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Original Scientific Paper

TRAUMATIC EXPERIENCES AS THE PREDICTOR OF MALADAPTIVE OUTCOMES AMONG CHILDREN IN FOSTER CARE

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Abstract. *The aim behind this study was to first analyze the nature and the extent of childhood trauma and existing maladaptive outcomes (internalized and externalized problems, and dissociation) among adolescents in the foster system, and then analyze the possibility of using traumatic experiences to predict the aforementioned outcomes of childhood trauma. The sample consists of 121 respondents, children and youths in the care of child protective services, without adequate parental care, residing in temporary foster care families on the territory of Serbia, aged between 11 and 18. The respondents filled out the Childhood Trauma Questionnaire – CTQ (Bernstein & Fink, 2003), the Dissociative experience scale for adolescents, A-DES (Armstrong et al., 1997), and the Child behavior checklist – youth self-report (Achenbach & Rescorla, 2001). The results of the analyses have indicated that physical and emotional neglect are the most frequent forms of maltreatment in early childhood, with a relatively high prevalence of the other individual forms of trauma. Early childhood trauma statistically significantly predicted all the analyzed maladaptive outcomes, explaining approximately 20% of the variance of internalized and externalized problems, and dissociation. Recommendations are given for future studies.*

Key words: *Trauma, Internalizing, Externalizing, Dissociation.*

1. INTRODUCTION

Foster care of adolescents is often a challenge due to the very nature of turbulent adolescent reactions, but also the oppressive experiences which a young person carries with them from the past, and which shape their experience of self and the world, as well as their psychological capacities. The most frequent direct reasons for separating intellectually

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unaffected children from their families and putting them in foster care include physical and mental abuse, neglect, or the inability of parents to care for their child due to their own medical condition, substance abuse, or a jail sentence (Žegarac 2014). Empirical studies have confirmed the high prevalence of experienced neglect (up to 80%) (Milan & Pinderhughes 2000) and various forms of abuse: physical (66%, according to Milan & Pinderhughes 2000), emotional (86%, according to Bovensen et al. 2016), and sexual (25%, according to Minnis, Everett, Pelosi, Dunn & Knapp 2006) among children in the foster care system, even though most of the children have actually experienced multiple forms of inadequate care from their parents. The consequences of inadequate parenting, as the unifying factor for children in foster care, are, as the research indicates, numerous. Early childhood trauma in the family of origin is associated with the general increased vulnerability of a child to maladaptive mental health outcomes, including externalized and internalized problems (Briggs-Gowan et al. 2010; Šilić 2018) and the extent of exposure to disassociation (Liotti 2004, 2017; Briere et al. 2002; Schore 2009; Farina & Imperatori 2017).

Externalized problems are manifested by a series of maladaptive forms of behavior ranging from disrespect of authority and of social values to antisocial and delinquent behavior, such as running away from home and vagrancy, theft, looting and destruction of property, early sexual activity, fighting, etc (Achenbach & Rescorla 2001). They are the outcome of a lack of self-control. The experience of a young person with these behavioral problems is dominated by anger, frustration, and hostility. Internalized problems related to mental health include emotional problems, and behavior that is the outcome of excessive personal control, such as anxiety, depression, social withdrawal, and psychosomatic disorders. They are based on emotions such as sorrow, fear, discomfort, guilt, and despair. They are often accompanied by dysphoria, loss of enjoyment in most activities, sleep disorders, appetite problems, concentration disorders, as well as a general decrease in energy. Disassociation (experiencing amnesia, depersonalization, derealization, emotional numbness, Armstrong et al. 1997) is seen as a direct response to events of high traumatic intensity which exceeds the capacity of the ego to overcome (Dalenberg et al. 2012); it occurs during exposure to traumatic content, as a defense mechanism. Disassociation enables the child to mentally escape, enables fragmentation, and the separation of psychological content from awareness, in a situation when it is physically not possible to escape the upcoming terror (Diseth 2005). However, if the traumatic events are repeated over again and last a long time, as is the case with experience of abuse and neglect in the family, relying on disassociation becomes excessive, constant and widely present, thus emerging as the dominant and central defense mechanism of one's personality (Dimitrijević 2009). This leads to deep changes in the personality of a child or adolescent, and opens the door for the development of psychopathology (Steinberg 1993; Diseth 2005).

Existing research on the mental health of children in the foster system provides contradictory findings. While Damnjanović (Damnjanović et al. 2012) reports that children in the foster system aged 8 to 18 predominantly suffer from anxious and depressive disorders compared to externalizing problems, Šilić (2018) found that these children are best described by delinquent and aggressive forms of behavior. The symptomatology of the dissociative type, even though very relevant for children and young people who are trauma survivors, has been studied very little in our country (Šilić 2018) and it continues to be studied but rarely. Bearing in mind these facts, the aim behind this study was to primarily study the nature and extent of childhood trauma and current maladaptive outcomes (disassociation, internalized and

externalized problems) among adolescents in foster care, and then to study to the possibility of using statistics to predict the outcomes of the impact of childhood trauma.

2. METHODOLOGY

2.1. The sample of participants

The sample consists of 121 respondents, all in the care of child protective services, residing in temporary foster care families on the territory of Serbia, aged between 11 and 18 (AS=14.50, SD=2.02). The respondents are mostly homogenous in terms of gender, with 45% of boys as opposed to 55% of girls. Approximately 70% of the respondents had been in foster care less than two years when the questionnaire was being distributed, while the remaining 30% had been in foster care between two and nine years (AS=3.12, SD=2.07). Respondents with lower intellectual abilities were excluded from the sample.

2.2. Instruments

The Childhood Trauma Questionnaire, CTQ, (Bernstein et al. 2003) was designed to provide a retrospective evaluation of the type and intensity of traumatic experiences during childhood among adolescents or adult respondents. It consists of 28 items, and a five-level scale used to express degree of agreement. Good reliability was noted in our study for all the scales, from moderate for physical neglect, to high for the remaining scales (Physical neglect .651; Physical abuse .899; Emotional abuse .839; Emotional neglect .836; Sexual abuse .897; Overall score of the traumatic experiences .724).

The CBCL – YSR version (the Child behavior checklist – youth self-report; (Achenbach&Rescorla 2001) was designed for the self-report of behavioral and emotional problems of adolescents, aged 11 to 18. Along with instruments based on information provided by the parents (PRF – Parent Report Form) and teachers (TRF – Teacher Report Form), it consists of an integrated set of scales for the evaluation of adaptive functioning, and the behavioral and emotional problems of children aged 4 to 18 ASEBA (Achenbach System of Empirically Based Assessment) (Achenbach 1991). Once a license to use was obtained, the study included the latest adapted Serbian version of the questionnaire which relies on multicultural norms, with the inclusion of the specific nature of the language and the culture of this area. Satisfactory measures of reliability for the entire scale were obtained, with Cronbach's Alpha coefficient ranging from .86, to .70 for internalizing and .78 for externalizing symptoms. The individual syndrome scales are also characterized by satisfactory reliability (from .56 to .89).

The Dissociative experience scale for adolescents (A-DES; Armstrong et al., 1997) consists of 30 items and was designed for adolescent-age respondents. They are supposed to evaluate the extent to which the experience described in the item refers to them, and to circle the suitable number on a scale from 1 (never) to 10 (always). The result is calculated as the average, and thus a single, overall score of disassociate experiences is obtained, even though the scale is constructed in such a way as to analyze the presence of numerous, internally different manifestations (amnesia, depersonalization, derealization, emotional numbness). A higher score indicates a higher level of disassociation, whereby a score of 3.7 could hint at a worrisomely high disassociation (Armstrong et al. 1997). In our study the scale showed excellent measures of internal consistency, considering that Cronbach’s alpha = .94.

3. RESULTS

Tables 1 and 2 present descriptive measures of the extent of traumatic experiences, and the behavioral and dissociative symptoms of adolescents in alternative family care.

Table 1 The descriptive parameters and intensity of abuse and neglect

Dimension	Range	Mean	SD
Emotional abuse	5-24	9.97	5.56
Physical abuse	5-25	8.73	5.90
Emotional neglect	5-20	11.63	5.33
Physical neglect	5-25	13.11	5.27
Sexual abuse	5-25	7.45	5.01
Trauma	25-98	50.71	18.40

Norms for the CTQ instrument allow us to classify average scores into categories based on intensity, on a scale from zero to weak, then to moderate, moderate to severe, and from severe to extreme. The average values obtained are within the boundaries of low to moderate for physical abuse, emotional abuse, and emotional neglect; moderate to severe for sexual abuse; and severe to extreme for physical neglect. The values provided by the respondents are distributed throughout the entire scale from the minimum to maximum theoretically possible values, for all the scales.

Physical neglect was experienced by 77.69% of the respondents (N=94) and was the most widely present form of trauma (9.9% weak, 6.6% moderate, 61% severe to extreme), followed by emotional neglect (N=74; 61.16%, of which 28.1% weak, 14.0% moderate, and 19.0% severe), emotional abuse (N=54; 44.63%, of which 14.9% weak, 11.6% moderate, and 18.2% severe), sexual abuse (N=46; 38.02%, of which 10.7% weak, 16.5% moderate, and 10.7% severe), and finally physical abuse (N=42), experienced by 34.71% respondents (5% weak, 9.9% moderate, and 19.8% severe).

In order to determine whether there is an association between various types of abuse, a partial correlation analysis was calculated for each two types of abuse, with the simultaneous control of the other three types. There is a positive correlation between physical and emotional neglect ($r=.500$, $p<.05$), while there is a negative correlation between emotional neglect and physical abuse ($r=-.575$, $p<.05$). Sexual abuse is not associated with other forms of trauma in a statistically significant manner.

Table 2 Descriptive measures for maladaptive mental health outcomes

Syndrome scale	Range		Mean	SD
Anxious/depressed	,00	16,00	5,34	4,04
Withdrawn/depressed	,00	14,00	3,87	3,47
Somatic complaints	,00	16,00	2,69	2,63
Internalizing	,15	43,00	11,92	8,12
Rule-breaking behavior	,00	30,00	4,20	5,83
Aggressive behavior	,00	32,00	7,54	5,63
Externalizing	,00	50,00	12,14	10,20
Dissociation	,43	7,93	2,73	1,80

Average values on the higher order scales of the questionnaire for the evaluation of emotional and behavioral problems of young people (internalization and externalization) are below the level of clinically significant values. However, the presented range of scores indicated that some respondents showed signs of very pronounced problems; the maximum empirically achieved scores for all the scales are found in the zone of clinical manifestation, while for some of the scales they are almost the highest possible scores (withdrawn/depression, 14 to 16; rule-breaking, 30 to 34; aggressive behavior, 32 od 36).

When it comes to disassociation, the average achieved value (AS=2.73, SD=1.80) is also below the threshold of the pathological (the cut-off score is 3.7). Still, the range of scores proves that the sample does contain respondents whose scores exceed the pathological.

Table 3 The association between individual forms and overall traumatic experience and maladaptive mental health outcomes

	Internalizing	Externalizing	Dissociation
Emotional abuse	,359**	,351**	,435**
Physical abuse	,250**	,221*	,381**
Emotional neglect	-,122	,023	-,107
Physical neglect	,150	,136	,235**
Sexual abuse	,039	,434**	,134
Trauma	,182*	,331**	,305**

Note: the * symbol indicates a p value of <0.05, ** p value of <0.01

The data in Table 3 indicate that the correlations between individual forms, but also the overall traumatic experience, with the exception of emotional neglect, are positive. The correlations range from low (for a certain number of relations they are below the level of statistical significance) to moderate.

The results of the regression analyses are shown in Tables 4 and 5.

Table 4 The results of the regression analysis with trauma as a predictor of maladaptive mental health outcomes

Predictor	Internalizing			Externalizing			Dissociation		
	ß	T	p(t)	ß	T	p(t)	ß	T	p(t)
Trauma	.33	2.02	.040	.18	2.02	.040	.30	3.50	.001
Regression model	R= .331			R= .182			R= .305		
	R^2 = .109			R^2 = .033			R^2 = .093		
	R^2 kor= .102			R^2 kor= .025			R^2 kor= .086		
	F (1)= 14.59; p=.000			F (1)= 4.08 ; p=.046			F (1)=12.24; p=.001		

The composite variable Trauma, as can be seen from the table, explains 10% of the variance of the values of internalization, 3% of the variance of the values of externalization, and 9% of the variance of problems in dissociation.

Table 5 The results of the regression analysis with individual forms of traumatic experience as predictors of maladaptive mental health outcomes

Predictor	Internalizing			Externalizing			Dissociation		
	ß	T	p(t)	ß	T	p(t)	ß	T	p(t)
Emotional abuse	.**293**	1.97	.050	.**479**	3.14	.002	.**419**	2.82	.006
Physical abuse	.010	.09	.924	.011	.09	.922	.162	1.48	.140
Emotional neglect	-.056	.55	.581	.148	1.43	.153	-.067	-.66	.508
Physical neglect	.188	1.43	.154	.046	.34	.730	.044	.33	.739
Sexual abuse	.**328**	3.30	.001	.182	1.79	.075	.115	1.11	.246
Regression model	R= .473			R= .435			R= .474		
	R^2 = .223			R^2 = .189			R^2 = .225		
	R^2 kor= .190			R^2 kor= .154			R^2 kor= .191		
	F (5)= 6.61; p=.000			F (5)= 5.36 ; p=.000			F (5)=6.67; p=.000		

Emotional abuse is a statistically significant predictor of all three dependent variables, internalization (ß=.29), externalization (ß=.47), and disassociation, while sexual abuse is a good predictor of internalization as the outcome (ß=.32). The multiple linear regression model, which takes into consideration the activities of individual forms of traumatic experiences, is a better predictor of the studied maladaptive outcomes (22% of the variance of internalization, 18% of externalization, and 22% of disassociation).

4. Discussion and Conclusions

The predictor variable of childhood traumatic experience is the result of the self-report of the respondents regarding the intensity of the trauma they experienced as part of their relationships with people close to them in early childhood. It was operationalized using the Childhood Trauma Questionnaire which for our sample showed good levels of reliability, as was expected considering the results of previous studies from around the world (Gerdner & Allgulander, 2009; Thombs et al., 2009), and locally (Protić, 2016). The average values for our sample were higher compared to the values obtained in some studies on the general (Wessel et al., 2001) and clinical population (Wessel et al., 2001; Şar, 2004), but are ranked among those obtained on a sample of traumatized young men and women in our environment (Protić, 2016). Physical neglect stands out as the most frequent form of trauma experienced by young people from our sample, which is in agreement with the data of the Center for Social Work (Obretković & Žegarac, 1998), as well as with previous research findings (Woller et al., 2012; Witt et al., 2017, 2018). It was experienced by 77.69% of our respondents, and in most cases, as many as 61%, it is severe to extreme. Physically neglected children are those whose parents did not provide them with the basic necessities (food, clothing, a roof over their head), irrespective of the family's financial situation. In practice it is not easy to separate the poverty of the parents and their mistakes in providing suitable care, but the fact that physical and emotional neglect, with control of the remaining forms of maltreatment, exhibit a moderate correlation maybe could indicate that the problem is rarely only a lack of funds. The parents' inability to recognize the child's feelings and needs, and thus the consequent lack of reaction to them, operationalized through the scale of emotional neglect, was experienced by 61% of our respondents. More than one half of the respondents, thus, reported that they had not received adequate emotional stimulation,

which is the necessary precondition for the formation of good objective relations; these are frequently children who were deprived of the basic necessities in life. Furthermore, 44 % of the respondents experienced emotional abuse, that is, were exposed to behavior which included inconsistency and unreliability on the part of their parental figures, rejection, degradation, intimidation, and even moral and behavior "corruption" and exploitation. There is a high percentage of respondents who stated they had experienced sexual abuse in childhood (38 %, of that 10 % weak, 16 % moderate, and 10 % severe), whereby there is the surprising fact of the only slightly higher frequency of sexual compared to physical abuse (34 % of the respondents, of which 5 respondents reported weak, 9 % moderate, and 19 % severe). For the purpose of comparison, the use of the same instrument on the general population revealed data on the prevalence of emotional neglect 13%, emotional abuse 10%, physical abuse 12 %, physical neglect 48 %, and sexual abuse 6 % (Iffland et al., 2013).

The variable of mental health problems, referring to the extent of behavioral and emotional problems among young individuals, was operationalized through the scores on the CBCL-YSR and is represented via broader factors of internalization (anxiety/depression, withdrawn/depression, somatization) and externalization (behavior involving breaking rules and social norms and aggressive behavior). This instrument is still not standardized for our population, even though the standardization process is ongoing, and so it is not possible to precisely view the level of clinical manifestation of the scores, considering the specific nature of the region and the age of the respondents. A more detailed comparison was carried out using norms obtained on numerous age-matched normative samples from around the world (Achenbach, & Rescorla, 2001), and data from several studies from our region, even though the studies involved younger respondents (Marković, 2011; Šilić, 2018). The conclusion is that all the average values of individual scales and broader factors which were obtained are in the zone of sub-clinical manifestation, thus are below the threshold which would indicate risk and the existence of evident emotional or behavioral problems in the studied segments of behavior. However, the scores were widely dispersed, which indicates that the sample consists of individuals who do not exhibit any mental health problems, or at least such that do not deviate from the developmental normative ones for that age, but also of those exhibiting very pronounced emotional and behavioral problems. The results obtained are expected when it comes to syndrome scales which belong to the broader factor of Externalization, considering a recently completed study involving a sample of children in foster care in our environment (Šilić, 2018). However, the values obtained for our sample are clearly higher when it comes to internalization - 11.92 for the broader factor of internalization in our sample, as opposed to 3.69 in the comparable one. One part of the explanation probably lies in the fact that the respondents in these two samples differ only when it comes to age: while Šilić picked respondents who were children aged five to eleven, our respondents are adolescents, who are at an increased risk of psycho-pathological manifestation in general, and in particular when it comes to symptoms of internalization (Ullsperger & Nikolas, 2017; Durbeej et al., 2019). Thus, the difference noted in the extent of the internalization symptoms is a consequence, supposedly, of the actual spike in the symptomatic manifestations which emerge with the onset of adolescence. Besides, in this study we used the self-report measure, compared to the version of the questionnaire where the foster parent evaluates the extent of any problems on the part of the child, which could additionally impact the spike in the results. Specifically, there is a tendency, confirmed in numerous studies, that other people – parents, guardians, or teachers – when evaluating the behavior of children, underestimate internalized problems, as they

are more difficult to detect than disruptive behavior which characterizes externalization (Mitković-Vončina, 2015, Achenbach et al., 2008; Macuka, Smojver-Ažić & Burić, 2012), and thus children themselves report more reliability about internalized symptoms (Zeanah et al., 1997). This is also the reason why we have decided to implement the aforementioned version of the Youth Self Report instrument, which the adolescents filled out themselves. And truly, our results indicated a deviation from the typical profile of the mental health of children who are in the system of social protection, one which is dominated by externalized problems. The prevalence of externalized and internalized symptoms is approximately equal in our sample, indicating possibly the need for a more sensitive evaluation of anxiety, dysthymia, and depression among adolescents in the system of foster care.

The variable of disassociated experiences is operationalized via the A-DES scale. It allows respondents to self-report on the experienced intensity of various dissociative manifestations (amnesia, depersonalization, derealization, emotional numbness). A higher score indicates a poor integration of memory, behavior, emotions, and identity (Armstrong et al.,1997), whereby the cut-off point is the value of 3.7; therefore, all higher scores are considered potentially pathological and require a more detailed evaluation. The average value for our sample was below this limit, but the range of scores indicates that the sample includes respondents who also achieved scores which exceed the limit of the pathological. Comparing the results obtained with those of other authors determined for samples of adolescents going through normal development, but also young people with anxiety disorders, mood disorders, attention deficit and hyperactivity, we can see that our respondents achieved higher scores (Muris, Merckelbach & Peeters, 2003; Zoroglu et al., 2002). This clearly indicates that these young people are trying to exhibit a certain tendency to more frequently use defense mechanisms of the dissociative type, which should, considering their pathology, be diagnosed upon their entering the foster system.

The results of the correlation analyses speak in favor of the empirically well-documented association between traumatic childhood experience and mental health disorders later in life (e.g. Liotti, 2004, 2017; Briere et al., 2005; Schore, 2009; Sar, 2011, 2017; Farina and Imperatori, 2017; Briggs-Gowan et al., 2010). A positive correlation exists between childhood trauma and all the studied forms of maladaptive reactions: dissociation, internalization and externalization. All correlations between individual forms of maltreatment are in the expected direction. The only exception are correlations with emotional neglect, but they are, even though negative, below the level of statistical significance. The regression analyses have shown that childhood trauma, as a compositive variable, is constructed in such a way as to include all the experiences of maltreatment during childhood, and to statistically significantly predict changes in the values of maladaptive mental health outcomes, such as dissociation, internalization and externalization. From the individual forms of maltreatment, emotional abuse which statistically significantly predicts all three dependent variables, and sexual abuse which significantly predicts internalized symptoms both emerged as good predictors. Sexual abuse is already associated with mood disorders and anxiety (Carr et al., 2013), and so our results do not deviate from those findings. Numerous authors indicate that emotional abuse underlies all forms of child maltreatment (according to Goldsmith & Freyd, 2005). Indeed, it is questionable whether childhood sexual or physical abuse can even take place in the family context in the absence of emotional abuse. Considering this all-encompassing nature of emotional abuse and its destructive component, since it disrupts

the basic feeling of security, it is no wonder that the distinct contribution of this form of maltreatment to the prediction of poor mental health outcomes is the greatest.

Early traumatic experiences attack a child's developmental relationship towards itself and others. The experience of betrayal from an individual who is responsible for that child, a person whom it trusts, or is in a position of power over the child, disrupts epistemic trust, leads to low self-respect, hopelessness, and the child feeling that it is not loved. This disrupts or has the high potential to disrupt the child's physical, mental, moral, and social development and increase its greater vulnerability. A comparison between abused children and children of the same age and socio-economic status who have not experienced abuse or neglect has shown that abused children have a series of developmental issues and deficits in the neuro-endocrine (Kagan, 2004; Perry, 2001), affective (Ciccheti & Toth, 2005) and cognitive functioning (Pears & Fisher, 2005). What frequently occurs are disorganized affective representations and damage done to the memory (Pears & Fisher, 2005), mentalization, emotional understanding and regulation; Fonagy et al, 2002). When a child is the victim of trauma which takes place in the family environment, the person abusing the child is the very one meant to help it survive abuse. Long-term and repetitive negative experiences pile up negative emotions, while understanding, support, and a resolution cannot be reached – the child has no capacities of its own to face this painful experience, and the abusive parent, or the parent who is not protecting the child from abuse, is of no help. This is how, developmentally speaking, the capacities for affective bonding and mentalization are damaged, and along with them the mechanism for emotion regulation and self-defense mechanism, which is why we see a rise in the child's vulnerability and the development of psychopathology.

The findings of this study indicate that early trauma experienced within the family is of considerable developmental importance. By comparing young people from our sample with the norm of the general population, we can note a greater manifestation of internalized, externalized, and dissociative symptomatology, even though the measures are still, on average, within the range of sub-clinical manifestation. This is congruent with the existing theoretical and research findings on the negative impact of trauma on mental health and psychological development, and therefore practice, which sees the physical relocation of traumatized children and youths from their traumatic environment to an environment which is physically and psychologically safe as a necessary step in their treatment. However, while earlier findings indicate that among the clinical population as many as two-thirds of the victims suffer from complex trauma (Ford et al., 2006), implying the great importance of traumatic experiences for the development of symptoms, our findings have indicated that traumatic experiences as the only predictor play no such strong and direct part in the prediction of mental health outcomes. A low percentage of the explained variance indicates that more attention needs to be focused on the study of possible factors of mediation and moderation in the relationship between trauma and mental health issues, making it a recommendation for further research.

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TRAUMATSKA ISKUSTVA KAO PREDIKTOR MALADAPTIVNIH ISHODA KOD DECE NA HRANITELJSTVU

Ovo istraživanje otpočeto je u nameri da se najpre ispita priroda i nivo izraženosti rano doživljenih traumatskih iskustava i aktuelnih maladaptivnih ishoda (internalizovanih i eksternalizovanih teškoća i disocijacije) kod adolescenata na hraniteljstvu, a potom da se ispita statistička moć rano doživljene traume da ove ishode predvidi. Uzorak se sastoji od 121 ispitanika, korisnika sistema zaštite za decu i mlade bez adekvatnog roditeljskog staranja, u privremenom porodičnom smeštaju na teritoriji Srbije, uzrasta između 11 i 18 godina Ispitanici su popunili Childhood Trauma Questionnaire – CTQ; Bernstain i Fink, 2003, Dissociative experience scale for adolescents, A-DES; Armstrong et al., 1997) and Child behavior checklist – youthself report; Achenbach & Rescorla, 2001. Rezultati sprovedenih analiza pokazali su da su fizičko i emocionalno zanemarivanje najučestalije forme maltretmana u ranom detinjstvu, uz relativno visoku prevalencu i za ostale pojedninačne forme traume. Rano doživljena trumatska iskustva statistčki značajno predviđaju sve ispitivane maladaptivne ishode, objašnjavajući približno po 20% varijanse internalizovanih, eksternalizovanih teškoća i disocijacije. Date su preporuke za buduća istraživanja.

Ključne reči: *trauma, internalizacija, eksternalizacija, disocijacija.*