



The linkages among childhood maltreatment, adolescent mental health, and self-compassion in child welfare adolescents[☆]

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ABSTRACT

Objectives: Childhood maltreatment is a robust risk factor for poor physical and mental health. Child welfare youths represent a high-risk group, given the greater likelihood of severe or multiple types of maltreatment. This study examined the relationship between childhood maltreatment and self-compassion – a concept of positive acceptance of self. While not applied previously to a child welfare sample, self-compassion may be of value in understanding impairment among maltreatment victims. This may be most pertinent in adolescence and young adulthood, when self-identity is a focal developmental process.

Methods: The present sample was drawn from the Maltreatment and Adolescent Pathways (MAP) Longitudinal Study, which followed randomly selected adolescents receiving child protection services across two years within an urban catchment area. Child maltreatment was assessed at baseline using the Childhood Trauma Questionnaire (Bernstein et al., 1994, 2003). Mental health, substance and alcohol use problems, suicide attempt, and self-compassion were assessed at the two-year follow-up point. There were 117 youths, aged 16–20 years (45.3% males) who completed the self-compassion scale (Neff, 2003). Bivariate correlations were computed between adolescent self-compassion and each form of self-reported maltreatment (physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect). Finally, hierarchical, stepwise regression was used to examine unique contributions of child maltreatment subtypes in predicting adolescent self-compassion, as well as maltreatment-related impairment.

Results: Higher childhood emotional abuse, emotional neglect, and physical abuse were associated with lower self-compassion. Controlling for age and gender, emotional abuse was significantly associated with reduced self-compassion, even when the effects of emotional neglect and physical abuse were taken into account. Youths with low self-compassion

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were more likely to have psychological distress, problem alcohol use, and report a serious suicide attempt, as compared with those with high self-compassion. A number of maltreatment-related areas of impairment, identified by screening instruments, were significantly associated with lower self-compassion.

Conclusion: Self-compassion may be a fruitful aspect of research to pursue in an effort to better understand the impact of childhood emotional abuse on adolescent functioning, particularly considering the under-researched group of those receiving child protective services.

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Introduction

In child maltreatment, the child is wronged, for no reason, and left to deal with the aftermath of a harsh relationship encounter(s). Maltreatment, which tends to cluster with other adverse events (e.g., parental dysfunction, intimate partner violence, loss), is a robust risk factor for victim mental health and substance abuse problems across the lifespan (Gilbert et al., 2009; McLaughlin et al., 2010). One study found that adverse childhood events accounted for 31–65% population attributable risk for mental health disorders (mood, anxiety, behavioral, substance abuse) in ages 4–12 years. In adolescence (13–19 years), it was between 24% and about 41%. Childhood adversity accounted for 17–41% of mental illness in young adulthood (Kessler et al., 2010). This suggests a higher mental health and substance use problem risk for maltreatment victims. While maltreatment levels are generally under-recognized, and there is overlap among subtypes (e.g., physical, sexual, and emotional abuse and neglect), emotional maltreatment is likely the most under-considered form in prevalence estimation and impact.

Hart and Brassard (1987) argued that psychological or emotional maltreatment is the core threat to victim's mental health. Although definition of child emotional maltreatment varies by context, it reflects caregiver's failure to provide a developmentally appropriate and supportive environment, including such acts as denigration (emotional abuse) and lack of affection (emotional neglect) (e.g., Garbarino, Guttman, & Seeley, 1986; Glaser, 2002; Hart, Brassard, Binggeli, & Gavidson, 2002; Trickett, Mennen, Kim, & Sang, 2009; WHO/ISPCAN, 2006). Exposure to intimate partner violence is not routinely recognized as emotional maltreatment, although it can be considered an indicator (Gilbert et al., 2009).

Emotional maltreatment is difficult to document by the child protective services (CPS), as it may not be identifiable as an event, or have clearly identifiable causal links to the victim's impaired functioning (Trocmé et al., 2005). Legal and medical definitions to guide CPS thresholds for intervention vary across states and regions (Hamerman, Pope, & Czaja, 2002). Although emotional maltreatment (not including exposure to domestic violence) represents a minority category among substantiated CPS cases, about one third to half of reported case had a sign of emotional harm (e.g., National Incidence Study of Child Abuse and Neglect (NIS-4), 2010; Public Health Agency of Canada, 2010; Trickett et al., 2009). Researchers have approached operationalizing emotional maltreatment in a variety of ways (e.g., Cicchetti, Rogosch, Sturge-Apple, & Toth, 2010; Egeland, 2009; Hart & Brassard, 1987). For example, self-report measures, such as the Childhood Trauma Questionnaire (CTQ), a well-validated and common tool, taps both emotional abuse and emotional neglect, in addition to three other subtypes of child maltreatment (Bernstein et al., 2003). However, in the child welfare and clinical domains, the unique contribution of emotional maltreatment has been under-attended relative to other forms of maltreatment (for example, see special issue in this journal, Yates & Wekerle, 2009).

Given that the phenomenology of maltreatment involves an attack on or disrespect of the child's personhood, the victim's self-identity processes seems germane to consider (Glaser, 2002; Hart & Brassard, 1987). Maltreated adolescents may engage in self-harming (Jacobson & Gould, 2007; Laye-Gindhu & Schonert-Reichl, 2005) or aggressive behaviors (Gordis, Feres, Oleszki, Rabkin, & Trickett, 2009) in an attempt to regulate (i.e., decrease or distract from) the experience of negative emotions, which may arise from maltreatment memories or environmental cues. Emotional maltreatment, in particular, has been linked to suicidal behaviors (Cicchetti et al., 2010) and relationship violence (e.g., Berzenski & Yates, 2010; Wekerle, Leung, Wall, et al., 2009; Zurbriggen, Gobin, & Freyd, 2010). However, not all maltreated children and youth develop dysfunctional features of the self-system.

To understand factors that differentiate youth who develop an overall healthy self-system from those who do not, aspects that may be protective need to be considered. Resilience is the process in which capacity of the individual to achieve positive and healthful outcomes despite the adversity (e.g., Cicchetti & Curtis, 2006; Ungar, 2007, 2008; Wekerle, Waechter, & Chung, in press). One candidate construct for resilience is self-compassion (Gilbert & Procter, 2006; Neff & McGehee, 2010), as it may represent an affective-cognitive stance that is facilitative of an adaptive response to personal adversity. Self-compassion is an orientation towards seeing the world, and the self, realistically, but kindly, and in a contextualized manner supportive of greater well-being (Neff, 2003; Neff & McGehee, 2010; Vettese, Dyer, Li, & Wekerle, 2011). It reflects a warm, accepting (not over-personalized) approach that is based on kindness, humaneness ("common humanity"), and deliberate and reflective cognitive approach that emphasizes the present, here-and-now experience ("mindfulness").

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