Child Abuse is Not Limited to Physical Harm.

*Emotional* abuse has recently been identified as *the most challenging and prevalent* form of child abuse.

It may also be the most harmful.
But words will really hurt me.
Childrenhood Emotional Abuse is:

Challenging:
• hard to define
• hard to identify
• hard to prove

Prevalent
• Occurs in all cases of physical and sexual abuse
• Occurs by itself
• Occurs in multiple environments: home, school, work

Harmful
• Emotionally abused children commit suicide at nearly twice the rate of sexually abused children
Childhood Emotional Abuse is Little-Studied

- it is harder to detect
- it frequently co-occurs with physical and/or sexual abuse
- still largely unrecognized as a separate type of abuse that carries unique consequences and forms of harm.
Children who have been abused psychologically, through chronic verbal or emotional torment, have clinical profiles that overlap but are different from those of children who were physically and/or sexually abused.
Some Forms of Emotional Abuse:

- Terrorizing
- Rejecting
- Isolating
- Gaslighting
- Ignoring
- Discounting
- Corrupting
- Exploiting
Don't you ever think about anyone else? You're such a baby.

selfish.

Don't be so sensitive.
Terrorizing

creating terror in a child by

- raging; threats; bullying; intimidating behavior
- unpredictable responses to child’s behavior (child “walks on eggshells”)
- displaying anger at or punishing normal childhood behavior (when child cries)
- inconsistent demands
Rejection

- endless criticism
- name-calling
- “silent treatment”
- verbal humiliation

- physical abandonment
- refusing hugs and loving gestures
- ranting, screaming, yelling, swearing
Isolating

• preventing access to the other parent

• preventing from, or punishing for, engaging in normal social experiences

• isolating child in room or closet

• not allowing child to have friends

• keeping a child from participating in activities outside the home
Ignoring

• consistently failing to respond to or interact with a child

• failing to teach a child age-appropriate behaviors (color identification; how to brush teeth; what menstruation is)

• failing to provide required health and dental care

• not paying attention to significant events in child's life
Discounting

• Repeatedly telling a child that he/she is wrong

• Minimizing the child’s problems (not taking them seriously)

• Trivializing the child’s concerns (telling the child that his/her concerns are unimportant)

• failing to consider the child’s perceptions

• undermining the child’s confidence
Corruption

• encouraging or permitting a child to do things that are illegal or harmful, or rewarding a child for doing such things (substance abuse, sexual activity)

• rewarding a child for inappropriate behavior (fighting, bullying, harassing)

• encouraging violence in sporting activities

• supplying child with drugs, alcohol and other illegal substances
Exploitation

• giving a child developmentally inappropriate (heavy) responsibilities

• using a child for profit

• “parentizing” or depending on child as a caregiver

• blaming child or youth for misbehavior of siblings

• requiring child or youth to participate in sexual exploitation
Effects of Emotional Abuse

Children who have been abused psychologically, through chronic verbal or emotional torment, have clinical profiles that overlap but are different from those of children who were physically and/or sexually abused.
Trauma From Emotional Abuse

Emotional abuse carries developmental consequences that are:

1. even more severe than other types of abuse, and
2. that predicts maladjustment well beyond the predictive effects of other types of abuse.
Known as Developmental Trauma, Complex Trauma, or Complex PTSD, the constellation of symptoms produced by emotional abuse is thought to occur, in part, because abused children are exposed to trauma on a chronic, sustained, and repeated basis.
Current research indicates that this form of abuse can produce a range of symptoms including, but also over and above, those of standard PTSD. This happens both with children and adult survivors.
STANDARD PTSD

According to the DSM-V, standard Post-Traumatic Stress Disorder can be diagnosed when 8 criteria have been met:

1. There is a stressor;
2. Intrusive symptoms result from exposure to the stressor;
3. Avoidant behavior occurs as a result of the exposure;
4. The client experiences negative alterations in cognition and mood;
5. There are alterations in the client’s arousal and reactivity;
6. For periods exceeding one month after the exposure;
7. These consequences affect the client’s functioning;
8. And the problems are not due to medication, substance abuse, or illness.
STANDARD PTSD

Criterion A: The Stressor

The person was exposed to:

- death
- threatened death
- actual or threatened serious injury
- or actual or threatened sexual violence

By: (one required)

1 Direct exposure.
2 Witnessing, in person.
3 Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4 Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.
The traumatic event is persistently re-experienced in one of the following way(s):

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.
STANDARD PTSD

Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1 Trauma-related thoughts or feelings.
2 Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
At least two of the following negative alterations in cognitions and mood must have begun or worsened after the traumatic event:

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.
STANDARD PTSD

Criterion E: Arousal and Reactivity

At least two of the following trauma-related alterations in arousal and reactivity must have begun or worsened after the traumatic event:

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance
STANDARD PTSD

Criterion F: Duration
The symptoms (criteria B, C, D, and E) must have lasted longer than one month.

Criterion G: Client Functionality
The client must have experienced significant symptom-related distress or functional impairment, such as impairment in social or occupational areas.

Criterion H: Exclusion
The disturbance is not due to medication, substance use, or other illness.
Emotionally abused individuals can show all of these symptoms and more.
Complex Trauma arises from

• chronic

• early

• maltreatment

• that occurs *within a care-giving relationship.*
This is a clinical definition, not a DSM IV or V diagnosis!
However, many researchers prefer this definition because it captures the pervasive effects of early maltreatment.
The harmful effects of childhood trauma are heightened by the fact that it is often inflicted by the caregivers:

the very people that the victims should be able to look to for protection from trauma.
7 Domains of Impairment

- Attachment
- Biology
- Emotional Regulation
- Dissociation
- Behavioral Regulation
- Cognition
- Self-concept
what happens when a parent creates both safety and danger?

Attachment

Children feel that the world is uncertain and unpredictable. They become socially isolated and have difficulty relating to and empathizing with others.

Need to attach, to love and be loved, to feel protected, safe, and secure

Danger

When early attachments are dangerous, children are caught between the need to attach and the need to be safe. Is it safe to approach, or time to hide?

Need to protect oneself, to fight or flee from the attachment
Biology

Traumatized children can experience problems with movement and sensation, including hypersensitivity to physical contact and insensitivity to pain. They may exhibit unexplained physical symptoms and increased medical problems.
Mood Regulation

Traumatized children can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states.
The kids are cute!
Dissociation - traumatized children can feel detached or depersonalized, as if they are observing something that is happening to them that is unreal.
Behavioral control - traumatized children can show poor impulse control, self-destructive behavior, and aggression toward others.

These kids can be misdiagnosed as:

- hyperactive
- oppositional defiant disorder
- borderline personality disorder
The vast majority of these who get professional attention will be misdiagnosed as suffering from Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, and will be medicated and treated accordingly.

Cognition - traumatized children can have problems focusing on or completing tasks, or planning for or anticipating future events. Some exhibit learning difficulties and problems with language development.
Self-concept - traumatized children frequently suffer from disturbed body image, low self-esteem, shame, and guilt.
Emotional child abuse can produce:

- elevated rates of noncompliance
- conduct problems
- hyperactivity

- inattention
- delinquency
- aggression
Some Consequences of Early Traumatic Stress

- creates changes in brain structure and function
- *impact varies* depending on the victim’s stage of development - exposure at different ages may lead to different clinical outcomes
- affects the victim’s maturational processes
- interferes with normal development, and
- may result in PTSD along with additional symptoms
Childhood trauma can cause vital areas of the brain to develop improperly, leading to a variety of physical, emotional, cognitive, and mental health problems.
Teicher Study

• Young adults, ages 18-25

• *no history* of exposure to domestic violence, sexual abuse, or parental physical abuse

• rated their childhood exposure to parental and peer verbal abuse

• Then received brain scans
Brain scans showed that those who suffered verbal abuse from peers in middle school years had:

- underdeveloped connections between the left and right sides of their brain through the corpus callosum

- higher levels of anxiety, depression, anger, hostility, dissociation, and drug abuse than others in the study
Other Brain Changes

Areas of the brain most affected:

corpus callosum - transfers motor, sensory, and cognitive information between the two brain hemispheres - reduced in size

hippocampus - emotional regulation, long-term memory

frontal cortex - thought and decision-making

grey matter - changes in size
Verbally abused children, *and the adults they become*, may have issues with:

- memory
- attention
- interpersonal relations
- affect regulation
- somatization
- and systems of meaning.
Additionally, survivors of childhood abuse may suffer dysfunction in neurohormone activity involving serotonin, glucocorticoids, endogenous opioids, and catecholamines, along with dysregulation of the hypothalamus-pituitary-adrenal (HPA) system. The HPA system regulates stress responses; studies show that women with a history of childhood trauma show increased HPA reactivity in response to psychosocial stress.
Emotional abuse has also been linked to internalizing symptoms such as depression, anxiety, suicidality, and poor self-esteem.
Relationship between Adverse Child Experiences and Lifetime Risk of Suicide Attempts

Parents Separated/Divorced
- No: 3.0%
- Yes: 6.6%

Physical Abuse
- No: 2.2%
- Yes: 7.8%

Battered Mother
- No: 3.1%
- Yes: 9.0%

Sexual Abuse
- No: 2.4%
- Yes: 9.1%

Mentally Ill Household Member
- No: 2.6%
- Yes: 9.6%

EMOTIONAL ABUSE
- No: 2.5%
- Yes: 14.3%

Percentage of Lifetime Suicide Attempts
Emotional abuse is *prevalent* among abused children but is *seldom the focus of intervention*, either for children or adult survivors.
Effective treatments for PTSD have been established and

Effective treatments for physical and sexual child abuse have been established.
But few interventions have been designed to directly target emotional abuse, either for youths or adults.
This may be, in part, due to the fact that the Developmental Trauma arising from emotional abuse differs from that arising from physical or sexual abuse and standard PTSD in many respects and the overlap among emotional abuse, physical and sexual abuse, and PTSD has not been extensively studied.
Also, to date, little attention has been paid to the
differences in trauma arising from chronic child
abuse versus that arising from single-episode or
chronic adult trauma.
Thus, we don't know whether Developmental Trauma will respond to standard PTSD treatments, or whether Developmental Trauma patients will tolerate the treatments well.
Some of the few studies that have been done to date suggest that standard PTSD treatments fail to address the entire range of symptoms prevalent in Developmental Trauma and that Developmental Trauma has been associated with poor treatment outcomes and high drop-out rates.
We also know that patients with Developmental Trauma show markedly less favorable results from some of the standard treatments than those with standard PTSD. For example, current preliminary indicators suggest that CBT treatments do not achieve satisfactory end states in Developmental Trauma populations.
One group of researchers in Boston has been wrestling with the issue of Developmental Trauma since the 1970’s. Bessel van der Kolk and Robert Pynoos, with ten other mental health professionals, proposed including in DSM-IV, and again in DSM-V, a Developmental Trauma Disorder diagnosis for children and adolescents.
They describe the current diagnostic system for emotionally maltreated children as having three problems:

- **no diagnosis**
- **inadequate** diagnosis
- **inaccurate** diagnosis
The failure to include Developmental Trauma in DSM-V has been roundly criticized by many researchers. One categorizes it as a “missed opportunity” and “a tragedy.” Despite DSM-V’s exclusion, Developmental Trauma continues to be the focus of a great deal of research, and as a practical matter, clinicians have developed the definition reviewed earlier.
Tests and Assessments

Most of the tests and assessments in use today:
1. were developed for adults
2. omit important sources of abuse (in-school bullying, for example)
3. don’t collect detailed information on when exposure occurred
4. or how exposure changed over time
M.A.C.E. Scale

M.H. Weicher and others have developed the Maltreatment and Abuse Chronology of Exposure scale. Although it again is targeted toward adults, it is more comprehensive in that it elicits information regarding exposure to ten types of abuse in each year of childhood.

The MACE scale shows that different types of maltreatment have different, and sometimes unique, developmental consequences.
Detecting Emotional Abuse

*Observe the family interacting with the child.* Watch for:

- indifference toward the child's welfare or problems
- coldness toward the child
- rejecting the child
- blaming the child
- putting the child down
- calling the child names
- withholding affection
- treating siblings preferentially
- monitor the child’s response to parental displays of affection (observer effect)
Detecting Emotional Abuse

Ask each parent or caregiver independently what the child is like as a person. Ask also about the child’s problems and issues. What the parent tells you may be what the parent is telling the child: that s/he is lazy, worthless, a troublemaker, etc.
Detecting Emotional Abuse

Children imitate adults. So, let them show you what their home life may be like!

Play “Let’s Pretend” games with the child (maybe using dolls). Have the child pretend to be the mother or the father, while you pretend to be the child. Misbehave and see how the child reacts. Does the child scream at you or call you names?
Detecting Emotional Abuse

Be aware that children may not realize they are being emotionally abused. Just as emotional abuse is harder for adults to detect, it’s harder for children as well. Also, children have no frame of reference and often tend to believe that all families resemble their own.
Detecting Emotional Abuse

Babies and pre-schoolers may:

• be overly-affectionate towards strangers

• lack confidence, seem wary or anxious

• fail to show attachment to a parent (show indifference when being picked up or dropped off at daycare, for example)

• be mean or aggressive or nasty to other children or animals.
Detecting Emotional Abuse

Older children may:

• use age-inappropriate language or behaviors

• seem unusually mature or immature

• struggle to control strong emotions or have extreme outbursts

• seem isolated from their parents

• lack social skills or have few, if any, friends.
Detecting Emotional Abuse

Older children or teens may also:

- seem overly compliant
- make negative self-statements
- display self-harming or self-destructive behaviors
- be reluctant to go to school or ride the bus
- find excuses not to go home or avoid home
Case Study: Emotional Abuse Scenario 1

A student is crying in class. You call her over and ask what is wrong. She said that the police came out to her house last night and arrested her dad after he and mom had a fight in her bedroom. She said that her dad had been drinking and mom had been hiding from him in the student’s room. She went on to say that dad broke down the door to her bedroom, came in and started slapping and punching mom in the face. The student reports that she called 911 on mom’s cell phone during the struggle.

Was this child emotionally abused?
Case Study: Emotional Abuse Scenario 2

A middle school aged boy is at parent/teacher conferences with both of his parents. One of the boy’s teachers expresses concerns regarding one of his grades and the boy’s mom goes off. First she starts yelling at her son – belittling him, telling him he is stupid, that he’s not trying, etc. She continues yelling at him to the point the teacher attempts to intervene at which point the mother goes off on the teacher. She is loud enough and verbally abusive enough that she is eventually asked to leave the school building.

Has the father maltreated the son in this scenario?
Case Study: Emotional Abuse Scenario 3

You are a participant in a student/parent/teacher conference. The student is not performing up to his ability in a number of subject areas and has been non-compliant with homework and classwork. You observe the mother becoming increasingly angry as the boy’s behavior is revealed more and more during the meeting. When the mother finally does speak, she says some expletives directed at the child and makes some threats about what will happen at home in terms of privileges and freedoms if he doesn’t turn his behavior and performance at school around. All of this is done in a loud fashion and is shocking to the faculty attending the meeting.

After the parent and student leave, the school participants talk about whether what they just witnessed was emotional abuse and whether it should be reported. The school counselor says that he has been in many meetings with the parent and student over the years and has never seen this behavior before. The counselor also says that the situations he has been involved in with the parent and student have never been as serious as this one.

The assistant principal also has never observed this type of behavior from the mother across settings and circumstances.

A teacher points out that the punishments mentioned by the mom did not seem out of the ordinary and were things she had done with her own child. A couple of other teachers on the team echoed that the restrictions mentioned by the mom were reasonable.

*Has this child been emotionally abused?*
Removal from Home

Removing a child from the home should not be limited cases of physical or sexual abuse; children exposed to psychological maltreatment may also require a level of protection that necessitates removal from the home.
Some Treatment Alternatives for Children

• Parent-Child Interaction Therapy (PCIT) is a parent training intervention that teaches parents/caregivers targeted behavior management techniques as they play with their child. PCIT focuses on improving the parent/caregiver-child relationship and on increasing children’s positive behaviors. It has been adapted for children who have experienced trauma.

• Integrative Treatment of Complex Trauma for Children (ITCT-C) is a comprehensive, assessment-driven, components-based multi-modal model. It is used to treat children from 2 - 21 years of age. ITCT-C integrates a variety of components, including affect regulation training, titrated exposure, cognitive therapy, and relationship processing, which are applied according to each child’s individual needs.
Some Treatment Alternatives for Adult Survivors

- Neurofeedback, a type of biofeedback that uses real-time displays of brain activity (usually through electroencephalography (EEG)), to teach self-regulation of brain function, is being used to help clients improve affect regulation and emotional dysregulation.

- Sensory Integration (SI) is being used to treat symptoms of dissociation, emotional dysregulation, and somatization.

- CBT alone has proven less effective with Developmental Trauma than with PTSD, but can be helpful when used in combination with other types of therapy.

- Eye Movement Desensitization and Reprocessing (EMDR), a therapeutic treatment that uses eye movements, sounds, or pulsations to stimulate the brain, can create changes in the brain that help a client overcome symptoms of depression, anger, and anxiety, among other conditions.
Research in general is finding that combinations of treatments are more efficacious for Developmental Trauma than single forms. For example, one small study suggests that a combination of sensory integration and psychotherapy yielded significantly greater gains than psychotherapy alone. Due to the small sample size and other limitations, the results of this study should be considered preliminary; nevertheless, the outcome suggests that the use of multiple treatment tracks should be the subject of further study.
Summary

People who undergo chronic, long-term abuse, emotional abuse in particular, often fall through the cracks because there is no one big single event they can point to as a cause for their symptoms.

The DSM-V’s failure to formally recognize these symptoms does not mean they don’t exist; PTSD itself was not formally recognized until DSM-III.
Further Research

There is a huge need for further research in this area:

• to determine the nature and extent of brain changes that occur as a result of chronic developmental trauma;
• to determine how the response to such trauma varies with the age, gender, and culture of the victim;
• to test the efficacy of differing forms of therapy, and
• to develop new ones.
Conclusion

If there is one thing to take away from this presentation, it should be an awareness that emotional abuse can produce severe and lifelong psychological effects, and that emotional abuse can masquerade as other conditions. Be aware of these issues, and don’t automatically label a kid as hyperactive without investigating whether that may be a symptom of the kind of chronic abuse that doesn’t leave visible scars.
From the book, *Coping with Bullying in Schools*, by Brendan Byrne (1994)