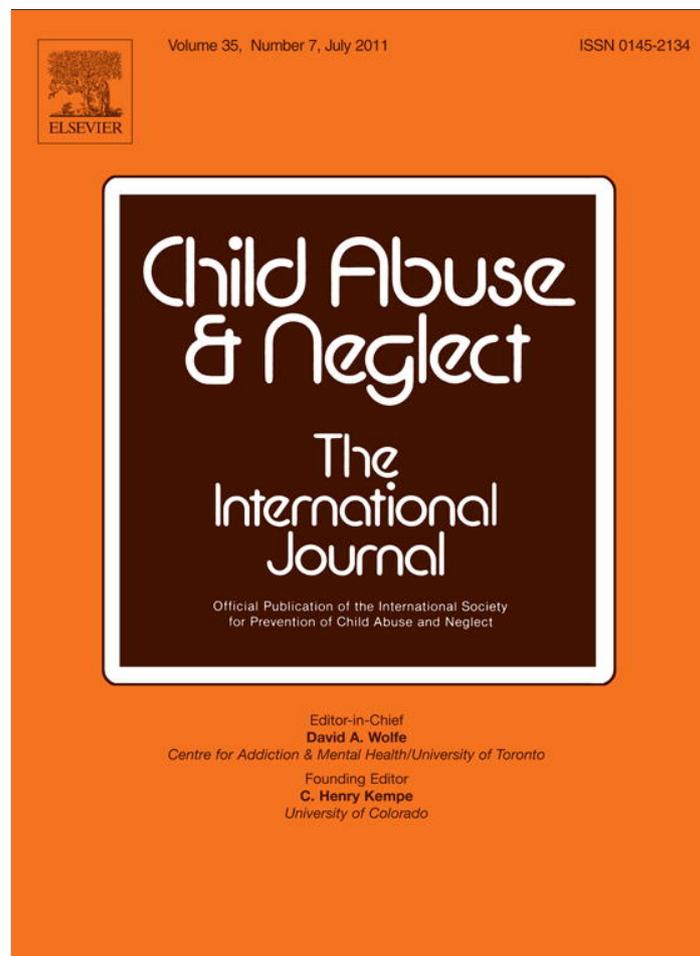


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Differential effects of psychological maltreatment on children of mothers exposed to intimate partner violence[☆]

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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.

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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

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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, Guttman, & 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 (NCPA) 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; Steinhilber, 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 0.84⁰⁰⁰ 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.

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