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Emotional Abuse: Strategies for Identifying and Reporting

Jill Bryant

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Emotional abuse is the least understood and most underreported type of child abuse (English et al., 2005; Goldsmith & Frey, 2005; Hart et al., 2002; Kumari, 2020). Although we know emotional abuse is linked to deleterious outcomes for survivors, studies illuminating this type of abuse have trailed other types such as physical or sexual abuse (Morelen & Shaffer 2012). Some authors purport emotional abuse lies beneath all other types of child abuse (English et al., 2015; Malo et al., 2016; Marshall, 2012), but for the purposes of this article, the focus will be solely on emotional abuse as a distinct form of child maltreatment. Considering the long-term effects of emotional abuse, and the lack of reporting coupled with weak statutes, more engagement is warranted professionally to better identify, report and advocate for legislative changes in many states.

Childhood Emotional Abuse

Childhood emotional abuse (CEA) is one of the reportable types of child abuse. Also known as psychological maltreatment, emotional maltreatment, and mental injury, this type of abuse has presented with challenges for researchers, scholars, lawmakers, and mandated reporters (Baker & Brassard, 2019). The Child Abuse Prevention and Treatment Act (CAPTA), originally passed in 1974 (P.L.93-247) was last reauthorized in 2010 and amended four times addressing human trafficking, infant safety after exposure to alcohol and illegal substances and further protections and immunity for reporters (Child Welfare Information Gateway, 2019). Most recently the CAPTA 2021 reauthorization bill was introduced in the senate by Senator Patty Murray. In spite of the numerous revisions over time, CAPTA has failed to provide any definitions for several types of abuse including emotional abuse (USDHHS, n.d.), further adding to the challenges for identifying and reporting this abuse. With the lack of guidance from the

federal government, states have been left to establish their own definitions, and variability in such definitions is substantial.

Scholars have attempted to define emotional abuse to better understand, identify, and study this form of child maltreatment. Perhaps the most comprehensive work in this area was done by Brassard and Donovan (2006). These authors attempted to examine classifications for CEA across models looking for commonalities among the models (English et al. 2015). In the end they created a classification system for CEA after discovering a great deal of agreement among the models (See Figure 7.1, p. 156, Brassard & Donovan, 2006). Starting with the definitional framework asserted by the American Professional Society on the Abuse of Children (APSAC, 2019) Brassard and Donovan (2006) took those initial six categories (i.e., spurning, terrorizing, isolating, exploiting/corrupting, denying emotional responsiveness, and mental health/medical/legal neglect) and created subcategories for each. Their work serves as a model to help practitioners and states create and/or improve their current definitions and frameworks for identification of CEA.

Status of Reporting in the United States

Thirty-three states provide some type of definition for emotional abuse as part of their legislation while Washington and Georgia have no law for reporting emotional abuse at all (USDHHS, n.d.). Another six states have a higher threshold for those mandated to report, only allowing physicians, qualified mental health professionals or what is known as an *expert witness* to even report a concern of emotional abuse to state child protection agencies. The variability not only in definition but also in eligible reporters (Buser & Buser, 2013) further challenges the ability to protect children from harmful psychological outcomes. This is a concern as literature suggests CEA may do more long-term damage than some other types of abuse (Marshall, 2012),

even altering brain structure in otherwise healthy child brains (Cicchetti, 2002). Exploring the reporting challenges and barriers followed by suggestions for improved reporting can help to address this gap currently present in the mandated reporting field.

The prevalence of CEA is difficult to accurately assess. This is due in part to the lack of reporting but also the discrepancy between the data found in research studies (e.g., Finkelhor et al., 2009) and the data found in the national data collected yearly (USDHHS, n.d.). A good example of this discrepancy would be the study by Trickett et al. (2009). In this study, abstracted DCFS records of maltreated youth found nearly 50% of the youth had experienced emotional abuse by use of Brassard and Donovan's framework, yet only 9% of these cases were identified as such at the time of the referral. CEA is seldom the focus of child abuse investigations yet likely accompanies the other forms of child abuse that are reported and investigated. Trickett et al. (2009) found physical abuse (63%) and neglect (76%) to be the most frequent abuse types where CEA was present but not identified.

Effects of Childhood Emotional Abuse

Unlike physical or sexual abuse, emotional abuse has some qualitative differences which create a unique albeit disconcerting reaction by the child who is abused. Emotional abuse is usually perpetrated by a parent or guardian, so the abuse relates precisely to the parent-child relationship (Buser & Buser, 2013). As a likely attachment figure the child is placed in a situation where they must develop cognitive strategies to accommodate their environment such as dissociation or denial (Goldsmith & Freyd, 2005). These strategies allow the child to continue living in a psychologically abusive environment with some insulation from the verbal and personal attacks. For other children, their method of accommodation may be to internalize the abuse; believing the attacks are warranted and deserved as this choice is preferable to admitting

the caregiver is truly that cruel (Goldsmith & Freyd, 2005). Further strategies may erase the memories altogether. In these situations, the child will not recognize, admit, or report any emotional abuse as they don't have historical recollection of the experience (Goldsmith & Freyd, 2005).

The effects of CEA have been documented in the literature. There are numerous articles revealing adult outcomes associated with a childhood of substantive emotionally abusive environments. Alloy et al. (2006) found CEA to be both associated with as well as a risk factor for depression in adulthood, while Ackner, et al. (2013) indicated a CEA history was highly prevalent in clients with psychotic experiences. Goldsmith and Freyd (2005) found correlations between CEA and alexithymia, dissociation, depression, and anxiety although they purported these should be conceptualized as a trauma reaction rather than psychopathology. Retrospective studies of adolescents and adults also find connections with personality disorders (Finzi-Dottan & Karu, 2006), anxiety (Fonzo et al.,2015) and aggressive behaviors (Allen, 2011). Adult outcomes from CEA found in the literature are typically analyzed using self-report questionnaires, psychosocial histories, assessments, national data sets, and interviews.

Furthermore, researchers are familiar with some of the likely signs to present during childhood which suggest a history of emotional abuse may be present. Gibb and Abela (2008) found CEA related to depressive symptoms in child clients. Children from toddler age through childhood are more likely to display aggressive behaviors while adolescents will be more prone to dissociative symptoms, substance abuse, delinquency (Brassard & Donovan, 2006) and an increased risk of suicide attempts (Miller et al., 2013). Taillieu et al. (2016) posited CEA interferes in a secure attachment bond, with children displaying insecure attachments symptoms

and behaviors during their childhood and/or adolescence. Perhaps most concerning is the literature regarding neural changes in children who have experienced CEA.

The literature suggests CEA likely influences the creation of negative beliefs of self-associations and such beliefs leave the child vulnerable to additional problems in childhood and adulthood (Ackner et al., 2013; van Harmelen et al., 2010). Sometimes known as pessimistic explanatory style or negative cognitive style, this phenomenon describes an individual's bias to see the cause of negative events globally, and personally and is a cognitive predictor of depression (Buser & Buser, 2013). In another study of emotional abuse on brain development, Zhao et al. (2015) found participants with more severe emotional abuse histories had higher neurological soft sign scores in the frontal area of the brain. These neurological soft signs are more commonly found in the brain areas of depressed patients. Zhao et al. (2015) defined neurological soft signs as "mild neurological and nonlocalizing abnormalities associated with defects of motor coordination, balance and integration, as well as sensory integration of the central nervous system" (p. 286). Cicchetti (2002) advanced that CEA may alter the structure, function and organization of healthy brains specifically if this occurs during those periods of rapid brain development while Schore (2001) suggested CEA can modify brains by over-pruning dendrites and influencing areas of brain development that are experience-dependent.

Another cognitive outcome from CEA is alexithymia. Alexithymia, sometimes known as emotional blindness, is an inability to express, perceive or identify feelings. Childhood trauma is one of the few identified causes of this disorder and studies have found positive correlations between CEA and alexithymia (Goldsmith & Freyd, 2005). It is suggested that some emotionally abusive environments teach children the world is not safe for expressing one's emotions while others dictate that children are not allowed to have feelings or to have their own feelings unique

from others (Goldsmith & Freyd, 2005). These invalidating environments cause individuals to doubt their own experiences and further thwart the ability to discern them.

Reporting Behaviors

With all the identified concerns for CEA, it becomes imperative for clinicians to do a better job of reporting with a well-supported rationale for their concerns. Former studies of school counselors found emotional abuse to be the most suspected but not reported of all abuse types and additionally ranked as the type of abuse school counselors felt least certain in abilities to recognize (Bryant & Milsom, 2005; Bryant, 2009). McTavish et al. (2017) also found less overt forms of child abuse to go unreported, including CEA even though it is likely one of the most prevalent forms of child abuse out there (Finkelhor et al., 2013). Perhaps the previously mentioned absence of a clear definition, for purposes of reporting contributes to these findings and with variability between states, clinicians must report according to the definition specifically for their state. Qualitative results from Kimber et al. (2019) identify views by reporters that Child Protective Service (CPS) will not likely get involved with CEA, making reporters more reluctant to call. CEA is also more challenging for CPS to substantiate when reports are made (Malo et al., 2016) illuminating the challenges not only for the reporter but also the investigator.

In light of the challenges inherent in this type of abuse and the long-term effects that have been reported in the literature, it is crucial to identify challenges and strategies to specifically address them. Mental health practitioners are one of the most likely professionals to be in a position not only to identify but to also verify the presence of CEA. To that end this section will attempt to support clinicians in their challenge and responsibility to identify and report CEA for their child and adolescent clients. With implementation of new strategies and hopefully additional confidence in reporting, there will be a marked improvement in reporting of CEA over

time. More than other types of abuse, it is likely CEA places more onus on the clinician from the start not only to make the difficult determination but also to know how to look for signs and explore possible abuse when working with clients in session.

Challenge One: Defining Emotional Abuse

As stated earlier, there is not a consensus within state statutes or the literature at large what is reportable emotional abuse of a child. Current definitions, while helpful are not always crafted in a manner that is behaviorally identifiable for clinicians. In other words, how can a practitioner clearly assess that the abuse has occurred and has caused measurable mental injury that an investigative body would appreciate and understand? This type of abuse does not lend itself to the concreteness of physical abuse, sexual abuse, or neglect. The damage literally is mental or emotional damage and therefore the manner in which we operationalize that must be clearly delineated. Clinicians who live in a state with clear guidelines can use those to their advantage for both identification and reporting. For instance, in the state of Iowa the definition of mental injury is as follows:

> “Mental injury" is defined as any mental injury to a child's intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child's ability to function within the child's normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional as defined in Iowa Code section 622.10.

This definition contains several of the specifics found in previous literature. The definition above describes the behavior as psychologically injurious. This would suggest that at report the clinician can identify the psychological harm. Additionally, in this definition the emotional abuse has caused impairment in the functional abilities of the child in one or more ways (i.e., cognitive, social, academic or behaviors as per Baker, 2009). While other definitions in the literature also offer consideration of the severity and intentionality, those may be used to support a report but

do not offer a measurement of abuse or harm per se. Defining the abuse with a focus on psychological harm and impairment of functioning reduces subjectivity and improves a common language for understanding and identifying this type of abuse.

For those living in a state with little to no guidance statutorily to the defining of CEA, clinicians may want to be proactive. One possible approach would be to create an outline or definition of CEA, taken from the definitions found in the literature. Using a self-created definition, clinicians would report concerns using scaffolding and structure to emphasize not only substantiated claims of abuse but also objective impairment. For instance, the APSAC (2019) categories are a good start for identifying and better defining the reported concern. While the APSAC had six categories the fifth (denying emotional responsiveness) and the sixth (mental health/medical/legal neglect) would be considered a form of neglect rather than abuse. That leaves the following four categories spurning, terrorizing, isolating, and exploiting/corrupting, as a structure for defining the types of emotional abuse. These four categories are then broken down into qualitatively different subcategories. Finally, connecting the emotionally abusive behaviors to observable harm is needed to close the loop on this type of abuse, as it cannot be inferred from the behaviors of the perpetrator. An example of one possible assessment is provided in Appendix 1. Using a self-created assessment would be an interim alternative while waiting for serious legislative changes.

Another approach to ameliorating the lack of guidance in reporting CEA would be to advocate. Advocating for a clearer definition and substantiation criteria would clearly fall into the realm of professional advocacy. Clinicians could work with their state professional organizations, their local legislators, or approach their child protective services and work

together to make the changes needed for the sake of the children and the clinicians charged with identifying and reporting. Baker and Brassard (2019) suggested

> a team of expert researchers, policy makers and child welfare professionals convene in order to develop a replacement for current statutory definitions of this form of child maltreatment…to develop a model law that will aid the United States in ongoing surveillance of child maltreatment (p. 9).

Clinicians could consider utilizing the child's diagnosis as it relates to past and possible future emotional abuse. For example, a child may have anxiety disorders including panic and possible post-traumatic stress disorder (PTSD) from years of CEA. Their parent continually ridicules and threatens them for not getting straight As and the child as a result runs away, becomes suicidal, self-harms after the verbal abuse, or perhaps experiences dissociations during the school day due to the CEA and stress about academics. Connecting these in reports, as only something the practitioner could understand, helps the investigators with their task at hand. This may be one reason some states require that the reporters of CEA are mental health professionals. We are the ones most likely to be able to connect such dots.

Challenge Two: Identifying Emotional Abuse

The challenge in identifying abuse is multi-faceted. First, clinicians have endorsed in past studies that they feel ill-equipped to identify emotional abuse when compared with other types of abuse (Bryant & Milsom, 2005; Bryant, 2009; Kenny & Abreu, 2016). Therefore, the first step in this process is to improve training and knowledge of the unique characteristics of this abuse both during training programs but also after a practicing clinician, through workshops, conferences, or state-specific trainings. As practitioners we must meet the challenge inherent in reporting emotional abuse rather than accepting feelings of inadequacy.

Another reason for difficulty in identification of emotional abuse may be our child or adolescent client. Inquiring with adult clients about past emotional abuse in childhood may be

standard practice in intake and counseling practice in general. But exploring the subtleties of emotional abuse with a child client or teen is not as easily accessible. Literature includes retrospective reports from adult clients able to identify emotional abuse and study that history in terms of clinical presentation in adulthood (Baker, 2009). However, the literature also illuminated that children, by the nature of the abuse, are less likely to identify their own victimization of emotional abuse, or even in some cases remember the abuse, as dissociation and internalization of the negative messages occurs. Therefore, it is challenging as clinicians to sometimes access the information that would identify the caretaker behaviors that are causing the psychological harm. A study by Kimber et al. (2019) found clinicians might ask broad questions about conflict in the home or parenting practices during intake or early sessions but nothing formally assessing emotional abuse. These respondents also felt that until they had developed a strong therapeutic relationship with their client, it was unlikely the client would share information regarding possible emotional abuse by their parent or caretaker. If this is the case, then at the very least clinicians should employ questions or screening tools developmentally appropriate for the client that will give some possible clues as to whether there is more that should be explored in future sessions.

Assessment is another option to explore the possibility of current or past emotional abuse. It is customary now to screen clients for Adverse Childhood Experiences (ACEs) using an ACEs screening tool, which measures types of abuse and neglect including emotional abuse in addition to other trauma experiences. Variations now exist for teens as well as younger children (or the caregiver of a child) and can be found free of charge on the Internet. Likewise giving a child a trauma screening tool or child abuse screening assessment may also uncover CEA that was not openly reported in sessions or intake. Meinck and Steinert (n.d.) and Eklund et al. (2018)

provide lists of trauma and child maltreatment scales practitioners may employ. Using the answers to specific items on an assessment is a natural way to explore past incidents with a child client, as they may not recall them initially on their own, but with a screening tool can recognize an event when queried. These tools may also offer additional support or substantiation in a later report of CEA.

Furthermore, if clinicians were educated on the common presentation of clients with an emotional abuse history, they too would have additional clues that could lead to future exploration of CEA. Earlier in this article a review of the literature offered common outcomes seen in children with a history of CEA. If we note these outcomes in a child or adolescent client, we can use this information as a form of reverse identification. If a toddler has aggressive problems and we know this is an outcome of an early history of CEA, we have a duty to explore this possibility further in sessions. Likewise, if we have a teen client with dissociation, so too we should use this information in reverse to implement a cursory assessment of possibly emotional abuse. Tying CEA, if identified, to those emotional, behavioral, cognitive, or psychological impairments connects the dots that lead to a cogent report.

Finally, while not a direct link to making a report of CEA, understanding the risk factors for caregivers who engage in CEA could be a helpful clue in identification. Simmel et al. (2016) found the most salient caretaker risk factors are a previous history of abuse, recent arrest, serious mental health problems, inappropriate parenting, low social support, and problems in paying necessities. As clinicians, if we assess parental status in these areas at intake, we will have a foundation for looking at future signs and symptoms of our child or teen client within the context of possible CEA and follow-up appropriately. This and other information can be used to bolster

the making of a strong report; adding to the data that may or may not be known to the person receiving our report.

Conclusion

While the literature is replete with articles about child maltreatment, childhood emotional abuse, mental injury or psychological maltreatment continue to lag behind in reporting, reporter efficacy as well as the statutes meant to guide mandated reporting. When clinicians are aware of the soft signs that might suggest a history of CEA in a child or adolescent client, they are more likely to explore that issue with them, as they are less likely to self-identify as being emotionally abused, in comparison to other types of abuse. Likewise, if clinicians would use available screening tools when appropriate, they may open the door to exploring CEA with their young client. Future research might study the efficacy of such interventions. Additionally, advocacy for changes in weak state statutes will support reporters, investigators, and child victims of emotionally maltreatment.

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Appendix

Childhood Emotional Abuse Assessment

Part 1

Check any of the following present in the report

Spurning – acts that reject or degrade the child

__________ singled the child out
__________ shamed the child
__________ belittled the child
__________ rejected the child

Please provide specific examples of each item that was endorsed.

Terrorizing – acts that threaten the psychological or physical safety of the child and/or others who are important to the child

___________ placed child in dangerous situations
___________ paired a rigid/unreasonable expectation with a threat if not met
___________ threatened violence towards the child
___________ threatened violence against the child's loved one
___________ perpetrated violence against the child's loved one

Please provide specific examples of each item endorsed

Isolating – confining or placing unreasonable restrictions on the child's social interactions with others

___________ confined the child within the environment
___________ restricted the child's ability to socialize with others

Please provide specific examples of each item endorsed.

Exploiting/Corrupting – encouraging the child to develop inappropriate behaviors and attitudes toward others

___________ modeled for the child antisocial/inappropriate/illegal behaviors
___________ encouraged the child in antisocial/inappropriate/illegal behaviors
___________ exposed the child to antisocial/inappropriate/illegal behaviors

Please provide specific examples of each item endorsed

Childhood Emotional Abuse Assessment

Part 2

Please list any mental health diagnoses the child has:

____

____

____

How does the emotional abuse affect this child's mental health? (In what ways does the emotional abuse create mental health difficulties or exacerbate the mental health disorders already present?)

Please check any behaviors noted that you believe are related to the emotional abuse:

_______ anxiety

_______ depression

_______ crying

_______ avoidance

_______ running away

_______ dissociation

_______ nightmares

_______ delinquency

_______ self-blame

_______ suicidality

_______ flashbacks

_______ stealing

_______ aggression

_______ nightmares

_______ difficulty concentrating

_______ lying

_______ substance use/abuse

_______ self-harm

_______ difficulty identifying emotions

________ Other ____________