CDS-specific clinical severity indicators. Psychologically maltreated youth exhibited equivalent or greater baseline levels of behavioral problems, symptoms, and disorders compared with physically or sexually abused youth on most indicators. The co-occurrence of psychological maltreatment with physical or sexual abuse was linked to the exacerbation of most outcomes. We found that the clinical profiles of psychologically maltreated youth overlapped with, yet were distinct from, those of physically and/or sexually abused youth. Despite its high prevalence in the CDS, psychological maltreatment was rarely the focus of intervention for youth in this large national sample. We discuss implications for child mental health policy; educational outreach to providers, youth, and families; and the development or adaptation of evidence-based interventions that target the effects of this widespread, harmful, yet often overlooked form of maltreatment.

*Keywords:* psychological maltreatment, emotional abuse and emotional neglect, physical and sexual abuse, clinical profiles of maltreated youth, complex trauma

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Joseph Spinazzola and Hilary Hodgdon, The Trauma Center at Justice Resource Institute, Brookline, Massachusetts; Li-Jung Liang, Department of Medicine, University of California, Los Angeles School of Medicine; Julian D. Ford, Department of Psychiatry, University of Connecticut Medical School; Christopher M. Layne and Robert Pynoos, National Center for Child Traumatic Stress, Los Angeles, California and Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles; Ernestine C. Briggs, National Center for Child Traumatic Stress, Durham, North Carolina and Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine; Bradley Stolbach, Department of Child and Adolescent Psychiatry, University of Chicago Pritzker School of Medicine; Cassandra Kisiel, Department of Psychiatry and Behavioral Sciences, Northwestern University Medical School.

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Correspondence concerning this article should be addressed to Joseph Spinazzola, Executive Director, The Trauma Center at JRI, 1269 Beacon St., Brookline, MA 02446. E-mail: jspinazzola@traumacenter.org

Nearly 3 million U.S. children experience some form of maltreatment annually, predominantly perpetrated by a parent, family member, or other adult caregiver (Children's Bureau, 2010). Although child maltreatment is often conceived as involving the deliberate infliction of physical harm, the American Academy of Pediatrics (AAP) has recently identified psychological maltreatment as "the most challenging and prevalent form of child abuse

increased risk of psychological harm to the child (Wolfe & Melsaac, 2011).

Despite the notably high federal prevalence data cited earlier, the *perceived* prevalence of PM in the United States appears to depend heavily on where one looks and whom one asks. For example, official reports of PM to child welfare agencies portray PM as a relatively rare phenomenon: Only 7.6% of official reports

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Table 2  
Frequency of Indicators of Severity and Clinical Evaluation by Maltreatment Comparison Groups

Indicators of severity	Sexual abuse (SA) N (%)	Physical abuse (PA) N (%)	Psychological maltreatment (PM) N (%)	Sexual & physical abuse (SA + PA) N (%)	Psychological maltreatment & sexual abuse (PM + SA) N (%)	Psychological maltreatment & physical abuse (PM + PA) N (%)	All three N (%)	Group significance
Academic problems	392 (39.4)	391 (52.3)	673 (54.8)	113 (51.8)	159 (54.6)	691 (59.6)	312 (61.2)	B <sup>***</sup> , D <sup>**</sup> , E <sup>**</sup>
Behavior problems at school	343 (34.3)	372 (49.3)	600 (48.3)	114 (52.3)	127 (44.1)	616 (52.9)	265 (52.0)	B <sup>***</sup> , E <sup>**</sup>
Skipping school or daycare	88 (8.8)	77 (10.2)	167 (13.5)	32 (14.4)	52 (17.9)	176 (15.0)	80 (15.7)	A <sup>*</sup> , B <sup>*</sup> , D <sup>*</sup> , E <sup>**</sup>
Behavior problems at home	474 (47.0)	459 (59.9)	828 (65.5)	142 (64.0)	175 (59.5)	848 (71.3)	362 (68.6)	A <sup>*</sup> , B <sup>*</sup> , D <sup>**</sup> , E <sup>***</sup>
Suicidality	153 (15.4)	103 (13.5)	166 (13.4)	41 (18.5)	62 (21.4)	243 (20.8)	147 (28.3)	B <sup>*</sup> , D <sup>**</sup>
Self-injurious behaviors	112 (11.2)	87 (11.5)	186 (14.9)	37 (16.7)	54 (18.6)	220 (18.6)	132 (25.4)	A <sup>*</sup> , B <sup>*</sup> , D <sup>**</sup> , E <sup>**</sup>
Sexualized behaviors	267 (26.9)	112 (15)	181 (14.5)	63 (28.6)	94 (32.4)	194 (16.7)	194 (37.7)	B <sup>***</sup> , C <sup>***</sup> , E <sup>***</sup>
Alcohol abuse	41 (4.1)	41 (5.4)	97 (7.7)	14 (6.4)	24 (8.3)	96 (8.3)	40 (7.8)	B <sup>*</sup>
Substance abuse	41 (4.2)	47 (6.3)	112 (9.0)	13 (6.0)	31 (10.7)	126 (10.9)	50 (9.9)	B <sup>*</sup> , C <sup>*</sup> , D <sup>*</sup> , E <sup>**</sup>
Attachment problems	298 (33.8)	302 (47.7)	635 (52.5)	101 (52.1)	152 (52.8)	674 (58.7)	344 (67.5)	B <sup>***</sup> , D <sup>**</sup> , E <sup>***</sup>
Criminal activity	34 (3.4)	53 (6.9)	99 (7.8)	22 (10.0)	23 (7.8)	136 (11.5)	56 (10.7)	B <sup>*</sup> , D <sup>**</sup>
Running away	52 (5.1)	46 (6.0)	79 (6.2)	17 (7.7)	34 (11.5)	121 (10.2)	65 (12.4)	D <sup>*</sup> , E <sup>*</sup>
Clinical evaluation								
Acute stress disorder	129 (14.1)	88 (12.1)	220 (18.6)	25 (11.7)	54 (19.9)	205 (18.1)	109 (21.8)	A <sup>***</sup> , B <sup>*</sup> , C <sup>*</sup> , D <sup>**</sup> , E <sup>*</sup>
Posttraumatic stress disorder	636 (68.3)	441 (59.9)	674 (57.0)	164 (75.6)	225 (82.1)	867 (75.5)	445 (88.7)	B <sup>***</sup> , C <sup>***</sup> , D <sup>***</sup> , E <sup>***</sup>
Traumatic/complicated grief	177 (21.5)	224 (35.2)	375 (32.1)	59 (30.6)	102 (37.8)	393 (34.6)	223 (44.5)	B <sup>***</sup> , E <sup>***</sup>
Dissociation	155 (16.9)	100 (13.7)	170 (14.4)	38 (17.6)	67 (24.9)	263 (23.1)	181 (36.3)	D <sup>***</sup> , E <sup>**</sup>
Somatization	138 (16.7)	90 (14.3)	190 (16.2)	30 (15.5)	58 (21.5)	215 (19.0)	143 (28.7)	D <sup>*</sup>
Generalized anxiety disorder	319 (34.7)	243 (33.1)	572 (48.4)	71 (33.2)	139 (51.3)	572 (50.2)	252 (50.3)	A <sup>***</sup> , B <sup>***</sup> , C <sup>***</sup> , D <sup>***</sup> , E <sup>***</sup>
Separation anxiety disorder	104 (11.3)	86 (11.8)	179 (15.1)	18 (8.4)	35 (12.9)	208 (18.3)	83 (16.6)	B <sup>*</sup> , C <sup>*</sup> , D <sup>**</sup>
Depression	438 (47.3)	372 (50.7)	680 (57.5)	107 (49.1)	195 (71.4)	758 (66.2)	365 (72.6)	A <sup>***</sup> , B <sup>***</sup> , C <sup>***</sup> , D <sup>***</sup> , E <sup>***</sup>
Attachment problems	238 (25.8)	263 (36.1)	532 (44.9)	83 (38.4)	127 (46.9)	623 (54.5)	309 (61.6)	A <sup>*</sup> , B <sup>*</sup> , D <sup>**</sup> , E <sup>***</sup>
Oppositional defiant disorder	151 (16.4)	193 (26.4)	279 (23.8)	50 (23.3)	71 (26.1)	325 (28.6)	157 (31.4)	B <sup>*</sup> , E <sup>**</sup>
Conduct disorder	42 (4.6)	76 (10.4)	77 (6.5)	13 (6.1)	21 (7.7)	128 (11.2)	60 (12.0)	A <sup>**</sup>
General behavioral problems	347 (41.8)	377 (59.2)	596 (50.9)	102 (52.9)	139 (51.3)	675 (59.2)	298 (59.6)	A <sup>***</sup> , B <sup>***</sup> , E <sup>***</sup>
Attention deficit hyperactivity	198 (21.6)	258 (35.3)	344 (29.1)	60 (27.9)	67 (24.6)	375 (32.9)	140 (27.8)	A <sup>*</sup>
Suicidality	88 (9.6)	89 (12.2)	118 (10.0)	23 (10.7)	45 (16.5)	156 (13.7)	118 (23.6)	A <sup>*</sup>
Sleep disorder	131 (15.8)	86 (13.7)	166 (14.2)	33 (17.2)	48 (17.7)	180 (15.8)	111 (22.2)	A <sup>*</sup>

Note. A = PM greater than PA; B = PM greater than SA; C = PM greater than SA + PA; D = PM + PA greater than PA; E = PM + SA greater than SA. Negative association is indicated by “-” sign. Age significant for everything except generalized anxiety disorder. Gender significant for academic problems, behavior problems at school and home, self-injurious behavior, attachment problems, criminal activity, posttraumatic stress disorder, dissociation, somatization, obsessive-compulsive disorder, conduct disorder, general behavioral problems, attention deficit hyperactivity disorder, and suicidality.

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .0001$ .

SA groups on 21 of 27 indicators of risk behaviors, behavioral problems, functional impairments, symptoms, and disorders. Figures 1 and 2 depict the adjusted ORs and corresponding 95% CIs for all indicators.

Compared with the PA group, the PM group had significantly higher odds on five indicators: behavior problems at home ( $OR = 1.29$ , 95% CI: 1.07–1.55;  $p = .0076$ ), attachment problems ( $OR = 1.42$ , 95% CI: 1.17–1.71;  $p = 0.0004$ ), depression ( $OR = 1.46$ , 95% CI: 1.20–1.79;  $p = 0.0002$ ), acute stress disorder (ASD;  $OR = 1.69$ , 95% CI: 1.29–2.20;  $p = 0.0001$ ), and generalized anxiety disorder (GAD;  $OR = 1.91$ , 95% CI: 1.57–2.31;  $p < .0001$ ); and marginally higher odds than the PA group on two indicators: skipping school or day care ( $OR = 1.43$ , 95% CI: 1.06–1.92;  $p = 0.0207$ ) and self-injurious behaviors ( $OR = 1.34$ , 95% CI: 1.02–1.77;  $p = 0.0345$ ).

Compared with the SA group, the PM group had higher frequencies on the majority (17 of 27; 63%) of outcomes, with estimated ORs ranging from 1.46 to 2.47. The PM group had significantly lower frequencies on only three study indicators compared with both the PA group: conduct disorder (CD;  $OR = 0.63$ , 95% CI: 0.45–0.89;  $p = 0.0075$ ), general behavior problems ( $OR = 0.72$ , 95% CI: 0.59–0.88;  $p = 0.0012$ ), and attention deficit hyperactivity ( $OR = 0.78$ , 95% CI: 0.64–0.95;  $p = 0.0149$ ); and the SA group: sexualized behaviors ( $OR = 0.47$ , 95% CI: 0.38–0.58;  $p < .0001$ ), PTSD ( $OR = 0.63$ , 95% CI: 0.52–0.76;  $p < .0001$ ) and, marginally, suicidality ( $OR = 0.78$ , 95% CI: 0.61–0.99;  $p = 0.0436$ ).

**Comparison of PM group to multiple-type PA + SA group.** Of further relevance to evaluating its predictive potency, the PM group had similar odds to the PA + SA group on 74% (20 of 27) of indicators and significantly higher odds on five indicators (substance abuse disorder [SAD], GAD, depression, and ASD). The PM group had significantly lower odds on only two indicators compared with the PA + SA group (sexualized behaviors, PTSD).

**Incremental Contribution of PM to the Clinical Profiles of Physically or Sexually Maltreated Youth**

**CBCL subscale & PTSD-RI total scale scores.** Compared with the PA group, the PM + PA group had significantly higher CBCL-Int. scores (Achenbach & Rescorla, 2004), estimated difference = 2.66,  $SE = 0.62$ ;  $p < .0001$ , and PTSD-RI scores (Steinberg et al., 2004), estimated difference = 2.45,  $SE = 0.81$ ;  $p = 0.0025$ . In contrast, the two groups reported similar CBCL-Ext. scores (Achenbach & Rescorla, 2004),  $M = 64.3$  vs. 63.8, respectively. Further, compared with the SA group, the PM + SA group had significantly higher scores on the CBCL-Ext., estimated difference = 2.62,  $SE = 0.86$ ;  $p = 0.0024$ , and CBCL-Int. composite scales, estimated difference = 2.14,  $SE = 0.84$ ;  $p = 0.0107$ , as well as marginally higher scores on the PTSD-RI, estimated difference = 2.15,  $SE = 1.09$ ;  $p = 0.0495$  (see Table 1 for group comparison details).

**Indicators of severity and clinical evaluation.** Compared with the SA group, the PM + SA group had significantly higher

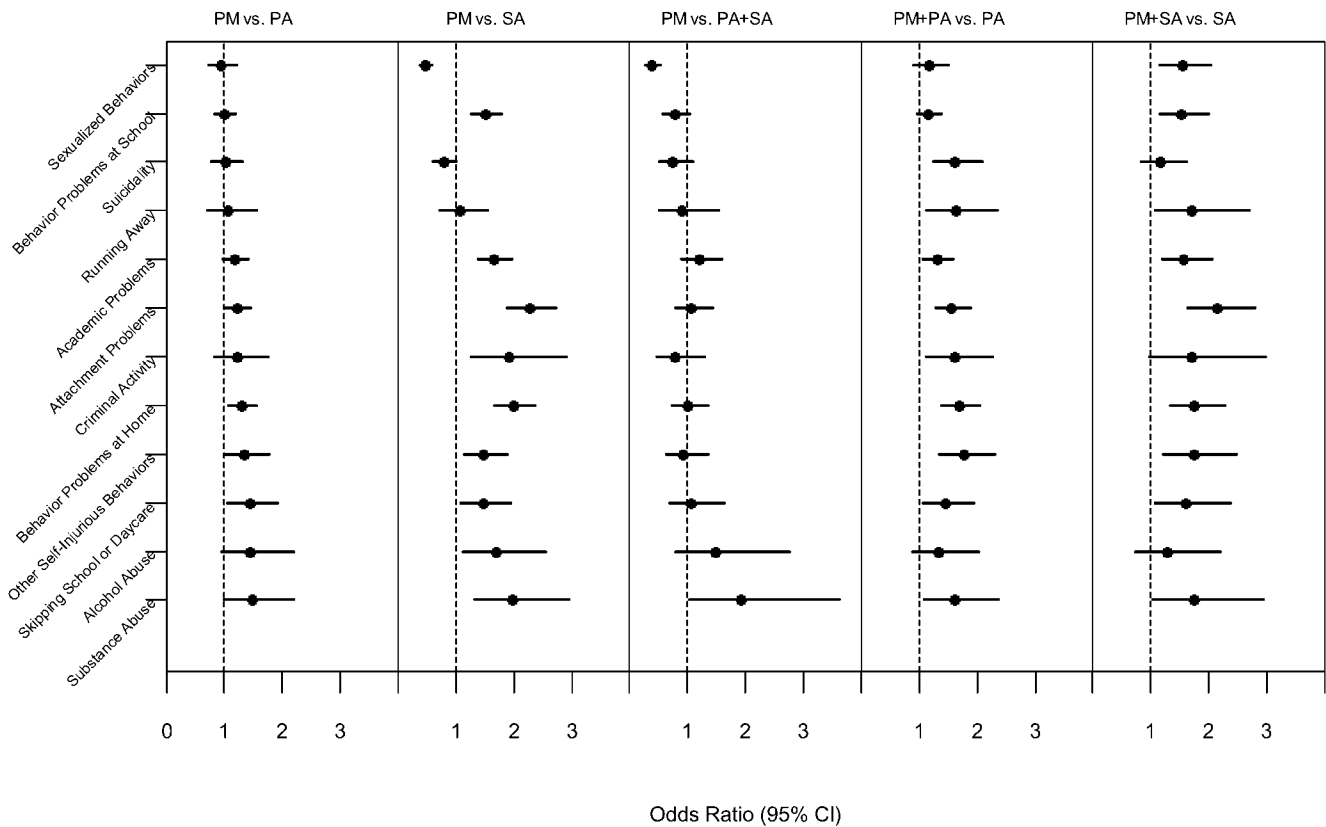


Figure 1. Estimated OR with 95% OR for indicators of severity (SA = sexual abuse; PA = physical abuse; PM = psychological maltreatment). The dash line represents an OR of 1.

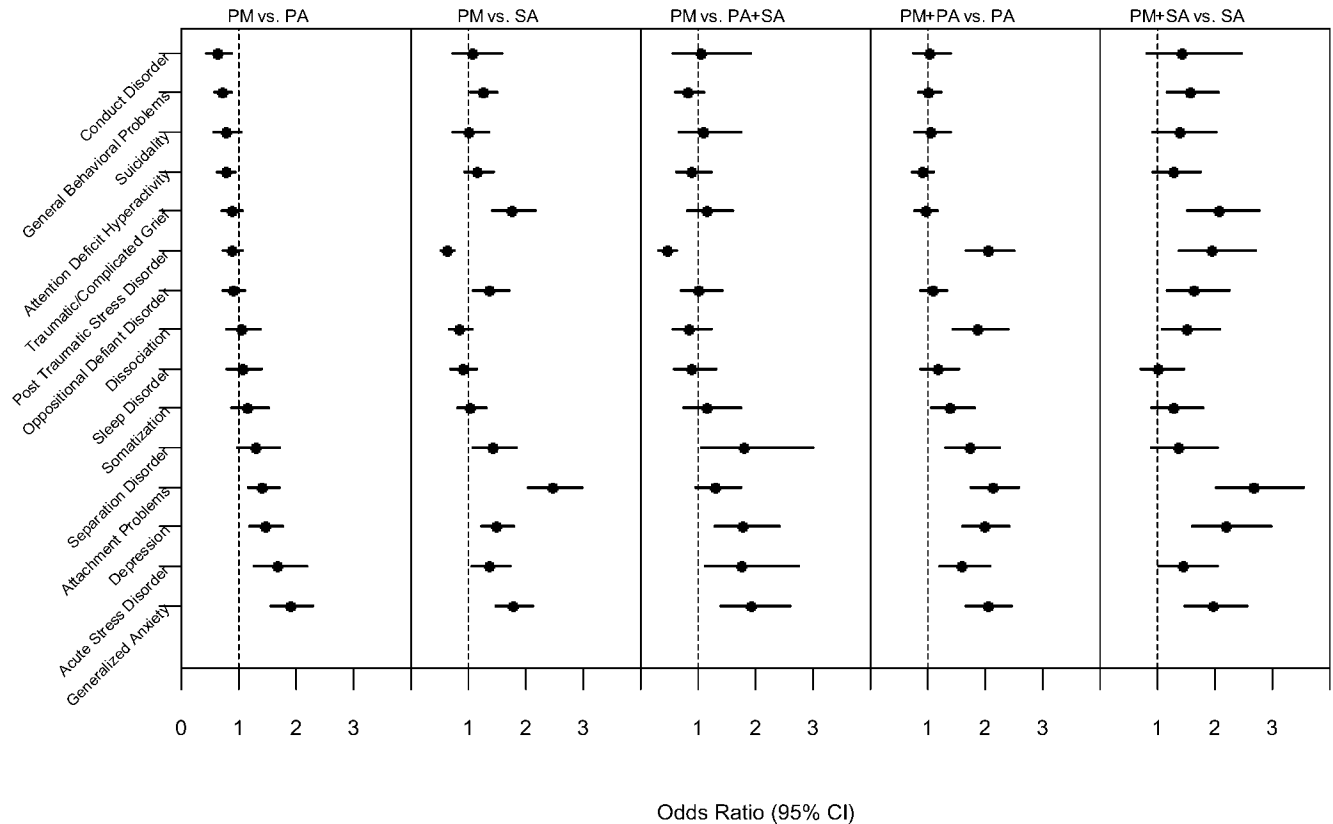


Figure 2. Estimated OR with 95% OR for clinical evaluation (SA = sexual abuse; PA = physical abuse; PM = psychological maltreatment). The dash line represents an OR of 1.

odds on the majority (18 of 27; 67%) of indicators (see Figures 1 & 2). Similarly, compared with the PA group, the PM + PA group had significantly higher odds on the majority (17 of 27; 63%) of indicators.

### Model Covariates

The results presented above were from the models adjusted for gender and age at baseline, and these model covariates were significantly associated with some of the measures and indicators of interest.

**Gender.** Male status was associated with significantly higher mean scores on the CBCL-Ext. subscale (Achenbach & Rescorla, 2004), as well as a significantly higher frequency (30%; 8 of 27) of respondent and clinician-rated indicators. Female status was associated with significantly higher PTSD-R1 scores (Steinberg et al., 2004) and with a significantly higher frequency (7 of 27; 26%) of rated indicators (See Tables 1 & 2).

**Age at baseline.** Older age (measured at intake) was positively associated with both CBCL-Ext. and CBCL-Int. subscale scores (Achenbach & Rescorla, 2004), and with a higher frequency of most (70%; 19 of 27) indicators. Younger age was significantly associated with 26% (7 of 27) of rated indicators.

### Discussion

Using a large national sample of clinic-referred youth, the present study casts light on the potential effects of PM (i.e.,

emotional abuse and/or emotional neglect) on child and adolescent traumatic stress and associated problems in child mental health, behavior, and functioning. Our findings strongly support the hypotheses that PM in childhood not only augments, but also independently contributes to, statistical risk for negative youth outcomes to an extent comparable to statistical risks imparted by exposure to physical abuse (PA), sexual abuse (SA), or their combination (PA + SA).

The occurrence of PM was associated with a broad range of clinical impairment types, exerting predictive effects of comparable or greater magnitude or frequency than the predictive effects of PA and SA. In addition, the co-occurrence of PM with PA (PM + PA) or SA (PM + SA) was associated with a greater magnitude or frequency of the majority of study outcomes compared with those associated with PA or SA alone. Further, the occurrence of PM was found to be an equivalent or significantly greater predictor of 27 of 30 negative outcomes compared with the co-occurrence of physical and sexual abuse (PA + SA). PM was thus associated with a clinical profile that overlapped with, but was distinct from, the profiles observed in the PA, SA, and PA + SA comparison groups.

Adding weight to these findings is evidence that PM is the most prevalent form of maltreatment in the NCTSN CDS (Layne et al., 2014). A history of PM exposure was identified in the majority (62%) of more than 5,000 maltreatment cases examined in this study, with nearly one quarter (24%) of maltreatment cases comprised exclusively of PM. Although cross-sectional, these findings

point to the role that PM may play as a formidable form of childhood trauma in its own right, and strongly suggest that PM should be an integral component of ongoing efforts to understand, assess, and address the nature and sequelae of maltreatment in children and adolescents.

### Impact of Psychological Maltreatment on PTSD

The PM group exhibited symptom frequencies on the PTSD-RI equivalent to those observed in the PA and SA groups. This finding is especially noteworthy given the exclusion of PM as a Criterion A event for PTSD in *DSM-5* and its prior editions (American Psychiatric Association, 2013). In contrast, the lower frequency of clinician-rated PTSD diagnosis in the PM versus SA groups may reflect, at least in part, a methodological artifact and clinical practice parameter: Clinicians may have refrained from assigning a PTSD diagnosis to the PM group—even in the presence of equivalent PTSD-RI symptom severity—precisely because the DSM does not recognize PM as a threshold stressor for PTSD. Nevertheless, equivalent PTSD-RI scores across PM, SA, and PA groups, coupled with the finding that the PM group was as likely as the PA group to receive a clinician rating of PTSD, provides support for both the inclusion of PM as a qualifying stressor for PTSD as well as healthy skepticism concerning the diagnostic utility of excluding PM from PTSD Criterion A (Van Hooff, McFarlane, Bauer, Abraham, & Barnes, 2009).

### Impact of Psychological Maltreatment on Associated Clinical Indicators

Findings revealed a robust association between PM and the majority of clinician-rated diagnostic and risk indicators assessed. Compared with the SA, PA, and SA + PA groups, the PM group exhibited equivalent or higher frequency scores on the great majority of study indicators. Although the PM group exhibited slightly lower frequencies on a small number of outcomes compared with either the SA (e.g., sexualized behaviors) or PA (e.g., CD) groups, the PM group was never associated with the lowest odds ratios on any of the 27 indicators examined. In sum, the predictive potency of PM appears to be at least on par with physical or sexual abuse across a broad range of adverse outcomes. These findings lend support to the recent report by the AAP highlighting the perniciousness of this form of maltreatment (Hibbard et al., 2012).

Some evidence concerning the potentially differential (unique) effects of PM emerged in the finding that PM was the strongest and most consistent predictor of internalizing problems (e.g., depression, GAD, SAD, attachment problems). PM was also the strongest predictor of substance abuse—raising the question as to whether substance abuse may serve as an associated coping mechanism and “cascading” secondary outcome (see Layne et al., 2014). These findings are consistent with earlier research linking PM to a range of internalizing symptoms, relational insecurity, and negative self-perceptions (e.g., Trickett, Kim, & Prindle, 2011). With respect to the prediction of externalizing problems (e.g., behavioral problems, self-injury, criminal activity), PM exhibited a strong association comparable to that of PA and greater than that of SA. This finding suggests that PM, PA, and their co-occurrence (PM + PA) may be potent risk factors for eliciting or reinforcing

externalizing behavior—a proposition consistent with prior research linking maltreatment to reactive aggression (Ford, Fraleigh, & Connor, 2010).

### Exacerbating Effect of Psychological Maltreatment for Other Maltreatment Groups

Consistent with prior studies suggesting that PM may potentiate the detrimental effects of SA or PA, the co-occurrence of PM with SA or PA was associated with higher PTSD symptoms, CBCL-Int., and CBCL-Ext. behavior problem scores compared with the occurrence of SA or PA alone. The co-occurrence of PM with PA or SA also significantly increased the odds ratios for a number of clinician-rated indicators including PTSD, ASD, dissociative symptoms, attachment problems, depression, and GAD. These findings add to a growing body of research demonstrating that exposure to multiple forms of trauma (Cloitre et al., 2009; Higgins, 2004) is associated with an exacerbation of psychosocial impairment.

In contrast, although the co-occurrence of PM with either PA (PM + PA) or SA (PM + SA) generally increased the risk for adverse outcomes compared with the predictive effects of PA or SA alone, the co-occurrence of PA with SA (PA + SA) rarely predicted greater outcome severity. Indeed, for a number of study indicators, the predictive effect of PA + SA was significantly lower than that of PM alone. As gauged by its incremental predictive potency, PM may represent a disproportionately more potent predictor, and candidate causal (i.e., traumagenic) contributor, to the risk for a broad array of trauma-related adverse outcomes in childhood and adolescence as compared with other more extensively studied forms of maltreatment, including PA and SA. These findings suggest that, in evaluating risk for PTSD and other adverse behavioral and psychosocial outcomes, the accumulation of multiple maltreatment types may not follow a simple equally weighted additive pattern (i.e., functional interchangeability in the relative potencies and causal pathways of different trauma types across outcomes). Consistent with the role of a vulnerability factor (Layne et al., 2009), the co-occurrence of psychological maltreatment in this study was associated with a significant increase in the prevalence and severity of a range of internalizing and externalizing problems for children exposed to either SA or PA.

This additive effect was unique to PM: the co-occurrence of PM with another type of maltreatment (PM + SA or PM + PA) was associated with significantly more severe (as measured by CBCL Internalizing and Externalizing subscale scores) and far-ranging (as measured by the wide array of clinical indices assessed) negative outcomes than when SA and PA co-occurred without PM (SA + PA). In fact, the co-occurrence of SA and PA appeared to be necessary to produce an equivalent predictive effect on several study indicators (e.g., behavioral problems at school, self-attachment problems, self-injurious behaviors) compared with PM alone. Investigating the comparative potency and potentially unique pathways by which PM contributes (both in its occurrence, as well as its co-occurrence with PA and SA) to adverse outcomes typically attributed to PA and SA, is a promising avenue for future research (see also Kisiel et al., 2014; Layne et al., 2014; Pynoos et al., 2014).



### Study Strengths and Limitations

Study strengths include the size, national scope, and demographic diversity of the sample. The present study constitutes one of the largest empirical studies on the comparative predictive potencies of various forms of child maltreatment ever conducted—a study for which the NCTSN CDS is uniquely suited to carry out. The study design nevertheless carries important limitations. First, because the CDS is a quality improvement initiative consisting of a large sample of youth referred for trauma treatment services, it is neither probability-based nor nationally representative, but rather a purposive sample of youth served by NCTSN centers. Our results thus most clearly generalize to trauma-exposed, treatment-seeking U.S. youth populations. Second, we operationally defined each child's maltreatment history in terms of his or her lifetime history of exposure to three primary forms of maltreatment captured in the CDS (PM, SA, PA) and their combinations that were most conducive to testing our two study hypotheses. We did not examine other facets of maltreatment (e.g., duration, age of onset, developmental timing of exposure) that may intersect with one or more of these maltreatment types to influence child outcomes (see Pynoos et al., 2014). Third, the study design utilized linear mixed-effects regression using discrete groups (PM, PA, SA, PM + PA, etc.) and cross-sectional data, and did not involve tests of interaction (i.e., moderated/vulnerability effects). Fourth, we did not account for the contributions of other forms of interpersonal (e.g., gross neglect, domestic, school or community violence) or impersonal (e.g., serious injury/accident) trauma measured by the CDS that may precede or occur in conjunction with or subsequent to child maltreatment. We plan to pursue these questions in future studies designed to unpack the elements of risk factor caravans and their influences on maltreated youth (Layne et al., 2014). Our results nevertheless clearly underscore the risks associated with maltreatment-related polyvictimization, especially elevated risk profiles and wide-ranging negative outcomes predicted by lifetime exposure to PM.

### Future Directions and Implications for Child Mental Health Services, Education, and Policy

Findings of this study carry important implications for public policy and the development, adaptation, and implementation of child trauma interventions. First, given its predictive potency and widespread prevalence, efforts to increase recognition of PM as a potentially formidable type of maltreatment in its own right should be at the forefront of mental health and social service training efforts, including incorporation of education on PM into graduate training curricula and continuing education of child service professionals (Courtois & Gold, 2009). This need is especially apparent in the child welfare system considering the low rates at which PM is currently detected. Enhancement of training initiatives for protective services personnel focused on screening and assessment of PM, as well as linking children to appropriate services, is critical. In tandem, mental health outreach, consumer resource development and public awareness initiatives are needed to achieve more widespread understanding of the detrimental consequences of PM for children and adolescents.

Second, psychometrically sound, clinically useful instruments are needed to help providers identify PM, categorize and appreci-

ate various forms of emotional abuse and emotional neglect, and assess their associated effects on a range of adverse youth outcomes. Third, effective, theoretically grounded interventions for the sizable subpopulation of traumatized youth exposed to PM are clearly needed. Of particular concern, whereas NCTSN sites have produced or adapted over three dozen empirically supported treatments for child trauma, few directly target psychological maltreatment or its subtypes (e.g., emotional abuse, emotional neglect), and no intervention has been developed to focus specifically on this widely prevalent form of trauma exposure. One partial exception is Attachment, Self-Regulation and Competency (ARC; Kiniburgh, Blaustein, Spinazzola & van der Kolk, 2005), which embeds a therapeutic focus on the effects of and response to psychological maltreatment within a “complex trauma” (Spinazzola et al., 2005; Spinazzola et al., 2013) paradigm. Nevertheless, the extent to which prevailing child trauma treatment models are applicable to, and sufficiently address the needs of, psychologically maltreated youth remains an open question. Likewise, the degree to which the extant evidence base on treatment outcome generalizes to this subpopulation of maltreated youth is unclear. Future research should seek to ascertain whether existing models sufficiently address, or can be adapted to accommodate, the needs of psychologically maltreated children and adolescents; or alternatively, whether new models or intervention components are required.

Finally, greater attention should be dedicated toward understanding the complex manner in which co-occurring forms of childhood trauma may intersect to influence traumatic stress reactions, attachment and self-image problems, affective and physiological dysregulation, risk behaviors, and functional impairment across development (D'Andrea et al., 2012). Appropriately constructed guiding theory, assessment tools, interventions, and clinical training methods are needed to support accurate risk screening and case identification, effective intervention, workforce development, and public policy. If we are to engender healing of the full spectrum of wounds inflicted by childhood trauma—both the visible and the unseen—such efforts must be guided by a clear appreciation for the variability in occurrence, intersection, etiology, developmental context, clinical course, and causal consequences of all forms of maltreatment.

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