



Youth self-report of emotional maltreatment: Concordance with official reports and relation to outcomes

Catherine Roller White ^a, Diana English ^a, Richard Thompson ^b, Yvonne Humenay Roberts ^{a,*}

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

^b Juvenile Protective Association, Chicago, IL, United States

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ABSTRACT

Emotional maltreatment (EMT) is an underreported, common, and pernicious type of maltreatment with long-lasting negative consequences. This paper examines concordance between youth self-report of EMT and official reports using data from 770 participants in the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN). In addition, the paper examines the relation between the experience of EMT in childhood (as measured both through self-report at ages 12 and 16, and in official reports throughout childhood) and trauma symptoms and risk behaviors in young adulthood (measured at age 18). The correlation between self-reported experiences of EMT and official reports was very low, ranging from 0.05 to 0.12 across the four EMT subtypes (*psychological safety and security*; *acceptance and self-esteem*; *autonomy*; and *restriction*). Controlling for race, gender, and official reports of other types of maltreatment, both youth self-report and official reports of the *psychological safety and security* subtype of EMT predicted trauma symptoms, including anger, anxiety, depression, intrusive experiences, defensive avoidance, and dissociation. Improved detection of EMT and more effective and targeted interventions are needed, both to decrease rates of EMT from caregivers and to assuage its harmful effects on children and youth.

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1. Introduction

Emotional maltreatment (EMT) receives relatively little attention compared to more easily recognized forms of maltreatment, such as physical abuse, physical neglect, and sexual abuse, yet it is a common and pernicious type of maltreatment with long-lasting negative consequences. Because EMT is more difficult for outside observers to define and detect than other forms of maltreatment, it may be useful to ask children and youth for information about their experiences with EMT. This paper examines youth self-report of EMT and its concordance with official Child Protective Services Agency reports. Further, the paper examines the relation between the experience of EMT in childhood (as measured both through self-report and in official reports) and trauma symptoms and risk behaviors in young adulthood, such as anxiety, depression, and substance use.

Mental health practitioners, child welfare staff, researchers, and leaders have begun to develop a consensus about the essential defining features of EMT (Brassard & Donovan, 2006; Egeland, Sroufe, & Erickson, 1983; Burnett, 1993, as cited in Glaser, 2002; Wolfe & McIsaac, 2011). Definitions of EMT include 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); “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); or “excessive and continuing criticism, denigration, terrorizing, repeated blaming insults, or threats” (Brassard & Donovan, 2006). As discussed by Glaser (2011), the term *maltreatment* is preferable to *abuse* or *neglect* as it is inclusive of both acts of omission (emotional neglect) and commission (emotional abuse).

So as not to be confused with inadequate parenting behaviors, EMT can be distinguished by the chronicity, severity, and potential harm to the child or youth (Wolfe & McIsaac, 2011). Research indicates, however, that even “low levels” of EMT, such as one or two occurrences per year, can have negative impacts on youth (Baker, Brassard, Schneiderman, Donnelly, & Bahl, 2011; Donovan & Brassard, 2011). EMT is defined in this paper using the LONGSCAN Modified Maltreatment Classification System (MMCS) and consists of four subtypes: (1) violation of *psychological safety and security* (e.g., threat of injury, exposure to extreme behaviors, abandonment); (2) failure to support *acceptance and self-esteem* (e.g., negativity/hostility, ignoring child, ridiculing child); (3) failure to allow age-appropriate *autonomy* (e.g., inappropriate responsibility, prohibiting age-appropriate socialization); and (4) *restriction* (e.g., confinement/isolation, binding) (Schneider, Ross, Graham, & Zielinski, 2005).

* Corresponding author at: Casey Family Programs, 2001 8th Avenue, Suite 2700, Seattle, WA 98121, United States.

E-mail address: yroberts@casey.org (Y.H. Roberts).

1.1. Prevalence of EMT

Research indicates that EMT is common (Baker et al., 2011), yet estimates vary tremendously by state. For example, analyses of 1998 National Child Abuse and Neglect Data System (NCANDS) data found a 300-fold difference in rates of substantiation for EMT, from a low of 0.37 incidents per 10,000 in Pennsylvania to a high of 113 per 10,000 children in Connecticut (Hammarman, Pope, & Czaja, 2002). State-to-state variation in rates of physical abuse and sexual abuse was significantly lower. The dramatic variations in rates of EMT persisted fourteen years later: The 2012 NCANDS report indicates that in nine states, 0.5% or less of child victims were substantiated or indicated for EMT, while in two states, more than 40% of child victims were substantiated or indicated for EMT. These striking differences, exceeding 200 to 1 at the extremes (0.2% in five states vs. 44.9% in Delaware), imply that EMT is conceptualized and measured significantly differently across states (U. S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, & Children's Bureau's, 2013). States whose statutes define EMT more broadly tend to have higher rates of substantiated EMT (Hammarman et al., 2002; Shpiegel, Simmel, & Huang, 2013), although the actual experiences of children in different states are likely more similar.

In Canada, of 4055 substantiated maltreatment investigations in 2003, 29% included EMT, either alone (12%) or in combination with some other type of maltreatment (17%; Chamberland, Fallon, Black, & Trocmé, 2011). Chamberland et al. (2011, p. 844) note that, when EMT is the only presenting type of maltreatment, cases are "less visible, less prioritized, and less subject to protective services and assessments". Another Canadian study found that, using a broad definition of EMT, the number of investigations classified as EMT nearly tripled between 1998 and 2003 (Trocmé et al., 2011).

Trickett, Mennen, Kim, and Sang (2009) conducted reviews and abstractions of case files using the Maltreatment Case Record Abstraction Instrument, which is based on the Modified Maltreatment Classification System (English & the LONGSCAN investigators, 1997). Trickett et al.'s investigation found that nearly 50% of 303 children aged 9 to 12 involved with the Los Angeles County Department of Children and Family Services for any type of maltreatment had actually experienced EMT, although only 9% were identified as having experienced EMT at the time they were referred to DCFS. A study of 97 youth in foster care ages 8 to 22 found that all but one (99%) self-reported EMT (assessed using an adaptation of the Modified Maltreatment Classification System; English & the LONGSCAN investigators, 1997), compared to a rate of 51% in case files (Hambrick, Tunno, Gabrielli, Jackson, & Belz, 2014).

EMT is not limited to those who come to the attention of child welfare agencies. A national community sample of 4549 children and youth found that 11.9% of respondents had experienced EMT in their lifetimes; the rate increased to 22.6% among 14 to 17-year-olds (Finkelhor, Turner, Ormrod, & Hamby, 2009).

1.2. Effects of EMT

Research indicates that EMT is linked to negative emotional and behavioral outcomes, including social withdrawal (Erikson & Egeland, 1996; Shaffer, Yates, & Egeland, 2009), post-traumatic stress (Graham-Berman & Levendovsky, 1998; Sullivan, Fehon, Andres-Hyman, Lipschitz, & Grilo, 2006; Taussig & Culhane, 2010; Wekerle et al., 2009), aggression (Shaffer et al., 2009), depressive symptoms, delinquency, and perceived victimization (Donovan & Brassard, 2011). Studies of college students have found that childhood EMT predicts higher levels of psychological distress, anxiety, depression, and paranoia (Coates & Messman-Moore, 2014; Miller-Perrin, Perrin, & Kocur, 2009).

Childhood emotional abuse is a strong predictor of emotional dysregulation (Burns, Jackson, & Harding, 2010, qtd. in Bruce, Heimberg,

Blanco, Schneier, & Liebowitz, 2012; Coates & Messman-Moore, 2014) and social anxiety disorder. Among 156 adult patients receiving treatment for social anxiety disorder, more than one in three (37%) reported a history of emotional neglect and half (51%) reported a history of emotional abuse (Bruce et al., 2012). Further, patients who had a history of emotional abuse were more likely to drop out of pharmacotherapy than patients without a history of emotional abuse.

EMT can also alter youth and adults physically, heightening their stress responses and negatively impacting neurodevelopment (van der Werff et al., 2012; Yates, 2007), weakening their immune system response in adulthood (Fagundes et al., 2012), and resulting in poorer adult health indicators (Rodgers et al., 2004).

EMT should not be considered one homogeneous type of maltreatment. Rather, different subtypes of EMT are associated with different developmental outcomes (English, Thompson, White, & Wilson, 2015; Taussig & Culhane, 2010), which has implications for the development of effective treatments (Brassard & Hardy, 1997). For example, among 806 eight-year-olds in a previous analysis of data from the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN), subtypes of EMT were linked to distinct effects: threats to a child's sense of self, self-esteem, and autonomy predicted symptoms of post-traumatic stress, while restriction and psychological threats to safety predicted anger (Schneider et al., 2005). Chamberland et al. (2011, p. 841) remarked that EMT can "threaten the adaptation of young victims in often insidious ways".

1.3. Youth self-report of maltreatment

Overall, there is a paucity of research on youth self-report of maltreatment. Several research studies have shown that youth self-report of maltreatment is a better predictor of outcomes than official reports. For example, self-reports of maltreatment from 160 youth ages 11 to 17 being served by child protective services in Canada were better predictors of both internalizing and externalizing symptoms compared to social worker reports and case files (McGee, Wolfe, Yuen, Wilson, & Carnochan, 1995). The authors concluded, "Subjective estimates of victimization appear to be more predictive of behavior problems than objective estimates" (McGee et al., 1995, p. 245), which has implications for how child-serving agencies assess victimization. In many cases, the youth voice is absent.

Agency staff, researchers, and others may be reticent to ask youth about their experiences of maltreatment for several reasons, including reporting laws, concerns about the validity of self-reported data, and concerns about upsetting youth by asking them to think about difficult experiences. However, research shows that youth are able to provide valid and reliable self-reports of abuse (Nooner et al., 2010) and are able to do so without being upset. A recent study of 2312 youth ages 14 to 17 who participated in the National Survey of Children Exposed to Violence found that only 4.5% reported being upset by answering survey questions (Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014). Of those who said they would not have participated had they known of the content (0.3%), most said they would not have participated because of the length. Only one child reported being upset by the sensitive content of the questions.

When asked about their maltreatment experiences, youth often report significantly higher rates of EMT than are found in official reports. In a previous analysis of data from 350 12- and 13-year-olds in LONGSCAN, self-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). Concordance between self-report and official reports was lower for emotional abuse (63%) than for physical abuse (78%) and sexual abuse (92%).

Although youth often report higher rates of EMT than are found in official reports, conversely youth may not disclose maltreatment that has been substantiated. In the Everson et al. (2008) study of 12- and 13-year-olds noted above, researchers found a 44% non-disclosure

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