

# Victimization and Poly-Victimization in Adolescent Outpatients from Mental Health Centers: A Case-Control Study

M. Soledad Álvarez-Lister<sup>1,2</sup> • Noemí Pereda<sup>1,3,2</sup> • Georgina Guilera<sup>4,3</sup> • Judit Abad<sup>1,2</sup> • Anna Segura<sup>1,2</sup>

**Abstract** The aims of the present study were to establish interpersonal victimization rates in a clinical sample and to analyze this sample's risk of victimization relative to the general population. The sample was composed of 472 adolescents (12–17 years of age): 118 outpatients from public mental health centers and 354 students who were matched by age and sex. Following previous studies, this research defined poly-victimization as four or more victimization types occurring during the previous year. The clinical group was more likely to report sexual victimization ( $OR = 9.540$ ), conventional crime ( $OR = 3.120$ ), caregiver victimization ( $OR = 3.469$ ), witnessing and indirect victimization ( $OR = 3.466$ ), electronic victimization ( $OR = 2.809$ ), and poly-victimization ( $OR = 4.319$ ) compared with the control group. Clinical samples present an increased risk of interpersonal poly-victimization compared with the general population. The influence of poly-victimization on mental health should be considered in the evaluation and treatment of adolescent outpatients.

**Keywords** Case-control studies • Victimization • Poly-victimization • Adolescent victims • Mental health services

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✉ M. Soledad Álvarez-Lister  
sole.alvarez@ub.edu

<sup>1</sup> Department of Clinical Psychology and Psychobiology, University of Barcelona, Passeig Vall d'Hebron, 171, 08035 Barcelona, Spain

<sup>2</sup> Research Group on Child and Adolescent Victimization (GReVIA), University of Barcelona, Barcelona, Spain

<sup>3</sup> Department of Social and Quantitative Psychology, Universitat de Barcelona, Passeig Vall d'Hebron, 171, 08035 Barcelona, Spain

<sup>4</sup> Institut de Recerca en Cervell, Cognició i Conducta (IR3C), University of Barcelona, Barcelona, Spain

Research on the epidemiology of child victimization experiences conducted with community samples in North America (Cyr et al., 2013; Finkelhor et al., 2005b; Romano et al., 2011) and European countries, such as the Finland (Ellonen & Salmi, 2011), Spain (Pereda et al., 2014), Sweden (Gustafsson et al., 2009) and United Kingdom (Radford et al., 2013), has shown that children who have experienced one form of interpersonal victimization are frequently exposed to other forms of victimization. This phenomenon has been conceptualized as poly-victimization by Finkelhor et al. (2007a, 2009b). The need to assess a wide spectrum of victimization experiences to determine their effects on the development and psychological well-being of children and adolescents has been recently highlighted (Cuevas et al., 2009).

Notably, the rates of poly-victimization differ depending on the methodology and samples used (Finkelhor et al., 2005b). Researchers have used the criteria of the top 10 % of the sample or children with victimization levels above the mean number suffered by all victims occurring during the past year. The method that considers an above-average number of different types of victimization has usually reported a cut-off point of four victimization experiences in community samples (e.g., Cyr et al., 2013; Finkelhor et al., 2007a; Pereda et al., 2014), but researchers have not used this method for clinical samples. Other studies have empirically established this group using a cluster or latent class analysis of both community samples (Ford et al., 2010) and clinical samples (Adams et al., 2015; Álvarez-Lister et al., 2014; Ford et al., 2009; Ford et al., 2011). The poly-victimization rates in different samples with different methods have ranged from 8 % (Cyr et al., 2013) to 48.6 % (Adams et al., 2015).

Poly-victimization has been shown to be related to psychological outcomes in a number of studies with community samples, including both internalizing behaviors, such as anxiety, depression, suicide risk, and post-traumatic stress disorder

(Cuevas et al., 2010; Cuevas et al., 2009; Finkelhor et al., 2005b; Finkelhor et al., 2007a; Ford et al., 2010; Higgins, 2004; Kirchner et al., 2014; Turner et al., 2006, 2010), and externalizing behaviors, such as drug abuse, anger and oppositional defiant/conduct disorder (Cuevas et al., 2010; Cuevas et al., 2009; Finkelhor et al., 2005b; Finkelhor et al., 2007a; Ford et al., 2010; Higgins, 2004; Turner et al., 2006, 2010). However, the few studies that have focused on the effects of poly-victimization on children and youth in either inpatient (Boxer & Terranova, 2008; Ford et al., 2009) or outpatient (Adams et al., 2015; Álvarez-Lister et al., 2014; Ford et al., 2011) clinical samples have found extensive support for externalizing symptoms (e.g., Adams et al., 2015; Álvarez-Lister et al., 2014; Boxer & Terranova, 2008; Ford et al., 2009; Ford et al., 2011), but more discrete evidence has been associated with internalizing symptoms. Some studies have supported this relationship (e.g., Adams et al., 2015; Álvarez-Lister et al., 2014; Boxer & Terranova, 2008) whereas other studies did not show significant association (Ford et al., 2009; Ford et al., 2011).

Although some research suggested that clinical populations report high rates of poly-victimization (Álvarez-Lister et al., 2014; Ford et al., 2011), to our knowledge, no case-control studies have been conducted to examine and quantify whether psychiatric patients have a higher risk of poly-victimization compared to adolescents in the general population. Case-control studies with clinical samples have analyzed the risk of specific types of interpersonal victimization (e.g., sexual victimization or child maltreatment) and diverse outcomes, such as drug dependence (Frigolo et al., 2009; Molnar et al., 2001), alcohol use Young-Wolff et al. (2011)), psychosis (Elklit & Shevlin, 2011; Heins et al., 2011; van Dam et al., 2014), non-clinical psychotic experiences (Heins et al., 2011), suicide (Gradus et al., 2012) and schizophrenia (Sturup et al., 2011). However, no previous case-control studies have considered the effects of multiple victimization experiences on psychological well-being. Furthermore, although some case-control studies on victimization have been conducted with adult psychiatric patients (Sturup et al., 2011), underage psychiatric samples have not yet been analyzed.

## Aims of the Study

The present research aims to conduct the first clinical case-control study of victimization among adolescent outpatients by assessing and quantifying victimization and poly-victimization, as well as their risks in the outpatient population compared with the general population. We use the same instrument of victimization used by previous studies (Álvarez-Lister et al., 2014; Cuevas et al., 2010; Cuevas et al., 2009; Finkelhor et al., 2007a; Finkelhor et al., 2005b, 2009b; Kirchner et al., 2014; Turner et al., 2006, 2010). Poly-victimization is defined

as the average plus one of the different types of victimization in the last year, as suggested by other studies (Cyr et al., 2013; Finkelhor et al., 2005b; Finkelhor et al., 2007a; Finkelhor et al., 2007b; Pereda et al., 2014). The use of the same methodology that has been established to define poly-victimization in previous studies is used to facilitate cross-cultural comparisons.

## Method

### Participants

The cases included 118 outpatients from 14 public mental health centers of a northeast region of Spain, with ages ranging from 12 to 17 years. Of these cases, 66.1 % were females and 33.9 % were males (see Table 1). To be included in the study, participants had to be between 12 and 17 years old and in the evaluation phase. Adolescents with cognitive or language problems were excluded from the study. The interviewers provided information about the research to each patient and his or her parents or guardians and subsequently requested signed informed consent.

The controls included 354 students who were matched by sex and age to the clinical cases. These participants were randomly selected from a sample of 1105 adolescents from seven secondary schools in the same geographical region as the outpatients. The inclusion criterion was age (i.e., being between 12 and 17 years old). To increase the validity of the results, the sample excluded students who were in psychological treatment during the past year and students with cognitive or language problems. Participants and their parents/guardians were informed about the research, and their consent was requested. Parents/guardians provided written consent, and the adolescents provided oral consent.

### Measures

**Sociodemographic Data** An ad hoc data sheet was created to obtain child and family sociodemographic characteristics, such as educational level, parental occupations and the country of origin. Information about previous or current psychological treatment was also collected.

**Juvenile Victimization Questionnaire (JVQ)** (Finkelhor et al., 2005a). This instrument evaluated 36 different forms of victimization against children and youth grouped into six modules: conventional crime (9 items), caregiver victimization (4 items), victimization by peers and siblings (6 items), sexual victimization (4 items), witnessing and indirect victimization (9 items) and electronic victimization (2 items). Two parallel versions of the JVQ were administered in Spanish or Catalan and used to assess the same 36 types of victimization.

Table 1 Socio-demographic characteristics of cases and controls

Variable	Cases ( <i>n</i> = 118)	Controls ( <i>n</i> = 354)	Statistics
Gender			
Male	40 (33.9 %)	120 (33.9 %)	
Female	78 (66.1 %)	234 (66.1 %)	
Age			
12	14 (11.9 %)	42 (11.9 %)	
13	27 (22.9 %)	81 (22.9 %)	
14	24 (20.3 %)	72 (20.3 %)	
15	26 (22.6 %)	78 (22.6 %)	
16	14 (11.9 %)	42 (11.9 %)	
17	13 (11.0 %)	39 (11.0 %)	
Adopted	1 (0.9 %) <sup>a</sup>	5 (1.4 %)	$\chi^2(1) = 0.212^b$ OR = 0.605 [0.070, 5.234]
Country of Origin Spain	97 (82.2 %)	339 (95.8 %)	$\chi^2(1) = 23.095^{***}$ OR = 4.891* [2.430, 9.853]
Foreign Country	21 (17.8 %)	15 (4.2 %)	
Diagnosis			
Adjustment Disorders	31 (26.3 %)	n/a	
Anxiety Disorders	29 (24.6 %)	n/a	
Attention-deficit and disruptive behavior disorders	26 (20.2 %)		
Mood Disorders	11 (9.3 %)	n/a	
Eating Disorders	9 (7.6 %)	n/a	
Other (all other diagnoses)	12 (10.1 %)	n/a	

Note. \* $p < 0.05$

\*\* $p < 0.005$

n/a: not applicable

<sup>a</sup> 1.9 % of the cases were counted as missing

<sup>b</sup> Given that the 20 % of the expected frequencies were less than 5, the significance was calculated by the *Fisher's exact test*

The outpatients were individually assessed with the full self-report version in an interview format that included additional information regarding the most recent episode (e.g., the identity of the aggressor, the use of any weapon, injuries, police reports). The students were collectively assessed with a screening version comprising of follow-up questions to assess the same forms of victimization in a shorter format. In both formats, each form of victimization included a screener question using a yes/no response format rated as 1 or 0. This question was used to assess victimization in the past year in both samples. These self-report versions of the JVQ may be applied to subjects between 8 and 17 years of age, and previous research has shown that the instrument has good reliability and validity in different contexts (Finkelhor et al., 2005a).

## Procedure

A total of 20 child and adolescent public mental health centers were invited to participate in the research. Nearly 70 % agreed to participate in the study (only 31.6 % declined). The outpatients were individually interviewed in the spaces provided by the center. Although 149 outpatients were interviewed in evaluation phase, only patients who were classified with a clinical

diagnosis based on a clinician's impressions and using the DSM-IV-TR criteria were considered for this study. As a result, 118 outpatients were included in the study. Their diagnoses are presented in Table 1. Instruments were administered by an individual interview. Following the interview, results were written up in a report that was filed with each adolescent's clinical history. Any cases in which the child appeared to be at risk of abuse or neglect were communicated to the center manager, in line with the guidelines set out in Article 13.1 of Spain's 1996 Protection of Minors Act.

For the controls, two trained researchers administered the questionnaires during a class session. Less than 3 % of the community sample chose not to participate in the study. Students received a brochure with the lead researchers' email to contact if needed.

All the participants were informed that their participation was voluntary and that refusal to participate would have no adverse consequences. No compensation was offered to any of the participants. Data were collected between December 2009 and May 2012 by researchers trained in developmental victimology. For each case, three controls matched by gender and age were randomly drawn from this group, resulting in 354 controls.

This study was approved by the Institutional Review Board of the University of Barcelona, as well as by an external Clinical Research Ethics Committee.

## Data Analysis

The data were analyzed using IBM-SPSS 21. All data are presented in terms of descriptive statistics. Bivariate analyses of the cases and controls were conducted based on demographic variables. The association between cases and controls was calculated by means of  $\chi^2$ , and the strength of this association was measured with the odds ratio (*OR*) in the country of origin and being adopted variables. Consistent with previous researchers (Finkelhor et al., 2005b; Finkelhor et al., 2007a, 2007b), poly-victimization was defined in the control group as the above-average number of different victimization experiences plus one among the victims during the past year ( $M = 2.53$ ,  $SD = 1.761$ ). Then, four types of victimization were used as the cut-off point, similarly established in other studies (Cyr et al., 2013; Finkelhor et al., 2005b). The crosstabs procedure for calculating the *ORs* was used to compare the cases and controls in general and to compare them by gender in each victimization category. The country of origin effect was controlled using the Cochran-Mantel-Haenszel test. The *ORs* were considered to be statically significant when their 95 % confidence intervals did not include the value of 1.

## Results

### General Characteristics

Table 1 includes the demographics and other characteristics of the sample. The majority of the sample of 118 patients was female (66.1 %), and more than half of the patients were between the ages of 13 and 15 ( $M = 14.32$ ,  $SD = 1.18$ ). In both samples less than 2 % of the participants were adopted (1.9 % of missing data in the clinical sample). Additionally,

17.8 % of the cases were from foreign countries, whereas 82.2 % were born in Spain. Moreover, 95.8 % of the controls were born in Spain, whereas 4.2 % were born in foreign countries. No significant differences were found between the cases and the controls in terms of being adopted, whereas cases were more likely to be born in a foreign country than were controls ( $OR = 4.891$ ). In the clinical sample, the most frequent diagnoses and symptomatology were adjustment disorders (26.3 %), anxiety disorders (24.6 %), and attention-deficit and disruptive behavior disorders (22.0 %). The least frequent diagnoses and symptomatology were mood disorders (9.3 %) and eating disorders (7.6 %). The remainder presented other diagnoses (such as substance-related disorders or somatoform disorders).

An adaptation of the Hollingshead Index (Hollingshead, 1975) was created to establish socioeconomic status (SES) for each group. The groups exhibited different distribution in their SES levels; the majority of cases were medium, medium-low, and low SES levels (20.3 %, 31.4 %, and 18.6 %), whereas controls were overrepresented in medium-high and high levels (30.2 %, and 39.5 %, respectively). Unfortunately, this index was not considered in any statistical analysis because of the large number of missing data, which was more than 20 % of the sample (10.2 % of the clinical sample, and 10.5 % of the controls).

### Interpersonal Victimization

The results showed that 85.6 % of the clinical group and 65.7 % of the control group endorsed some type of interpersonal victimization during the previous year ( $OR = 3.549$ , 95 % CI [1.972, 6.387] after controlling for country of origin). As shown in Table 2, the clinical group presented higher rates in each module evaluated, and significant differences ( $p < .05$ ) were found in almost all modules. In the *sexual victimization* module, which included rape, sexual assault by peers, and flashing/sexual exposure, the odds reached 9.540 times higher for the clinical group in comparison with the control group.

Table 2 Interpersonal victimization modules and poly-victimization

	Cases % (n)	Controls % (n)	<i>OR</i> <sup>a</sup>	95 % CI
Conventional Crime	67.9 (72)	40.9 (130)	3.120*	[1.988, 4.896]
Caregiver Victimization	36.8 (39)	12.9 (41)	3.469*	[2.109, 5.706]
Sexual Victimization	6.8 (8)	0 (0)	9.540 <sup>b*</sup>	[2.165, 42.034]
Peer and Sibling Victimization	36.8 (39)	27.7 (88)	1.272	[0.811, 1.995]
Witnessing/Indirect Victimization	57.5 (61)	32.4 (103)	3.466*	[2.217, 5.418]
Electronic Victimization	17.9 (19)	9.1 (29)	2.809*	[1.490, 5.297]
Poly-victimization	40.6 (43)	13.8 (44)	4.391*	[2.693, 7.159]

<sup>a</sup> Country of origin effect was corrected by using the Cochran-Mantel-Haenszel test

<sup>b</sup> Adjusted by adding 1 to each cell of the  $2 \times 2$  table

\*The *OR* is statistically different from 1 at a significance level of  $p < .05$

Moreover, the odds were tripled for the clinical group in the module of *conventional crime* ( $OR = 3.120$ ), including assault with and without a weapon, kidnapping, and robbery, among others; *caregiver victimization* ( $OR = 3.469$ ), including physical abuse, psychological or emotional abuse, neglect and custodial interference/family abduction; and *witnessing and indirect victimization* ( $OR = 3.466$ ), including the murder of a family member or friend, witnessing assault with a weapon, and witnessing the parental assault of a sibling or domestic violence, among others. The odds were almost three times higher in the clinical group for *electronic victimization* ( $OR = 2.809$ ), which included harassment and sexual solicitation by electronic means. Furthermore, the odds of poly-victimization (defined as four or more different types of victimization within the past year) were four times higher in the clinical group ( $OR = 4.391$ ). No differences were found in the *peer and sibling victimization* module, which included gang or group assault, bullying, and dating violence.

Table 3 shows data for every victimization category by gender. Males from the clinical group were 4.120 times more likely to experience caregiver victimization than males from the control group were. The former group presented statistically significant higher odds in the conventional crime module ( $OR = 2.642$ ) and the witnessing and indirect victimization module ( $OR = 3.000$ ). Modules related to peer and sibling victimization, sexual victimization, and electronic victimization did not yield statistically significant differences. By contrast, females from the clinical group showed statistically significant differences in relation to female controls on nearly all victimization experiences measured. Females from the clinical group were 8.867 times more likely to experience any sexual victimization than were females from the control group. The odds were tripled for females from the clinical group for witnessing and indirect victimization ( $OR = 3.789$ ), electronic victimization ( $OR = 3.419$ ) conventional crime ( $OR = 3.388$ ), and caregiver victimization modules ( $OR = 3.155$ ) compared

with the females from the control group. Only peer and sibling victimization were no differences found between the female cases and controls. Although poly-victimization practically quadrupled the odds for both genders, there were higher odds for females than for males ( $OR = 4.512$  and  $OR = 3.755$ , respectively), and both odds were statistically significant.

## Discussion

The purpose of the present study was to assess and quantify victimization and poly-victimization rates in adolescent outpatients and their risk compared with a community sample using a case-control design. Notably, this work has analyzed the risk of various types of victimization, as well as poly-victimization in adolescent outpatients. Few previous studies have focused on these types of samples (Álvarez-Lister et al., 2014; Ford et al., 2011). Consistent with the results of these studies, the findings of the current study suggested that victimization and poly-victimization are prevalent problems for adolescents in clinical settings (Álvarez-Lister et al., 2014; Boxer & Terranova, 2008; Fehon et al., 2001; Ford et al., 2009; Ford et al., 2011). This finding suggests that adolescents from mental health centers should be asked about their victimization experiences, as they are likely to show more extensive victimization profiles than other youth. Therefore, evaluating these diverse types of victimization is essential to properly determining the therapeutic needs of these children (Álvarez-Lister et al., 2014; Cuevas et al., 2009).

Furthermore, compared with the general population, adolescent outpatients showed nearly triple the risk of victimization in various modules. Being an outpatient tripled the risk of conventional crime, caregiver victimization, caregiver witnessing and indirect victimization compared with the controls. The risk of presenting these types of victimization within the outpatient group remained higher across gender according to subgroups

Table 3 Interpersonal victimization modules and poly-victimization by gender

	Males			Females		
	Cases % (n)	Controls % (n)	OR <sup>a</sup> [95 % CI]	Cases % (n)	Controls % (n)	OR <sup>a</sup> [95 % CI]
Conventional Crime	78.4 (29)	57.7 (64)	2.642 <sup>b*</sup> [1.208, 5.776]	62.3 (43)	31.2 (66)	3.388* [1.950, 5.886]
Victimization by caregivers	35.2 (13)	6.3 (7)	4.120 <sup>b*</sup> [1.671, 10.161]	37.7 (26)	16.4 (34)	3.155* [1.740, 5.720]
Sexual Victimization	2.7 (1)	0 (0)	2.604 <sup>b</sup> [0.424, 15.981]	10.1 (7)	0 (0)	8.867 <sup>b*</sup> [1.955, 40.225]
Peer and Sibling Victimization	45.9 (17)	29.7 (33)	1.391 [0.657, 3.945]	31.9 (22)	26.6 (55)	1.205 [0.686, 2.116]
Witnessing/Indirect Victimization	51.4 (19)	34.2 (38)	3.000* [1.399, 6.432]	60.9 (42)	31.4 (65)	3.789* [2.170, 6.617]
Electronic Victimization	8.1 (3)	9 (10)	1.303 <sup>b</sup> [0.359, 4.726]	23.2 (16)	9.2 (19)	3.419* [1.654, 7.065]
Poly-victimization	40.5 (15)	15.3 (17)	3.755 <sup>b*</sup> [1.661, 8.488]	40.6 (28)	13 (27)	4.512* [2.474, 8.226]

<sup>a</sup> Country of origin effect was corrected by using the Cochran-Mantel-Haenszel test

<sup>b</sup> Adjusted by adding 1 to each cell of the 2 × 2 table

\* The OR is statistically different from 1 at a significance level of  $p < .05$

analyses. In fact, being a female outpatient tripled the risk of conventional crime and caregiver victimization when compared with female controls. Male outpatients presented double the risk of conventional crime and a quadrupled risk of caregiver victimization compared with the male controls.

One strength of this work was the separate comparison by gender, which enabled us to expand the body of knowledge on prevalence rates and the risk of victimization and poly-victimization, thus providing a more comprehensive overview of interpersonal victimization (Finkelhor et al., 2009a). In general, the rates for male and female controls are consistent with those found in previous studies using a community sample to assess conventional crime (Finkelhor et al., 2009b; Pereda et al., 2014). According to our results, children and youth outpatients suffer from more conventional crimes than their community peers do, but more research is needed on this topic with clinical samples. Less frequently studied crimes (e.g., conventional crimes) may have a significant effect on children's well-being, and attention should be devoted to children who suffer from these victimization experiences. Prevention strategies should address this group of children when they enter the mental health system.

Similarly, compared with the male participants, both the clinical and control females showed higher prevalence rates for caregiver victimization, which is also consistent with other studies (Cyr et al., 2013; Finkelhor et al., 2009a; Pereda et al., 2014). The results could be explained by the relationship between caregiver abuse and adverse psychological consequences found in numerous studies (Cuevas et al., 2010; Cuevas et al., 2009; Fehon et al., 2001). In fact, psychologically disturbed adolescents reported more victimization by caregivers than the controls did, thus confirming our results, although the direction of the relationship (i.e., whether victimization is a cause or effect of psychopathology) cannot be established in the present study.

The rates of witnessing and indirect victimization for the controls followed the trend that has been observed in several studies with community samples (Cyr et al., 2013; Finkelhor et al., 2009a; Pereda et al., 2014). Researchers have established that the rates of specific interpersonal victimization types, such as exposure to community violence, are higher in inpatients and tend to increase the risk of psychopathology (Fehon et al., 2001). Based on the results of our study, the same pattern appears to apply to male and female adolescent outpatients, who presented higher percentages and higher risk compared with males and females from the control group.

Other victimization modules presented a higher risk in the outpatients than in the controls, such as sexual victimization and electronic victimization. However, after stratifying the sample by gender, the elevated rates were found only in female outpatients, who showed almost nine times higher risk of sexual victimization and a threefold risk of electronic victimization compared with the female controls.

Sexual victimization rates for outpatients are similar to those in other studies with community samples (Cyr et al., 2013; Finkelhor et al., 2009a). However, the percentages for the control group were lower than the results reported for other studies conducted with Spanish community samples of adolescents (Pereda & Forns, 2007; Pereda et al., 2014). Subsequently, these findings should be considered cautiously. The relatively low percentages found in both samples and the high risk associated with the clinical sample may be related to two factors. First, the psychopathological maladjustment associated with this type of victimization could explain the sexual victimization rate found in outpatients (e.g. Maniglio, 2012, 2014). Second, the low percentage found in the sample of controls may be associated with the specific characteristics and consequences of this type of victimization (e.g., embarrassment, dissociation, lack of reporting). The victims of these experiences could have difficulties identifying their experience as victimization, in addition to recognizing themselves as victims (Finkelhor et al., 2014).

In this study, the electronic victimization rates for the controls followed the trend reported by a previous study with a larger community sample from the same country (Pereda et al., 2014), in which females tended to exhibit higher rates of victimization than males did. The same result was obtained in our sample of outpatients. Electronic victimization has typically been analyzed as an alternative to face-to-face bullying (e.g., Cook et al., 2005; Salmivalli et al., 2013) or as a form of online child grooming (e.g., Whittle et al., 2013). Because few studies have discussed electronic victimization as part of a larger assessment of victimization, the findings of this study should be interpreted cautiously. Additional studies are needed to confirm these trends.

One of the victimization categories examined in this study presented no statistically significant differences between the cases and controls, even after stratifying the sample by gender. This category was peer and sibling victimization. These results require further investigation as several studies have reported that these types of victimization produce serious psychological impairment in their victims (e.g., O'Brennan et al., 2009). Based on this finding, outpatients would be expected to show higher rates of victimization compared with the control group. However, it could be hypothesized that many children and youth who report peer and sibling victimization do not seek psychological treatment because of the consequences of this type of victimization, including loneliness, diminished self-esteem, psychosomatic complaints, shame, and depression (Cook et al., 2005). In turn, this could make it more difficult for them to ask for help, or because adults (teachers and parents) fail to identify these situations in a timely manner. In addition, it should be considered that researchers and clinicians have attempted to accurately design and apply interventions for the bullying and aggression that occur in schools rather than in clinical settings. Finally, it is possible that the

age of this sample (12 to 17) may have had an effect on these findings because some studies have found that sibling assaults and physical and emotional bullying increase between 6 and 9 years of age (Cook et al., 2005; Finkelhor et al., 2009b). However, sibling assault and physical bullying begin to decrease between 10 and 13 years of age, whereas emotional bullying declines between 14 and 17 years of age.

In this study, poly-victimization was defined as the experience of four or more different types of victimization in the previous year, and high rates were observed for the cases and controls (40.7 % and 14.7 %, respectively). These rates for controls are higher than those found in Canada (8 %, see Cyr et al., 2013) and Finland (9 %, see Ellonen & Salmi, 2011), similar to those found in another study with a community sample in Spain (19.3 %, see Pereda et al., 2014), and lower than those reported by Finkelhor and colleagues (22 %, see Finkelhor, Ormrod, et al., 2005) and by Ford et al. (32.5 %, see Ford et al., 2010) with U.S. community samples. The rates for outpatients were consistent with those found in previous studies with outpatients (Ford et al., 2011) and inpatients (Boxer & Terranova, 2008). Other studies with clinical samples of adolescents and different methodologies have reported lower rates for outpatients (as low as 7.4 %, see Ford et al., 2011) and higher rates for inpatients (51.9 %, see Ford et al., 2009). In our study, outpatients showed quadrupled odds of poly-victimization relative to the controls, and this risk remained across genders. These rates of risk and prevalence should provide guidance for practitioners and for prevention policies for this population. Professionals should consider that outpatients present a high risk of becoming chronic victims of interpersonal violence. As previously stated, research has found poly-victimization to be the strongest predictor of psychological impairment relative to any other individual victimization, even chronic victimization (Boxer & Terranova, 2008; Cuevas et al., 2009; Turner et al., 2006). Accordingly, the accumulation of victimization experiences throughout one's lifetime must be considered when evaluating the effects of poly-victimization on mental health.

## Limitations

The limitations of the current study must be considered. First, the results were obtained through different self-report methods (i.e., data were collectively gathered in controls and through personal interviews in the clinical sample). The variation of self-report methods could have led to an administration bias on the part of the participant and consequently, it should be taken into account when interpreting current results. Also, self-report methods should be considered with caution when applied to teenagers, for example, because of the potential biases stemming from a negative mood (Fehon et al., 2001). However, others defend the use of this type of measurement,

given that many victimization experiences are not reported to the police or other organizations, which appears likely for victims in clinical samples (Kooyman et al., 2007). Second, a sample bias could have influenced the results because cases and controls showed different distributions in their SES. Unfortunately, since a considerable amount of missing data in both samples were present, this variable could not be controlled for in our analyses as other studies have done (e.g., Finkelhor et al., 2011; Turner et al., 2006, 2010). However, researchers that have analyzed the SES between different profiles of victimization found inconclusive results. For example, some studies showed that poly-victims had low income levels (e.g., Finkelhor et al., 2011), whereas others found that poly-victims presented a high SES level (e.g., Romano et al., 2011), and some studies did not even find socioeconomic differences between the poly-victim and victim groups (e.g., Finkelhor et al., 2007a). Therefore, it remains to be seen how SES might contribute to the prevalence of victimization. Third, because of the limited amount of existing research with clinical samples and poly-victimization, few studies offer results that are comparable to our findings, and most comparisons have been made with community samples of adolescents. Fourth, the nature of case-control studies enables several insights into the topic of study; however, this type of study did not allow us to establish a cause-effect relationship between the variables. Accordingly, future studies that aim to explain the relationship between psychopathology and poly-victimization should consider other designs and variables, such as a history of prior victimization, the severity and frequency of victimization, the presence of injuries, and parental involvement (Finkelhor et al., 2007a).

## Conclusions

In conclusion, this study provides further evidence of the high risk of various interpersonal victimization experiences in clinical samples. According to Fehon, Grilo and Lipschitz (2001), the frequency of the occurrence of these experiences warrants careful clinical consideration and treatment planning for both adolescent inpatients and outpatients.

Clinicians should inquire about a broad range of victimization experiences when working with children in psychological settings. Lesser-known forms of victimization, such as conventional crimes, witnessing/indirect victimization or electronic victimization, should also be noted. There are some assessment instruments that can be used for this purpose, such as the screening version of the JVQ, which may be a good alternative for professionals given their limited time. The act of considering all of these forms of victimization may help professionals identify poly-victims, who present higher externalizing symptoms and overall impairment relative to the general population, as observed in several studies (Álvarez-Lister



et al., 2014; Boxer & Terranova, 2008; Cuevas et al., 2010; Cuevas et al., 2009; Ford et al., 2011). Furthermore, because symptomatology is a risk factor for further victimization (Cuevas et al., 2009), mental health practitioners need information about the dynamics of this problem and should take greater care to identify and properly treat these children to prevent further re-victimization. The effect of victimization experiences on the type of psychopathology should be considered in the assessment and treatment of adolescent outpatients.

The results reported in this study are exploratory. We expect that this work will encourage further research on polyvictimization in adolescent clinical samples. Such findings will be valuable in both clinical work and theoretical work on the dynamics or patterns of victimization and will inform the policies designed to prevent these traumatic experiences.

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**Compliance with Ethical Standards** All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

**Conflict of Interest** All authors declare that they have no competing interests.

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