Do Evidence-Based and Effective Programs for Abused and Traumatized Children Address the Issue of Psychological Maltreatment? A Survey of Program Developers

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During 2008, over 770,000 children were deemed to be victims of child abuse or neglect (U.S. Department of Health and Human Services, 2010). Because a portion of maltreated children goes undetected, the actual rates are likely to be even higher. Decades of research have documented the short- and long-term harm of maltreatment to children's cognitive, social-emotional, and physical development (Cicchetti & Toth, 2000). Costs also accrue to society in the form of juvenile delinquency and adult criminality, both of which are associated with childhood maltreatment (Luntz & Widom, 1994), as well as the intergenerational transmission of abuse (Kaufman & Zigler, 1987). More immediate costs also include out-of-home placement, prevention, emergency room and other medical care, and related social services.

In response to the need to provide treatment to victims of child maltreatment, interdisciplinary professionals of the last 3 decades have contributed to the development and validation of evidenced-based and best practice treatments for physically abused and sexually abused children, including the development of "abuse-specific" treatments as an alternative to generic-eclectic psychotherapeutic interventions (Cohen, Mannarino, & Deblinger, 2006). Abuse-specific treatment is based on theory and clinical experience regarding the impact of various forms of abuse on social, emotional, and cognitive functioning over the course of an individual's development (Deblinger & Heflin, 1996; Friedrich, 2002; Herman, 1997; Kolko, 1996; Pearce & Pezzot-Pearce, 1997; Urquiza & Winn, 1994).

These models share an acknowledgment that developing rapport with the abused child is particularly challenging because issues of trust and betrayal are paramount. Also key is the recognition that early abuse affects memory and information processing and can cause emotion dysregulation and distorted cognitions and relational styles (Perry, 2000). Common to many abuse-specific treatments are a planned incremental exposure to and discussion of the abuse event(s) in the context of the therapeutic relationship (i.e., the narrative) as a way of integrating the memories and making new meaning of the abuse experience.

Another innovation in the field has been the articulation of "trauma-informed" therapeutic interventions that aim to address the specific needs of a traumatized child without making assumptions about the specific abuse or trauma experienced. An underlying belief of these treatments is that there are common responses children have to a range of *traumatic events* (defined as "sudden or unexpected shocking events; death or threat to life or bodily integrity; and/or the subjective feeling of intense terror, horror, or helplessness" [APA, 2000, p. 463]).

Trauma-informed interventions focus on trauma symptoms: the behavioral, cognitive, physical, and emotional difficulties that are directly related to traumatic experiences. Trauma-informed treatment represents an approach to engaging clients with histories of trauma that starts with the recognition of the impact of trauma-related symptoms on their lives. Currently, a number of these trauma-informed as well as abuse-specific treatments have been deemed evidence-based or best practice in the field (e.g., California Clearinghouse for Child Welfare, National Child Traumatic Stress Network).

The purpose of the current study was to consider whether and how these programs address a child's experience of psychological maltreatment (PM), which has been shown to have a high incidence of co-occurrence with physical and sexual abuse (Claussen & Crittenden, 1991; Trickett, Mennen, Kim, & Sang, 2009). To perpetrate physical or sexual abuse, some nonphysical and nonsexual attitudes and behaviors typically take place that constitute psychological maltreatment. For example, the harsh, demeaning, and

threatening words spoken to a child prior to the infliction of physical injury and the quiet seduction of the child into the secret and exploitive world of the sexual abuser both reflect aspects of PM that accompany physical and sexual abuse. Psychological maltreatment is also likely to co-occur with physical abuse because the ineffectual parenting practices that can culminate in physical abuse can also lead to psychologically maltreating parenting practices as preliminary attempts at control and discipline, such as humiliation, singling out, shaming, threatening to abandon, and so forth. Thus, children who are referred for treatment to abuse-specific or trauma-informed interventions because of physical or sexual abuse are likely to have also experienced psychological maltreatment (although children referred to trauma-informed treatments for traumatic events unrelated to childhood maltreatment—such as illness, natural disaster, or random community violence—may not have also experienced psychological maltreatment).

Psychological maltreatment is widespread and has been found to be harmful to children's development even at relatively low levels (see Binggeli, Hart, & Brassard, 2001; Brassard & Donovan, 2006; Barnett, Manly, & Cicchetti, 1993; Kairys & Johnson, 2002; English & LONGSCAN Investigators, 1997; Portwood, 1999; Trickett, Mennen, Kim, & Sang, 2009; Wright, 2007, for recent reviews). Evidence of damage has been found in a range of behavioral and emotional domains of children's development, including problems of intrapersonal thoughts, feelings, and behaviors (e.g., depression, low self-esteem, suicidal ideation); emotional problems (e.g., emotional instability, impulse control problems, substance abuse); social competency problems and antisocial functioning (e.g., self-isolating behavior, social phobia, aggression, and violent behavior); learning problems (e.g., decline in mental competence, academic problems); and physical health problems (e.g., asthma, hypertension; somatic complaints). Retrospective studies with adults have found associations between various forms of psychological maltreatment and a range of negative outcomes including eating disorders (Allison, Grilo, Masheb, & Stunkard, 2007; Grilo & Masheb, 2002; Bardone-Cone et al., 2008), substance abuse (Eiden, Foote, & Schuetze, 2007; Hyman, Paliwal, & Sinha, 2007; Klein, Elifson, & Sterk, 2006; Medrano, Hatch, Zule, & Desmond, 2003; Medrano & Hatch, 2005; Minnes et al., 2008; Surratt, Kurtz, Weaver, & Inciardi, 2005), and psychiatric conditions (Garno, Gunawardane, & Goldberg, 2008; Simeon, Knutelska, Yehuda, Putnam, Schmeidler, & Smith, 2007).

In light of the prevalence of PM, its co-occurrence with other forms of childhood maltreatment, and its adverse and pervasive impact on the child's development and psychological functioning, we designed this study to investigate whether and how current treatment approaches in the field were addressing children's experiences of PM. It was our understanding that most abuse-specific interventions focus on sexual abuse and physical abuse rather than psychological maltreatment. Further, our clinical experience led us to question whether psychological maltreatment was being adequately addressed in trauma-informed interventions. To that end, we identified 11 evidence-based and best practice abuse-specific or trauma-informed treatment programs and interviewed the program developers or other relevant authority of 10 of them to learn about their perspective on whether and how their programs address children's experiences of psychological. Five main issues were explored in these interviews.

The first issue we addressed was whether the program developers had a working definition of PM that could then be used as the basis for therapeutic interventions for children with experiences of PM. Of particular interest here was whether the American Professional Society on the Abuse of Children (APSAC) definition was mentioned. To define PM, we used the definitional framework published by APSAC (Binggeli, Hart, & Brassard, 2001; Hart & Brassard, 1995) as *Guidelines for Psychosocial Evaluation of Suspected Psychological Maltreatment of Children and Adolescents*. The guidelines begin with a broad definition: "Psychological maltreatment means a repeated pattern of caregiver behavior or extreme incident(s) that conveys to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (Binggeli, Hart, & Brassard, 2001, p. 2). Six categories of PM are offered: (1) spurning, (2) terrorizing, (3) isolating, (4) exploiting/corrupting, (5) denying emotional responsiveness, and (6) mental health, medical, and educational neglect.

We chose the APSAC framework for several reasons: It was developed with input from many of the leading scholars in the field and has been subject to modification based on empirical evidence (Bingelli, Hart, & Brasard, 2001; Brassard, Hart, & Hardy, 1993; Garbarino, Guttman, & Seely, 1986; Hart & Brassard, 1991); there is a high degree of agreement between the APSAC definition and other major definitional systems of PM (e.g., National Incidence Study II, Modified Maltreatment Classification System; McGee & Wolfe, 1991; see Brassard & Donovan, 2006, for a review); there are now many research studies demonstrating the damage caused during (or correlated with) specific developmental periods by each of the subtypes of PM (see Binggeli, Hart, & Brassard, 2001; Brassard & Donovan, 2006; Hart, Binggeli, & Brassard, 1998, for reviews); there is strong evidence for the cross-cultural validity for many of the PM subtypes (Dunne et al. 2009; Rohner, 1975; Rohner & Rohner, 1981; Runyan, Dunne, et al., 2009); and major governments and professional organizations have adopted definitions that are very similar (e.g., Singapore, American Academy of Pediatrics, American Humane Association).

After exploring a working definition of PM, other questions we addressed in this study were as follows: (1) What is the estimated prevalence of PM in the population served by the programs? (2) How is the issue of PM addressed in the written program materials? (3) How well do the interviewees believe that the program addresses the issue of PM? and (4) What role do the interviewees believe psychologically maltreating parents should play in the treatment of the child?

Program Selection

We conducted a comprehensive Internet search to identify programs for inclusion in this analysis. Criteria included the following: (1) group or individual child therapy program, (2) aimed at addressing childhood abuse or traumatic experiences, (3) with manuals written in the English language, (4) manualized with materials available for review, and (5) deemed evidence-based or best practice (e.g., included in the SAMHSA or a comparable model program registry). Each program registry uses different criteria for determining whether a program is deemed effective or evidence-based. For example, acceptance into the SAMHSA model program registry is based on staff discussions with program developers and an independent review of research evidence that culminates in a decision to include the program or not in the model registry. Factors taken into account include the quality of research (reliability and validity of measures, intervention fidelity, handling of missing data and attrition, presence of potential confounding variables, and appropriateness of analysis) and the program's readiness for dissemination (availability of implementation materials, quality and availability of training and support resources, and quality assurance procedures). Other registries employ different approaches but share the feature of reviewing the ability of the program to be disseminated and the quality of the evidence of the effectiveness of the program. Six sources were examined for possible programs to include. They represent the only sources that we were aware of. Table 1 provides an overview of these sources and which programs that we identified from each.

Table 1. Overview of Program Selection Search Results

Source	Search Criteria	Have Met Study Criteria
Office of Juvenile Justice and Delinquency Prevention http://www.ojjdp.gov/programs/ProgResults.asp	Searchable database. Keywords used: all ages, both genders, all problem types, all settings, all program types, ratings of exemplary or effective, which resulted in 100 programs.	CB-ITS PE TF-CBT
Substance Abuse and Mental Health Services National Registry of Evidence-Based Programs and Practices (NREPP). http://www.nrepp.samhsa.gov/	Searchable database. Keywords used: mental health treatment for children 0–17 years of age, which resulted in 25 programs.	RLH TF-CBT
Kauffman Best Practices Project to Help Children Heal From Child Abuse (2004) http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf	Nonsearchable list of 3 programs.	TF-CBT AF-CBT
Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.) (2004). http://www.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf	Nonsearchable list of 9 programs.	EMDR AF-CBT TF-CBT Trauma-Focused Play Therapy
California Evidence-Based Clearinghouse for Child Welfare http://www.cebc4cw.org/	Searchable database. Criteria = Levels 1 and 2, which resulted in 52 programs.	AF-CBT EMDR SITCAP-ART TF-CBT
National Child Traumatic Stress Network http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom	Nonsearchable listing of 38 programs.	AF-CBT CB-ITS, Integrated Treatment for Complex Trauma (ITCT) RLH SPARCS TF-CBT TST

CB-ITS: Cognitive Behavioral Intervention for Trauma in Schools, PE: Prolonged Exposure Therapy, TF-CBT: Trauma Focused Cognitive Behavioral Therapy, RLH: Real Life Heroes, AF-CBT: Abuse-Focused Cognitive Behavioral Therapy, EMDR: Eye Movement Desensitization and Reprocessing, SICAP-ART: Trauma Intervention Program for Adjudicated and At-Risk Youth, SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress, TST: Trauma Systems Therapy

In all, 11 programs met the criteria for inclusion: (1) Cognitive Behavioral Intervention for Trauma—in the schools (Jaycox, 2003); (2) Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006); (3) Real Life Heroes (Kagan, 2007); (4) Abuse-Focused CBT (Kolko & Swenson, 2002); (5) EMDR for children (Adler-Tapia & Settle, 2008); (6) Trauma-Focused Play Therapy (Gil, 1991); (7) SITCAP-ART (Raider, Steele, Delillo-Storey, Jacobs, & Kuban, 2008); (8) Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (DeRosa et al., 2006); (9) Integrated Treatment of Complex Trauma–C (Lanktree & Briere, 2008); (10) Trauma Systems Therapy (Saxe, 2007); and (11) Prolonged Exposure Therapy (Foa, Hembree, & Rothbaum, 2007). See Table 2 for program information.

The Interview Protocol

Each author conducted from three to four semi-structured interviews, each of which lasted between 30 and 45 minutes. Informed consent was obtained prior to the interview proper. The developer of one program declined to participate because the term *psychological maltreatment* was deemed to be too vague to be discussed. The interviewees were assured confidentiality and anonymity of their responses. The protocol comprised a series of open-ended and closed-ended questions designed to address the following five topics:

1. Definition of Psychological Maltreatment

This was assessed with a single open-ended question about which definition of PM the person relied on in his or her work.

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Table 2. Program Information

Program	Duration	Core Elements	Evidence of Effectiveness
Abuse-Focused CBT Kolko & Swenson (2002)	12–16 weekly individual sessions	Socialization to models of stress and CBT, Understanding and cognitive processing of the child's exposure to hostility /violence and abusive experience(s), Psychoeducation about child abuse laws, child safety/welfare, and common abuse-related reactions/attributions, Training in affect identification, expression, and management skills, Coping skills, Training to address everyday problems, Development of social support plans, and Interpersonal skills training to enhance social competence.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA. Clear = 3 (promising) 5. NCTSN = included 6. Kauffman = included
CB-ITS Jaycox (2003)	10 group sessions	Imaginal exposure to stress or trauma, introduction to cognitive therapy, combating negative thoughts, introduction to real life exposure, exposure to stress or trauma memory, introduction to social problem solving, practice with social problem solving, relapse prevention, and graduation.	1. OJJDP = exemplary 2. SAMHSA quality ratings of research = 3.4 and dissemination 3.8 3. Saunders = not included 4. CA clear = not included 5. NCTSN = included 6. Kaufman = not included
EMDR Greenwald (1993)	2–3 sessions	Preparation, assessment, desensitization and reprocessing, installation of positive cognition, body scan, closure, re-evaluation.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = 3 4. CA Clear. = 1 5. NCTSN = not included 6. Kaufman = not included
Integrated Treatment of Complex Trauma–C. Lanktree & Briere (2008)	variable	Assessment of complex trauma, Advocacy and systems interventions, Client-therapist relationship, Developing and enhancing a safe therapy environment, Distress reduction and the development of affect regulation skills, Facilitating positive identity, Psychoeducation, Cognitive and emotional processing, Relational/attachment processing, Behavior self-control.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = not included 5. NCTSN = included 6. Kaufman = not included

Table 2 Program Information *continued*

Program	Duration	Core Elements	Evidence of Effectiveness
Prolonged Exposure Therapy Foa, Hembree, & Rothbaum (2007)	9–12 90-minute sessions	The program consists of four treatment components: (a) clinical interview including assessment of PTSD symptomatology, psychoeducation about common reactions to trauma, and construction of client's troublesome thoughts and avoided situations, (b) training in controlled breathing to help clients manage anxiety, (c) imaginal exposure to the memory of the traumatic event, both in session, and as homework, (d) in-vivo exposure to trauma reminders that are avoided and feared.	1. OJJDP = exemplary 2 = SAMHSA quality of research = 2.9 to 3.7 readiness to disseminate = 3.1 3. Saunders = not included 4. CA clear = not included 5. NCTSN = not included 6. Kaufman = not included
Real-Life Heroes Kagan (2007)	6–18 months of weekly individual sessions	Safety planning, trauma psychoeducation, skill building in affect regulation and problem solving, cognitive restructuring of beliefs, nonverbal processing of events, and enhanced social support.	1. OJJDP = not included 2. SAMHSA quality of research = 3.7 and dissemination = 4.0 3. Saunders = not included 4. CA clear. = not included 5. NCTSN = included 6. Kaufman = not included
SITCAP-ART Raider, Steele, Delillo-Storey, Jacobs, & Kuban (2008)	10 sessions of 6 youth	Education, debriefing, focusing on themes, drawing, details, trauma-specific questions, cognitive reframing.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = 3 5. NCTSN = not included 6. Kaufman = not included
SPARCS DeRosa, Habib, Pelcovitz, Rathus, Sonnenklar, Ford, et al. (2006)	16 1-hour groups for 12–19-year-olds	Mindfulness, problem solving, meaning making, relationship building/communication skills, distress tolerance. Also includes psychoeducation regarding stress and trauma.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = NR 5. NCTSN = included 6. Kaufman = not included
Trauma-Focused CBT Cohen, Mannarino, & Deblinger (2006)	12 individual sessions or more plus parent component	Psychoeducation, relaxation, affective expression and modulation, cognitive coping and processing I, trauma narrative, cognitive coping and processing II, in-vivo mastery, conjoint parent-child sessions, enhancing future safety, grief psychoeducation, grieving the loss, preserving positive memories, redefining the relationship.	1. OJJDP = exemplary 2. SAMHSA quality ratings research 3.7 and dissemination 3.7 3. Saunders = 1 4. CA. clear. = 1 5. NCTSN = included 6. Kaufman = included

Table 2 Program Information *continued*

Program	Duration	Core Elements	Evidence of Effectiveness
Trauma-Focused Play Therapy Gil (1991)		Selection and display of appropriate toys and miniatures based on the particular child's traumatic situation; Giving therapeutic permission and encouragement to move at the child's own pace; Observation and recording of the child's post-trauma play and accompanying affect; Reflective commenting on the child's posttrauma play or therapeutic questions that ask the child to expand on narrative already provided of play; Assisting with clarification, processing of idiosyncratic meaning, affect discharge, sequential organization and integrating of difficult cognitions and affect; Helping the child manage anxiety, develop new coping strategies, and identify external resources; Providing parental support and education as well as guidelines for observing and participating in child's everyday play without overinterpreting and/or becoming intrusive; Collateral individual therapy for parents, particularly if prior abuse issues interfere with current abilities to address their child's needs for safety and support.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = 4 4. CA Clear. = not rated 5. NCTSN = not included 6. Kaufman = not included
Trauma Systems Therapy Saxe, Ellis, & Kaplow (2007)	variable	Key components: Trauma Systems Therapy can be seen as a framework for organizing a series of empirically validated interventions to address the real-world needs of children facing considerable adversity. It is designed to help children and families where there is ongoing stress in the social environment. Traumatic stress and the intervention involve two elements: • a child with difficulty regulating his or her emotional state, and • a system of care that cannot effectively regulate the child's response to his or her social environment. In this program, social context includes family, school, and neighborhood. Services are tailored to the child/family using a 3 X 3 matrix with stability of social environment on one axis and the child's ability to regulate emotions on the other.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = not included 5. NCTSN = included 6. Kaufman = not included

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2. Estimate of Prevalence of Psychological Maltreatment
This was assessed with a single closed-ended question about how many child clients were perceived to have experienced PM, however it was defined (0 = not at all, 1 = a few, 2 = some, 3 = many, 4 = most, 5 = all, 6 = don't know).

3. How the Issue of PM Is Covered in the Curriculum and Training Materials
Five questions were asked within this general topic, three of which used the same closed-ended response options (0 = not at all, 1 = in passing, 2 = somewhat, 3 = in-depth): How, if at all, is the concept of psychological maltreatment addressed in the portion of the book or manual that presents the background and theoretical underpinnings of the program? How, if at all, is the concept addressed in the portion of the book or manual that presents the content of the sessions? And how, if at all, is the concept addressed in the training materials for therapists? We also asked two open-ended questions: How does the program aim to address the psychological maltreatment experiences of children; and, if the program uses a trauma narrative, how is PM dealt with when it comes up in that context?

4. How Well the Program Addresses PM and Need for Improvement
We asked six questions, all but one using the following response options: (0 = not at all, a little bit, 2 = somewhat, 3 = much, 4 = very much). The questions were (1) Do you believe that the program as it stands allows children to adequately process/acknowledge any PM they might have experienced? (2) Do you believe that any modifications in the program would allow a therapist using it to work more productively with children

who have been psychologically maltreated? (3) Do you think therapists using the program could benefit from being training to understand and recognize the 18 types of psychological maltreatment as defined by APSAC? (4) Do you see any need for a standalone program for children who have been both psychologically maltreated in addition to some other form of maltreatment as well? (5) Do you see any need for a standalone program for children who have been psychologically maltreated without also having been maltreated in some other way as well? and (6) Are you aware of any programs that specifically address PM experiences of children (0 = no, 1 = yes).

5. How Psychologically Maltreating Parents Should Be Involved in Treatment

We asked two open-ended questions about what role, if any, the interviewee believed that psychologically maltreating parents should play in an intervention for psychologically maltreated children and what services, if any, should be provided to psychologically maltreating parents.

Results

Definition of Prevalence of Psychological Maltreatment

Interviewees were not familiar with the APSAC definition. Not one mentioned the definition by name or by its 18 components. Three interviewees said that they had not defined PM, or did not use the term, or both. Four said that it was "abuse or neglect" in general, two defined it as "psychological aggression," and one referenced Garbarino's (1986) definition.

Estimate of Prevalence of Psychological Maltreatment

Interviewees all acknowledged that at least some children served by their program had experienced PM, although they cited a range of prevalence. One interviewee said that this was true of "some" clients; two interviewees said that this was true of "many" clients; five said that this was true of "most" clients, and two said that this was true of "all" clients. Three interviewees commented that it is hard to disentangle PM from other forms of abuse or neglect: "I think that PM is pervasive, and I think it overlaps with other types of maltreatment out there. I know it sometimes happens only on its own, but mostly it does not happen on its own but it occurs with other types of maltreatment."

How the Issue of PM Is Covered in the Curriculum and Training Materials

Table 3 presents these data.

Five of the ten interviewees reported that their programs covered content related to psychological maltreatment in an "in-depth manner." This was true for the background materials of the manual, the curriculum of the program, and the program training materials. Comments made by the interviewees regarding the intent of their program to address PM are illustrative of the general difficulty in defining the term and disentangling it from other forms of abuse: for example, "This is tricky. What we try to do is create a safe environment, not specific to PM," and "This therapy is generic, not specific to any particular trauma."

Eight of the ten interviewees reported that their programs utilized a trauma narrative. When asked how PM would be incorporated into that, the developers generally made the point that whatever came up in the narrative would be addressed in treatment, including but not limited to any kind of maltreatment, such as psychological maltreatment.

How Well the Program Addresses PM and Need for Improvement

These data are presented in Table 4.

Table 3. How the Issue of PM Is Covered in the Curriculum and Training Materials

	None	Somewhat	In-Depth
Background	2	3	5
Curriculum	1	5	4
Training	1	3	5

Table 4. How Well the Program Addresses PM and Need for Improvement

	No	A Little/Somewhat	Much/Very Much
Program as It Stands	0	2	8
Would Modifications Help?	3	6	1
Would Therapist Training Help?	1	4	5
Need for Standalone for Children Multiabused	6	3	1
Need for Standalone for Children PM Only	6	3	1

Our data show that 8 of the 10 interviewees felt their program, as it stands now, can "much" or "very much" adequately address the needs of a child who has experienced psychological maltreatment. Most, however, thought that modifications would be "a little bit" or "somewhat" useful. All but one thought that additional therapist training in the APSAC definition of psychological maltreatment would be helpful. The interviewees were divided as to whether a new program would be beneficial for children who had experienced PM in addition to other forms of trauma/abuse or had experienced it as the only form of trauma and abuse.

Regarding awareness of any programs specifically for children who have been psychologically maltreated, interviewees were unanimous in saying that they were not aware of any such programs.

How Psychologically Maltreating Parents Should Be Involved in Treatment

Each of the interviewees responded affirmatively that the parents of maltreated children should be involved in their children's treatment, with many considering it "critical" or a "central role." In general, they reported that the parents needed support and therapy to address their own unmet needs and "ghosts in the nursery" as well as to understand the damage they are causing to their children in order to support the child's treatment and to prevent relapse of psychologically maltreating behaviors.

Discussion

The purpose of this study was to determine whether and how evidence-based and best practice trauma-informed and abuse-specific therapeutic programs address children's experience of psychological maltreatment. Eleven programs were identified and ten program developers and authorities agreed to be interviewed. Before discussing the data, we mention a few limitations at the outset. First, individual therapists bring their own knowledge base and skill set into the therapeutic session with abused and traumatized children. It is quite likely that some of them are knowledgeable about the topic of psychological maltreatment and engage child clients specifically on dimensions of PM identified by APSAC (i.e., spurning, terrorizing, and so forth).

Needless to say, there was no way to assess the content of these discussions. However, it is likely that some clinicians are not knowledgeable about the topic of PM and do not engage the child clients on this experience. For the purposes of this study, we inferred that if the interviewees (who were for the most part the program developers) intended that a concept be routinely covered in the program, they would reflect on it in their comments during the interview and in their survey reports regarding program materials. It is also worth noting that these programs are all well established and highly regarded, which is the reason they were selected for this review. Nothing written in this article is intended to be critical of the programs. Our only intention is to assess whether and how they address the issue of PM.

Turning to the current study, we found that in general the interviewees did not have sufficient knowledge and were unable to articulate a coherent description of any recognized definition of PM in the field. In particular, they appeared to be unfamiliar with the definition of psychological maltreatment endorsed by APSAC. They did not spontaneously offer it when given an opportunity to do so and generally expressed unfamiliarity with it when told that it involved 18 subtypes of PM. This suggests that the topic of PM is not yet as prominent as it needs to be. Reasons for this abound. As Baker (2009) noted, there is no uniform legal definition of this form of maltreatment, and there is ongoing conceptual and definitional confusion in the research literature, including multiple terms for the same general issue (e.g., emotional abuse, verbal abuse, psychological abuse, and so forth). While the APSAC definition could be a helpful rubric for the creation of measures of psychological maltreatment, most measures of the construct do not yet incorporate it, and thus, most research published is not grounded in the theory and research underlying its development (Baker, 2009). Further, it appears that the APSAC definition in particular might not be as well disseminated as it needs to be. Thus, it appears that the program developers and authorities interviewed for this study are not clear about the definition of PM and the many forms it can take, which suggests that issues related to PM if not raised by the child may not be addressed in treatment.

Consistent with this is the fact that only half of the interviewees believed that their program (i.e., background materials, curriculum, training) covered "in-depth" the issue of psychological maltreatment. Some of those who reported that it was less than in-depth coverage responded that this was not problematic because their program was designed to address traumatic events as identified by the client. In that sense, the program is "generic" in being able to address the resulting thoughts and feelings of any and all precipitating events. This belief is exemplified in the following quote from one interviewee, "Trauma program is general, doesn't matter what the person has experienced. We focus on their perception of their trauma not how we believe it was traumatic. Start from the person's perception. Even something we believe might have been very traumatizing, if they don't see it that way, that is what we work with."

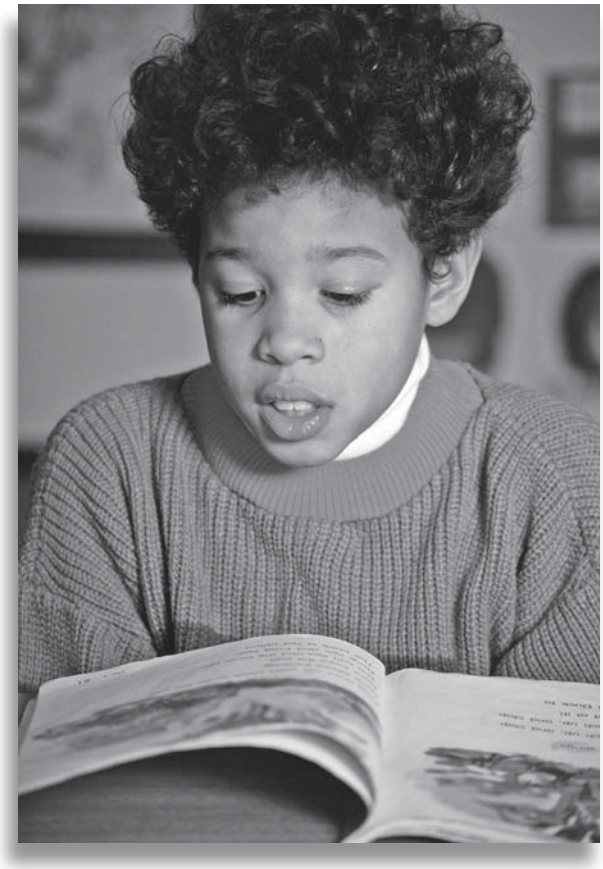
However, we believe that many children do not spontaneously talk about their trauma experience (nor do adults or children consider PM experiences as traumatizing) and that many children may not be "traumatized" by PM experiences but may be suffering nevertheless. If the clinician does not have a clear definition of PM, then it may be likely that the issue may never surface since neither the child nor clinician may consider it a treatment issue. For example, children may not report that a parent threatens to kill them or kick

them out of the home, and if the therapist does not ask questions about this, the issue may never arise. Thus, even for trauma-informed as opposed to abuse-specific treatment, awareness about PM on the part of the clinician with information provided by the program could potentially be useful for the treatment of children who have been psychologically maltreated. In the absence of clear direction on the part of the program and knowledge on the part of the clinician, it is possible that the child's PM experiences will go unreported and hence untreated.

A second response to the question about whether program materials covered psychological maltreatment in-depth was made by interviewees regarding abuse specific programs who stated that their materials did attend to the concepts of verbal aggression and verbal rejection, which can co-occur with physical abuse, and thus PM is at least in part addressed in the program. This idea was captured in the following statement: "We do not refer to it as PM but what children experience by adults that is a trauma. We are interested in what the child experiences. We do not use the term PM that much, but we certainly recognize and deal with it more than we deal with physical abuse. In a way, PM is the psychological underpinning that children carry into adolescence and adulthood." However, according to the APSAC definition, psychological maltreatment consists of 18 types (including but not limited to verbal aggression), and unless the clinician is aware of these other types and can probe for them and or respond appropriately when the child shares information related to them, the experience might go unaddressed in treatment.

Nonetheless, not one of the interviewees expressed the belief that a standalone program specifically for children who experienced psychological maltreatment would be warranted. The reason offered was that their programs were not specific to any one form of abuse, and thus while not intended specifically for children who have experienced PM, the program would work well with that population. Thus, while it was generally believed that abused children could benefit from therapy especially designed for abused children, there was no perceived benefit to having a treatment be specific to psychological maltreatment per se. They shared the belief that their program would be able to adequately address the treatment needs of children who experienced psychological maltreatment.

How well these programs address the PM experience of child clients is something we consider to be an unresolved issue that requires further empirical exploration. It appears relevant to us to determine how well these programs are addressing children's experiences with psychological maltreatment, in the absence of a working definition that captures many of the specific types of PM that can occur. What is clear is that unless a frontline mental health provider implementing one of these programs receives training on PM from some other source, he or she will



most likely be uninformed about it (beyond a general idea that it is verbal abuse). The question remains whether the clinician—in the absence of specific training—can effectively recognize and treat it. It seems possible that in the absence of training, therapists might not elicit information about psychological maltreatment from a client, or not recognize it as PM when a client discusses a behavior that is considered PM in the APSAC definition (which the therapist is unfamiliar with), or both. Thus, therapists might overlook and minimize clients' PM experiences, in the absence of specific training or direction in the treatment program materials. In addition, it is unclear how these programs would treat children who have been psychologically maltreated but are not exhibiting signs of traumatic stress or symptoms. The quote from the 1927 Nobel Prize in literature winner, Henri Bergson, appears apt. "The eye sees only what the mind is prepared to comprehend."

It is interesting that interviewees generally agreed that training for therapists about psychological maltreatment would be helpful. Most of the interviewees endorsed this item. Presumably this is because training could lead to greater awareness of the different types of PM identified by APSAC and could inform the work that the clinicians do. This suggests that despite believing that their programs could adequately address PM, they also believe that it could be helpful to alert frontline staff about the many

forms that PM can take. This suggests that without explicitly saying so, the program developers acknowledge that their programs may not be fully addressing issues related to PM and that if therapists were more trained, they would be more attuned to this issue in their interventions with children. The implication is that with greater training, clinicians would better be able to identify the issue of PM and then address it. Hence, once PM is identified, the program can address it adequately and, therefore, a standalone program is not needed to address PM. Again, this is an empirical question that should be addressed.

Despite the general agreement among the interviewees, some areas met with disagreement. A notable one pertains to whether the child is the level of the intervention and sole recipient of the treatment or whether the program aims to treat or modify the social ecology within which the child is living. A natural implication flowing from these different orientations is how to address the ongoing abusive experiences of the child who may still be in the stressful, traumatizing environment.

When asked about the role and services of the psychologically maltreating parents, there was consensus that as long as parents are not dangerous to the child, they should be involved in therapy. Comments included, "Yes, should be involved. Psychoeducation component for parents, parents should have adjunct therapists to address ghosts in nursery, and they all need a witness to what their child's perception and experience is like so that they can understand it as child does. A lot of parents don't know the damage they are doing. They are practicing what they experienced; matter of ignorance rather than intent to harm." And, "Critical. Trying to do anything without the parents' involvement, doesn't work as well. In our experience when we don't have access to parents, kids idealize them. Lots of opportunities to work with parents who are really harsh with their kids. Can alter how they perceive and interact with them. Optimistic about changing in parents [*sic*]. Worth making investment in, but some parents cannot be helped."

While sharing this vision, programs varied as to how much third parties (especially parents) were involved in the treatment. At one end of the spectrum are programs like EMDR, in which the child is the client and the services are provided to that client in the office; and at the other end of the spectrum is Trauma Systems Therapy, in which the child's ecology is considered holistically and services are provided in a range of locations and settings.

The set of findings that resulted from the interviews suggests a number of important next steps for research and practice. One critical direction for future research is to document the extent of psychological maltreatment experienced by children in abuse-specific and trauma-informed treatment programs. If high levels are established (and there is every reason to believe that they will be), then studies should be conducted to determine the differential effectiveness of abuse-specific vs. trauma-informed programs for addressing the psychological maltreatment experiences of children in treatment.

Since PM often co-occurs with other forms of abuse, another direction for research is to explore whether addressing the trauma of sexual abuse or physical abuse also reduces the adverse impact of PM. This raises the issue of how the programs aim and actually address multiple abuse experiences. Is each form of abuse mentioned by the child included in the trauma narrative or just the primary one? What about children for whom the sole maltreatment experience is psychological maltreatment? How well do these programs help those children, or would a standalone program focused exclusively on PM be more appropriate and effective? Surveys of frontline mental health clinicians could ascertain what level, if any, of training they have in psychological maltreatment and whether that training per se is associated with improved outcomes. Based on the findings from these suggested research directions, the development of specific training modules might be indicated, which could lead to a new round of evaluation investigations. In light of the prevalence of psychological maltreatment coupled with the lack of specific information about the concept and inconsistency with which the best practice treatments incorporate information about it in their curricula, these next steps represent a path forward in the field of abuse and trauma treatment, practice, and research.

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