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Emotional Maltreatment of Children

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Abstract: Emotional abuse of children is a subtype of maltreatment and is very common in the 21st century. Although, it is very difficult, scientists and health professionals can detect all the risk factors and identify the perpetrators. The consequences of emotional abuse on the child may vary according to its nature and severity. Emotional abuse may result in greater susceptibility to life-long social and cognitive impairments and to health risk behaviors. Governments, health professionals and well-updated parents are ultimately responsible for the protection of children.

Key words: Emotional (psychological maltreatment) child abuse, risk factors, consequences, prevention, intervention, severity, Greece

INTRODUCTION

Child maltreatment is referred to as child abuse and neglect. This definition includes all forms of physical and emotional ill treatment, sexual abuse, neglect and exploitation that result in actual or potential harm to the child's health, development or dignity. Within this broader definition, there can distinguish the physical abuse, the sexual abuse, the neglect and negligent treatment, the emotional abuse and the exploitation (Kenney and Spencer, 1995; Stavrianos and Metska, 2002; U.S. Department of Health and Human Services, 2005; Stavrianos *et al*., 2007a, b, 2009a, b).

There are many complicated factors that lead to child abuse. One overlooked risk factor is the family history. Often adults that have been abused in any way, in their childhood show abusive behaviour towards their children. Stress and lack of support are two elements that young parents in adolescence or parents with disabled children or caregivers with financial problems face constantly. Parenting is very intense and difficult job and is even harder when the above situations rise. Sometimes prohibited substances are in use by parents and lead to serious lapses in judgment. They can interfere with impulse control making emotional and physical abuse more likely. Domestic violence is a common phenomenon in modern society. Chaos and instability characterize the family atmosphere. Children are the witnesses of this situation. Frequently domestic violence will escalate to physical violence against children as well (Stavrianos *et al*., 2007a, b). Child abuse is a crime that can be identified and measured by using specific indicators as the following: aggressive, disruptive and sometimes illegal behavior; anger and rage or feelings of sadness or other symptoms of depression; anxiety or fears or flashbacks and nightmares; broken bones or internal injuries; burns; changes in a child's behavior or school performance; constant hunger or thirst; cuts and bruises; dirty hair and skin, frequent diaper rash; drug and alcohol abuse; hard to believe stories about how accidents occurred; lack of interest in surroundings; lack of supervision; passive or withdrawn behavior; poor self-image; sexual acting out; self destructive or self abusive behavior, suicidal thoughts; school problems or failure; the child seems guarded and startles easily; the child loiters at school or friends' houses and the child seems reluctant to go home (Vale, 1997; Hwang, 1999; AMA, 2009; APA, 2009).

Emotional child abuse is the maltreatment that results in impaired psychological growth and development (Garbarino and Garbarino, 1994). Words, actions and indifference are involved in this kind of abuse (Stavrianos and Metska, 2002). Children that are emotionally abused face rejection, ignorance, domination and criticism (Garbarino and Garbarino, 1994). Emotional abuse and physical abuse can sometimes occur simultaneously, although there is often an overlap (Vale, 1997). Emotional abuse cuts across boundaries of geography, race, class, religion and culture. It occurs in homes, schools and streets; in places of work and entertainment and in care and detention centers. Almost any adult involved in a relationship with a child is a potential perpetrator. In the list of perpetrators can be included parents, family members, teachers, caretakers,

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law enforcement authorities, pastors, social workers, neighbors and other children (Garbarino and Garbarino, 1994; Korfmacher, 1998; Daher, 2007). Some children are more vulnerable because of gender, race, ethnic origin, disability or social status. No country is immune whether rich or poor (Daher, 2007).

Associations between cognitive risk factors and child abuse risk and maladaptive discipline style and practices were examined in an at risk population (McElroy and Rodriguez, 2008). Results of one particular study suggest that several cognitive risk factors significantly predict risk of parental aggression toward children. A parent's ability to empathize and take the perspective of their child, parental focus of control and parental level of frustration tolerance were significant predictors of abuse potential and inappropriate discipline practices (McElroy and Rodriguez, 2008). Exposure to marital psychological and physical abuse has been established as a risk factor for children's socio-emotional, behavioral and cognitive problems. Understanding the processes by which children develop symptoms of psychopathology and deficits in cognitive functioning in the context of marital aggression is imperative for developing efficient and effective treatment programs for children and families and has mental health implications (Cummings *et al*., 2009). Relationships among early maternal maltreatment risk, children's self-regulation and later development were examined in a project. It was expected that early maltreatment risk would impact children's emerging self-regulation which in turn would foster pre-academic delays and behavior problems.

The results that came out from this project, suggest that self-regulation was a key process variable in the relationship between maltreatment risk and children's progression of developmental difficulties often found in maltreated children (Schatz *et al*., 2008). Also, causal relationship between the experience of childhood psychic trauma and long-term effects on cognitive emotional and social development has been established by studies of early childhood traumatic experiences. Children exposed to chronic trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings. The long term impact of risk factors on personality development, result in high numbers of emotional disorders like depression, anxiety and phobic disorders and co-morbid conditions like alcohol and drug abuse and antisocial behavior (Stavrianos and Metska, 2002; Stavrianos *et al*., 2007a, b; Purtscher, 2008).

DETECTING EMOTIONAL CHILD ABUSE

Although, emotional abuse can hurt as much as physical abuse, it can be harder to identify because the marks are left on the inside instead of the outside (Korfmacher, 1998). It is an under-recognized but actually common form of child abuse. Professionals in the field continue to find difficulty in recognizing and operationally defining it and experience uncertainty about providing it legally. These difficulties have led to delays in recognition. Emotional abuse is defined as a carer-child relationship that is characterized by patterns of harmful interactions, requiring no physical contact with the child. Motivation to harm the child is not necessary for the definition. Unlike sexual abuse that is a secret activity, this form of ill treatment is easily observable. Concerns about the presence of emotional abuse need to trigger an assessment process that includes identifying the nature of the abusive interactions (Glaser, 2002).

One of the greatest methological problems in the study of childhood maltreatment is the discrepancy in methods by which cases of child maltreatment are identified. One study compared incidents of maltreatment identified prospectively, retrospectively or through a combination of both methods (Shaffer *et al*., 2008, 2009). This study emphasizes the variability in the incidence rates of maltreatment and the psychological outcomes that result from utilizing different methods of identification. The most severe cases of maltreatment are likely to be identified by both prospective and retrospective methods, however cases that are identified solely through retrospective self-report may have unique relations to psychopathology in late adolescence (Shaffer *et al*., 2008, 2009). Clinicians can use a revised version of the Child Abuse and Trauma Scale (CATS) which targets measures of emotional abuse (Kent and Waller, 1998).

Childhood psychosocial problems have profound effects on development, functioning and long-term mental health. The pediatrician is often the only health professional who regularly comes in contact with young children and it is recommended that health care supervision should include care of behavioral and emotional issues. However, it is unknown whether pediatricians believe they should be responsible for this aspect of care.

One study showed the percentage of pediatricians that are willing to go one step forward and not only identify but also treat and manage cases of emotional child abuse. These data suggest that American pediatricians think that they should identify patients with mental health issues, especially when mental illness is the outcome of an abuse but less than one-third agreed that it is their responsibility to treat/manage such problems, except for children with Attention-deficit/Hyperactivity Disorder (ADHD) (Stein *et al*., 2008).

The processing of facial emotions in a sample of maltreated children showing high rates of Post-traumatic Stress Disorder (PTSD) was examined by scientists. The

results of this study showed that maltreated children displayed faster reaction times than controls when labeling emotional facial expressions and this result was most pronounced for fearful faces (Masten *et al*., 2008). Relative to children who were not maltreated, maltreated children both with and without PTSD showed enhanced response times when identifying fearful faces. The conclusion was that maltreated children show heightened ability to identify fearful faces, evidenced by faster reaction times relative to controls. This association between maltreatment and atypical processing of emotion is independent of PTSD diagnosis (Masten *et al*., 2008; Trickett *et al*., 2009).

Among the medical staff that comes across to abuse children are nurses. They were the object of a study in which the aim was to identify nurse's experience in the clinical care of children experiencing abuse. The objective was to assess how nurses remain professional, especially when the suspected perpetrator is a parent. The nurses expressed that they had devised strategies to remain professional in the clinical encounter with abused children and their parents.

To remain professional, education, counseling and experience was essential (Tingberg *et al*., 2008). In Finland, nurses were also the case of a study. It was determined how public health nurses defined child abuse and how they assessed their capability to identify child abuse in the family. They described emotional abuse as teasing the child, frightening the child, rejecting the child in the family and forcing the child to assume an adult role. The nurses divided the identification of child abuse into two categories; tools for identifying child abuse and markers indicating child abuse.

The tools for identifying abuse included knowledge acquisition and interactive skills, intuition and the capacity of the nurse to handle problematic situations. Public health nurses identified child abuse in the child's behavior and appearance and in family behaviors. Public health nurses seem to be aware of child abuse but further research is needed if they need more specific skills regarding how to apply their theoretical knowledge to nursing practice to provide nursing care for abused children and their families (Paavilainen and Tarkka, 2003).

CONSEQUENCES

The consequences of emotional child abuse can be serious and log-term (Rich *et al*., 1997). Many research studies conclude that psychopathologic symptoms are more likely to develop in emotionally abused children. These children may experience a lifelong pattern of depression, estrangement, anxiety, low esteem, inappropriate or troubled relationships or lack of empathy (Garbarino and Garbarino, 1994; Rich *et al*., 1997; Sanders and Becker-Lausen, 1995). During their childhood, victims may fail to thrive or their developmental process may be halted. Some may also become poorly adjusted emotionally and psychologically (Purtscher, 2008; Faulkner, 2009).

Theoretically, exposure to experiences of emotional abuse in child hood may threaten the security of attachment relationships and result in maladaptive long-term outcome. The extent to which the relationships between emotional abuse and later symptoms were mediated by specific internalized maladaptive interpersonal schemas was also explored. Hierarchical regression analyses revealed that perceptions of childhood emotional abuse continued to exert an influence on later symptoms after controlling for gender, income, parental alcoholism and other child abuse experiences. Emotional abuse was associated with later symptoms of anxiety and depression and was mediated by schemas of vulnerability to harm, shame and self-sacrifice (Wright *et al*., 2009; Raes and Hermans, 2008).

Childhood trauma appears to be a potent risk factor for Chronic Fatigue Syndrome (CFS). Evidence from developmental neuroscience suggests that early experience programs the development of regulatory systems that are implicated in the pathophysiology of CFS including the hypothalamic-pituitary-adrenal-axis. However, the contribution of childhood trauma to neuroendoctrine dysfunction in CFS remains obscure. Results of recent study confirm childhood trauma as an important risk factor of CFS. In addition, neuroendoctrine dysfunction appears to be associated with childhood trauma. This possibly reflects a biological correlate of vulnerability due to early developmental insults (Heim *et al*., 2009).

As teenagers, ex-victims find it difficult to trust, participate in and achieve happiness in interpersonal relationships and resolve the complex feelings left over from their childhoods. As adults, they may have trouble recognizing and appreciating the needs and feelings of their own children and emotionally abuse them as well (Garbarino and Garbarino, 1994). Suicide is a leading cause of death in the USA and in other countries but identifying persons at risk is difficult. An expanding body of research suggests that childhood trauma and adverse experiences can lead to a variety of negative health outcomes including attempted suicide among adolescents and adults. A powerful graded relationship exists between adverse childhood experiences and risk-attempted suicide throughout life span. Alcoholism, depressed affect and illicit drug use which are strongly associated with such

experiences, appear to partially mediate this relationship (Dube *et al*., 2001). Borderline Personality Disorder (BPD) is a cluster B personality disorder. It is characterized by erratic behaviors, emotional instability and one of its hallmarks is self-injurious behavior which starts in adolescence. Patients with BPD are difficult to treat and most have history of child abuse. Although, personality disorders are diagnosed only in adults, BPD manifests itself in adolescence in the form of uncontrollable anger, self-mutilations, dissociation and other such behaviors. Hence, there is a growing number of scientists discussing the possibility of diagnosing BPD in adolescents (Al-Alem and Omar, 2008).

Current and past history of Domestic Violence (DV), including physical, sexual and emotional abuse is common among women patients seen in health care settings and is associated with higher frequency of many health problems. However, the association of DV with self-assessed social functioning is less well known. Current and past DV including emotional abuse, adversely affect social functioning. Therefore, clinicians in the health care setting have a unique and important opportunity to assist women victims of DV and abuse (McCaw *et al*., 2007; Stavrianos *et al*., 2007b; Faulkner, 2009).

DISCUSSION

To effectively identify and confirm emotional abuse, it is necessary to observe the abuser-child interaction on varied and repeated occasions. If emotional abuse is suspected, action can be taken regardless of whether the suspected offender is within the child's home, childcare setting or elsewhere in the community. It is the caregiver's responsibility to report and not investigate suspicions of child abuse. It is the child protection agency's responsibility to investigate reports of any type abuse. Appropriate and skilled professionals should complete a careful evaluation of those involved and the sources of stress. Usually, a team consisting of a child protection worker, a physician, a psychiatrist or psychologist, a public health nurse, a childcare staff and a teacher will become involved (Stavrianos *et al*., 2007a, b). For Child Protective Services (CPS) youth may have experienced >1 form of maltreatment, the unique contribution of emotional abuse may be overlooked when other forms are more salient and more clearly outside of accepted social norms of parenting. Results of studies indicate that CPS youth are a high priority group for dating violence and Post-traumatic Stress Disorder (PTSD) linked intervention and CPS youth continue to experience the unique negative impact of childhood emotional abuse in their adolescent adjustment. All CPS children should be evaluated for emotional abuse incurred and appropriate intervention attention be given as to how it specifically impacts on the child's approach to relating themselves and others (Weckerle *et al*., 2009). Suicide is a serious cause of morbidity and mortality among young people. Important risk factor for suicidal behavior is the history of abuse. Pediatricians can play a major role in suicide prevention by identifying emotional and behavioral problems and intervening appropriately. As part of a comprehensive strategy to prevent youth suicidal behavior, child health professionals are uniquely positioned to promote resiliency among youth and families as well as identify and provide appropriate treatment and service coordination for risk factors before injuries occur. Adequate training is critical to ensure that pediatricians are prepared to provide effective assessment, prevention and intervention for suicidal behavior (Borowsky, 2002). Although, a broad range of programs for prevention of child maltreatment exists, the effectiveness of most of the programs is unknown. Two specific home-visiting programs; the nurse-family partnership and early start have been shown to prevent child maltreatment and associated outcomes such as injuries. Additional in-hospital and clinic strategies show promise in preventing abuse and neglect. However, whether school-based educational programs prevent child sexual abuse is unknown and there are currently no known approaches to prevent emotional abuse (MacMillan *et al*., 2009).

For maltreated children, foster care placement can lead to benefits compared with young people who remain at home or those who reunify from foster care, enhanced foster care shows benefits for children. Future research should ensure that interventions are assessed in controlled trials using actual outcomes of maltreatment and associated health measures (MacMillan *et al*., 2009). The Safe Environment for Every Kid (SEEK) model of pediatric primary care seems promising as a practical strategy for helping prevent child maltreatment. Replication and additional evaluation of the model are recommended (Dubowitz *et al*., 2009). Some scientists explored whether breastfeeding was protective against maternally perpetrated child maltreatment. The findings of this study showed that among other factors, breastfeeding may help to protect against maternally perpetrated child maltreatment, particularly emotional abuse and neglect (Strathearn *et al*., 2009).

At last in an evaluation of television series, scientists concluded that media interventions depicting evidence based parenting programs may be a useful means of reaching hard to engage families in population-level child maltreatment prevention programs (Calam *et al*., 2008).

CONCLUSION

Health care professionals and concerned individuals need to increase awareness for and education in emotional child abuse in the community and among parents. Secondly, parents and guardians need to be encouraged to develop strong attachments with their children and learn to express warmth and positive regard for them. Finally, families have to be encouraged to form relationships with support systems available to them. In addition, more research in topics related to emotional child abuse and parent-child relationships must be undertaken (Stavrianos and Metska, 2002; Diaz *et al*., 2002; Stavrianos *et al*., 2009a, b, 2010).

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