



Why should child welfare pay more attention to emotional maltreatment?[☆]



Diana English^{a,*}, Richard Thompson^b, Catherine Roller White^a, Dee Wilson^a

^a Casey Family Programs, Seattle, WA, United States

^b Richard H. Calica Center for Innovation in Children and Family Services, Juvenile Protective Association, Chicago, IL, United States

ARTICLE INFO

Article history:

Received 15 September 2014

Received in revised form 9 January 2015

Accepted 12 January 2015

Available online 17 January 2015

Keywords:

Emotional maltreatment

Emotional abuse

Emotional neglect

Child welfare

Psychological maltreatment

ABSTRACT

A significant body of research indicates that emotional maltreatment (EMT) is harmful to children, resulting in long-term negative impacts on emotional and behavioral development. The child welfare system's focus on physical abuse, physical neglect, and sexual abuse has led a relative lack of attention to EMT. Reported rates of EMT vary widely across states – ranging from 0.2% to 44.9% in a recent national report on child maltreatment – indicating that it is not being measured consistently. This paper uses data collected by the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) to (1) describe the nature and characteristics of emotional maltreatment experienced by 846 LONGSCAN youth across time, and (2) describe the relation between four subtypes of emotional maltreatment (psychological safety and security, acceptance and self-esteem, autonomy, and restriction) and child trauma symptoms and risk behaviors at age 18. Exposure to EMT was related to increased trauma symptoms and risky behaviors. EMT is common, identifiable, harmful, and potentially preventable; and a better understanding of it will help to inform the provision of effective child welfare and mental health services to children and their families. Findings suggest a need for greater understanding of parental behaviors, and the motivations behind them, that result in emotionally harmful outcomes for children, as well as a better understanding of appropriate interventions for children who experience various types of EMT.

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1. Introduction

Interest in the topic of emotional maltreatment (EMT) was evident as early as the 1950s, and the past 60 years have been witness to ongoing discussions, refinements and research (Garbarino, 2011). For the past 20 years, significant discussion about definitions of emotional maltreatment (variously called psychological abuse, psychological neglect, emotional abuse, and emotional neglect) has ensued. While some scholars have noted limited agreement and uncertainty regarding definitions of EMT (Feerick & Snow, 2006, as cited in Trickett, Mennen, Kim, & Sang, 2009), a review of the research literature indicates a growing scholarly consensus and a generally accepted understanding among researchers, mental health practitioners, and child welfare staff and leaders regarding the defining characteristics of EMT (Brassard & Donovan, 2006; Egeland, Sroufe, & Erickson, 1983; Burnett, 1993, as cited in Glaser, 2002; Wolfe & Mclsaac, 2011). Related terms include *emotional abuse*, *emotional neglect* and *psychological maltreatment*. As proposed by Glaser (2011), the term *maltreatment* is preferable as it is inclusive of both acts of omission and commission. The use of *emotional vs. psychological* is more a matter of

convention, as it is not clear that distinctions can be made in the two terms; *emotional maltreatment* is the one most commonly used in an American context (Glaser, 2011).

Examples of EMT definitions include “psychological tactics aimed at undermining emotional security and sense of self that includes guilt induction, and exertion of power through psychologically coercive means” (Bornstein, 2006); a “repeated pattern of behavior that conveys to children that they are worthless, unloved, unwanted, only of value in meeting another’s needs, or seriously threatened with physical or psychological violence” (Hart, Brassard, & Karlson, 1996), or “excessive and continuing criticism, denigration, terrorizing, repeated blaming insults, or threats” (Brassard & Donovan, 2006). Some argue that the difference between poor parenting and EMT is the degree of chronicity, severity, and potential harm to the child or youth (Wolfe & Mclsaac, 2011).

Several models and approaches to classifying EMT exist, with varying levels of research that support using one method or another. In 2006, Brassard and Donovan identified and compared nine different approaches to conceptualizing EMT (Brassard & Donovan, 2006, Fig. 7.1, p. 156). As noted by Brassard and Donovan, the models share many commonalities but have some differences. In 2005, Schneider and colleagues modified the 27 subtypes of EMT initially developed by Barnett, Manly, and Cicchetti (1993) to create the Longitudinal Studies on Child Abuse and Neglect (LONGSCAN) Modified Maltreatment Classification System (MMCS; English, Bangdiwala, & Runyan, 2005),

[☆] The authors would like to thank Casey Family Programs for its support of these analyses.

* Corresponding author at: Casey Family Programs, 2001 8th Avenue, Suite 2700, Seattle, WA 98121, United States. Tel.: +1 206 282 7300.

E-mail address: denglish@casey.org (D. English).

which provides the four categories of EMT utilized in this study: 1) failure to support psychological safety and security; 2) failure to support acceptance and self-esteem; 3) failure to allow age-appropriate autonomy; and 4) restriction (see the [Methods](#) section for a description).

Although a definition of EMT that includes chronicity, severity, and potential harm is generally accepted, some research suggests that even one or two incidents of verbal abuse per year can be harmful to children. In other words, it is not just chronic EMT that is harmful. [Donovan and Brassard \(2011\)](#) argue that the experience of EMT results in variable effects based on differences in intensity and whether the EMT is stable, increasing, or decreasing in frequency across time. Furthermore, while definitions differentiate characteristics of emotional maltreatment into *emotional abuse* (EMT-EA) and *emotional neglect* (EMT-EN) ([Brassard, Hart, & Hardy, 1993](#); [Garbarino, Guttman, & Seeley, 1986](#); [Iwaniec, 1995](#); [O'Hagen, 1995](#)), research suggests that there are different impacts for hostile, indifferent, and misguided and/or inattentive parenting ([Iwaniec, 2006](#)). Until further research is conducted on children's experiences of maltreatment and the related consequences of those experiences, it is difficult to arrive at definitive conclusions about these definitional issues.

1.1. Incidence and prevalence of EMT

Although definitions and classifications vary, findings from a number of research endeavors demonstrate that EMT is common. In 2009, based on a national community sample of 4549 children and youth, [Finkelhor, Turner, Ormrod, and Hamby \(2009\)](#) reported a past-year 6.4% victimization rate for psychological or emotional abuse, and a lifetime 11.9% victimization rate for psychological or emotional abuse. Among the 14 to 17-year-olds in the sample, 22.6% had experienced psychological or emotional abuse in their lifetime.

The Fourth National Incidence Study (NIS-4) provides information on national rates of EMT. The NIS-4 compared rates of child maltreatment based on the knowledge of "sentinels" of child abuse and neglect cases in 122 counties around the United States. NIS-4 used two standards, a *harm standard* and a less stringent *endangerment standard*, to classify cases of child maltreatment identified by sentinels (mostly mandated reporters) and including both cases reported and not reported to Child Protective Services (CPS). NIS-4 found large reductions in physical, sexual, and emotional abuse using both the harm and endangerment standards from 1993 to 2006, but identified a doubling of emotional neglect using the endangerment standard from 1993 to 2006. The increase in emotional neglect was much larger for children ages 0–5 than for older children; there was a 259% increase for children ages 0–2 and a 214% increase for children ages 3–5 compared to a 10% increase for 6–8 year olds ([Sedlak et al., 2010](#)).

While the increase in emotional neglect as measured by the NIS-4 may reflect increased awareness of EMT, any increase in awareness has not translated into consistent identification and reporting. An examination of states' child welfare system data on the identification and substantiation of EMT reveals widely varying practices in terms of definitions and reports to national databases. The 2012 National Child Abuse and Neglect Data System (NCANDS) report indicates that in 18 states, less than 1% of child victims were substantiated for EMT, and in nine states, 0.5% or less of child victims were substantiated for EMT. However, in six states, more than a quarter of child victims were substantiated for EMT, and in two states, more than 40% of child victims were substantiated for EMT. Such dramatic differences in the percentages of child victims substantiated by states' child welfare systems for EMT that exceed, at the extremes, 200 to 1 (44.9% vs. 0.2%) suggest major differences in the way EMT is conceptualized and measured rather than differences in incidence rates per se ([U. S. Department of Health et al., 2013](#)). Both NCANDS and NIS studies likely reflect changes in advocates' and practitioners' understanding of EMT, not just changes in incidence.

Concerns about the accuracy regarding the incidence of EMT in official records are further supported by research examining Child Protective Services (CPS) records to determine whether EMT was reported but not documented in the official classification of maltreatment. In an examination of CPS records, [Trickett et al. \(2009\)](#) found that nearly 50% of 303 adolescents who had been substantiated for maltreatment experienced EMT, although only 9% were identified as having experienced EMT at the time they were referred to CPS. Furthermore, when asked about their maltreatment experiences, youth reported EMT occurred at a rate more than six times higher than the rate found in official reports for the same youth ([Everson et al., 2008](#)).

1.2. Why does the incidence of EMT matter?

A significant body of research indicates that EMT is harmful to children, resulting in negative impacts on both emotional and behavioral development across developmental stages ([Claussen & Crittenden, 1991](#); [Hart, Binggeli, & Brassard, 1997](#); [Hart & Brassard, 1987](#); [Miller-Perrin, Perrin, & Kocur, 2009](#)). In their longitudinal study, [Erickson and Egeland \(1996\)](#) found that EMT-EN in the first few years of life predicted later social withdrawal, angry noncompliance, and lower academic achievement. [Graham-Berman and Levendovsky \(1998\)](#) found that exposure to traumatic events such as domestic violence was related to post-traumatic stress symptomatology in children. [McGee, Wolfe, and Wilson \(1997\)](#) found that EMT-EA, such as hostility and rejection, was associated with child behaviors that were negative and hostile. In one longitudinal, multi-informant study of 421 youth from two low income middle schools, verbal aggression (EMT-EA) by parents was associated with depressive symptoms, delinquency, and perceived victimization ([Donovan & Brassard, 2011](#)). In another study, [Miller-Perrin et al. \(2009\)](#) found that experiencing EMT-EA as a child predicted higher psychological distress scores in 298 college students and also predicted anxiety, depression, and paranoia. This study also found that psychological aggression by a parent was the strongest predictor of later psychological symptoms in young adulthood ([Wekerle et al., 2009](#)). Furthermore, EMT can affect physiology, heighten children's stress responses, and negatively impact neurodevelopment ([Yates, 2007](#)).

In other research, childhood EMT has been linked to poor immune system response in adulthood ([Fagundes et al., 2012](#)) and poorer adult health indicators ([Rodgers et al., 2004](#)). Furthermore, given that EMT often occurs in conjunction with other types of child maltreatment, EMT may persist even after physical abuse, sexual abuse, or neglect of basic physical needs has stopped. Children may not feel safe in homes where EMT periodically occurs even when they are deemed safe by CPS caseworkers or other professionals, because these professionals are focused on other forms of abuse or neglect. EMT may have long-term toxic effects on the nurturing environment in which other types of child maltreatment occur, and in doing so creates major obstacles to recovery from maltreatment, trauma, and other adversities.

Research has also demonstrated the importance of examining outcomes by subtype of EMT ([Taussig & Culhane, 2010](#)). Different types of EMT have been found to be associated with different developmental outcomes. For example, a previous analysis of LONGSCAN data found that among 806 eight-year-olds, subtypes of EMT had distinct effects: psychological threats to safety and security predicted anger/irritability, while threats to a child's sense of self, self-esteem, and autonomy predicted symptoms of post-traumatic stress ([Schneider, Ross, Graham, & Zielinski, 2005](#)). In a prospective study of 243 children in out-of-home care, [Taussig and Culhane \(2010\)](#) found that for males, EMT-EA was related to poorer self-esteem, and abandonment was related to higher levels of anxiety and lower levels of life satisfaction after controlling for other types of child maltreatment.

Although EMT is often found in conjunction with other forms of maltreatment, EMT contributes uniquely to negative outcomes (see, for example, [Claussen & Crittenden, 1991](#); [Miller-Perrin et al., 2009](#); [Sullivan, Fehon, Andres-Hyman, Lipschitz, & Grilo, 2006](#); [Wright, Crawford, & Del](#)

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