



## CLINICAL REPORT

## Psychological Maltreatment

## abstract

FREE

Psychological or emotional maltreatment of children may be the most challenging and prevalent form of child abuse and neglect. Caregiver behaviors include acts of omission (ignoring need for social interactions) or commission (spurning, terrorizing); may be verbal or nonverbal, active or passive, and with or without intent to harm; and negatively affect the child's cognitive, social, emotional, and/or physical development. Psychological maltreatment has been linked with disorders of attachment, developmental and educational problems, socialization problems, disruptive behavior, and later psychopathology. Although no evidence-based interventions that can prevent psychological maltreatment have been identified to date, it is possible that interventions shown to be effective in reducing overall types of child maltreatment, such as the Nurse Family Partnership, may have a role to play. Furthermore, prevention before occurrence will require both the use of universal interventions aimed at promoting the type of parenting that is now recognized to be necessary for optimal child development, alongside the use of targeted interventions directed at improving parental sensitivity to a child's cues during infancy and later parent-child interactions. Intervention should, first and foremost, focus on a thorough assessment and ensuring the child's safety. Potentially effective treatments include cognitive behavioral parenting programs and other psychotherapeutic interventions. The high prevalence of psychological abuse in advanced Western societies, along with the serious consequences, point to the importance of effective management. Pediatricians should be alert to the occurrence of psychological maltreatment and identify ways to support families who have risk indicators for, or evidence of, this problem. *Pediatrics* 2012;130:372–378

## INTRODUCTION

Psychological or emotional maltreatment of children and adolescents may be the most challenging and prevalent form of child abuse and neglect, but until recently, it has received relatively little attention. The American Academy of Pediatrics (AAP) reviewed the topic in a technical report in 2002.<sup>1</sup> This clinical report updates the pediatrician on current knowledge and approaches to psychological maltreatment, with guidance on its identification and effective methods of prevention and treatments/intervention.

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## KEY WORDS

psychological maltreatment, child abuse, emotional maltreatment, neglect, verbal abuse, development

## ABBREVIATIONS

AAP—American Academy of Pediatrics  
NFP—nurse family partnership

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## DEFINITION

There is no universally agreed definition of psychological maltreatment or emotional maltreatment, terms that are often used interchangeably. Psychological maltreatment encompasses both the cognitive and affective components of maltreatment.<sup>2</sup> One of the difficulties in clearly defining what such maltreatment comprises involves the absence of a strong societal consensus on the distinction between psychological maltreatment and suboptimal parenting.<sup>3</sup> Exposure to psychological maltreatment is considered when acts of omission or commission inflict harm on the child's well-being, which may then be manifested as emotional distress or maladaptive behavior in the child. Psychological maltreatment is difficult to identify, in part because such maltreatment involves "a relationship between the parent and the child rather than an event or a series of repeated events occurring within the parent-child relationship."<sup>4</sup> Isolated incidents of behaviors identified in Table 1 do not necessarily constitute psychological abuse. Psychological maltreatment refers

to a repeated pattern of parental behavior that is likely to be interpreted by a child that he or she is unloved, unwanted, or serves only instrumental purposes and/or that severely undermines the child's development and socialization.<sup>4</sup> Recent conceptualization<sup>5</sup> of psychological maltreatment focuses on the caregiver's behaviors as opposed to the disturbed behaviors in the child. Such behaviors of the caregiver include acts of omission (ignoring the need for social interaction) or commission (spurning, terrorizing); may be verbal or nonverbal, active or passive, and with or without intent to harm; and negatively affect the child's cognitive, social, emotional, and/or physical development. Table 1 summarizes the different types of psychologically abusive caregivers' behaviors across 6 main categories.<sup>2,5</sup>

Although the psychological components of any form of child maltreatment are key to understanding its effects, psychological maltreatment is often not recognized when other forms of maltreatment coexist.<sup>3</sup> When psychological maltreatment occurs alone, it can be even harder to identify, and

opportunities for intervention may be missed. This form of child maltreatment is possibly the most underreported to authorities.<sup>3,6</sup>

## DISTRIBUTION OF PSYCHOLOGICAL MALTREATMENT

A recent review of the burden and consequences of psychological abuse concluded that, although there were few studies reporting its prevalence, a number of large population-based, self-report studies in the United Kingdom and United States found that approximately 8% to 9% of women and 4% of men reported exposure to severe psychological abuse during childhood.<sup>7</sup> This review found even higher rates reported in Eastern Europe. A number of US surveys found that psychological and emotional maltreatment were the most frequently self-reported forms of victimization.<sup>8</sup>

## DETERMINANTS OF PSYCHOLOGICAL MALTREATMENT

Although it is recognized that psychological maltreatment occurs in a wide range of families, it is more often associated with multiple family stresses<sup>9</sup> and, in particular, with factors such as family conflict, adult mental health problems, and parental substance abuse<sup>10</sup> that may be co-occurring.<sup>11</sup> For example, some parental mental health problems are associated with unpredictable and frightening behaviors, and others (particularly depression) are linked with parental withdrawal and neglect.<sup>12,13</sup> Similarly, in terms of family conflict, attacks on a parent almost always frighten a child, even if the child is not the direct target. Threats or actual violence as part of a pattern of aggression against one parent will sometimes exploit the other parent's or child's fears.<sup>14,15</sup> Children exposed to violence in the home are at disproportionate risk of injury,

**TABLE 1** Types of Psychologically Abusive Behaviors by Caregivers

Spurning	<ul style="list-style-type: none"> <li>• Belittling, denigrating, or other rejecting</li> <li>• Ridiculing for showing normal emotions</li> </ul>
Terrorizing	<ul style="list-style-type: none"> <li>• Singling out or humiliating in public</li> <li>• Placing in unpredictable/chaotic circumstances</li> <li>• Placing in recognizably dangerous situations</li> <li>• Having rigid/unrealistic expectations accompanied by threats if not met</li> <li>• Threatening/perpetrating violence against child or child's loved ones/objects</li> </ul>
Isolating	<ul style="list-style-type: none"> <li>• Confining within environment</li> <li>• Restricting social interactions in community</li> </ul>
Exploiting/Corrupting	<ul style="list-style-type: none"> <li>• Modeling, permitting, or encouraging antisocial or developmentally inappropriate behavior</li> <li>• Restricting/undermining psychological autonomy</li> <li>• Restricting/interfering with cognitive development</li> </ul>
Denying emotional responsiveness	<ul style="list-style-type: none"> <li>• Being detached or uninvolved; interacting only when necessary</li> <li>• Providing little or no warmth, nurturing, praise during any developmental period in childhood</li> </ul>
Mental health/medical/educational neglect	<ul style="list-style-type: none"> <li>• Limiting a child's access to necessary health care because of reasons other than inadequate resources</li> <li>• Refusing to provide for serious emotional/behavioral, physical health, or educational needs</li> </ul>

Adapted from Hart et al<sup>2</sup> and Brassard et al.<sup>5</sup>

eating disorders, and self-harm,<sup>16</sup> even when they are not themselves victims of physical violence. The AAP statement “Intimate Partner Violence: The Role of the Pediatrician” deals with how such issues should be addressed.<sup>17</sup> Although there is a paucity of literature specifically addressing the issue of parental substance abuse and psychological maltreatment,<sup>18</sup> substance abuse on the part of one or both parents is associated with high rates of child maltreatment.<sup>19,20</sup>

### ASSOCIATED IMPAIRMENT

Precisely because it interferes with a child’s developmental trajectory, psychological maltreatment has been linked with disorders of attachment, developmental and educational problems, socialization problems, and disruptive behavior.<sup>21,22</sup> Research involving institutionalized Romanian orphans demonstrated the effects of severe emotional and sensory deprivation on later IQ, executive function and memory, psychological processing, attachment, and psychiatric disorders.<sup>23,24</sup> The effects of psychological maltreatment during the first 3 years of life can be particularly profound, because rapid and extensive growth of the brain and biological systems takes place during this period, and this growth is significantly influenced by the young child’s environment and, in particular, the early parenting that he or she receives.<sup>25</sup> Psychological maltreatment also negatively affects the organization of the child’s attachment to important adults in his or her life.<sup>26,27</sup> Longitudinal studies have shown that impairment in security of attachment is associated with a range of later problems,<sup>27</sup> because early parenting plays a significant role in influencing children’s beliefs about themselves (ie, in terms of the extent to which they are lovable) and about themselves in relation to other people

(ie, when they have needs, people will respond appropriately to them). The research suggests that these internalized beliefs can affect children’s later cognitive schemas and, thereby, their psychological adjustment.<sup>28</sup>

Psychological maltreatment in early childhood is also associated with insecure attachment in adulthood.<sup>29</sup> A recent overview of the evidence found that as the child grows older, such attachment problems interfere with a number of aspects of later functioning, including peer relations, intimacy, caregiving and caretaking, sexual functioning, conflict resolution, and relational aggression.<sup>29</sup> The findings from longitudinal<sup>30</sup> and retrospective<sup>28</sup> studies also suggest a strong association with psychiatric morbidity. For example, one longitudinal study found that psychological unavailability and neglect in early childhood were associated with increased social problems, delinquency, aggression, and attempted suicide in adolescents and also that most psychologically abused children received at least 1 diagnosis of mental illness, with three-quarters having comorbid conditions for 2 or more disorders. Factors that may influence the effects of the abuse include early caregiving experiences; frequency, intensity, and duration of the abuse; factors intrinsic to the child, such as behavioral and coping strategies, self-esteem, and disposition; and the availability of supportive relationships.<sup>31</sup> For example, although the evidence does not relate specifically to psychological maltreatment, 1 study found that boys who experienced abuse that started before 12 years of age had more serious problems (eg, arrests and severity of delinquency) compared with boys who were abused after 12 years of age.<sup>32</sup> Without intervention, the cycle of abuse is often repeated in the next generation.<sup>29</sup>

Psychological maltreatment carries a significant burden for society, as can

be seen in its effects on the health and social care systems,<sup>33</sup> such as the costs of educational failure, crime, and health services as a result of poor mental health.

### ASSESSMENT

Psychological maltreatment poses a real challenge to pediatricians dedicated to ensuring the health and well-being of children. Pediatricians need to be alert to the possibility of psychological maltreatment and consider such exposure in any assessment of psychological and behavioral conditions in childhood. Just as history about a psychological or behavioral problem should be obtained from multiple informants whenever possible, this is also the case when considering whether a child is being exposed to psychological maltreatment. Much emphasis has been placed on appropriate skills for interviewing children about sexual abuse, but it is also important to develop approaches for asking children about their relationships with caregivers, experiences of discipline (some psychological maltreatment occurs in this context), and feelings of self-worth, safety, and being loved. Once it is possible to interview a child from a developmental standpoint and the pediatrician is comfortable doing so, an individual interview with the child becomes important for assessment of any concerns of major psychological or behavioral problems. Even very young children, once they are speaking in sentences, can often provide this information. It is important to interview children alone, away from their caregivers, because they may be experiencing maltreatment from the very caregivers who accompanied them to an appointment. The AAP resources, *Bright Futures*<sup>34</sup> and *Addressing Mental Health Concerns in Primary Care, A Clinician’s Toolkit*<sup>35</sup> provide guidance

that may be helpful in approaching these issues. The pediatrician needs to be aware of risk indicators for psychological maltreatment, such as parental psychiatric illness, including depression and substance abuse, among others. It is also important to be aware of the psychological maltreatment that can accompany exposure to intimate partner violence, although this is considered a separate type of maltreatment and is the focus of a previous AAP report as outlined above.<sup>17</sup> For children of all ages, major caregivers need to be interviewed (this should be performed individually to ensure the parent's safety when asking about such issues as intimate partner violence), and information should be gathered from teachers or child care personnel. Even brief telephone contact with school or child care personnel can be helpful in assessing a child's exposure to psychological maltreatment. Because this can be time consuming, ideally, the task of obtaining this information can be shared with another member of the pediatrician's office staff. Consultation with a pediatrician who has expertise in assessing child maltreatment or a mental health professional may assist the pediatrician in completing an assessment and plan.

Although there are no specific physical indicators for psychological maltreatment, it is essential to assess a child's growth and development, because these can be impaired in association with exposure to psychological maltreatment. The extent of impairment can vary; severe forms of psychological deprivation can be associated with psychosocial short stature, a condition of short stature or growth failure formerly known as psychosocial dwarfism.<sup>36</sup> Observing a child and parent(s) together can provide valuable information about the quality of their relationship and ability of a parent to

respond to a child, although appropriate behavior by a parent in the context of a brief office visit does not rule out the possibility that a child is experiencing psychological maltreatment. Conversely, a single interaction that is of concern between a parent and child is generally not diagnostic of psychological maltreatment. Close clinical follow-up may be needed to clarify any issues of concern.

As outlined in the earlier technical report on this topic,<sup>1</sup> reporting of psychological maltreatment can be difficult. In some jurisdictions, clear indication of impairment in growth and/or development may be necessary for a child protective services agency to accept a report; detailed documentation is essential in such situations. It is important that the pediatrician record specific statements from the child, the family, and other sources and that the pediatrician is systematic in assessing the child's behavioral, psychological, and physical status in relation to the baseline assessment. For example, the pediatrician who has been providing general pediatric care to a child whose parents become involved in an extremely contentious custody/access dispute can alert the parents to the potential for the child to experience psychological trauma and can be aware of early indicators of impairment in the child. If identification for the parents of a child being exposed to potential psychological maltreatment does not lead to improvement in parenting behavior, the pediatrician can then make referrals to such services as mediation, mental health services, or child protective services. Careful follow-up is very important, because parents who are psychologically abusive may not be reliable in providing information about their child's functioning or their own response to intervention.

## PREVENTION

The potential for major impairment associated with psychological maltreatment during the early years of life underscores the importance of identifying approach to intervention in infancy and toddlerhood. Prevention before occurrence involves both the use of universal interventions aimed at promoting the type of parenting that is now recognized to be necessary for optimal child development, alongside the use of targeted interventions directed at improving parental sensitivity to infant cues. This would include, for example, the recommendation that all routine contact between professionals and parents be used as an opportunity to promote sensitive and attuned parenting using a range of approaches (including media-based strategies, such as leaflets, books, and videos, among others) and to observe and identify parent-child interactions that require further intervention using targeted approaches. Although it is unknown whether these strategies actually prevent psychological maltreatment, there is preliminary evidence to suggest that the use of population strategies of this nature show promise in the prevention of child maltreatment generally.<sup>37</sup>

Targeted programs aimed at preventing early indicators of psychological abuse often focus on infants and younger children.<sup>38</sup> Much less is known about approaches to preventing psychological maltreatment in the older age groups. Specifically, maternal insensitivity to infant cues,<sup>39</sup> which is associated with insecure attachment, is a significant predictor of socioemotional maladaptation.<sup>27</sup> A meta-analysis of attachment-based interventions that ranged from home-visiting programs to parent-infant psychotherapy, found significant improvements in maternal sensitivity ( $d = 0.33$ ) and infant attachment insecurity ( $d = 0.22$ ).<sup>40</sup>



Greater effectiveness was associated with programs that included several sessions and had a clear behavioral focus. Maternal insensitivity is an important element of psychologically harmful parent-child relationships; brief focused interventions, such as those involving video feedback and attachment discussion, might improve insensitive parenting, but there is no direct evidence at this time that these interventions prevent psychological maltreatment. Furthermore, interventions to date have focused on maternal-child interactions; it is important to address paternal-child interactions as well as other significant caregiving relationships.

One targeted program that has been shown effective in preventing child maltreatment generally is the Nurse Family Partnership (NFP), an intensive home-visitation program provided by nurses to low-income first-time mothers beginning prenatally and during infancy.<sup>41</sup> Because the goals of the NFP include assisting women to promote healthy prenatal behaviors and parents' competent care of their children, it is possible that the NFP could prevent psychological maltreatment as part of the overall reduction in maltreatment, but its effectiveness in preventing this specific type of maltreatment has not been assessed.

## TREATMENT

Despite ongoing debate about the role of formal child protection processes for dealing with psychological maltreatment,<sup>42</sup> there is agreement about the need to intervene early to minimize poor outcomes. It is important to consider what is known about approaches to prevent recurrence of psychological maltreatment and treat associated impairment, once it has been identified. There is a paucity of studies evaluating the effectiveness of approaches specifically designed for

parents or caregivers who psychologically abuse their children. One randomized trial compared 2 group-based cognitive-behavioral therapy parenting programs (standard and enhanced models of the Triple-P Program) aimed at psychologically abusive parents.<sup>43</sup> The standard program focused on child-management strategies, and the enhanced model included components to alter parental anger and misattributions. Both groups made gains, there was no actual control group, and many parents had self-referred, reducing the generalizability of the results. Parents who are psychologically abusive may not be able to recognize their own behavior and self-refer.<sup>44</sup> Results of another trial suggest that a preschool child-parent psychotherapy program may be beneficial in improving specific aspects of the mother-child relationship, but further research is necessary.<sup>45</sup> A number of innovative methods of working with parents with mental health<sup>46</sup> and substance misuse problems have recently been developed and evaluated.<sup>47</sup>

There is major need for research to develop and test effective treatments for children who have experienced psychological maltreatment, either alone or in combination with other forms of maltreatment.

## GUIDANCE FOR THE PEDIATRICIAN

Psychological maltreatment is just as harmful as other types of maltreatment. Although little is known about approaches to its prevention or treatment, it is important for pediatricians to be alert to its occurrence and consider ways to support families who have risk indicators for this problem. Pediatricians should develop approaches for asking children about their relationships with caregivers, experiences of discipline and feelings of self-worth, safety, and being loved.

Bright Futures<sup>34</sup> and the Addressing Mental Health Concerns in Primary Care toolkit<sup>35</sup> are resources that can assist the pediatrician in the evaluation; however, they are not specific to psychological maltreatment.

The pediatrician should encourage parents who are experiencing mental health problems, intimate partner violence, or substance misuse to consider the effects of such conditions on their parenting and assist them in accessing appropriate resources, such as referrals to mental health professionals and substance misuse treatment programs. With respect to identification of psychological maltreatment, Rees<sup>48</sup> suggests that pediatricians need to be "as confident in assessing inadequate emotional care as physical and sexual abuse." This might include an assessment of parent-child interactions through the use of interviews or consultation with other clinicians, such as mental health providers, to assess the child's feelings and understanding about the situation. As with other types of child maltreatment, children showing signs of behavioral and psychological problems should be assessed to identify specific conditions, such as depression or posttraumatic stress disorder, for which there are evidence-based treatments, such as cognitive-behavioral therapy. Several trauma-specific interviews have been developed to determine whether children and adolescents presenting with mental health problems have been exposed to maltreatment.<sup>49</sup> To date, such instruments have been used mainly in research settings, but studies are increasingly examining their clinical applicability.

Although the evidence is limited with regard to interventions for psychological maltreatment, it is important for pediatricians to refer families for additional assessment and treatment if psychological abuse or neglect is

suspected, in addition to referring to child protective services in accordance with individual state laws, and follow-up appointments should be made so that the progress of the situation can be monitored.

Another equally important aspect of responding to psychological maltreatment is professional communication; collaboration among pediatric, psychiatric, and child protective services professionals is essential in formulating a management plan for a child at risk for or experiencing psychological maltreatment. Specific goals need to be put in place, and in cases where exposure to psychological maltreatment persists, the pediatrician should advocate for the needs of the child to remain paramount. Although efforts should focus on ways to assist the family with the child remaining in the home, it is important for the pediatrician to be alert to situations in which a child's needs are better met outside the home, either on a temporary or permanent basis. Consideration of out-of-home care interventions should not be restricted to cases of physical or

sexual abuse; children exposed to psychological maltreatment may also require a level of protection that necessitates removal from the parental home.

Pediatricians are uniquely positioned to educate those working in child welfare, child health care, and the judicial system about the complex needs of children exposed to psychological maltreatment. Because determination of and response to psychological maltreatment by child protective services can vary considerably across regions, pediatricians can assist child protective services workers in understanding the effects of exposure to maltreatment on the child as well as possible resources for intervention. Because less is known about psychological maltreatment and it has been recognized relatively recently compared with other subtypes of abuse and neglect, there is even less standardization of approaches to investigation and intervention by child protective services agencies. The pediatrician is well situated to advocate on behalf of the child and can take on an important liaison role with professionals in the child welfare system.

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#### REFERENCES

- Kairys SW, Johnson CF; Committee on Child Abuse and Neglect. Technical report: the psychological maltreatment of children. *Pediatrics*. 2002;109(4). Available at: [www.pediatrics.org/cgi/content/full/109/4/e68](http://www.pediatrics.org/cgi/content/full/109/4/e68)
- Hart SN, Brassard MR, Binggeli NJ, Davidson HA. Psychological maltreatment. In: Myers JEB, Berliner LA, Briere JN, Hendrix CT, Reid TA, Jenny CA, eds. *The APSAC Handbook on Child Maltreatment*. Thousand Oaks, CA: Sage Publications; 2002:79–104
- Trickett PK, Mennen FE, Kim K, Sang J. Emotional abuse in a sample of multiply maltreated, urban young adolescents: issues of definition and identification. *Child Abuse Negl*. 2009;33(1):27–35
- Glaser D. Emotional abuse and neglect (psychological maltreatment): a conceptual framework. *Child Abuse Negl*. 2002;26(6-7):697–714
- Brassard MR, Donovan KL. Defining psychological maltreatment. In: Feerick MM, Knutson JF, Trickett PK, Flanzer SM, eds. *Child Abuse and Neglect: Definitions, Classifications, and a Framework for Research*. Baltimore, MD: Paul H Brookes Publishing Co Inc; 2006:3–27
- Barnett O, Miller-Perrin CL, Perrin RD. Child psychological maltreatment. In: Barnett O, Miller-Perrin C-L, Perrin RD, eds. *Family Violence Across the Lifespan: An Introduction*. 2nd ed. Thousand Oaks, CA: Sage Publications; 2005:151–178.
- Gilbert R, Widom CS, Browne K, Fergusson D, Webb E, Janson S. Burden and consequences of child maltreatment in high-income countries. *Lancet*. 2009;373(9657):68–81
- Reyome ND. Childhood emotional maltreatment and later intimate relationships: themes from the empirical literature. *J Aggress Maltreat Trauma*. 2010;19:224–242
- Doyle C. Emotional abuse of children: issues for intervention. *Child Abuse Rev*. 2002;6:330–342.
- Department of Health, Home Office, Department for Education and Employment. *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children*. London, England: The Stationery Office; 2006.
- Stromwall LK, Larson NC, Nieri T, et al. Parents with co-occurring mental health and substance abuse conditions involved in Child Protection Services: clinical profile and treatment needs. *Child Welfare*. 2008; 87(3):95–113

12. Loh CC, Vostanis P. Perceived mother-infant relationship difficulties in post-natal depression. *Infant Child Dev.* 2004; 13:159–171
13. Foster CJ, Garber J, Durlak JA. Current and past maternal depression, maternal interaction behaviors, and children's externalizing and internalizing symptoms. *J Abnorm Child Psychol.* 2008;36(4):527–537
14. Creighton S, Russell N. *Voices from Childhood: A Survey of Childhood Experiences and Attitudes to Childrearing among Adults in the United Kingdom.* London, England: National Society for Prevention of Cruelty to Children; 1995
15. Bifulco A, Moran P. *Wednesday's Child: Research into Women's Experience of Neglect and Abuse in Childhood.* London, England: Routledge; 1998
16. World Health Organization. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization; 2002. Available at: [www.who.int/violence\\_injury\\_prevention/violence/world\\_report](http://www.who.int/violence_injury_prevention/violence/world_report). Accessed December 17, 2011
17. Thackeray JD, Hibbard R, Dowd MD; Committee on Child Abuse and Neglect; Committee on Injury, Violence, and Poison Prevention. Intimate partner violence: the role of the pediatrician. *Pediatrics.* 2010;125(5):1094–1100
18. Straussner SLA, Fewell CH. Preface. *J Soc Work Pract Addict.* 2006;6:xxi–xxviii
19. Ammerman RT, Kolko DJ, Kirisci L, Blackson TC, Dawes MA. Child abuse potential in parents with histories of substance use disorder. *Child Abuse Negl.* 1999;23(12):1225–1238
20. Chaffin M, Kelleher K, Hollenberg J. Onset of physical abuse and neglect: psychiatric substance abuse, and social risk factors from prospective community data. *Child Abuse Negl.* 1996;20(3):191–203.
21. Iwaniec D. An overview of emotional maltreatment and failure-to-thrive. *Child Abuse Rev.* 1997;6:370–388
22. Erickson M, Egeland B, Pianta R. The effects of maltreatment on the development of young children. In: Cicchetti D, Carlson V, eds. *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect.* New York, NY: Cambridge University Press; 1989:647–684
23. Zeanah CH, Egger HL, Smyke AT, et al. Institutional rearing and psychiatric disorders in Romanian preschool children. *Am J Psychiatry.* 2009;166(7):777–785
24. Zeanah CH, Nelson CA, Fox NA, et al. Designing research to study the effects of institutionalization on brain and behavioral development: the Bucharest Early Intervention Project. *Dev Psychopathol.* 2003; 15(4):885–907
25. Schore AN. *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development.* Hillsdale, NJ: Lawrence Erlbaum Associates; 1994
26. Jacobvitz D, Hazen N, Riggs S. Disorganized mental processes in mother, frightening/frightened caregiving and disorganized behavior in infancy. Paper presented at The Meeting of the Society of Research in Child Development. Washington, DC: Society of Research in Child Development; 1997
27. Sroufe LA. Attachment and development: a prospective, longitudinal study from birth to adulthood. *Attach Hum Dev.* 2005;7(4): 349–367
28. Wright MO, Crawford E, Del Castillo D. Childhood emotional maltreatment and later psychological distress among college students: the mediating role of maladaptive schemas. *Child Abuse Negl.* 2009;33(1):59–68
29. Riggs S, Kaminski P. Childhood emotional abuse, adult attachment, and depression as predictors of relational adjustment and psychological aggression. *J Aggress Maltreat Trauma.* 2010;19(4):75–104
30. Egeland B. Taking stock: childhood emotional maltreatment and developmental psychopathology. *Child Abuse Negl.* 2009;33(1):22–26
31. Iwaniec D, Larkin E, Higgins S. Research review: risks and resilience in cases of emotional abuse. *Child Fam Soc Work.* 2006;11:73–82
32. Smith CA, Thornberry TP. The relationship between childhood maltreatment and adolescent involvement in delinquency. *Criminology.* 1995;33(4):451–481
33. Glaser D, Prior V, Lynch M. *Emotional Abuse and Emotional Neglect: Antecedents, Operational Definitions and Consequences.* York, United Kingdom: BASPCAN; 2001:iii–iv.
34. Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008:77–107
35. American Academy of Pediatrics, Task Force on Mental Health. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit* [CD-ROM]. Elk Grove Village, IL: American Academy of Pediatrics; 2010
36. Muñoz-Hoyos A, Molina-Carballo A, Augustin-Morales M, et al. Psychosocial dwarfism: psychopathological aspects and putative neuroendocrine markers. *Psychiatry Res.* 2011;188(1):96–101
37. Prinz RJ, Sanders MR, Shapiro CJ, Whitaker DJ, Lutzker JR. Population-based prevention of child maltreatment: the U.S. Triple P system population trial. *Prev Sci.* 2009;10(1):1–12
38. MacMillan HL, Wathen CN, Barlow J, Fergusson DM, Leventhal JM, Taussig HN. Interventions to prevent child maltreatment and associated impairment. *Lancet.* 2009;373(9659):250–266
39. Barlow J, Schrader-MacMillan A. *Safe-guarding Children from Emotional Maltreatment: What Works?* London, England: Jessica Kingsley; 2010
40. Bakermans-Kranenburg MJ, van IJzendoorn MH, Juffer F. Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. *Psychol Bull.* 2003;129(2): 195–215
41. Olds DL, Sadler L, Kitzman H. Programs for parents of infants and toddlers: recent evidence from randomized trials. *J Child Psychol Psychiatry.* 2007;48(3-4): 355–391
42. Glaser D, Prior V. Is the term child protection applicable to emotional abuse? *Child Abuse Rev.* 1998;6:315–329
43. Sanders MR, Pidgeon AM, Gravestock F, et al. Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? *Behav Ther.* 2004;35(3):513–535
44. Boulton S, Hindle D. Emotional abuse: the work of a multidisciplinary consultation group in a child psychiatric service. *Clin Child Psychol Psychiatry.* 2000;5(3):439–452
45. Toth SL, Maughan A, Manly JT, Spagnola M, Cicchetti D. The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory. *Dev Psychopathol.* 2002;14(4):877–908
46. Slade A, Sadler LS, De Dios-Kenn C, Webb D, Currier-Ezepchick J, Mayes LC. Minding the baby a reflective parenting program. *Psychoanal Study Child.* 2005;60:74–100
47. Dawe S, Harnett P. Reducing potential for child abuse among methadone-maintained parents: results from a randomized controlled trial. *J Subst Abuse Treat.* 2007;32(4):381–390
48. Rees CA. Understanding emotional abuse. *Arch Dis Child.* 2010;95(1):59–67
49. Gilbert R, Kemp A, Thoburn J, et al. Recognising and responding to child maltreatment. *Lancet.* 2009;373(9658):167–180