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Maltreatment type, exposure characteristics, and mental health outcomes among clinic referred trauma-exposed youth

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ABSTRACT

Building upon prior research documenting differential effects of psychological maltreatment, physical, and sexual abuse on youth mental health outcomes (Spinazzola et al., 2014), the present study sought to clarify the relative predictive contributions of type of maltreatment compared to salient exposure characteristics. The sample included 5058 clinic-referred youth from the Core Dataset (CDS) of the National Child Traumatic Stress Network (NCTSN) with lifetime histories of exposure to one or more of three specific types of maltreatment: *psychological maltreatment* (PM), *physical abuse (PA)*, and *sexual abuse (SA)*. First, we examined variations in salient trauma characteristics (age of onset, duration of exposure, number of co-occurring trauma types, and perpetrator type and number) by maltreatment group. Second, we examined whether type of maltreatment remained associated with mental health measures after adjusting for demographic variables and trauma characteristics. Profiles for youth with PM were more severe than youth who experienced either PA or SA only. Co-occurring PM and PA was associated with the most severe trauma exposure profile and with severity of PTSD symptoms, even after adjusting for demographic and trauma characteristics. Youth exposed to SA only had a distinct trauma profile and greater PTSD symptom severity after adjusting for demographic and trauma characteristic variables. Study findings hold important implications for trauma screening, assessment, and intervention, as well as for traumatic stress research methods that extend beyond abuse-specific or cumulative-risk approaches.

1. Introduction

Evidence continues to accumulate that psychological maltreatment (PM), defined as "thwarting of the child's basic emotional needs," including "needs for psychological safety and security in the environment, for acceptance and positive regard, and for age appropriate autonomy" (Barnett, Manly, & Cicchetti, 1993, p. 36) exerts potent negative effects on development and leads to a range of adverse mental health and functional outcomes (Hart, Binggeli, & Brassard, 2011). A growing body of research illustrates how PM

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comparatively "stacks up" to other forms of abuse and neglect as gauged by its sequelae (Vachon, Krueger, Rogosch, & Cicchetti, 2015). Longitudinal research examining the impact of PM, as compared to physical abuse, found the PM elements of maternal verbal abuse and emotional unresponsiveness to be equally or more detrimental to attachment, learning, and mental health (Sroufe, Egeland, Carlson, & Collins, 2005). Moreover, a number of recent studies demonstrate that PM is associated with increased risk for a variety of clinical symptoms (e.g. depression, anxiety, posttraumatic stress) even when other forms of maltreatment, such as physical and sexual abuse, are accounted for (English, Thompson, White, & Wilson, 2015; Paul & Eckenrode, 2015; Taillieu, Borwnridge, Sareen, & Afifi, 2016).

A recent study of a clinical sample of over 5000 trauma-exposed youth demonstrated that PM, compared to physical and sexual abuse, was associated with equivalent or greater severity and frequency of the majority of 30 clinical problems and risk indicators assessed. Moreover, results revealed a partially overlapping yet distinct clinical profile for psychologically versus physically or sexually abused youth. Specifically, PM was the strongest predictor of internalizing problems, an equivalent predictor of posttraumatic stress symptom severity, and a robust predictor of externalizing problems (equivalent to physical abuse and greater than sexual abuse (Spinazzola et al., 2014). The current study drew on the same clinical sample of youth to extend these findings and to explore their implications further.

Findings from the initial study by Spinazzola et al. (2014) invite further efforts to "unpack" PM to clarify its core features and identify candidate mechanisms through which it may operate and exert its effects (Layne, Briggs, & Courtois, 2014). In particular, PM tends to co-occur within a constellation of theorized risk factors (e.g., age of onset of exposure, duration of exposure, co-occurring maltreatment). Underscoring the value of exploring its distinguishing features, PM tends to have an earlier age of onset and more chronic course than other forms of abuse and neglect (McGee, Wolfe, & Wilson, 1997). These contextual features may intersect with PM and contribute to psychological distress and dysfunction (Claussen & Crittenden, 1991; Layne et al., 2009). Recent research also suggests that PM tends to co-occur with other forms of maltreatment including neglect, impaired care giving, domestic violence exposure, and physical maltreatment (Kim, Mennen, & Trickett, 2017; Pynoos et al., 2014; Trickett, Kim, & Prindle, 2011) and may intersect with these co-occurring types in complex ways. For example, PM may "enhance" the predictive effects of other forms of abuse (McGee et al., 1997), suggesting that the combination of PM with physical abuse or neglect may result in worse outcomes among youth than either risk factor in isolation.

Although the extant literature clearly suggests that PM adversely affects development, there is a continued need to clarify how, why, and for whom PM is comparatively detrimental. Historically, investigations of risk factors have measured and analyzed the impact of trauma (such as PM) using one of two approaches. These include (1) *specificity models,* which examine the impact of particular trauma types on negative outcomes; and (2) *cumulative risk models*, which look at the impact of the total "dosage" (i.e., total number of trauma types experienced over the life course) on negative outcomes (Anda et al., 2006; Finkelhor, Turner, Hamby, & Ormrod, 2011). Limitations of the specificity approach include its inherent assumption that trauma types exert independent effects, its tendency to focus on commonly-occurring trauma types (e.g. sexual and physical abuse) while ignoring potential contributions of other types (e.g. PM) that often co-occur but are infrequently measured, and a failure to account for additive, multiplicative or synergistic interactions between trauma types (Vachon et al., 2015). In contrast, the cumulative risk approach, although better accounting for the impact of multiple exposures than the specificity approach, is also limited by its treatment of trauma types as interchangeable, independent, and thus additive in their effects (Flouri, 2008).

Emerging evidence (Kisiel, Fehrenbach, Torgersen et al., 2014; Pynoos et al., 2014; Spinazzola et al., 2014) suggests that neither the specificity nor the cumulative risk approach adequately captures the impact of child trauma. In particular, both approaches fail to measure and delineate: (1) how particular types of trauma exposure co-occur in clusters that can lead to additive or synergistic effects; (2) developmental timing of exposures and subsequent efforts at adjustment; and (3) the reverberating effects and varying causal pathways of different types of exposure across levels of the ecology (individual, family, broader community, etc.). Recent studies demonstrate that among high risk populations, such as children in the child welfare system or those seeking treatment for traumatic sequelae, trauma types tend to co-occur in coherent and recognizable clusters (Kisiel, Fehrenbach, Torgersen et al., 2014; Pynoos et al., 2014).

An examination of constellations of trauma exposure among over 14,000 clinic-referred youth revealed that both age of onset (developmental timing) and overall duration of trauma vary by trauma type. For example, impaired caregiving, neglect, exposure to domestic violence, and PM have their initial onset early in the life course (before age 5 years) and have a relatively long duration (4 years or more). A principal components analysis demonstrated that these four trauma types also tend to co-occur in clusters with physical abuse, whereas other types of trauma formed separate co-occurring clusters. These included acute forms of trauma (serious injury, accident, traumatic loss, natural disaster, and medical trauma), broader contextual traumas (community and school violence, war, terrorism, political violence), and different forms of assault (sexual abuse, sexual assault, and physical assault; Pynoos et al., 2014). Moreover, recent work demonstrates that exposure to particular combinations of trauma, such as physical *and* psychological maltreatment, or interpersonal *and* non-interpersonal forms of trauma, are linked to the greatest degree of dysfunction in youth when compared to the impact of physical or sexual abuse alone (Kisiel, Fehrenbach, Torgersen et al., 2014; Spinazzola et al., 2014).

In sum, evidence suggests that the nature, potency, and sequelae of childhood PM may be influenced by a complex set of exposure parameters or characteristics. These include: the specific type(s) of maltreatment/trauma experienced; the developmental timing of specific types of exposure (Manly, Kim, Rogosh, & Cicchetti, 2001); the particular combinations in which different types of trauma co-occur (Kisiel, Fehrenbach, Torgersen et al., 2014; McGee et al., 1997; Spinazzola et al., 2014), and the cumulative impact thereof (Anda et al., 2006; Felitti & Anda, 2009). Parsing out the effects of childhood PM is complicated by findings that PM rarely occurs in isolation, but rather tends to co-occur in constellations with other trauma types (Layne et al., 2014; Pynoos et al., 2014; Spinazzola et al., 2014) thereby making it difficult to isolate the independent influence of PM on specific outcomes. The high degree of overlap