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**Childhood emotional maltreatment and its impact on emotion
regulation**

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Doctorate in Clinical Psychology

The University of Edinburgh

2010

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ABSTRACT

Objectives:

An aim of this research was to gain prevalence rates of emotional abuse (EA) and emotional neglect (EN) in a community based adolescent sample. This exploratory research also attempted to determine the impact of EA, EN and a combination of the two (emotional maltreatment; EM) on adolescent's emotion regulation (ER). The impact of temperament, gender and age was also considered, along with the adolescent's subsequent quality of life ratings.

Method:

A total of 540 adolescents (mean age 14 years) were recruited through their secondary schools, and completed the following questionnaires: the EN and EA subtests of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1994); the Early Adolescent Temperament Questionnaire – Short Form (EATQ – SF; Ellis & Rothbart, 1999); the Basic Emotions Scale (BES; Power, 2006); the Regulation of Emotions Questionnaire (REQ; Phillips & Power, 2007) and the Kid Screen -10 item Health Questionnaire for Children and Young People (Ravens-Sieberer *et al.*, 2005).

Results:

Prevalence rates of EA and EN were reported. Differences were detected between EA and EN in terms of how they affect experiences of basic emotions and how they impact on ER, even after controlling for temperament. Only EA was associated with aggression, whereas both EA and EN were associated with depressive mood and reduced quality of life.

Conclusions:

EA and EN are different maltreatment experiences which have different detrimental effects on the individual, therefore requiring different interventions.

Chapter 1: INTRODUCTION

1.1 Overview

1.1.1 Child Maltreatment

Childhood maltreatment is generally considered to be the collective term used to describe all forms of childhood experiences of abuse and/or neglect (Cawson *et al.*, 2000), although it is difficult to define because of differing cultural expectations and subjective interpretations of what constitutes appropriate parenting (Cicchetti & Toth, 2005). These maltreatment experiences include physical, sexual or emotional abuse and physical or emotional neglect (Scher *et al.*, 2004). These acts of abuse or neglect can be perpetrated by any person (child or adult), either known to the child or by a stranger, within any number of possible circumstances or settings (World Health Organisation (WHO), 2006). Maltreatment is often experienced on a regular basis, representing a chronic and traumatising experience (Milot *et al.*, 2010). In the most severe cases, maltreatment can result in the child's death (O'Hagan, 2006).

The Glossary (pp. 205-208) of the Scottish Executive Publication *It's everyone's job to make sure I'm alright* (2002) provides the following definitions of the forms of abuse and neglect:

- Physical Abuse – actual or attempted physical injury to a child where there is definite knowledge or reasonable suspicion that the injury was inflicted or knowingly not prevented.

- Sexual Abuse – actual or threatened sexual assault or exploitation of a child or adult victim.
- Emotional Abuse - occurs when there is a failure to provide for the child's basic emotional needs such as to have a severe effect on the behaviour and development of the child.
- Neglect – occurs when a child's essential needs are not being met and this is likely to cause impairment to physical health and development.

Importantly, the neglect category focuses on the impairment of physical development, without explicit reference to emotional development, highlighting how challenging and potentially under-recognised emotional neglect can be. Categories of maltreatment may also include racial abuse, bullying or witnessing domestic violence.

When considering what constitutes abuse or neglect, the issue of harm is often pivotal (Gough, 1996). As can be seen from the above definitions, behaviours (or lack of action, as with neglect) become abusive or neglectful when there are associated harmful outcomes, such as injury or developmental implications. These outcomes can be challenging to observe or quantify, particularly when there are few external indicators, for example no physical bruising. Research has been necessary to gain a fuller understanding of the less obvious outcomes of maltreatment, in order to protect children from such harm.

Child maltreatment has been associated with a range of negative outcomes, such as increased risk of psychopathology, for example, depression (Toth, Manly & Cicchetti, 1992) or posttraumatic stress disorder (PTSD) (Wekerle *et al.*, 2001), challenges in cognitive and social functioning (Dodge, Pettit & Bates, 1994), behavioural problems and emotion dysfunction (Shields & Cicchetti, 1998) and physical ill-health (Imbierowicz & Egle, 2003). Childhood maltreatment has a negative consequence not only to the victim and their families, but also on the wider communities, as it also represents a financial burden to the agencies such as social work and the health services that are required to respond to the harmful repercussions (Irazuzta *et al.*, 1997).

Children are a vulnerable population that rely on the adults around them to protect them. Child Protection is therefore both legally and morally the responsibility of any adult, and the recognition of, and response to, concerns for a child's safety is a particular duty of agencies such as the National Health Service (NHS), police, education and social work. To this end, there have been a number of legal frameworks and guidelines in order to aid child protection agencies. For example, in Scotland over the last decade, The Children (Scotland) Act (1995) has been passed, outlining a legal framework with which to promote child welfare and protection. This was followed by a review of the Child Protection Services in Scotland – *It's everyone's job to make sure I'm alright*, (2002), aimed at improving how services respond to and reduce cases of child maltreatment, using case examples and scenario based information.

Within the Scottish context, social and economic deprivation affects many of the approximately one million children living in Scotland, for example, 42 per cent of children in Glasgow live in deprivation. These children live in challenging circumstances, such as with parents with substance misuse or witnessing domestic violence (Scottish Executive, 2002). Although there is no one risk factor but rather a range of potential risks, such as community environments, parental experiences of growing up or family dynamics (WHO, 2006), services need to be aware of these mounting vulnerabilities to being maltreated. The levels of risk factors may be further represented by the increase in referrals made to the child protection services, for example in 2007/08 there were 12,382 referrals made, which represented a four percent increase from the previous year (Scottish Government, 2008). This figure increased again last year, with 12,713 referrals (2008/09), representing a further three percent rise. From these referrals, 3,628 were registered on the Child Protection Register (Scottish Government, 2009). The Child Protection Register is a confidential list of names of children deemed at high risk of harm, held by the Local Authority. Each child on the list is to have a specific plan of support and action, initiated by their social worker, in order to reduce their risk and provide support to the family. These referral figures highlight that there are significant numbers of young people and children at risk of maltreatment.

This official data is only the number of cases which go on to be referred to child protection services and so is likely to be a conservative representation of the actual levels of maltreatment (Cawson *et al.*, 2000). This may be the result of difficulties

defining and conceptualising maltreatment, under-estimation of the negative impacts experienced by the child or lack of resources to manage all potential referrals.

Support agencies therefore have many challenges to overcome when attempting to protect children from harm. Munro (1999) conducted a content analysis on all child abuse inquiries in Britain between 1973 until 1994, in order to better understand the reasoning behind the decisions made by professionals, when managing child protection concerns. Although based solely on inquiries, which result due to a need to investigate tragic outcomes from child protection cases, the findings showed that professionals were often unable to use new information to aid their decision making and therefore did not revise their opinions. Munro (1999) highlighted that professionals who had large demands placed on them, such as heavy case loads and limited resource were unlikely to be able to process all material available. Instead, they often relied on intuitive first impressions, which were inaccurate and misinformed. Challenges have also been highlighted with collaborative multidisciplinary working between agencies. Complexities can arise because each agency has their own different viewpoint and role which can be difficult to resolve (Darlington, Feeney & Rixon, 2005).

In summary, child maltreatment refers to all forms of child abuse and neglect. Although no universal definitions of the various forms of abuse and neglect are available, legal frameworks and reviews have attempted to aid recognition and intervention, for example, using scenarios to aid understanding. Child maltreatment

represents a significant threat to young people and children in Scotland and is associated with a range of negative outcomes. Although services are becoming more aware of child protection issues, a number of challenges remain, such as the recognition of more subtle negative outcomes (such as psychological damage, as opposed to physical injury), the lack of resource and true collaboration between services.

1.1.2 Child Emotional Maltreatment

There has been growing recognition of and subsequent research into examining emotional maltreatment and its detrimental effects. Previously when considering child protection issues, such as abuse and neglect, research tended to focus around the more visible and concrete concepts of physical and sexual abuse or physical neglect (Barnett, Miller-Perrin & Perrin, 2005; Shaffer, Yates & Egeland, 2009). This tendency may be the result of challenges in determining clear and universal definitions for emotional abuse and neglect. Due to a lack of concrete definitions and visible negative outcomes, such as physical injuries, emotional abuse and emotional neglect are often slow to be recognised, even when an individual is within a high risk population, such as being known to the social services (Glaser & Prior, 1997). The challenges of definition and subsequent poor recognition will therefore be discussed in further detail (see from section 1.2 to 1.2.5), as a clear understanding of these challenges must be acknowledged to appreciate the complex nature of emotional abuse and emotional neglect.

Although difficult to define and quantify, emotional maltreatment (also referred to as psychological maltreatment) is a combination of emotional abuse and emotional neglect. This has long been considered the core component of all forms of maltreatment, rather than simply the “side effect of other forms of abuse and neglect” (Barnett, Miller-Perrin & Perrin, 2005, pp.9). O’Hagan (1995) has also highlighted the inevitable relationship between being physically abused and the subsequent resulting emotional/psychological abuse. This highlights how prevalent but under-appreciated the problem of emotional maltreatment is. There is a clear need to develop our understanding of its effects on the individual and to raise awareness regarding its identification. An exploration of the growing evidence base regarding the negative implications of emotional maltreatment will provide the context of why this topic of research is clinically, legally (particularly in terms of child protection) and socially important.

Although there has been a clear growth in the research conducted examining emotional maltreatment; few studies have separated out the two experiences which are represented by this term, specifically, emotional abuse and emotional neglect. However, with the development of measures such as the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), which has been widely used to measure the five main constructs of abuse and neglect (physical neglect, physical abuse, sexual abuse, emotional abuse and emotional neglect), it is possible to pull apart some of these often linking threads of maltreatment. The relatively small number of studies that have examined these two concepts separately have offered insights into the emerging evidence that emotional abuse and emotional neglect

affect an individual via differing pathways. A full review of these studies will be provided as they lay the foundations for the present study.

Attachment theory will be used as a framework to conceptualise how experiences of emotional maltreatment may impact on a developing child's attachments. More specifically, using this approach to appreciate how children and young people understand and manage their emotional world, the implications for emotional regulation can be explored. Finally, temperament will also be considered, as a biological construct that may play a role in the interactions between emotional maltreatment experiences and emotion regulation strategies.

In summary, emotional maltreatment research had previously been a neglected area of interest, with focus being placed on the more observable concepts of physical and sexual abuse. However this is changing with a growing number of articles being published examining emotional maltreatment. Most authors have not chosen to separate out the two components of emotional maltreatment [emotional abuse (EA) and emotional neglect (EN)], although there are initial indications of vital differences between EA and EN. Challenges faced when conducting research of this nature will be addressed and relevant theoretical frameworks will be outlined.

1.2 Problems of Definition

The quest for a concise and universal definition for emotional neglect and emotional abuse, or indeed emotional/psychological maltreatment in general, has been long standing and remains ongoing. This challenge has continued through the years, potentially hindered by the reliance on observable harm when considering what constitutes child maltreatment (O'Hagan, 2006). O'Hagan describes recent high profile United Kingdom (UK) cases of mismanaged child protection cases in his book *Identifying Emotional and Psychological Abuse (2006)*, identifying in these cases the “fixation on physical health to the virtual exclusion of emotional and psychological health” (pp.15). This exclusion has resulted in children not being safeguarded against these forms of emotional maltreatment. Hamarman, Pope and Czaja (2002) described child emotional abuse as having an “intangible quality” (pp.303) resulting in inconsistent legal definitions, and subsequent inconsistent child protection definitions and legal frameworks, which ultimately result in a system that is reluctant to intervene.

Researchers over the years have employed a number of terms to describe EA and EN including psychological maltreatment (Chamberland *et al.*, 2005; Hart, Brassard & Karlson, 1996; Perry, DiLillo & Peugh, 2007), psychological abuse and neglect (Baker, 2009; Brassard & Donovan, 2006), childhood trauma (Kong & Bernstein, 2009), emotional maltreatment (Gibb, 2002; Iwaniec, Larkin & McSherry, 2007) and psychological unavailability (Egeland & Erickson, 1987). Although these terms all broadly describe the same concepts, O'Hagan (1995) argues that psychological abuse

and emotional abuse are NOT the same, although often experienced together. O'Hagan (1995) reports emotional abuse as having a detrimental impact on emotional development, whereas psychological abuse impacts on mental development. The range of terms used within the research literature and their subsequent individual definitions has left the field in difficulty, in terms of replication and making robust generalised inferences from findings reported.

The tendency to use umbrella terms reduces the complexity of separating out the subtle differences between EA and EN, which has previously been viewed as being an unnatural distinction to make (NSPCC, 2007). However, by ignoring the distinguishing features of EA and EN, definitions become over-simplified which undermines the potentially significant differences between these two experiences. There is growing evidence to suggest that EN and EA have differing pathways in how they affect the maltreated individual (Shaffer, Yates & Egeland, 2009; Soffer, Gilboa-Schechtman & Shahar, 2008; Wright, Crawford & Del Castillo, 2009). These differences will be explored later in this introduction. Prior to exploring the details of potential differences between EA and EN, it is necessary to seek clarification on how these two constructs are defined and conceptualised.

1.2.1 Development of legal definitions: local perspective

Legislation has advanced with the growing recognition of the rights of children, influenced by the United Nations Convention on the Rights of the Child in 1991, which focused on issues of child protection. In response to the Convention, Scotland

subsequently passed the Children (Scotland) Act 1995, which set out rules and regulations for local authorities and other agencies to follow when acting to promote child welfare and protection. This legal framework outlined how agencies should respond to allegations of concern, in terms of how each case should be investigated and potentially prepared for case conference and children's hearing.

Further to this, *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation* (1998) was produced by the Scottish Executive in order to offer guidance to agencies working with families on how best to work collaboratively with parents to reduce child abuse. The focus on family collaboration was in response to the Children (Scotland) Act 1995, which stated that it was the parents' responsibility to safeguard their children. Therefore agencies were to support parents to fulfil this responsibility.

Included in *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation* (1998) are descriptions of the five categories of abuse used for child protection registration. They are physical injury, sexual abuse, non-organic failure to thrive, emotional abuse and physical neglect. Emotional abuse is described as "failure to provide for the child's basic emotional needs such as to have a severe effect on the behaviour and development of the child" (Annex C). Emotional neglect was not specifically mentioned.

In 2002, The Scottish Executive released a review of Child Protection in Scotland, *It's everyone's job to make sure I'm alright*. This document states that “the aim of this review is to promote the reduction of abuse or neglect of children and to improve the services for children who experience abuse or neglect” (pp. 1). Although it offers no clear definitions of child abuse and neglect, it outlines (with case examples) a range of abusive or neglectful situations, incorporating the views of young people and children who have been affected by abuse and neglect. This review also acknowledges that children are often the victim of more than one form of abuse, which is frequently as a result of parental personal and social problems, but that *intent* is not always present. For example, a significant link between parental substance misuse and parental mental health difficulties and subsequent child maltreatment has been reported (Glaser, Prior & Lynch, 2001). In the absence of definitions, this review offers practical advice on recognition, risk factors and reviews of research from both the UK and abroad.

1.2.2 Development of legal definitions: International Perspective

Similarly within the wider, international context, there also continues to be review and changes made within the definitions of emotional maltreatment, but no one clear definition. For example, witnessing domestic violence is gaining recognition as being a form of emotional maltreatment. In six provinces in Canada witnessing parental violence is now legally deemed as grounds for intervention by child support agencies. However, in Quebec psychological maltreatment is not recognised in the Quebec Youth Protection Act (Chamberland *et al.*, 2005).

In the United States (US), Baker (2009) published a review of the legal and conceptual definitions of emotional maltreatment. Baker highlights that within the literature there are a range of legal definitions used, with no uniform legal definition of psychological child abuse. Although there are some reoccurring statements, such as, 'acts or omissions', the main consistency highlighted by Baker (2009) was the emphasis on the impact to the child, as opposed to the parental acts that lead to these outcomes. The focus on negative outcomes for the child results in a limited ability to prevent maltreatment, as negative outcomes are required first, before safe guarding action can be implemented (Glaser, 2002).

In summary, these studies highlight that the difficulties that surround legal definitions are apparent both locally and internationally. Locally, there have been significant developments in Scottish law and policy, which aim to enhance and aid recognition, intervention and highlight ongoing challenges of child protection. These developments demonstrate the rigour with which society has tried to tackle child maltreatment. However in the absence of a universally agreed definition this progress is likely to be hampered. However, conceptual or research definitions will also be addressed to aid clarity in this matter.

1.2.3 Development of conceptual/research definitions

When considering conceptual definitions the variation becomes greater still; potentially highlighting the varying needs, settings, professional outlooks and purpose of the definition at any one time (Knutson & Heckenberg, 2006). Baker

(2009) found that as well as being led by the outcomes to the child (as with the legal definitions), the conceptual definitions could also be lead by the parental behaviour that resulted in those outcomes.

Although legal frameworks focused on the impact to the child, the first clear example of the focus moving towards parental behaviours can be seen in the guidelines produced by The American Professional Society on the Abuse of Children (APSAC, 1995) on how to identify child psychological maltreatment. The APSAC describe six forms of psychological maltreatment: spurning (verbal and non-verbal hostility); terrorising (behaviour that threatens or causes physical harm to child); exploiting/corrupting (encouraging inappropriate behaviours); denying emotional responsiveness (ignoring child's need, limited emotional or positive interaction); isolating (denying interactions/communication with others); mental, health, medical and educational neglect (not ensuring these needs are met). These categories focused solely on the actions of the parents, which Glaser (2002) argued was not empirically appropriate, leading to the development of an integrative approach.

Glaser (1993; as reported in Glaser, 2002; pp. 703-4) proposed five conceptual categories of emotional abuse and neglect, based on research, clinical experience and theoretical considerations. These were:

1. Emotional unavailability, unresponsiveness and neglect; primary care giver usually preoccupied due to their own difficulties, such as, substance misuse

or mental health difficulties. They therefore are unavailable to respond to child's emotional needs.

2. Negative attributions and misattributions to the child; perceive child as deserving hostility and rejection.
3. Developmentally inappropriate or inconsistent interactions with the child; not responding to child in age appropriate manner, expecting more than developmentally capable. May also include exposure to inappropriate interactions, such as domestic violence.
4. Failure to recognise or acknowledge the child's individuality and psychological boundary; using the child to fulfil parent's psychological needs, for example, being unhelpfully involved in parents' divorce proceedings.
5. Failing to promote the child's social adaptation; isolating the child, neglecting them of opportunities for experiential learning. Also may include the corruption of the child, such as involving them in criminal activities.

These categories encapsulate both the impact on the child and the parental behaviours, therefore acknowledging that the impact of psychological maltreatment is rooted in the *interaction* between child and care giver. Glaser (2002) reports that "a high level of agreement has been found in our clinical experience with 60 cases, seen in a multidisciplinary team which has been assessing and treating children and

families referred for concerns about emotional abuse and neglect since 1997” (pp. 705).

This increased variation within conceptual definitions appears to be the result of the growing theoretical knowledge regarding child development (Haugaard, 2006). Key theories in the 1960’s and 1970’s include Bandura’s Social Learning Theory (1977), which described how a child learns through its observations of others behaviours, emphasising the vital role of modelling in a child’s development. Additionally, Bowlby’s Attachment Theory (Bowlby, 1958) demonstrated the lasting detrimental effects of neglectful or abusive parents.

In summary, although growth and development can be seen through these attempts at definitions, there is clear tendency to amalgamate emotional neglect and emotional abuse into the one category. From the legislation and frameworks which have been outlined above, it would seem that definitions of emotional abuse have been slightly more successful, in for example, the Scottish Executive Publication, *It’s everyone’s job to make sure I’m alright*, (2002). As neglect, and more specifically emotional neglect, has less relative clarity, the next section will attempt to address the possible reasons for the “neglect of neglect” (Wolock & Horowitz, 1984) in child protection research.

1.2.4 Neglect of Neglect

Neglect is the least well researched and therefore the least understood form of child maltreatment (McSherry, 2007). The term 'neglect' is often used to describe both physical and emotional *omissions* by the care giver, both within the legal definitions and within empirical research (Dubowitz, 2006; NSPCC, 2007; Scottish Executive, 2002, 2009).

McSherry (2007) examined the key reasons as to why neglect (both physical and emotional) is so significantly under-represented within the child maltreatment literature. She highlighted that as neglect is the *lack* of behaviours or situations, this is more difficult to recognise than if there were adverse overt behaviours such as with abuse. Also the negative impact of neglect tends to be under-appreciated, with focus fixed on visible cases of physical or sexual abuse, often due to resource limitations (Rose & Meezan, 1996). In a bid to reduce these problems McSherry (2007) suggests that more research is required to better understand the impact of neglect, to increase awareness which may raise its profile within child protection work.

Drawing from a range of authors (e.g. Hegar & Yungman, 1989; Munkel, 1994; Sedlak & Broadhurst, 1996; Wolock & Horowitz, 1984; Zuravin, 1991), Barnett, Miller-Perrin and Perrin (2005) described eleven categories of child neglect: healthcare neglect, personal hygiene neglect, nutritional neglect, neglect of household safety, neglect of household sanitation, inadequate shelter, abandonment,

supervisory neglect, educational neglect, fostering delinquency and emotional neglect. The authors provided a description of emotional neglect as “failure to provide (the) child with emotional support, security and encouragement” (pp. 133). They also highlight that the category of EN attracts the greatest amount of debate, in terms of how it should be defined. Some aspects of EN could potentially be viewed as being another form of neglect, such as educational or physical neglect.

In summary, neglect in general and EN specifically are under-researched and therefore the least understood form of maltreatment. EN is arguably the most challenging form of maltreatment to identify and conceptualise as it is characterised by the omission of adequate care giver behaviours. This may also lead professionals to assume that as no visible action is taking place, it is less harmful than other forms of maltreatment, such as abuse.

1.2.5 Definition conclusions

Experiences of EA and EN are considered fundamentally different from the experiences of other forms of maltreatment, such as sexual or physical abuse, as the emotional maltreatment experiences occur within a *relationship*, generally the caregiver/parent, as opposed to being an explicit episode or series of episodes (Glaser, 2002). Although both EA and EN share the similarity of being experienced within a relationship they involve different aspects of maltreatment. From the evidence presented previously in this section, EN could be considered to involve the *omission* of caregiver behaviours, such as being psychologically unresponsive,

whereas EA involves acts of *commission*, such as being terrorised or threatened (Barnett, Miller-Perrin & Perrin, 2005).

For the purposes of this study the definitions of EN and EA will be taken from Bernstein and Fink's Childhood Trauma Questionnaire (CTQ; 1998), as this questionnaire is widely used within the literature, demonstrates excellent psychometric properties, and was administered in this study. They define emotional neglect as the "failure of caretakers to provide a child's basic psychological and emotional needs, such as love, encouragement, belonging and support" (pp. 2) and emotional abuse as "verbal assaults on a child's sense of worth or well-being, or any humiliating, demeaning, or threatening behaviour directed toward a child by an older person" (pp.2).

As the challenges of defining EN and EA have been explored it seems appropriate to consider the scale of the problem. In the next section, prevalence of emotional maltreatment will be outlined based on various research articles. However, as there are ongoing challenges with definitions, caution must be employed when considering the figures highlighted, as different researchers have applied different criteria and definitions.

1.3 Prevalence

These variations in definition (both legal and conceptual) have resulted in prevalence rates being variable and difficult to interpret. Across the USA, reported emotional abuse figures range from .37 cases per 10,000 in Pennsylvania to 113.02 cases per 10,000 in Connecticut (Hamarman, Pope & Czaja, 2002). Using a sample of 900 children known to social services in Denmark, Christoffersen & DePanfilis (2009) carried out detailed assessments of families experiences. Within this sample over a third of the children had been exposed to “some kind of psychological maltreatment” (pp.31). Also, when Hamarman, Pope and Czaja (2002) carried out a retrospective review of abuse and neglect in the US as reported on the National Centre for Child Abuse and Neglect Data System, they found that there was a 300-fold variation in the rate of emotional abuse across the states, as compared to the rates of physical and sexual abuse, which appeared to be significantly more consistent. They hypothesised that this huge variation was the result of inconsistent laws against emotional abuse, whereas sexual and physical abuse are better legally defined. As different countries and different research articles use a range of measures and definitions it is difficult to gauge if variations are due to true differences in populations or methodological variance.

The Child Protection Statistics 2008/09 released by The Scottish Government (2009) reported that 25 per cent of all registered cases are due to emotional abuse, with 47 per cent due to physical neglect, 21 per cent due to physical abuse and 7 per cent due to sexual abuse. The number of emotional abuse cases recorded has almost doubled

since the previous year (an increase of 43 per cent). Although not the largest, it is the fastest growing category of abuse in Scotland. This growing trend had been aided by a shift in the way that local authorities in Scotland have been reporting child protection referrals. Since 2005, if a child is subject to more than one form of maltreatment, then it is recorded in the Child Protection Statistics as more than one referral. Previously the child would only be recorded once on the Child Protection statistics, regardless of the multiple forms of abuse or neglect experienced. This provides the opportunity for an often co-morbid (Ney, Fung & Wickett, 1994) emotionally abusive component of other forms of abuse to also be recognised and acknowledged.

However, even with these changes, it is likely that these figures are not true representations of the scale of the problem, as when conducting surveys of children, adolescents and parents, reports of maltreatment are often much higher than those reported by the child protection agencies (Gilbert *et al.*, 2008). Concerns regarding under-reporting will be discussed further in section 1.3.1.

The Brassard and Donovan (2006) framework, codes four subtypes of emotional abuse (spurning, terrorising, isolating, exploiting/corrupting), and was based on the original six APSAC categories (described previously in section 1.2.3). Trickett and colleagues (2009) coded a sample of maltreated youths for levels of EA and reported that, compared to the original classification system that had been employed, using the Brassard and Donovan (2006) coding framework resulted in an increase in the

prevalence of children recorded as being emotionally abused increased from 8.9 per cent of the sample to 48.4 per cent. This clearly demonstrates how important having clear definitions and categories are, in order to determine the frequency of maltreatment occurring. Without this information, emotionally maltreating experiences may continue to be overlooked, under estimated and under reported.

Baker and Maiorino (2010) reviewed North American studies of retrospective accounts of childhood EA and EN, using the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) in both clinical and community populations. A total of 69 studies were included; all used the 28 item version of the CTQ, which is the version recommended by the CTQ authors (as reported by Baker and Maiorino, 2010), as opposed to the longer and less well psychometrically evaluated 34, 53 or 70 item version. By reviewing only the 28 item version valid comparisons between papers were possible. However, a number of studies (e.g. Arata & Lindeman, 2007; Cuomo et al., 2008) which had used the longer versions of the CTQ were not included, potentially limiting the findings and conclusions gained from the review. The authors suggest that a way in which to overcome this obstacle, for future comparisons, is to ensure that all such research uses the 28 item version.

Using the figures gained within this review, Baker and Maiorino (2010) report that within community samples (including college undergraduates and individuals using a medical facility), they found that 15.4 per cent reported severe to extreme EA and 13.1 per cent reported severe to extreme EN. Within the clinical sample (including

individuals with eating disorders and self harmers) they found that 32.2 per cent reported severe to extreme EA and 19.1 per cent reported severe to extreme EN.

Although the clinical sample had significantly higher levels of both EA and EN than the community sample, both samples reported very high levels of severity; highlighting the need for recognition and research into this significant problem area. The authors suggest that the significantly higher levels of reported EN and EA within the clinical population may highlight a link between these forms of maltreatment and subsequent psychological distress.

In considering the methodology used in the Baker and Maiorino (2010) review, a number of limitations should be highlighted. Firstly, the papers included showed significant variation in their mean scores of levels of EA and EN, therefore making comparisons and overall judgements difficult. Secondly, all the papers reviewed were from North American populations, potentially rendering the findings non-representational for the UK population. Thirdly, only research that had presented means and/or proportions for the EA and EN scores were included. The authors report that many of the articles were excluded from their review as neither means nor proportions were reported, however the actual number of exclusions made was not stated within their review. Similarly, no information was provided as to the search engines used or the keywords included in their search. The lack of specific search information makes it not only difficult to replicate but also renders the reader unsure that a thorough and full review took place. It can therefore only be assumed that the

relatively large number of included studies (i.e. a total of 69) is representative, considering that the subject area is in its infancy.

The Baker and Maiorino (2010) review also highlighted that there were a range of cut-off scores/criteria used to categorise the severity and subsequent presence, or absence, of EA and EN. They noted that some researchers had utilised two categories, that is, none to minimal versus moderate to severe (e.g. Watson *et al.*, 2006), others have used a three category option, that is, low to moderate, moderate to severe and severe to extreme (e.g. McGaw *et al.*, 2007) and finally some authors reported the presence of EA or EN if *any* item of the relevant subscales were endorsed (e.g. Gerke *et al.*, 2006).

The creators of the CTQ (Bernstein & Fink, 1998) recommend using specific cut-off scores for four severity categories of EA and EN, namely ‘none to minimal’, ‘low to moderate’, ‘moderate to severe’ and ‘severe to extreme’ (see section 2.5.2 for full critique of the CTQ and its psychometric properties). This approach was also endorsed by Baker and Maiorino (2010) who reported that this approach would overcome the challenges associated with the variations in categorisation, such as difficulty with comparing and contrasting research data.

The recommended cut-off scores for these four categories have been validated using the Receiver Operating Characteristic (ROC) analysis (Hsiao *et al.*, 1989), when

applied to samples of adolescent psychiatric inpatients ($N = 398$) and a group of randomly selected female members of a health maintenance organisation ($N=147$, Bernstein & Fink, 1998). By using the ROC method of cut-off score development the sensitivity and specificity for each category is calculated, therefore reducing the misidentification of EA/EN (specificity) while increasing the chances of detecting EA/EN (sensitivity). The low to moderate category (which capture the lowest levels of maltreatment severity) have been shown to be the most sensitive and specific, misidentifying less than 20 per cent with 80 per cent specificity (Bernstein & Fink, 1998).

Variations of how the categories were used in order to determine the presence or absence of maltreatment were noted during the review of literature conducted for the present study. Table 1 outlines some examples of studies whereby a number of methods have been used in order to report the severity/prevalence of maltreatment using the CTQ.

Table 1. Studies using the CTQ and the methods by which maltreatment severity was categorised and subsequently reported.

<u>Author and Year</u>	<u>Sample</u>	<u>N</u>	<u>CTQ category(s) used to indicate presence of maltreatment</u>
Balsam <i>et al.</i> , 2010	Adult outpatient	669	Low/moderate or above
Grilo & Masheb, 2002	Adult outpatient	116	Low/moderate or above
Messman-Moore & Brown, 2004	Adult outpatient	925	Moderate to severe
Wolfe <i>et al.</i> , 2001	Adolescents	1419	Moderate to severe

As can be seen from the above table, there has been a range of methods employed when determining how CTQ severity categories are utilised in order to determine prevalence (i.e. the presence or absence of maltreatment). Although researchers have often chosen to use the cut off scores/categories as outlined by the CTQ's authors (Bernstein & Fink, 1998), the level at which it is concluded that maltreatment is considered present or absent is not consistent.

In the absence of clear established procedure for determining prevalence (as seen in Table 1), it was decided that for the current study the presence of EA and EN would be identified by scores that ranged from the 'low to moderate category' of severity and above. This approach was taken in order to maximise acceptable sensitivity and specificity (discussed above), as intended and recommended by the CTQ creators (Bernstein & Fink, 1998).

Sfoggia and colleagues (2008) administered the CTQ to a psychiatric inpatient population. The Portuguese version of the CTQ was used as the research took place in Brazil. Although there is some support for the validation of this translated version (Grassi-Oliveira, Stein & Pezzi, 2006), further psychometric testing is required to ensure its reliability. From a sample of 120, the highest scores reported were for the emotional abuse and emotional neglect categories, as opposed to the sexual abuse, physical abuse and physical neglect categories that the CTQ also measures. Caution may be required when interpreting these findings as the higher scores within the EA and EN categories may be due to cultural differences or translation difficulties,

resulting in skewed or unreliable results. The link between EN/EA and psychopathology will be discussed in detail in section 1.4 of the Introduction.

In summary, it is challenging to gain reliable prevalence information for EN and EA, given the changing definitions and criteria used; which has been shown to have a significant impact on recordings (Trickett *et al.*, 2009). However the data available suggest that emotional maltreatment is a relatively common experience, worthy of acknowledgment and further exploration. An added challenge to interpreting prevalence rates are the issues of under-reporting and minimising of these experiences, both of which will be considered in the following section.

1.3.1 Under reporting and minimising

Emotional abuse and neglect are considered to be significantly under-reported (Gilbert *et al.*, 2009). Glaser (2002) suggests that the under-reporting of emotional maltreatment may be in part due to the reluctance of professionals to label parents or caregivers as abusive when they are doing so without clear intent to harm the child. Often the primary caregivers can be demonstrating damaging parenting styles, potentially harming their child, but be unaware and unintentional in this harm (Hildyard & Wolfe, 2002).

Similarly, under reporting is also noted when seeking information from the young people themselves. For example, young people within the Child Protection Services

were asked to report on their experiences of maltreatment, with their reports being compared to how their social worker scored their experiences. The main disagreements tended to be due to the young person reporting less maltreatment than their social worker (Wekerle *et al.*, 2001), therefore indicating that the young person may be under-reporting or under-identifying with maltreatment experiences. The difference between these two ratings could be the result of over concern of the professionals for the young people in their care or, as suggested by the authors, as a defensive denial coping mechanism. It is worth considering that there is also potential for the professionals working within child protection services to under-report, due to concerns that they could cause more harm than good (Gilbert *et al.*, 2009). Therefore in Wekerle and colleagues (2001) research, both the social workers and young peoples' reports could be minimised.

Growing up in a maltreating environment may be accepted as 'normal' family life and the young person may not identify this as detrimental or indeed that they themselves have experienced maltreatment (Kruttschnitt & Dornfeld, 1992). Identification of maltreatment is often based on subjective opinion, particularly in the absence of clear definitions.

1.3.2 What is 'normal'?

A challenge to child protection agencies, and indeed the general public, is deciding when these acts of commission or omission become maltreatment and when actions or inaction are simply 'normal' family interactions (Cicchetti & Lynch, 1995). The

boundary between what is deemed acceptable or abusive, is often led by cultural and community norms (Barnett, Miller-Perrin & Perrin, 2005).

For example, Straus and Field (2003) conducted a randomised telephone survey across the USA seeking information regarding acts of psychological aggression; defined by the authors as “a communication intended to cause the child to experience psychological pain...communicative act may be active or passive or verbal or nonverbal” (pp.797). The authors view psychological aggression as a means of controlling or correcting a child’s behaviour, through shouting at the child, name calling, swearing and verbal threats. These actions could arguably begin to resemble emotionally abusive behaviours. The authors report that psychological aggression is present in nearly all American homes contacted, indicating that this is a ‘normal’ interaction style when attempting to discipline a child.

In summary, this example highlights the challenges that face child protection services when attempting to determine when to take action and when to judge a situation “good enough parenting” (Winnicott, 1960). In a society of increased accountability and litigation or public enquires, coupled with an increasingly limited resource, it is perhaps understandable why these more subjective forms of maltreatment (EN/EA) are neglected, in favour of the other more physical or better understood and recognised forms of abuse. In order to aid better recognition and subsequent action in order to protect children against emotional maltreatment, the

negative consequences of EA and EN must be highlighted. Accordingly, the current research into this area will now be reviewed.

1.4 Associated risks and negative consequences of emotional maltreatment

Childhood emotional maltreatment (EM) has been associated with a number of negative outcomes, such as post-traumatic stress disorder (PTSD) (Wekerle *et al.*, 2001); depression (Gibb *et al.*, 2007; Steinberg *et al.*, 2003); increased risk of adult rape (Messman-Moore & Brown, 2004); anxiety (Wright, Crawford & Del Castillo, 2009); increased risk for alcohol problems in adolescents (Moran, Vuchinich & Hall, 2004); increased risk of dating violence (Wolfe *et al.*, 2001); increased risk of suicide attempts (Mullen *et al.*, 1996; Sfoggia, Pacheco & Grassi-Oliveira, 2008); self harm (Polk & Liss, 2007); and eating psychopathology (Kong & Bernstein, 2009).

Emotional maltreatment has been considered to be potentially more detrimental than any other form of abuse. It has been shown to have a significant relationship with the development of depression, when other forms of abuse (sexual and physical) do not (Soffer, Gilboa-Schechtman & Shahar, 2008). Similarly, individuals reporting emotional abuse alone have been shown to experience similar levels of depression, symptomatic distress and borderline personality features as individuals reporting sexual abuse or multiple forms of abuse (Braver *et al.*, 1992). Therefore emotional

abuse is thought not only to be a form of abuse in its own right but also to be a core component of all other types of abuse (Hart, Brassard & Karlson, 1996; Iwaniec, Herbert & Sluckin, 2002; Ney, Fung & Wickett, 1994). EN has also been associated with increased clinginess, psychosomatic complaints, increased frequency of tantrums and low affect (Egeland, Sroufe & Erickson, 1983).

Although most research has examined EN and EA as the combined category of emotional maltreatment, some more recent researchers have begun to recognise the validity in examining these concepts separately. As discussed previously, EN and EA entail very different experiences. EN involves the omission of emotionally nurturing parenting; this experience would involve psychologically unavailable or unresponsive parenting. EA involves the commission of abusive behaviours that humiliate and reduce emotional development. These fundamentally different experiences would logically impact on a child's development in different ways. The following section explores these differences further.

1.5 Why separate out emotional abuse and emotional neglect?

The specific and differing impacts of EN and EA has been reported recently by Shaffer, Yates and Egeland (2009) who conducted a prospective and longitudinal study examining the impact of EN and EA, as rated by parental and teacher observation, on adolescent adaption outcomes. As most previous studies had relied on cross-sectional methods of data collection, this study was able to overcome the

restrictions of such designs, instead gaining information regarding their participants from early childhood, throughout middle childhood into adolescence. Therefore they could investigate the impact of emotional maltreatment within a developmental context. Another strength of this research was the use of multiple methods of information gathering, such as observational information and self-report, from both teachers and parents. These multiple methods may increase validity of the findings as they did not rely exclusively on for example, self-report measures, which can be susceptible to response biases (Widom, Raphael & DuMont, 2004).

Shaffer, Yates and Egeland (2009) reported that although both forms of maltreatment were associated with increased aggression and social withdrawal and subsequent lower ratings of socio-emotional competence (that is, self-esteem and peer competence) in early adolescence, only the effects of EA on lowered competence were mediated by social withdrawal. That is, the negative impact of EN on adolescent competence could not be explained via the development of social withdrawal and aggression in middle childhood. It would therefore seem that although the outcomes are the same, the processes by which an individual arrives at these outcomes are different, depending on whether their experiences were of EN or EA.

Interestingly the authors also reported that from a community sample of 196 high risk children (i.e. with young, unmarried mothers that had not completed high school) only eight (four per cent) reported both EA and EN. This suggests that it is

unwise to continue to combine these two concepts under the umbrella term emotional maltreatment, as they may not necessarily be experienced together.

Similarly, when investigating the unique and separate impact of EN and EA, Soffer and colleagues, (2008) reported that they pose differing risks to the individual. They examined the relationship between childhood maltreatment, including EA and EN, and depressive vulnerability and low levels of self-efficacy/resilience. The authors identified the need to address these two components of EM separately, as previous research (Gibb, Alloy & Abramson, 2003; Steinberg *et al.*, 2003) into the area of depression following EM, did not. Therefore they administered self report questionnaires to undergraduate students (age range = 17 to 33; mean = 24 years) that identified levels of child maltreatment, self efficacy, psychological distress and depressive risk factors (negative cognitive styles, such as self-criticism). Using the structural equation modelling (SEM; Hoyle & Smith, 1994) technique of analysis, it was possible to differentiate between the effects of maltreatment on the various vulnerability factors. They could therefore ascertain the associations between the various forms of maltreatment against either a general depressive vulnerability or specific depressive vulnerabilities (for example, self-criticism and sociotrophy, i.e. the need to please others and being overly concerned with what others think). Although there were no significant relationships found between the specific forms of depressive vulnerability, Soffer and colleagues (2008) did report that depressive vulnerability (in the more general sense) was significantly related to emotional abuse but not for emotional neglect. Conversely emotional neglect was significantly related to reduced self-efficacy/resilience, whereas emotional abuse was not. These

findings remained after controlling for the effects of psychological distress, suggesting that emotional abuse and emotional neglect represent different predictors of risk to the individual. The authors describe resilience as “the ability to quickly regain emotional equilibrium following life-unsettling events” (pp.158). This definition could be construed as resilience being a form of emotional regulation. This potential impact of EN and EA on emotional regulation will be explored further in section 1.4.

Wright and colleagues (2009) explored the impact of self reported levels of EA and EN within a college student sample with a mean age of 20. Based on the principles of attachment theory (Bowlby, 1982, 1988) and cognitive schema therapy (Young, Klosko & Weishaar, 2003) the authors hypothesised that EN and EA would have a negative impact on the security of their attachments, resulting in maladaptive models of self and subsequent long term outcomes of symptoms of anxiety, depression and dissociation. Both childhood EN and EA predicted symptoms of anxiety and depression, mediated by schemas of vulnerability to harm, shame and self sacrifice; however only EN was linked with later symptoms of dissociation. The authors suggested that dissociation may occur following EN as a method of coping with overwhelming feelings, indicating poor emotion regulation skills.

In summary, these few studies highlight the subtle but significant differences between the impact of EN and EA on an individual’s internal process. There appears to be some indication that emotion regulation factors may be involved in the negative

outcomes associated with EN and EA, i.e. dissociation and reduced resilience. There are also clear indicators of internalising difficulties following EN and EA, as seen in the schema research conducted. In order to conceptualise the internalising of these maltreatment experiences (which result in detrimental outcomes such as depression) the theoretical framework of Bowlby's (1969) attachment theory will aid the understanding of the importance of the caregiver relationship in child development.

1.6 Attachment Theory

Attachment Theory has been influential in the development of definitions of abuse and neglect and also in how our social services and policies have been shaped (Mennen & O'Keefe, 2005). The development of Attachment Theory resulted in the World Health Organisation (WHO) recognising the detrimental effects of parent-child separations, during, for example, hospital stays or while living in child care homes. It also highlighted the importance of the unique bond between mother (or other primary care-giver) and child required for optimum child development (Bowlby, 1951). This significant bond between child and care-giver is likely to be impacted on when the relation is abusive or neglectful.

1.6.1 Background

Dr John Bowlby (1969, 1973, 1979) is considered the father of Attachment Theory. This theory is concerned with the biological need to form an affection driven bond

between child and caregiver. Bowlby viewed this bond as being a vital component of human development. This was a departure from previous views, such as Freudian theory of development (Freud, 1957) that considered the quest for food to be the dominant driving force for child-parent interactions. However, during Bowlby's (1944) observations of children and their mothers he postulated that human children seek out an attachment figure (typically the mother), not only to receive food in order to survive, but also to satisfy their *psychological* needs, for example, their need for affection. Bowlby viewed the psychological need for affection and proximity to an attachment figure, as being as instinctual for survival, as needing and seeking out food.

Babies are born with innate biological mechanisms that aid their ability to engage an attachment figure and gain this closeness, which Bowlby described as attachment behaviours (Bowlby, 1979). Behaviours such as crying, smiling or vocalising alert the mother or care giver to the child presence, therefore promoting interaction and subsequent proximity.

“Attachment behaviour is conceived as any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser” Bowlby (1979, pp.129).

Babies, children and adults have a range of attachment behaviours available to them in order to seek out these interactions and proximity. The behaviours may be maladaptive but they are flexible, changing and evolving dependent on the needs of the current situation (Cassidy, 2008). For example, if the behaviour of crying is unsuccessful then the child may then try to crawl to the mother or throw something to get her attention; demonstrating the intricate way these attachment behaviours can be played out.

1.6.2 Internal Working Models

Attachment behaviours and interactions between mother and child were not fully explained by the relatively simplistic view that attachment is based solely on proximity seeking (Bowlby, 1958). A cognitive component was therefore required in addition to this previously exclusively behavioural theory, to aid explanation of the varying behaviours demonstrated during and after separations (Ainsworth *et al.*, 1978). This cognitive component was conceptualised as ‘internal working models’ (IWM) of the individual, their attachment figure and the world around them. Bowlby (1969) describes internal working models as a way for the brain “to transmit, store and manipulate information that helps in making predictions” (pp. 80).

An IWM is formed during very early relationships, depicting what the individual can expect, or not, from future relationships. Based on how emotionally available and nurturing the attachment figure is, the child develops a model of how valued or worthy they are as an individual (Bowlby, 1973). Therefore these first *interactions*

and emotional experiences with the attachment figure (Crittenden, 1992), go on to represent all future expectations of relationships. Although these models of interaction lead to particular behaviour patterns, such as emotional avoidance or isolation, these behaviour patterns can be played out without the conscious awareness of the individual (Crittenden, 1992). It was therefore hypothesised that if these early experiences are abusive and/or neglectful then subsequent working models of one's self will be negative and distorted (Bowlby, 1988). Within an abusive or neglectful context the child is unable to see themselves as separate and objective from their experiences (Main, 1991) rendering them developmentally unable to understand the abstract nature of inconsistencies when a carer is both nurturing and harmful (Woodcock, 2003).

Adolescence has been considered a particularly pivotal time in the development of IWMs as new relationship experiences are being integrated, therefore reforming and updating previous internal models (Simpson & Belsky, 2008). Bowlby (1988) wrote of how these internal models of the parent and of the self, are enduring and unconscious, leading the individual to respond and interact in the same manner that they experienced relationships as children, for better or worse.

The concept of internal working models (IWM's) has been developed further by Young, Klosko and Weishaar, (2003) in their Schema Therapy development. The authors define schemas as emotional and cognitive representation, based on childhood experiences, which provide the individual with beliefs about themselves

and their relationships with others. They argue that the development of maladaptive schemas, due to “toxic childhood experiences” (pp. 7) are the central cause of psychopathology, such as personality disorder and chronic depression.

In summary, humans have a biological need to seek proximity and affection from a primary care giver, often (but not exclusively) the mother. Babies are born with a range of attachment behaviours, such as crying for attention or smiling to engage, which aid their ability to gain proximity and interaction. These behaviours develop and change as they grow, flexing to fit the context as required, for example, as they grow they can crawl and pull to gain attention rather than simply crying. Through the interactions or attachment style with their primary care giver people develop IWMs of how they understand themselves and others. The type of relationships that people experience as children therefore plays a pivotal role in later relationships and healthy emotional development. To better understand the impact of these early interactions, Ainsworth’s work will be explored in the following section.

1.6.3 Classifications of Attachments

Although Bowlby developed the initial theoretical constructs of attachment, it was Ainsworth (1967) – one of Bowlby’s colleagues – who went on to develop the theory into a diagnostic and clinically applicable tool. She created ‘the strange situation’, which is used to determine the type of attachment (secure or insecure) formed between a child and their parent and subsequent IWMs developed from these relationships (Ainsworth *et al.*, 1978). This involves a structured observational

experiment by which year old children are subjected to two separations and reunions with their mother. Within this situation a stranger is either present or enters the room during separation.

Central to attachment theory is the concept of the 'secure base', a term initially introduced by Ainsworth. This concept relates to the security felt by the child to be able to venture from close proximity to the care giver, to explore and seek out new experiences which are vital for further developments (Bowlby, 1988). The ability to use the mother as a secure base provide insights into the types of working models children hold regarding their mother, such as whether they view their mother as being available or as being untrustworthy (Goldsmith & Alansky, 1987).

Not all children responded in the same way, and so Ainsworth went on to categorise three differing forms of attachment, secure, insecure-avoidant and insecure-ambivalent. A fourth category, the disorganised category, was later added by Main and Solomon (1986). Within a secure attachment the mother is responsive, attuned to their child's needs and wants, the child therefore goes on to internalise their experience with their mother as being helpful and available; therefore the child is easily comforted and confident in social interaction situations (Mennen & O'Keefe, 2005).

An insecure-avoidant attachment is often demonstrated when the mothers are described as 'rejecting', becoming easily angered by the child and unable to respond to their needs sensitively, being over involved with the child when unnecessary but unavailable when actually required (Ainsworth *et al.*, 1978). Youngblade and Belsky (1989) report that children who have been physically or emotionally abused are over represented in this category of attachment. If a parent is harmful and stressful to be around the child may therefore have adapted its behaviour in order to limit contact without completely breaking the attachment bond (Main, 1981).

Within the insecure-ambivalent category, the parent tends to be inconsistent in their response to the child, leaving the child uncertain of their parent's availability to meet their needs, creating internal models of rejection and need for emotional autonomy (Mennan & O'Keefe, 2005). Children who have been neglected by their parents have been shown to be overly represented in this category of attachment (Youngblade & Belsky, 1989); the behaviour of displaying clearly heightened distress may serve to gain attention and interaction with otherwise often unavailable parents (Cassidy & Berlin, 1994).

As mentioned previously, not all children could be assigned to one of the above three attachment categories, as they would exhibit a mixture of both anxious and ambivalent responses (Crittenden, 1985). Therefore the disorganised/disorientated category of attachment style was added by Main and Solomon (1986), who speculated that this form of attachment may be the result of parents who are

unpredictable in their availability and responses to their child. The unpredictable nature of these parents renders them both fear provoking and a source of comfort, resulting in these contradictory displays of attachment behaviours (Main and Hesse, 1990). Disorganised patterns of attachment therefore arise from fear of the parent, which could be caused by parental as threats, parental displays of fear, parental dissociation, the parent being overly timid in their response to the child, excessive caressing of the child or the parents having disorganised attachment behaviours themselves (Main & Hesse, 1992; 2006). Between 80 to 90 per cent of children who have been maltreated tend to be categorised as having a disorganised attachment style (Carlson *et al.*, 2006; Cicchetti, Rogosch & Toth, 2006).

1.6.4 Attachment and maltreatment

Attachment behaviours are so fundamental to our cognitive and emotional development that, against what may be considered logical, children who are abused and/or neglected still form attachments with their abusive parent/s (Bowlby, 1956). Children who have been brought up within an abusive context subsequently tend to form insecure attachments (Crittenden, 1985; Morton & Browne, 1998; Ward, Kessler & Altman, 1993), often viewing themselves as worthless and to blame for their abuse, resulting in the individual being vulnerable to further abuses and isolation (Woodward, 2003).

Rose and Abramson (1992) hypothesised that EM would be the most detrimental form of maltreatment in terms of the development of negative IWMs regarding one's

self and subsequent depressive outcomes, as the negative representations are being explicitly communicated to the child or young person (e.g. being told you are stupid or conversely not being worthy of response by being ignored). Alloy and colleagues (2003) reported that in sample of undergraduates only emotional maltreatment was associated with negative inferential styles, potentially as the result of negative IWMs.

As secure attachments are developed from responsive and available parenting, it is unlikely that a secure attachment can be fostered when the parent represents both the safety and the danger (Kobak & Madsen, 2008). Crittenden (1988) also noted that some children responded to their abusive or neglecting parents with extreme cooperation, making every possible attempt to accommodate their parent. Crittenden described this as ‘compulsive compliance’; a technique used by a maltreated child to avoid negative attention.

Emotional maltreatment may be so detrimental to the individual because the perpetrator is most often the child’s primary care giver and therefore their primary attachment figure. Trickett and colleagues (2009) reported that biological parents are the most frequent perpetrators of emotional abuse. Morton and Browne (1998) conducted a literature review on attachment and maltreatment, with a view to better understand how insecure attachment styles may result in an “intergenerational transmission” (pp.1093) of maltreatment from parent to child. They suggest that, due to their own difficulties and subsequent insecure attachments, and associated negative IWM’s, maltreating parents find it difficult to form secure relationships

with their own children, instead repeating the controlling or unavailable nature of their own early attachments. This has serious implications for the management and reduction of childhood maltreatment, in that, these patterns of behaviour may be long standing through a number of generations, and therefore these abusive or neglectful behaviours can become potentially viewed as 'normal' and typical. Families that have firm negative patterns of IWMs of what it is to be a parent and what to expect from relationships, will require a lot of support and re-evaluation to aid positive interactional change.

1.6.5 Attachment and emotional experience

Attachment and emotional response and experience are intertwined with each other. On discussing the types of attachment (Ainsworth *et al.*, 1978) or the attachment behaviours themselves (Bowlby, 1979), emotions clearly play a central role, for example the fear and anxiety following separation functioning to engage and gain proximity with the attachment figure. How the attachment figure responds to these exhibited emotions impacts directly on the security or insecurity of subsequent attachment and interaction models (Cassidy & Berlin, 1994). Bowlby viewed an important part of the role of the mother as regulating the child's emotions, demonstrating to the child that such strong feelings can be managed (Woodward, 2003). By fostering open communication and non-punishing responses towards emotions and their expression, the parent promotes the child's ability to self regulate his own emotions; this potential is therefore heightened within a secure as opposed to an insecure attachment pattern (Thompson & Meyer, 2007).

A child adapts to their attachment figure's emotional cues, learning whether to inhibit or show their emotional experiences, based on how the care giver responds to the child's emotional needs (Cassidy, 1994). For example, if a child is punished or rebuked for expressing their emotions then this may lead to them reducing external emotional responses.

In summary, attachment styles provide understanding to the types of internal working models that infants begin to develop. Maltreated children are at a much higher risk of developing an insecure attachment and subsequent negative internal working models regarding themselves and those around them. More specifically, emotional maltreatment has the potential to be particularly detrimental as this form of maltreatment is most often perpetrated by the primary care-givers (attachment figures), directly impacting on attachment development. Subsequent relationship difficulties are likely to result in abusive or neglectful parenting practices being continued through the generations from parent to child, representing a chronic and long-term problem. Furthermore, as attachment interactions are the initial introduction to emotional experience and subsequent emotion regulation development, it is vital to recognise that within a context of maltreatment, emotion regulation strategies are likely to be negatively affected by insecure and problematic early relationships.

1.7 Emotion Regulation

Emotional maltreatment has been seen to be detrimental to development, in terms of how an individual develops their relationships and internalises their experiences to form representations of themselves and the world around them, ultimately resulting in greater risks of psychopathology, such as depression, self-harm and anxiety. The role of emotional regulation (ER) will be explored further as a means to better understand the relationship which it may play in the development of these detrimental outcomes.

ER is thought to be a particular form of coping, specifically concerned with managing emotional experiences in order to meet emotional goals (Gross, 1999; Phillips & Power, 2007). It is concerned with the *flexible* reducing or increasing of the emotional experience, depending on the context and individual goals at the time (Gross & Thompson, 2007). For example, to avoid mania in bipolar disorder, increased suppression regulation of positive emotions may be most adaptive, whereas in another context, such as depression this would seem a maladaptive emotion regulation strategy (Rottenberg & Johnson, 2007). ER is not simply about suppressing unpleasant emotions, as it would be dysfunctional to never experience sadness or anger, as even these emotions can be helpful, for example, to respond assertively to an injustice or to grieve a loved one.

Gross and Thompson (2007) have outlined the core features of ER as situation selection, situation modification, attention focus, cognitive change and response modulation. The authors refer to situation selection as the ability to either avoid potentially emotionally upsetting situations or promote exposure to pleasing situations, such as seeking out support or avoiding a difficult colleague. Situation modification refers to the changes that can be made within a situation in order to manage the emotional repercussions, for example, if in a meeting with above mentioned difficult colleague the situation might be modified to avoid confrontation by bringing in cakes! Attention deployment refers to the possibility of regulating emotions without changing the situation but rather by attending to specific aspects of a given situation, for example, by distracting yourself from the difficult colleague's negative comments, and instead concentrating on the positive statements. Cognitive change refers to the appraisal of a situation in determining its relevance to the individual and subsequent emotional response to it. Finally, response modulation refers to the ability to manage the behavioural or physiological outcomes of emotions, such as trying to use relaxation techniques to reduced physical tension. However any of these components could be considered functional or dysfunctional depending on context, for example, constant avoidance of stress inducing situations would ultimately not be an adaptive long term strategy.

Thompson and Calkins (1996) suggest that it is unhelpful to view emotions as 'good' or 'bad' as this leads to confusion and misconceptions regarding what are adaptive responses or maladaptive, for example, although a child is screaming and distressed, experiencing 'bad' emotions, this situation will promote gaining care giver attention

and accomplishes the goals of the child (Gross & Thompson, 2007). In contrast, Phillips and Power (2007) believe that some ER strategies are inherently functional or dysfunctional, even when seemingly adaptive within, for example, an abusive situation. They argue that defensive emotional regulation strategies (such as dissociation) if used frequently are likely to have negative psychological consequences for the individual, therefore rendering them dysfunctional strategies. This viewpoint would also seem to be supported by the high correlation between psychopathology and emotion regulation difficulties, for example, over use of avoidance to manage fear in anxiety disorders (Werner & Gross, 2010).

In summary, optimum ER is the ability to flexibly manage or cope with emotional experiences. This can be done by using strategies such as, situation selection, situation modification, attention focus, cognitive change and response modulation. The context of the emotional situation will impact on strategies employed, however over an extended period of time strategies could be regarded as either functional or dysfunctional. Before considering the impact and development of functional and dysfunction ER, it is first important to consider what emotions are and why they might need regulating.

1.7.1 What are emotions?

It could be assumed that because we all regularly experience a range of emotions at any given time or situation we must therefore understand exactly what is meant by the term 'emotion'. In fact, defining what is meant by 'emotion' is a challenging

proposition, with both philosophers (e.g. Plato and Descartes) and scientists (e.g. Darwin) debating its function and origin (Power, 2010). Therefore an influential model of emotion and its production will be explored.

Emotions are a whole body experience, both physiologically and psychologically (Mauss *et al.*, 2005), which often result in a response or behaviour (Frijda, 1986). Gross and Thompson (2007) state that something needs to happen to provoke or trigger an emotion. This can be external, for example, watching a sad film, or internal, thinking about a potential disagreement. The trigger can be subtle or obvious. The situation (trigger) will be relevant to the individual in some way, for example, it impacts on the value system or personality; this relevance is what draws the individual's attention to the triggering situation. Once attention has been given to the situation, the individual appraises it, which results in an emotional response. The appraisal may vary depending on developmental stage of the individual's goals at that time; therefore this process is changeable and adaptive. Each person can potentially respond differently to the same situation depending on its personal relevance and their appraisal of it, based on individual values and goals. This sequence of events, which encapsulate the core features of emotion, is represented in Figure 1.

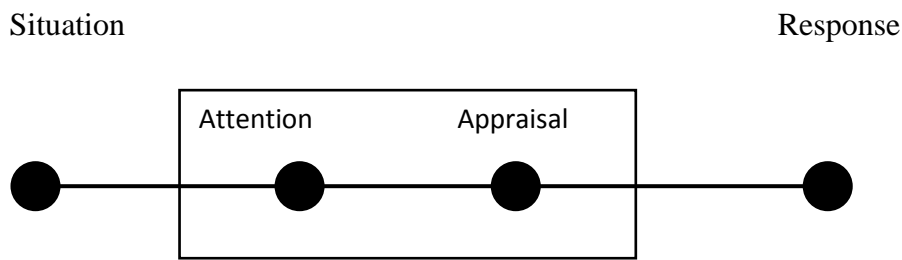


Figure 1. The modal model of emotion. From Gross & Thompson (2007, pp.5).

Having been introduced to the concept of emotion and its production, it follows to explore the types of emotions that may be experienced, within the above framework. Therefore both basic and complex emotions will be considered in the following section.

1.7.2 Basic Emotions

Basic emotions are considered to be a small set of biologically innate emotions, which can be identified across different cultures (Ekman, 1999; Ortony & Turner, 1990). Although most researchers agree there are such things as ‘basic’ emotions, there has been some debate within the literature as to which emotions are indeed basic. For example, Ekman (1982) initially suggested seven basic emotions before reducing this to six (Ekman, 1999) before finally deciding on five (Ekman, 2003); all were based on external expression of emotion via facial expression.

However, a general level of consensus has been agreed that the basic emotions are anger, fear, disgust, happiness and sadness, from which complex emotions are derived (Johnson-Laird & Oatley, 1989; Power & Dalgleish, 1997; 2008). The categorical structure of these five basic emotions has been empirically tested and validated using the Basic Emotions Scale (BES; Power, 2006).

Power and Dalgleish (2008) have postulated that complex emotions can be derived from basic emotions via the blending of two or more basic emotions. For example, the blending of disgust and anger will produce contempt. The authors also argue that the key factor in understanding why one basic emotion is triggered and not another is the way in which the individual appraises the situation. The appraisals that take place and initiation of subsequent responses may, in part be based on temperament and previous experiences of similar situations. Power and Dalgleish (2008) have postulated a list of core appraisals which lead to one of the five basic emotions, as seen in Table 2.

Table 2. Appraisals for five basic emotions (Power & Dalgleish, 2008; as cited in Power, 2010, pp.26).

<u>Basic Emotion</u>	<u>Appraisal</u>
Sadness	Loss or failure (actual or possible) of valued role or goal
Happiness	Successful move towards or completion of a valued role or goal
Anger	Blocking or frustration of a role or goal through perceived agent
Fear	Physical or social threat to self or valued role or goal
Disgust	A person, object or idea repulsive to the self, and to valued roles and goals

The appraisals of a situation therefore have a dramatic impact on subsequent emotional experiences.

In summary, basic emotions are innate and universal emotions which form the basis for all other more complex emotions. The basic emotions are generally agreed to be anger, fear, sadness, happiness and disgust. Depending on the way in which a situation is appraised, impacts on the subsequent emotion experienced. Therefore it would seem logical to assume that if, for example, someone appraises the world to be threatening and dangerous then they may be more likely to experience fear (Carthy *et al.*, 2010). These theoretical considerations will be explored further within the context of the emotional experiences of emotionally maltreated young people.

1.7.3 Basic emotions, ER and negative outcomes

The trauma of growing up in an emotionally maltreating family is likely to increase the experience of negative emotions as the individual is subjected to high levels of emotional stimulation (Polk & Liss, 2007). Negative emotions, such as anger and fear, are associated with higher levels of arousal than positive emotions, such as happiness (Bradley, 1990). The level of emotional intensity experienced by an individual, particularly intense levels of negative emotions, will have an impact on emotion regulation, as there will be increased need for effective regulation strategies (Eisenberg & Fabes, 1992; Suveg & Zeman, 2004). Emotional regulation can reduce the negative consequences of such heightened emotional experiences (Eisenberg *et al.*, 1996). However if emotion regulation skills are not well developed these intense negative emotions can lead to reduced social competence, as these children may display socially undesirable behaviours, such as aggression (Eisenberg *et al.*, 1993; Gottman, Katz & Hooven, 1997). Aggression has negative social repercussions for a young person as it is has been associated with peer rejection and increase risks of deviant social behaviours such as alcohol and drug use (Hawkins, Catalano & Miller, 1992).

Silk, Steinberg and Morris (2003) conducted research examining the relationship between ER and depressive symptoms and behavioural problems. The authors collected information on emotion intensity as well as regulation strategies. Information about the participant's thoughts and feelings were gathered intensively, they were asked to record these details every 90 to 150 minutes, prompted by a signal from a programmed wristwatch. This was done in order to reduce reliance on

retrospective recall of emotional experiences. The researchers reported that within a sample of adolescent school pupils, increased emotion intensity (sadness, anger and anxiety) were shown to be associated with increased depressive traits and behavioural problems. This increased intensity of emotions was considered to be a dysregulation of these emotions, resulting in externalising and internalising behaviours.

Other maladaptive coping strategies may also be employed, such as deliberate self-harm (DSH; Favazza, 1998) and dissociation (Wright *et al.*, 2009); both of which have been associated with the inability to regulate overwhelming emotional experiences (Wright *et al.*, 2009; Zlotnick, Mattia & Zimmerman, 2001). In a student sample, the increase use of alcohol has also been associated with regulating emotions following maltreatment (Goldstein, Flett & Wekerle, 2010). Therefore having well developed emotion regulation strategies is particularly important for maltreated young people, who are at increased risk of becoming overwhelmed by intense emotion provoking situations, such as being belittled or ignored.

It has been suggested that children who experience negative parental responses to their expression of emotions (such as being ridiculed or not having these emotions acknowledged) are likely to have a reduced ability to manage these emotions, as adaptive strategies are not taught by their parents (Gottman, Katz & Hooven, 1997). Polk and Liss (2007) have also suggested that children of emotionally neglectful parents do not learn how to express their emotions and that because emotional

management has not been modelled by their parents, these young people are at greater risk of DSH, as it is a means of regulating their emotional experience.

Eisenberg and colleagues, (1999) reported that punitive parental response to emotion was associated with reduced regulation and increased externalising behaviours. However when the parents minimised their reactions to emotional displays, children, particularly boys, seemed to internalise these experiences. Whereas children of parents who are responsive to their experiences of emotion tend to be more socially adept, appearing to regulate their emotional arousal (Gottman, Katz & Hooven 1997). Similarly, parental warmth towards a child, as measured by the Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979), has demonstrated predictive ability for emotion regulation development and subsequent appropriate behaviour development (Walton & Flouri, 2009). Children that have developed secure attachments, having been emotionally supported and who have observed functional methods of emotion regulation (such as seeking advice or support), internalise their beliefs that emotions can be experienced without losing control and that there are means in which to problem solve and reduce their distress (Shaver & Mikulincer, 2007).

By its very nature an emotionally maltreating family environment is unlikely to provide an emotionally responsive and positive model of emotion regulation strategies. It would therefore be expected that within this context young people may

experience heightened intensity of emotions and reduced access to functional and adaptive methods of emotion regulation.

Difficulties with regulation of emotion have been strongly associated with mental health difficulties, ranging from anxiety and mood disorders through to borderline personality disorders and PTSD (Cicchetti, Ackerman & Izard, 1995; Werner & Gross, 2010). Children with anxiety disorders have been found to experience difficulties regulating their worries, sadness and anger (Suveg & Zeman, 2004).

Maltreated children are particularly at risk of emotion regulation dysfunction as they have to manage high levels of emotional distress, due to their maltreatment, without the help and support of their caregiver who is often the source of their distress (Thompson & Goodman, 2010). One way of managing such an arousing environment is to become hyper-vigilant to potentially distressing situations. By being aware of facial expressions and body language the child is able to anticipate potential threatening situations, enabling them to remove themselves from the situation or prepare themselves for it (Thompson & Goodman, 2010).

Alink and colleagues (2009), examined a sample of 110 maltreated and 110 nonmaltreated children (Mean age nine years old) for emotion regulation dysfunction and attachment security with their mothers. They reported that risk of psychopathology is mediated by emotion dysregulation following maltreatment.

They found this relationship only when children had an insecure pattern of attachment; although not all maltreated children had insecure attachments or emotion dysfunction. Alink and colleagues therefore concluded that the more content the child is with their closeness to their mother the less emotional dysfunction they are likely to experience, i.e. closeness or attachment has a buffering effect. Alternatively as closeness to mother scores was based on children's self-report, the increased scores of closeness or 'relatedness' may be a form of defensive coping (Kelly & Kahn, 1994). As this study explored child maltreatment as a whole, the authors recommended that further such studies should be carried out in future with larger samples and by investigating this mediating relationship with the different maltreatment categories separated out.

In summary, these findings indicate that parental reactions and subsequent attachments play a significant role in the developing child's ability to regulate emotions and subsequent management of behavioural outcomes. Difficulties of ER are associated with negative outcomes, such as increased risk of depression and an increased risk of displaying socially undesirable behaviours (e.g. aggression). Maltreated children are at increased risk of experiencing emotions more intensely, which require more regulation to manage, however, as these young people are also at increased risk of developing dysfunctional ER strategies, they are substantially more at risk of negative outcomes than non-maltreated young people. The risk of negative outcomes may potentially impact on the quality of life of these young people.

1.8 Quality of Life

Quality of Life (QoL) is a complex construct which encapsulates a range of areas of well-being, such as materially, physically, socially and emotionally (Wallander *et al.*, 2001). There was initial debate as to whether children and young people would be able to adequately understand the abstract nature of these well-being concepts, in order to self-report on their QoL (Ravens-Sieberer *et al.*, 2005). However, research has now demonstrated that if children and young people are provided with age and developmentally appropriate QoL self-report measures then this information can be reliably measured (Riley, 2004). The development of child and adolescent self-report QoL questionnaires has increased as a result.

To this end, the KIDSCREEN Group Europe (2006) began a large scale, multi-cultural investigation to develop a reliable and valid child and adolescent QoL questionnaire which acknowledged developmentally specific factors that may impact on or reduce QoL. For example, by examining the young person's sense of autonomy (e.g. choosing how to spend their free time), concentration at school and how they are socially accepted by their peers. During the development and validation of this tool, the researchers noted that children and adolescents with mental health and behavioural problems, as scored on the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), had significantly reduced quality of life scores.

In summary, young people are able to contribute insight into aspects of their well-being and ultimately their QoL. Reduced QoL has been associated with mental health and behavioural problems.

1.9 Temperament

Temperament is explored in this section as it is a fundamental component of human development and individual differences (Harrington *et al.*, 1998). It is therefore likely to have an impact on the relationship between environmental pressures, such as EN and EA, and ER strategies.

1.9.1 What is temperament?

Temperament is a biological construct of individual differences in reactivity (e.g. attention, emotional intensity) and self-regulation (e.g. emotional reactivity and behaviour regulation) (Rothbart, Ellis & Posner, 2004). Although temperament is primarily biological it can be impacted on by environmental influences (Rothbart & Bates, 2006). Rothbart and colleagues, (2004) describe temperament as the “evolutionary core” (pp.358) of the more general concept of personality, which is based on consistent patterns of thoughts and behaviours. Southam-Gerow & Kendall (2002) further describe temperament as the basis and starting point, on which emotional development is subsequently built. Although temperament and ER are different constructs, temperament (individual differences) is likely to impact on the

development of emotion regulation (Rothbart & Sheese, 2007). Individual temperament styles are apparent from birth (Thomas & Chess, 1977) and develop through experience (Rothbart & Bates, 2006). Temperament will be further explored by outlining the components of Rothbart's model of temperament in the following section.

1.9.2 Model of Temperament

Rothbart and colleagues, (Capaldi & Rothbart, 1992; Ellis & Rothbart, 2001) developed a model of temperament, specifically focusing on adolescent self-regulation temperament dimensions. This model contains four components; surgency, negative affectivity, affiliativeness and effortful control.

Surgency encapsulates the temperamental disposition to seek out high intensity pleasurable experiences, not being held back by either shyness or fear. Negative affectivity relates to the frustration and anger experienced when a defined goal is unachieved or obstructed. This component represents the tendency to experience heightened distress when in stressful situations (Rothbart, Ahadi & Hershey, 1994). This tendency towards heightened distress has been linked with externalising and internalising difficulties (Eisenberg *et al.*, 1996). Affiliativeness relates to the wish to seek out closeness with others, gaining pleasure from low intensity activities or environments. Finally, effortful control is the ability to voluntarily shift attention, in order to regulate behavioural responses, by either inhibiting responses or activating them, even when there may be a tendency to want to avoid a particular action, for

example, giving up your seat for someone else. This ability to inhibit potentially socially inappropriate behavioural reactions, such as delaying gratification, is central to being socially accepted (Posner & Rothbart, 2000). Effortful control has also been associated with the development of strong empathic abilities, again, promoting social competency (Rothbart, Ahadi & Hershey, 1994). This link with increased empathy has been hypothesised to be the result of an ability to attend to others feelings and difficulties without becoming overwhelmed by them (Posner & Rothbart, 2000).

Temperamental disposition will therefore impact on intensity of emotions experienced, for example, an individual with high levels of negative affectivity will experience increased anger and frustration. These individual differences are likely to impact on the relationships between EN/EA and subsequent emotion regulation strategies. The manner by which a child and parent interact, may have a greater or lesser impact on the child's developmental outcomes, or adjustment, depending on the child's temperamental characteristics (Sanson & Rothbart, 1995). It could therefore be hypothesised that the impact of emotional maltreatment may be moderated by their temperamental disposition. Therefore, in line with previous research (Gallagher, 2002) temperament will be considered as a moderating factor.

1.9.3 Temperament's relationship with EA and EN

Harrington and colleagues (1998) reported that children who are perceived as having difficult temperaments by their mothers may be at greater risk of being emotionally neglected, as compared to if their mothers perceived them more positively. Using a

sample of low income families, the authors examined the levels of social supports available to the families and the mothers' views of their children. They reported that mothers with higher levels of support viewed their children as having easier temperaments than those mothers with less support; indicating that mothers who are very stressed and isolated have skewed perceptions, leading to EN (as coded using child protection information). Only neglect was examined in this research, therefore it is unclear if these children would also be at risk of abuse; however it does highlight how important subjective parental views are and the vulnerabilities of having limited supports. Similarly, when adolescents communicate increased negative emotions, their parents appear to also increase their levels of negative expressed emotion in response, perpetuating a negatively charged environment (Cook, Kenny & Goldstein, 1991).

In summary, temperament is a biological construct of reactivity and regulation that can be impacted on by environmental experiences, such as emotional maltreatment. Temperament appears to have an influence on how parents and children respond to one another, which may in turn impact on attachment development, or even promote maltreatment responses. Temperament could be considered a confounding variable in the relationship between emotional maltreatment, ER and negative consequences, such as depression.

1.10 Additional considerations – Age, gender and developmental stage

There is a growing body of research indicating that age and gender may also impact on ER. For example, Silk, Steinberg and Morris (2003) reported significant differences between the sexes in terms of ER strategies and also in levels of intensity of emotions experienced. They found that females reported significantly more anger, sadness and anxiety than males. The authors in this study used a different method of ER measurement that measured primary control (e.g. problem solving), secondary control (e.g. distraction), disengagement (e.g. avoidance) and involuntary engagement (e.g. rumination). They reported that females tended to use more primary control and involuntary engagement than males; no other ER differences were found. Gender differences were also noted by Shaffer and colleagues (2009) when investigating the impact of EA on social competence. They reported that within their adolescent sample only males used social withdrawal as a way of managing their social situations. Yates and Wekerle (2009) suggest that due to these emerging themes of gender-specific differences of outcome, gender should always be considered in child maltreatment research.

Murphy and colleagues (1999) conducted a longitudinal study of children from four to twelve years old, examining their experiences of emotion intensity and emotion regulation. The authors reported that within their sample of children and young people, emotion intensity reduced with age and emotion regulation strategies

increased. However caution should be used when interpreting these findings as all information was gathered using parental and teacher ratings, increasing the reliance on external manifestations of these concepts. Also as this study took place over a number of years the levels of attrition were reported as being “substantial”, which may have lead to biased sampling.

Wolfe and colleagues (2001) highlighted that although there is growing recognition that maltreatment results in poor outcomes, few studies have examined the effect of maltreatment on adolescent samples. They state that this may be a particularly relevant population to consider, as adolescence is a developmental stage of transition, where children become more autonomous from parents, through developing new relationships with peers. Negative or maltreating early experiences are likely to have an impact on later, adult relationship formation (Capaldi & Crosby, 1997). Adolescence also appears to be a developmental stage whereby emotions are experienced more strongly and more often than at any other stage of development (Larson & Lampman-Petratis, 1989). During this developmental stage, adolescents are more likely to attempt to regulate their own emotional experiences, as opposed to seek out attachment figures, such as their parents (Allen & Miga, 2010).

In summary, there appear to be significant implications to ER strategies depending on an individual’s age and gender. Also, adolescence is not only a developmental stage that has received limited research exploration of this kind, but it is also a particularly interesting and appropriate time to examine ER strategie

1.11 Rationale for current study

There are clear links between emotional maltreatment (EM) and subsequent negative outcomes for the individual. However, there have been a very limited number of studies that have explored emotional neglect (EN) and emotional abuse (EA) separately. This preference to amalgamate these two maltreatment experiences is likely the result of definition challenges and under-recognition of the unique differences between EN and EA. Of the studies which have explored these two maltreatment experiences separately, interesting results have been reported. Specifically, although both appear to result in increased risks for negative outcomes, the processes by which these consequences arise are not the same. Therefore EN and EA and their impacts will be explored separately, to identify further differences between these two experiences and how they impact on the individual.

Attachment theory describes how internal working models (IWM) of the self and others are developed through early relationships/interactions with primary caregivers. Insecure attachments are associated with negative IWMs, which are likely to render a child vulnerable to challenges with future relationships, increased risk of negative emotional experience and reduced ER abilities. As development of insecure attachments is more prevalent within maltreatment contexts, this study aims to explore the impact of emotional maltreatment on ER strategies. Also, as temperament is a biological construct of individual differences, which disposes the

individual to specific traits of reactivity or regulation, it is likely to play a role in the relationship between maltreatment experiences and subsequent ER strategies.

As previous research has demonstrated that EM has negative consequences, increased depressive mood and aggression are expected to be detected in this sample, but it is unclear if EN and EA will be related to different extents of these internalising and externalising outcomes. However, lowered quality of life has been previously associated with these psycho-social difficulties.

Therefore the following aims and hypotheses have been developed.

Aims

1. To report on the prevalence of EA and EN in an adolescent community sample, both in terms of the severity of EA and EN and in terms of how many individuals experience EA alone, EN alone, both EA and EN or reported no maltreatment.
2. To explore the extent of minimising among the individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment.
3. To explore the impact of age and gender on the experiences of emotion and emotion regulation strategies.

4. To explore the differences in the experience of emotions between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment.

Hypotheses

1. As EA and EN increase, the use of dysfunctional ER strategies will increase and the use of functional ER strategies will decrease. These associations will remain significant even when demographic variables and temperament are controlled for.
2. As EA and EN increase, the severity of depressive mood and aggression will also increase.
3. There will be differences between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment in terms of the extent of depressive mood and aggression.
4. As EA and EN increase, quality of life will decrease.
5. There will be differences between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment in terms of their quality of life.

Chapter 2: METHOD

2.1 Design

This was a cross-sectional study of community based adolescents (12 – 16 years old), in state and independent secondary schools, using standardised self-report questionnaire measures. Quantitative methods were used to conduct both between and within group analyses.

2.2 Participant recruitment

2.2.1 Participant criteria

The study included both male and female secondary school pupils, from independent and community high schools, aged 12 to 16 years old. Young people with learning difficulties or those in additional learning support units were excluded, as appropriate literacy skills and cognitive ability were required for consent and for subsequent completion of the questionnaires.

2.2.2 Recruitment of schools

Permission to approach state secondary schools was requested from, and granted by, a Scottish City Council, Child and Families Department (see Appendix 1). A letter

inviting schools to participate in the research (see Appendix 1) and a full questionnaire pack (containing all questionnaires, a consent form, a participant information sheet and a list of helpful contacts) were sent out to all secondary schools within the council area. This ensured that schools had access to all materials and could make an informed choice about whether or not to be involved in the project. As local authority permission was not required to approach independent schools, these were contacted directly.

Schools that had not responded after one month were sent a reminder letter about the research project (see Appendix 1). A total of 32 schools were approached with a total of five choosing to participate in the study. The sample included one community high school and four independent secondary schools (three of which were single sex schools and two offered boarding as well as day places). Those schools which provided feedback on why they chose not to participate cited limited time and already being involved with other research studies as reasons for not participating.

Permission had also been requested from another Scottish City Council to approach secondary schools in a second local authority area, however, this application had not been responded to within the time scale of the study and was subsequently unable to be pursued.

2.2.3 Procedure

The head teachers of schools that agreed to participate designated a teacher to liaise with the primary researcher, in order to lead the administration of the questionnaires within their school. The designated teachers were fully briefed, by the primary researcher, about what would be involved in participation, for example, the procedure of administration and how long completion would take. All queries and concerns were addressed at this planning stage, before the designated teacher cascaded this information to other appropriate teachers, that is, those who would be involved with questionnaire administration (for example, Personal and Social Education (PSE) teachers).

A minimum of one week before questionnaires were administered, pupils were provided with the study information sheet (see Appendix 1) by their teacher who was able to answer any further questions at this time. The same participant information sheets and parental-opt out forms (with covering letter) were sent out to parents at this time (see Appendix 1). This enabled potential participants and their parents/guardians to have sufficient time to provide informed consent or opt-out, as recommended by the British Educational Research Association (BERA; 2004) and Scottish Educational Research Association (SERA; 2005). Contact details of the primary researcher were on the information sheets and parents' covering letter, should young people or their parents have any further queries. One parent contacted the primary researcher for further information before agreeing to allow their child to participate.

2.3 Consent

2.3.1 Participant Consent

All participants were required to provide informed consent prior to participation (BERA, 2004; SERA, 2005). Pupils who decided to participate completed the consent form on the front of the questionnaire pack, before removing it and handing to their teacher (see Appendix 1). By removing this form, which had their name and signature on it, the questionnaires remained anonymous. An identifying number was printed on both the consent form and the questionnaire pack to ensure that all questionnaires could be matched to a consent form before data entry. Any questionnaires that did not have a corresponding consent form were excluded and destroyed confidentially.

Completed questionnaires were placed into a sealed box at school, which was provided by the primary researcher. Once all questionnaires were completed, participants were provided with a 'Helpful Information Sheet', which detailed websites and telephone numbers of various organisations which they could access should they wish to discuss their thoughts and feelings further (see Appendix 2). Pupils were also reminded, by their teachers, about other resources available to them within their school, such as on-site medical centres, guidance teachers and school support networks. A teacher was present whilst pupils completed their questionnaires to ensure confidentiality and to answer questions if required. There were no reports from schools of adverse reactions from pupils or parents.

All boxes with completed questionnaires and consent forms were held securely by each school until collected by the primary researcher.

2.3.2 Parental Consent

Parental consent for young people's participation was not required, as reported in the Age of Legal Capacity (Scotland) Act 1991, Chapter 50, Section 2 (4) "A person under the age of 16 years shall have legal capacity to consent on his own behalf...where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment". The Children (Scotland) Act (1995) also states that parental consent is only required for children under 16 years old when research involves a clinical trial of a medicinal product. All pupils approached were deemed by their school to have capacity to consent.

A parental consent opt-out procedure was however recommended to schools. This option allowed parents not to have their child included within the study. One independent school chose not to use the recommended parental opt-out system as their view was that the young people in their care were deemed the school's responsibility within term time and therefore the school had ultimate responsibility for consenting to participate. This was in line with how they managed all pupil activities.

2.4 Research Setting

2.4.1 School setting

Four schools used Personal and Social Education (PSE) classes to administer questionnaires, as recommended by the primary researcher. This class typically addresses personal and social issues, such as, sex, religion and mental health and seemed, therefore, the most appropriate setting within which to administer the questionnaires. One school administered their questionnaires to consenting boarding pupils within their evening timetable. Any pupils, who did not wish to participate, took part in another activity, such as reading or other school work.

2.4.2 Final Sample

144 pupils from the state school and 396 pupils from independent schools gave their consent to participate in the study. One opt-out form was received from a parent who did not wish their child to participate.

2.5 Measures

2.5.1 Demographic information (Appendix 2)

Participants were asked to indicate their gender and age.

2.5.2 Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998)

(Appendix 2)

The CTQ is a 28 item self report inventory that provides brief, reliable and valid screening for histories of abuse and neglect, that is, sexual abuse, physical abuse, physical neglect, emotional abuse and emotional neglect. The CTQ is suitable for use with participants aged from 12 years old to adulthood. Each form of maltreatment is detected using five items, with an additional three items which represent a minimisation/denial scale. Any score on the minimisation/denial scale may suggest possible under-reporting and therefore potential false negatives, indicating that caution should be used during interpretation of these questionnaires (Bernstein & Fink, 1998). Only the emotional abuse and emotional neglect domains were used within this study.

Negatively and positively framed items ask respondents to recollect how often certain childhood events occurred (e.g. “I thought that my parents wished I had never been born” and “My family was a source of strength and support”). The responses are given on a five-point Likert scale from 1 = ‘*never true*’ through to 5 = ‘*very often true*’, with scores ranging from 5 to 25 for each domain. The sum of scores for each area of maltreatment indicates the severity of childhood treatment, with higher scores representing increased severity. These continuous scores for each maltreatment type can also be used to create severity categories as cut-off scores are provided by the authors. Table 3 outlines cut-off scores for both emotional and emotional neglect domains (see section 1.3 for a discussion of the development of these cut-off scores).

Table 3. Cut off scores for the emotional abuse and emotional neglect domains on the CTQ (Bernstein & Fink, 1998)

	<u>Classification</u>			
<u>Scale</u>	None to minimal	Low to moderate	Moderate to severe	Severe to extreme
Emotional abuse	5-8	9-12	13-15	≥ 16
Emotional neglect	5-9	10-14	15-17	≥18

The CTQ has been widely used in research assessing childhood maltreatment in both community and clinical samples. It has consistently demonstrated strong psychometric properties (Baker & Maiorino, 2010), with median internal consistency reliability coefficients within the validation samples reported at .89 for emotional abuse and .89 for emotional neglect (Bernstein & Fink, 1998). Scher and colleagues, (2001) have also reported similar levels of internal consistency for emotional abuse (.83) and emotional neglect (.85) within a community sample of over 1500 young people. Test-retest reliability has been demonstrated over a four month period, that is, emotional abuse coefficients ranging from .83 to .94 and emotional neglect coefficients ranging from .81 to .93 (Bernstein & Fink, 1998). Confirmatory factor analyses have revealed a five factor solution representing the five forms of maltreatment (i.e. sexual abuse, physical abuse, emotional abuse and physical and

emotional neglect, Bernstein & Fink, 1998). Scher and colleagues (2001) also reported a five factor model within their community sample. The CTQ has also shown good convergent validity between therapists' ratings and CTQ scores (Bernstein et al., 2003; Bernstein & Fink, 1998).

The CTQ has been recommended as a valid and reliable measure of childhood emotional abuse and emotional neglect within research samples (e.g. Baker & Maiorino, 2010). It is worth noting that the majority of the psychometric testing has been conducted with adult populations, and the validation with an adolescent population was conducted within an inpatient context (Bernstein & Fink, 1998). As the present study uses a community sample, this should be considered when interpreting the scores and findings. See section 4.6.4 for further discussion of the limitations of the use of this measure within the present study.

2.5.3 Basic Emotions Scale (BES; Power, 2006) (Appendix 2)

The BES is a self report measure that contains 20 emotions which are rated on a 7-point Likert scale (1 = 'not at all' through to 7 = 'all the time'). Based on Johnson-Laird and Oakley's (1989) linguistic analyses of emotion, the 20 emotions in the BES can be considered to encompass the five basic emotions of anger (frustration, irritation, aggression, jealousy, resentment), sadness (despair, misery, defeated, gloominess, mournful), disgust (shame, guilt, repulsion, humiliated, blameworthy), fear (anxiety, nervousness, tense, worried, shy) and happiness (joy, elation, pride, loving, cheerful, Power, 2006). A total score for each of the five basic emotions can

therefore be calculated. The BES has been shown to have good internal consistency in a student community (ranging from .79 to .84 for the five subscales) and clinical sample (ranging from .84 to .94 for the five subscales) and has demonstrated discriminant group validity in a clinical sample of adults with anxiety and depression (Power & Tarsia, 2007).

2.5.4 Regulation of Emotions Questionnaire (REQ; Phillips & Power, 2007) (Appendix 2)

The REQ is a self-report measure, containing 21 statements representing emotional regulation strategies, which the responder rates the frequency which they feel that they use each strategy on a five-point Likert scale (1='never' through to 5='always'). The items represent four subscales of emotional regulation: internal dysfunction (e.g. "I dwell on my thoughts and feelings"); internal function (e.g. "I review (rethink) my thoughts or beliefs"); external dysfunction (e.g. "I take my feelings out on other people") and external function (e.g. "I talk to someone about how I feel"). These four categories were developed in order to capture not only the adaptive and maladaptive but also cognitive and behavioural aspects of emotional regulation, therefore encompassing a holistic view of a young person's experience. This questionnaire was specifically designed for use with adolescents, as previous emotion regulation assessments had been reliant on observational data, rather than self-report (Phillips & Power, 2007). Using a sample of 225 young people, Phillips and Power (2007) established good psychometric properties, including good internal consistency within subscales (ranging from .46 to .88) and construct validity –

demonstrating how the REQ findings correlate strongly with other established behavioural and emotional scales, for example, the Strength and Difficulties Questionnaire (SDQ; Goodman, 1997).

2.5.5 The Early Adolescent Temperament Questionnaire – Revised – Short Form (EATQ-R-SF; Ellis & Rothbart, 2001) (Appendix 2)

This scale is the revised and shortened version of the Early Adolescent Temperament Questionnaire (EATQ), developed by Capaldi and Rothbart (1992). It contains 65 items which are designed to assess ten components of temperament, with an additional two psychosocial behavioural scales (i.e. aggression and depressive mood). Following exploratory factor analysis of the ten temperament components, four factors were revealed. These are Effortful Control, Surgency, Affiliation and Negative Affectivity. The EATQ-R-SF has demonstrated good internal reliability, with alpha levels ranging from .65 to .82. Full details of the subscales have been summarised in Appendix 2.

2.5.6 The KIDSCREEN-10 Index; Health Related Quality of Life Questionnaires for Children and Adolescents (KIDSCREEN Group (Europe), 2006) (Appendix 2)

This self report measure, consisting of 11 items, can be administered to healthy or chronically ill children and adolescents from 8 to 18 years old, taking only five minutes to complete. The authors highlight that the Index version, which represents

an overall global score for quality of life, is most appropriate for large surveys, as it is short, easily understood and provided a global score of health related quality of life. Respondents are required to mark on a five point Likert scale (1 = 'not at all' through to 5 = "extremely") how much they agree with each statement, over the last week. Total scores therefore range from 11 to 55, with higher total scores indicating a better quality of life. Statements capture information about a young person's moods, relationships, feelings and perceived cognitive abilities.

The KIDSCREEN-10 has demonstrated good internal consistency and reliability with good-to-excellent Cronbach's Alphas of 0.82, when administered to a sample of 20,823 children and adolescents. Test-retest reliability coefficient, following a two week time scale, was reported as 0.55, which was slightly below the adequate coefficient for test-retest stability (0.6). The KIDSCREEN-10 has also been reported as showing good discriminatory power, across different countries and for a multicultural sample. KIDSCREEN-10 scores demonstrated strong correlations with psychosomatic complaints (-0.52). Large effect sizes were reported between the KIDSCREEN-10 and the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) in relation mental health and behavioural problems (0.67). Similarly, large effect sizes (1.04) were also found in relation to levels of social support, as measured by the Social Support Scale (Brevik & Dalgard, 1996), indicating excellent construct validity.

Convergent validity was also demonstrated as significant correlations were found between the KIDSCREEN-10 and three other validated and similar questionnaires, such as, the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), (KIDSCREEN Group Europe, 2006).

2.6 After-care

2.6.1 Helpful Information (Appendix 2)

Participants were provided with a list of telephone numbers and websites of various organisations which they could contact, should they wish to discuss their feelings or thoughts following participation in the study. This safeguarding method of providing information to participants has been successfully employed by other researchers investigating maltreatment experienced by young people (Wekerle *et al.*, 2001). Participants were also reminded by their teachers, of their school's resources which were also available to them, should they require further support. This included, for example, school guidance teachers or their affiliated medical centres.

2.7 Ethical approval and considerations

Ethical approval was received from the University of Edinburgh Clinical Psychology Research and Ethics Committee and from the University of Edinburgh School of Health and Social Science Research Ethics Committee (REC). Advice was also

sought from the South East Scotland Research Ethics Service (NHS Lothian) as to whether NHS approval was also required. However it was recommended that this approval was not required as the participants were from a non-clinical population (see Appendix 3).

A number of ethical issues were considered during the design and implementation of this study.

2.7.1 Participation

In line with the Scottish Education Research Association's (SERA; 2005) ethical guidelines, it was made explicit that young people could withdraw from the study at any time, without reason and without rebuke. Also, in accordance with these guidelines, participant information sheets were provided to both parents and young people in advance, to ensure that potential participants had sufficient time to discuss and understand the study's aims and procedure. This enabled participants to make an informed decision as to whether they participated or not. Informed consent was sought from all participants, with an additional parental opt-out procedure recommended. Dissemination of results was offered to both the individual participants and the participating schools.

2.7.2 Confidentiality

All questionnaires were anonymous and treated as strictly confidential, in accordance with NHS Code of Confidentiality and University ethical guidelines. Questionnaires and consent forms were held in separate secure locations to avoid participant identification. Raw data will be kept until completion of this project, after which time it will be destroyed.

2.7.3 Participant Distress

In the unlikely event that participation in this study caused any distress to participants, all were provided with information on where they could access emotional supports, both formally and informally.

2.8 Power calculation and sample size

In order to avoid making a Type II error, that is, rejecting an insignificant finding by mistake as the sample size was too small in order to detect a significant finding, a power calculation was conducted prior to recruitment, in order to calculate the sample size required for this investigation.

G*Power 3 was used for this purpose (Faul *et al.*, 2007). To test my hypotheses both correlations and hierarchical regressions were to be used. Therefore an EN/EA

sample of 134 was calculated as being acceptable for parametric correlations to obtain power of .8, with a medium effect size of .3 and an alpha of .05. For the regression, the power calculation indicated that a sample of 160 would be required in order to obtain power of .8, with a medium effect size of .15 and an alpha of .05. This calculation was based on entering eight variables (i.e. two demographic variables, four temperament variables and the EA and EN variables) into the regression analysis.

Similar research indicated that in order to recruit the suggested sample size of 172 participants, who reported EN or EA, a much larger recruitment sample would be required. Previous research such as, Wekerle *et al.*, (2009) reported that in a random sample of 402 young people from a non-clinical sample, (mean age 23 years) 6 per cent of females and 56 per cent of males experienced emotional abuse and 30 per cent of females and 31 per cent of males experienced emotional neglect. Also, Courtney *et al.*, (2008) reported that from the 92 adolescents sampled in their study, (mean age 17 years) just under a third (28 per cent) experienced emotional abuse. As approximately one third of these sample populations reported EN or EA, it was therefore considered appropriate that when recruiting for this research at least three times the recommended sample size for power, would be required. A recruitment target of 480 was therefore set.

2.9 Data preparation

2.9.1 Missing Data

Determining the extent and pattern of missing data is of interest as these factors may affect outcomes and interpretations of data (Fox-Wasylyshyn & El-Masri, 2005). Following Missing Values Analysis (SPSS 17 Inc.), the most missing data for any one variable was 26.6 per cent for emotional abuse. This percentage of missing data was over double that of the next highest missing percentage, that is, 13.8 per cent missing for the aggression category of the EATQ-R-SF.

To investigate whether or not the data were missing at random the Little's Missing Completely at Random (MCAR) test was carried out. Results were insignificant ($\chi^2 = 2455.04$, $df = 2356$, $p = 0.76$), indicating that data were missing at random. Missing variable data were therefore replaced with individual means (per subscale), which is potentially more robust than using group mean scores as it takes account of individual differences. This method was employed, as opposed to case deletion as this is widely criticised as it leads to reduction in sample size and subsequent power, while also potentially producing bias (Tabachnick & Fidell, 2001). Where there was insufficient data in a participant's response to calculate a supplementary individual mean, the participant was excluded from the analysis (for that measure only). See Table A, Appendix 4 for full details.

2.9.2 Statistical analysis

Descriptive statistics, independent samples *t*-tests, Pearson's correlations, one-way ANOVAs and hierarchical regressions were all undertaken using SPSS version 17.0.

Chapter 3: RESULTS

In this section data screening will initially be discussed before presenting the demographic information. The analysis of the study's aims and hypotheses will then be presented in sequence.

3.1 Data screening

As the data sample is very large, many of the assumptions of parametric statistical tests may appear to be broken (Clark-Carter, 2004). For example, the Kolmogorov-Smirnov test is commonly used to determine if a distribution is normal. However, when a sample is very large this test can often produce significant results (indicating a non-normal distribution) from very small deviations; therefore rendering it redundant in large samples (Field, 2009). Field (2009) also reports this problem with tests of skew, kurtosis and homogeneity of variance. On examination of the data, significant results of these tests were often reported, indicating violations of parametric assumptions. However, parametric tests are considered to be robust enough to remain accurate even when assumptions have been unmet, particularly when analysing a large sample, i.e. ≥ 40 (Clark-Carter, 2004).

As the usual tests of assumptions are inappropriate, both parametric and non-parametric tests were used, to check if differences between them are shown. When no differences were noted, the parametric tests are reported, whereas if differences were revealed, then non-parametric results are reported.

Because of the number of correlations and t-tests conducted, a more stringent p value of $p < 0.01$ was adopted to protect against the possibility of Type I errors. As there were a limited number of one-way ANOVAs conducted, it was unnecessary to use a more stringent p value; therefore the usual p value of $p < 0.05$ was used.

All measures were shown to have good internal reliability with this community sample, see Table B in Appendix 4 for further details.

3.2 Description of full sample

A total of 540 participants were included, with seven being excluded as no consent forms could be found for these participants questionnaires. For information, the demographic information for the full sample is presented below (Table 4).

Table 4. Full sample demographic information

			<i>N</i>
Sex (%)	Male	33	179
	Female	67	360
	TOTAL	100	539 ¹
Age (Years)	Mean (SD)	14 (1.24)	540
	Range	12 – 16	540
Pupil Type (%)	Boarder	28	153
	Day Pupil	72	387
	TOTAL	100	540
School Type (%)	Private	73	396
	State	27	144
	TOTAL	100	540

3.3 EA and EN prevalence

Aim 1: To report on the prevalence of EA and EN in an adolescent community sample, both in terms of the severity of EA and EN and in terms of how many individuals experience EA alone, EN alone, both EA and EN or reported no maltreatment.

¹ One person did not specify gender.

3.3.1 Severity

Using Bernstein and Fink's (1998) criteria for severity cut-offs, the prevalence's of EA and EN, as measured by the CTQ, for the community sample of young people (12-16 years old) have been reported below.

Table 5. Prevalence and severity of reported emotional abuse (EA) and emotional neglect (EN), as measured by the CTQ.

Categories of Severity	EA N (%)	EN N (%)
None to minimal	365 (67)	300 (55)
Low to moderate	107 (20)	160 (30)
Moderate to Severe	37 (7)	46 (9)
Severe to Extreme	31 (6)	34 (6)
TOTAL	540 (100)	540 (100)
<i>Overall prevalence (Low to Severe)</i>	<i>175 (33)</i>	<i>240 (45)</i>

Overall, 33 per cent ($N = 175$) of this community based sample reported *some* degree of EA, and 45 per cent ($N = 240$) reported *some* degree of EN.

50% of the total sample scored on at least one of the three minimisation scales, indicating that these figures may be conservative estimates due to a strong level of minimisation.

3.3.2 Emotional maltreatment grouping

In order to also capture the prevalence of emotional maltreatment (reported scores of both EA *and* EN), participants information was further analysed and placed into four groups.

From the total sample, four groups were formed based on self-report scores of either emotional abuse or emotional neglect, or a combination of both. That is, all participants who reported low to severe levels of emotional abuse *only* were placed in the ‘emotional abuse’ group; all those participants reporting low to severe emotional neglect *only* were placed in the ‘emotional neglect’ group. Any participants reporting both low to severe levels of emotional abuse *and* emotional neglect were placed within the ‘emotional maltreatment’ group. All participants that reported none to minimal levels of EN and EA were placed in the ‘no maltreatment’ group.

The number and percentage of participants who were placed into these four groups is provided in Table 6.

Table 6. The number of individuals in each maltreatment group (N = 539)

	Emotional Abuse	Emotional Neglect	Emotional Maltreatment	No Maltreatment
N (%)	53 (9.8)	118 (21.9)	122 (22.6)	246 (45.7)

3.4 Minimisation

Aim 2: To explore the extent of minimising among the individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment.

Table 7. Extent of minimising in the four maltreatment groups (N = 540)

	Emotional Abuse	Emotional Neglect	Emotional Maltreatment	No Maltreatment
Mean (SD)	11.25 (3.2)	9.22 (3.0)	7.23 (3.0)	12.63 (2.3)

To ascertain whether the groups displayed significantly different degrees of minimising, a one-way ANOVA was conducted.

Significant differences were revealed between the groups in terms of the extent of minimising scores ($F(3, 536) = 119.11; p < .001$). Post hoc (Tukey HSD) revealed that *all* groups significantly differed to each other in respect to their minimising scores ($p < .001$). As can be seen by the mean scores, the no maltreatment group were the largest minimisers, followed by the EA group, the EN group and then the EM group.

3.5 Age and Gender

Aim 3: To explore the impact of age and gender on the experiences of emotion and emotion regulation (ER) strategies.

3.5.1 Gender

In order to explore the impact of gender on subsequent experiences of emotions and ER strategies *t*-tests were conducted.

As can be seen from Table 8 below, there are significant gender differences between levels of reported experiences of emotion and ER strategy use. Females reported significantly more happiness and fear than their male counterparts. Females also reported significantly more use of the internal-dysfunction and external-function strategies, whereas males used more external-dysfunctional strategies.

In summary, females reported higher levels of both positive and negative emotions than males. Males used more externalising and dysfunctional means of regulating their emotions, whereas females tended to rely on external strategies when using functional approaches. Females were more likely to be internally dysfunctional, in terms of their ER strategies.

Table 8. Means and standard deviations and comparisons of variables by gender

Measure		Male		Female		t-test	Sig.
		Mean (SD)	Range	Mean (SD)	Range		
BES	Anger	15.72 (4.4)	5-26	15.02 (4.7)	4-28	-1.662	.097
	Sadness	9.86 (4.1)	4-21	10.72 (4.7)	4-28	2.092	.037
	Happiness	20.3 (4.9)	4-28	21.95 (3.9)	6-28	3.887	< .001
	Fear	13.13 (4.7)	4-27	15.27 (5.2)	4-28	4.656	< .001
	Disgust	12.9 (4.5)	5-29	13.95 (5.3)	5-32	2.404	.017
ERQ	Internal-function	13.97 (3.9)	5-23	13.78 (3.4)	5-24	-0.569	.57
	Internal-dysfunction	11.23 (3.7)	5-21	12.26 (4.0)	5-24	2.844	.005
	External-function	16.96 (4.8)	7-28	18.22 (4.5)	7-28	2.965	.003
	External-dysfunction	9.58 (3.6)	5-25	8.17 (2.9)	5-25	-4.803	<.001

3.5.2 Age

Using Pearson's correlations, significant positive correlations were found between age and levels of reported fear and anger. From examination of the means it can be seen that anger and fear increase with age, although it is worth noting that correlations were of small magnitude. See table 9 for details. In terms of ER strategies, only internal-function was significantly associated with age. See table 9 for details.

Table 9. Means, standard deviations and correlations of variables by age for the BES.

Measure and subscales	Age					<i>r</i>	Sig.	
	12	13	14	15	16			
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)			
BES	Anger	13.77 (4.4)	14(4.5)	15.33 (4.8)	15.9 (4.7)	16.23 (4.3)	0.163	<.001
	Sadness	9.55 (4.3)	10.10 (4.5)	10.67 (4.5)	10.63 (4.6)	11.03 (4.3)	0.092	.033
	Happiness	21.81 (4.3)	21.31 (4.8)	21.24 (4.2)	21.13 (4.1)	21.96 (4.0)	0.001	.98
	Fear	13.38 (5.2)	13.27 (4.9)	15.04 (5.4)	15.31 (4.7)	15.63 (4.7)	0.171	<.001
	Disgust	12.65 (4.5)	13.10 (4.8)	14.07 (5.2)	14.04 (5.1)	13.69 (5.1)	0.079	.06

Table 10. Means, standard deviations and correlations of variables by age for ERQ.

Measure and subscales	Age					<i>r</i>	Sig.	
	12	13	14	15	16			
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)			
ERQ	Internal-function	12.87 (3.0)	13.04 (3.5)	14.01 (3.7)	14.32 (3.5)	14.92 (3.4)	0.192	<.001
	Internal-dysfunction	11.07 (3.6)	11.66 (4.1)	11.76 (4.2)	12.66 (3.7)	12.08 (3.7)	0.103	.017
	External-function	17.54 (4.5)	17.86 (4.6)	17.56 (4.6)	17.79 (5.0)	18.41 (4.3)	0.038	.37
	External-dysfunction	7.75 (2.3)	8.85 (3.5)	8.59 (2.9)	9.06 (3.3)	8.45 (2.8)	0.060	.16

3.6 Emotions and maltreatment groups

Aim 4: To explore the differences in the experience of emotions between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment.

One-way ANOVAs with additional Tukey HSD post hoc tests were conducted in order to explore the differences between the four maltreatment groups and experience of emotions. Means and standard deviations can be found in Table C in Appendix 4.

3.6.1 Fear

A significant main effect of maltreatment group on the fear subscale was revealed ($F(3, 535) = 6.07; p < .001$). Post hoc tests found that fear is significantly elevated in the EA group ($p = .024$) and EM group ($p = .004$) groups as compared to the no-maltreatment group. There was no significant differences between the EN group and the no-maltreatment group ($p = 1.0$). The EM and EA groups were not significantly different in terms of levels of fear reported ($p = .98$). EM was significantly different from EN ($p = .022$), whereas the levels of reported fear were not significantly different between the EA and EN groups ($p = .051$).

3.6.2 Anger

A significant main effect of maltreatment group on the anger subscale was revealed ($F(3, 535) = 15.33; p < .001$). Post hoc tests found that anger is significantly elevated in the EA ($p < .001$) and EM ($p < .001$) groups as compared to the no-maltreatment group. The EM and EA groups were not significantly different in

terms of the reported levels of anger ($p = 1.0$). However EM and EA were both significantly different than the EN group ($p < .001$; $p = .004$, respectively). There was also no significant difference between the EN group and the no-maltreatment group ($p = .88$).

3.6.3 Disgust

A significant main effect of maltreatment group on the disgust subscale was revealed ($F(3, 535) = 19.44$; $p < .001$). Post hoc tests found that reported disgust is significantly elevated in the EA ($p < .001$) and EM ($p < .001$) groups as compared to the no-maltreatment group. The EM and EA groups were not significantly different in terms of the reported levels of disgust ($p = .58$). However EM and EA were both significantly different than the EN group ($p < .001$; $p = 0.26$, respectively). There was also no significant difference between the EN group and the no-maltreatment group ($p = .74$).

3.6.4 Happiness

A significant main effect of maltreatment group on the happiness subscale was revealed ($F(3, 535) = 16.44$; $p < .001$). Post hoc tests revealed that EA and the no-maltreatment group were not significantly different ($p = .82$), whereas EN and EM groups reported significantly lower happiness scores than the no-maltreatment group ($p < .001$; $p < .001$). EN and EM groups did not significantly differ in the rated scores of happiness ($p = .54$). EN and EA groups were not significantly different (p

= .076). However, the EM group was significantly different from the EA group ($p = .003$).

3.6.5 Sadness

A significant main effect of maltreatment group on the sadness subscale was revealed ($F(3, 535) = 20.10; p < .001$). Post hoc tests revealed that reported sadness is significantly elevated in the EA ($p < .001$) and EM ($p < .001$) groups as compared to the no-maltreatment group. The EM and EA groups were not significantly different in terms of the reported levels of sadness ($p = .74$). However EM and EA were both significantly different than the EN group ($p = .00; p = .017$, respectively). There was also no significant difference between the EN group and the no-maltreatment group ($p = .67$).

3.6.6 Summary

In the Anger, Sadness, Disgust and Fear subscales the EA and EM groups reported significantly higher levels of these negative basic emotions, as compared to the EN and no-maltreatment groups. There were no significant differences highlighted between the EA and EM groups, indicating that experiences of these emotions were comparable between these groups. For the four negative basic emotions the EN and no-maltreatment groups were not significantly different, indicating that their levels of experience of these emotions were of comparable levels.

In the Happiness subscale a different pattern was revealed. The EN and EM groups report significantly reduced experiences of this emotion compared to the EA and no-maltreatment groups. EN and EM had similar/comparable levels of reduced happiness and EA and no-maltreatment had similar levels of increased happiness.

Finally, experiences of Disgust, Anger and Sadness within the EA and EM groups were significantly increased compared with EN; whereas with the Fear and Happiness subscales, the EA and EN groups experiences were at similar levels.

3.7 Emotion regulation

Hypothesis 1: As EA and EN increase, the use of dysfunctional ER strategies will increase and the use of functional ER strategies will decrease. These associations will remain significant even when demographic variables and temperament are controlled for.

3.7.1 Correlations

Using Pearson's correlation, EA was significantly positively correlated with internal-dysfunction ($r = .389, p < .001$) and external dysfunction ($r = .284, p < .001$). No significant correlations were found between EA and internal-function ($r = -.076, p = .08$) or external-function. ($r = -.087, p = .043$).

EN was significantly positively correlated with internal-dysfunction ($r = .2, p < .001$) and external dysfunction ($r = .169, p < .001$). EN was significantly negatively correlated with internal-function ($r = -.313, p < .001$) or external-function. ($r = -.353, p < .001$).

In summary, EN is associated with reduced functional and increased dysfunction ER strategies, whereas EA is only associated with increased use of dysfunctional strategies.

3.7.2 Hierarchical Regressions

In order to determine if the above associations would remain after controlling for age, gender and temperament, four hierarchical regressions were conducted with each of the four ER strategies as the dependent variable. Before conducting a regression a number of considerations must be explored.

Examination of histograms for each variable for the four regressions revealed normal distributions. Scatter-plots of standardised residuals against predicted scores (for each regression conducted) showed no obvious pattern (such as a crescent or funnel-shaped cloud of points), and so it was concluded that the assumptions of linearity and homogeneity of variance were met. Also, following examination of each regression correlation matrix, none of the predictor variables (i.e. demographic information, temperament subscales, EN or EA) were highly correlated; they were all

substantially less than .8; therefore there were no concerns regarding multicollinearity (Field, 2009). See Appendix 5 for details.

The demographic variables (age and gender) were entered (forced entry) into block 1, the temperament variables (surgency, affiliativeness, effortful control and negative affectivity) were entered (forced entry) into block 2 and EA and EN entered into block 3 (stepwise entry). Because there was insufficient literature to justify a preferential order of entry of EA and EN in block 3, a stepwise method of entry was used for this block.

3.7.3 Internal-dysfunction

All variables accounted for a total of 28.3% of the variance in internal-dysfunction emotion regulation strategy. Age and gender predicted 3.1% of the variance, temperament predicted a further 15.3%, and EA predicted a further 9.9%. EN did not load into the regression as it was not a predictive variable. See Table 10 for details.

EN and EA had both positively correlated with the internal-dysfunctional strategy, however further analysis has revealed that when demographics and temperament are controlled EN is no longer associated with this ER strategy.

Table 11: Hierarchical regression analysis for internal-dysfunction.

	R²	R² Adjusted	B	SE B	Beta
Block 1.					
Gender			-.355	.329	-.042
Age	.31	.027	.308	.121	.097*
Block 2.					
Negative affect.			.100	.036	.116**
Surgency			-.104	.024	-.164***
Affiliativeness			.123	.025	.201***
Effort Control	.184	.174	-.085	.025	-.134***
Block 3.					
EA	.283	.274	.366	.043	.327***

* $p < .05$, ** $p < .01$, *** $p < .001$.

3.7.4 Internal-function

All variables accounted for a total of 26.5% of the variance in internal-function emotion regulation strategy. Age and gender predicted 3.5% of the variance, temperament predicted a further 19.8%, and EN predicted a further 3.2%. EA did not load into the regression as it was not a predictive variable. See Table 11 for details.

EA had not been correlated with internal-function ER strategies, therefore (as expected) it did not load into this regression. Lower reports of EN remained associated with internal-functional strategies even after controlling for temperament and demographics.

Table 12: Hierarchical regression analysis for internal-function.

	R²	R² Adjusted	B	SE B	Beta
Block 1.					
Gender			.477	.302	.063
Age	.035	.031	.438	.110	.154***
Block 2.					
Negative affect.			.034	.033	.044
Surgency			.050	.022	.087*
Affiliativeness			.185	.024	.334***
Effort Control	.233	.224	.069	.023	.121**
Block 3.					
EN	.265	.255	-.155	.033	-.192***

* p < .05, ** p < .01, *** p < .001.

3.7.5 External-dysfunction

All variables accounted for a total of 26.1% of the variance in external-dysfunction emotion regulation strategy. Age and gender predicted 4.7% of the variance, temperament predicted a further 16.4%, and EA predicted a further 5%. EN did not load into the regression as it was not a predictive variable. See Table 12 for details.

EN and EA had both positively correlated with the external-dysfunctional strategy, however further analysis has revealed that when demographics and temperament are controlled EN is no longer associated with this ER strategy.

Table 13: Hierarchical regression analysis for external-dysfunction.

	R²	R² Adjusted	B	SE B	Beta
Block 1.					
Gender			1.509	.265	.227***
Age	.047	.043	.009	.097	.004
Block 2.					
Negative affect.			.184	.029	.209***
Surgency			-.019	.019	-.038
Affiliativeness			-.065	.020	-.134**
Effort Control	.211	.202	-.079	.020	-.158***
Block 3.					
EA	.261	.251	.205	.035	.231***

* $p < .05$, ** $p < .01$, *** $p < .001$.

3.7.6 External-function

All variables accounted for a total of 23.2% of the variance in external-function emotion regulation strategy. Age and gender predicted 1.9% of the variance, temperament predicted a further 13.4%, and EN predicted a further 7.9%. EA did not load into the regression as it was not a predictive variable. See Table 13 for details.

EA had not been correlated with external-function ER strategies, therefore (as expected) it did not load into this regression. Lower reports of EN remained associated with external-functional strategies even after controlling for temperament and demographics.

Table 14: Hierarchical regression analysis for external-function.

	R²	R² Adjusted	B	SE B	Beta
Block 1.					
Gender			-.1.117	.403	-.113**
Age	.019	.015	.051	.148	.014
Block 2.					
Negative affect.			.079	.044	.077
Surgency			.126	.030	.169***
Affiliativeness			.150	.032	.208***
Effort Control	.153	.143	-.075	.031	-.100*
Block 3.					
EN	.232	.222	-.320	.044	-.303***

* $p < .05$, ** $p < .01$, *** $p < .001$.

3.7.7 Summary

The above regressions revealed that EA was significantly predictive of both internal- and external-dysfunctional ER strategies, after controlling for demographic variables and temperament variables. EN had initially been correlated with all four ER strategies, however following regression analysis it was revealed that lower scores of reported EN were only predictive of internal- and external- functional ER strategies.

3.8 Depressive mood and aggression

3.8.1 EA and EN

Hypothesis 2: As EA and EN increase, the severity of depressive mood and aggression will also increase.

Using Pearson's correlation EN was positively correlated with aggression ($r = .317$, $p < 0.001$) and depressive mood² ($r = .370$, $p < 0.001$). EA was also positively correlated with aggression² ($r = .231$, $p < 0.001$) and depressive mood ($r = .262$, $p < 0.001$). These correlations indicate that EA and EN are associated with increased risk of both externalising and internalising difficulties.

3.8.2 Maltreatment groups

Hypothesis 3: There will be differences between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment in terms of the extent of depressive mood and aggression.

To ascertain whether the groups displayed significantly different levels of depressive mood and aggression, two one-way ANOVAs were conducted, with additional post hoc Tukey HSD tests. Means and standard deviations can be found in Table D in Appendix 4.

3.8.3 Depressive mood

Significant differences were revealed between the groups in terms of levels of reported depressive mood ($F(3, 535) = 16.77$; $p < .001$). Post hoc tests revealed that EA, EN and EM all reported significantly higher levels of depressive mood than the

² Depressive mood and aggression are the two additional psycho-social behavioural subscales from the EATQ-R-SF

non-maltreated group ($p = 0.001$, $p = .23$, $p < .001$, respectively). EN and EA did not significantly differ ($p = .38$), however EN did differ from EM ($p < .001$). No differences were noted between EA and EM ($p = .19$).

3.8.4 Aggression

Significant differences were shown between the levels of reported aggression between the groups ($F(3, 535) = 23.66$; $p < .001$).

Post hoc tests revealed that EA ($p = .003$) and EM ($p = <.001$) groups reported increased aggression than the no-maltreatment group. EA and EM were not significantly different in this regard ($p = .48$). EN was not significantly different from the non-maltreatment group ($p = .084$). EA and EN were not significantly different ($p = .396$), although EN did differ from EM ($p < .001$).

3.8.5 Summary

Analysis revealed that the EN, EA and EM groups all reported higher levels of depressive mood, compared to the no-maltreatment group. There were no differences found between the EN and EA groups or the EM and EA groups. The EN group was significantly different from the EM group.

In terms of aggression, the EM and EA groups reported significantly higher levels of aggression than the no-maltreatment group. The EN and no-maltreatment groups were not significantly different, nor were the EA and EM groups.

3.9 Quality of life

3.9.1 EA and EN

Hypothesis 4: As EA and EN increase, quality of life will decrease.

Quality of life was negatively correlated with EN ($r = -.415, p < .001$) and EA ($r = -.398, p < .001$), indicating that individuals who report being emotionally abused or emotionally neglected have a reduced quality of life.

3.9.2 Maltreatment groups

Table 15. Means and standard deviations for quality of life

	Emotional Abuse	Emotional Neglect	Emotional Maltreatment	No Maltreatment
Mean (SD)	38.38 (7.7)	38.15 (6.1)	33.91 (7.3)	41.88 (6.2)

To ascertain whether the groups displayed significantly different quality of life scores, a one-way ANOVA was conducted.

Significant differences were revealed between the groups ($F(3, 526) = 40.22; p < .001$). Post hoc (Tukey HSD) tests revealed that the EA, EN and EM groups all reported significantly lower quality of life scores as compared to the no-maltreatment group ($p = .004, p < .001, p < .001$, respectively). The EN and EA groups reported comparable levels of quality of life ($p = .99$), whereas the EM group reported significantly more than both the EN and EA groups (both $p < .001$).

3.10 Results summary

To summarise, prevalence rates of EN, EA and EM in a community school based sample have been presented, along with information on the extent of potential minimising of these maltreatment experiences. Gender and age were shown to impact on the experience of emotions and ER strategies used. With further exploration, EA, EN and EM were all found to also impact on experiences of the basic emotions. When considering the impact of EN and EA on ER strategies, it was discovered that they have different predictive power depending on the type of strategy used, and most associations remained after demographics and temperament were controlled for. That is, lower EN scores held predictive power for the utilisation of internal- and external-functional strategies; whereas increased EA scores were predictive of external- and internal dysfunction. In terms of outcomes, EA, EN and EM all were shown to increase risk to depressive mood, whereas only EA and EM result in increased aggression, as compared to the no-maltreatment group. Finally, EA, EN and EM all were associated with a reduced quality of life, as compared to the no maltreatment group.

Chapter 4. DISCUSSION

4.1 Research overview

The main aim of this exploratory study was to separate emotional maltreatment (EM) into its component parts, namely emotional abuse (EA) and emotional neglect (EN), in order to gather information on prevalence within an adolescent community sample. Also, by separating the sample into groups indicating emotional neglect only, emotional abuse only and EM (reports of both EA and EN) this offers the opportunity to determine the specific impacts of these maltreatment experiences on emotion regulation strategies, quality of life and externalising and internalising behavioural outcomes. In this chapter the specific aims and hypotheses of this study will be examined in sequence, with reference to findings from previous literature and consideration given to the possible clinical implications of the findings. Methodological limitations and strengths will be discussed before finally exploring areas in which similar research could be developed in the future.

4.2 Summary of Findings - Aims

4.2.1 EA and EN prevalence

Aim 1: To report on the prevalence of EA and EN in an adolescent community sample, both in terms of the severity of EA and EN and in terms of how many individuals experience EA alone, EN alone, both EA and EN or reported no maltreatment.

In this study, the overall prevalence of EA was 33 per cent and 45 per cent for EN. Although most cases were categorised as being in the ‘low to moderate’ category, these are clearly significant levels, especially when taking into consideration that 50 per cent of the overall sample had some degree of minimising (as indicated by any score on the minimisation/denial scale on CTQ, e.g. “I had a perfect childhood”).

The overall scores of EA and EN were unable to differentiate between whether an individual reported both, neither or just EA or EN. Therefore to better understand the potential differences between EN and EA the sample were placed into four groups indicating EN only, EA only, both EA and EN (called the ‘emotional maltreatment’ (EM) group), and no reported EA or EN (called the ‘no maltreatment’ group). Just under half of the sample reported no maltreatment (45.7 per cent), with 22.6 per cent reporting both EN and EA, 21.9 per cent reporting EN only and 9.8 per cent reporting EA only.

Within this sample, of those that reported maltreatment, most reported experiencing both EN and EA (22.6 per cent). This is unlike the findings reported by Shaffer, Yates and Egeland (2009) who reported only four per cent of adolescents reporting both EA and EN. The differences in findings may have been the result of methodological influences. In the present study the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) was used (a validated and reliable self-report measure), whereas Shaffer, and colleagues (2009) relied on observational data to ascertain if a young person was being emotionally neglected. As described in

detail in the introduction section, EN is particularly difficult to quantify, potentially rendering observational information less robust than exploring the internal processes (thoughts and feelings) regarding a young person's experiences directly from the individual.

A more methodologically similar study investigating rates of EA and EN a school sample of American adolescents, reported (also using the CTQ) the prevalence of EA to be 15 per cent and EN to be 11 per cent ($n = 1419$), (Wolfe *et al.*, 2001). These prevalence rates are considerably lower than the present studies although the differences in prevalence could have been the result of, for example, cultural factors, the impact of age as the American sample was older (mean age 16 years, whereas this study's mean age was 14 years) or methodological factors, such as monetary incentives being provided to the American sample.

In summary, the prevalence of EA and EN, and the combination of the two (EM), are at unexpectedly high proportions. The large prevalence of EN is particularly surprising as in previous studies EN has been reported to be less prevalent than EA (see review of studies by Baker & Maiorino, 2010), whereas the opposite was demonstrated in this study. It is unclear why this might be the case, however it does highlight the importance of assessing for both of these different forms of maltreatment as not only are they both highly prevalent but the different patterns of prevalence indicate that they are not always experienced together.

4.2.2 Minimisation

Aim 2: To explore the extent of minimising among the individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment.

The 'no maltreatment' group were found to be the greatest minimisers, closely followed by the EA group, then the EN group and finally the EM group were the smallest minimisers. Interesting, the order of these groups (most minimising to least minimising) is the same order they would be placed if placed in order of least reported maltreated to most reported maltreatment. Therefore it could be suggested that minimising may be being used as a denial coping strategy, used in an attempt to gain more control over their situation and to protect themselves from further psychological distress (Vondra, Bennett & Cicchetti, 1989; Wekerle *et al.*, 2001).

4.2.3 Age and Gender

Aim 3: To explore the impact of age and gender on the experiences of emotion and emotion regulation strategies.

Gender

Females were found to report higher levels of both positive and negative basic emotions than males. Specifically, females reported more fear and happiness. Also, although not statistically significant, increased disgust was also reported by females

than males. Experiences of anger and sadness were comparable between the two sexes. Similar gender differences were reported by Wolfe and colleagues (2001) who found that maltreated females tended to report more emotional distress than the maltreated males in their sample. Also, Silk, Steinberg and Morris (2003) noted that females reported significantly more anger, sadness and anxiety than males. This may demonstrate that females are more able to express a wider range of emotions or have improved emotion recognition skills. Alternatively, males have been previously reported to use more suppression of their emotions as a means of regulation (Gross & John, 2007).

Males were found to use significantly more external-dysfunctional means of regulating their emotions; whereas when females used dysfunctional ER strategies they were internalised. These results seem indicative of gender stereotyping whereby males are more likely to externalise their emotions whereas females will internalise, prompted by social expectation of gender roles (Eagly, 1987). Males have often been associated with increased anti-social behaviours as compared to females (e.g. Moffitt *et al.*, 2001). However, Perry, DiLillo and Peugh (2007) have suggested that males may attract different levels of emotional maltreatment than females, therefore accounting for the differing outcomes.

Age

In this sample, reported levels of anger and fear increased with increasing age. No previous studies have reported on age differences in relation to changes in the

experience of emotion. The increase of fear and anger may indicate that as a young person becomes more emotionally independent, building closer relationships with peers outside of their family, they may become more aware of the differences between their own family's interactions (maltreatment interactions) and the way in which their friends family's interact (Savin-Williams & Berndt, 1990). These comparisons could reduce the ability to use denial coping strategies, increasing their feeling of fear at their current situation and anger possibly directed both at themselves for not being worthy and at their parents for maltreating them. Further research into this area is required.

In terms of ER, only internal-functional ER strategies were associated with increased age; as the age increased the use of internal-functional strategies also increased. Murphy and colleagues, (1999) also reported that ER abilities increased with age. The increased use of internal-functional strategies may indicate that there is a developmental element in mastering emotion management (Wolfe *et al.*, 2001).

In summary, both gender and age had an impact on the experiences of emotions and ER strategies. Females reported increased experiences of both positive and negative emotions, as compared to males. Although it is unclear why this is, it is suggested that males may be less emotionally expressive and/or rely on suppression or denial for managing their emotions. Further research is required in order to explore these differences further. As found in previous research, functional ER abilities increase with age, demonstrating the developmental element of emotional coping.

4.2.4 Emotions and maltreatment groups

Aim 4: To explore the differences in the experience of emotions between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment.

The EA only and EM groups reported higher levels of anger, sadness, disgust and fear, as compared to the EN only and ‘no maltreatment’ groups. The increase in negative basic emotions within a maltreating context is supported by previous findings (Polk & Liss, 2007). Increased negative emotions heighten emotional arousal thereby potentially placing ER strategies under greater pressure in order to avoid the individual becoming overwhelmed by these emotions (Eisenberg & Fabes, 1992; Suveg & Zeman, 2004).

Interestingly, EN does not show this pattern of increased negative emotion; instead EN is associated with reduced experiences of happiness. Therefore EN and EA are impacting on experiences of emotions in different ways. As there are no other studies available that have examined these differences, it can be tentatively suggested that EN reduces a potential resilience and protective factor, i.e. the ability to experience happiness. The EM group also reported reduced experience of happiness.

In summary, the accumulative impact of EA and EN (i.e. EM) results in the most potentially detrimental emotional profiles, that is, increased negative emotions and decreased happiness. EA and EN have differential impacts on the experience of

emotions, which may in turn influence the way in which emotions are regulated, as it would seem that the EA group would require increased regulation, whereas the EN group would potentially require less regulation as they do not reported increased negative emotional experiences (anger, fear, disgust and sadness).

4.3 Summary of Findings - Hypotheses

4.3.1. Emotion Regulation

Hypothesis 1. As EA and EN increase, the use of dysfunctional ER strategies will increase and the use of functional ER strategies will decrease. These associations will remain significant even when demographic variables and temperament are controlled for.

This hypothesis was partially supported. Increased EA scores were found to be predictive of both internal- and external-dysfunctional ER strategies, whereas lower EN scores were predictive of internal- and external-functional ER strategies, after controlling for temperament (effortful control, surgency, affiliativeness and negative affectivity) and demographic variables (age and gender); therefore EA and EN contribute differential outcomes on ER strategies.

Experiencing EA appears to result in increased ER dysfunction, which in the longer term is likely to result in difficulties in relationships (Capaldi & Crosby, 1997) and as

described later, reduce quality of life and increase the risk of internalising and externalising problems. However, although these strategies are not optimal they are arguably adaptive within a context of abuse or neglect (Schatz *et al.*, 2008) for example, a child may display limited negative emotions (suppressing and internalising) so to limit the negative attention this may attract (Gross & Thompson, 2007).

In contrast, experiences of EN seem to reduce the ability to use functional ER strategies. If a child has been ignored or emotionally abandoned, as with EN, it is unlikely that they will have had adequate opportunity to develop appropriate skills in identifying, expressing and managing emotions (Gibb, 2002). The inability to develop these skills may be reflected in the reduction of functional ER strategies following EN.

Also, it is important to note that temperament variables were also predictive of ER strategies. This is not surprising as temperament is related to individual differences of reactivity and regulation (Rothbart, Ellis & Posner, 2004). Although temperament was a moderating factor, which was subsequently controlled for, EA and EN remained predictive of ER indicating the additional role of *experience* on self-regulation (Rothbart & Bates, 2006).

4.3.2 Depressive mood and aggression

Hypothesis 2. As EA and EN increase, the severity of depressive mood and aggression will also increase.

Hypothesis 3. There will be differences between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment in terms of the extent of depressive mood and aggression.

Support was found for hypothesis 2 as correlations revealed that increased EA and EN scores were associated with increased depressive mood and increased aggression. However these relationships were further analysed following being grouped (that is, once participants were grouped into EN only, EA only, EM (both EA and EN), and ‘no maltreatment’), in order to determine more specifically which relationships were most significant.

Support was also found for hypothesis 3, as differences were revealed between the groups in terms of aggression and depressive mood. Aggression and depressive mood will be discussed in turn.

Aggression

Aggression was only associated with EM and EA only, but *not* EN only, which in contrast to Shaffer and colleagues (2009) findings who reported that EA and EN

were both associated with increased aggression. Aggression may be related only to EA as this form of maltreatment is characterised by being verbally assaulted and threatened, therefore this form of ER is clearly being modelled by their attachment figures. These interactions may result in internal working models (IWMs) that assume that aggressive interactions are both an effective method of communication but also achieve attention and meet emotional goals (O'Hagan, 1995). Aggression may also be the behavioural manifestation of overwhelming and therefore uncontrolled negative emotions (Messman-Moore & Coates, 2008), which is quite possible given that the EA group reported significantly more negative emotions than the EN group.

This difference between EA and EN groups may also be due to the EN group being more likely to withdraw from people based on IWMs of others being represented as rejecting and cruel (Crittenden, 1992). Rather than having aggressive and threatening methods of interaction and regulation being modelled by care givers, passive and absent methods are being modelled. Crittenden (1992) states that this avoidance of human contact in order to limit emotional distress, based upon rejection, is the most concerning adaption as this strategy (or as they author states "lack of strategy", *p.* 340) removes the possibility of re-adjusting their IWMs through the development of non-maltreating relationships.

Depressive Mood

EA only, EN only and EM (both EA and EN) all increased the risk of experiencing depressive mood difficulties as compared to the 'no maltreatment' group. Although no statistical differences were revealed between the three maltreatment groups, the EM group reported the highest levels of depressive mood, followed by EA and finally EN. This suggests that multiple forms of maltreatment increase this risk (Messman-Moore & Brown, 2004).

A number of previous studies have also reported childhood emotional maltreatment increases the risk of depression as parental experiences of abuse and neglect are internalised as negative IWMs about one's self, which in turn reduces self-confidence, social competency leading to increased vulnerability to depression (e.g. Courtney, Kushwaha & Johnson, 2008; Gibb *et al.*, 2007; Rose and Abramson, 1992; Soffer, Gilboa-Schechtman & Shahar, 2008).

These findings may be due to the development of negative IWMs about the self and others (e.g. self as hopeless, unlovable, unworthy and others as threatening or unpredictable) as a result of negative (maltreating) interactions with primary care givers (Bowlby, 1969; Crittenden, 1992; Rose & Abramson, 1992). Rose and Abramson's (1992) proposed a model of cognitive vulnerability to depression following maltreatment as negative IWM result in the individual making negative inferences about themselves and others, therefore reducing self-confidence and reducing social competence. A number of studies have supported this model of

depressive vulnerability following maltreatment (e.g. Gibb *et al.*, 2003; Gibb *et al.*, 2007).

4.3.3 Quality of Life

Hypothesis 4. As EA and EN increase, quality of life will decrease.

Hypothesis 5. There will be differences between individuals who experience EA alone, EN alone, both EA and EN or reported no maltreatment in terms of their quality of life.

EA and EN were both associated with reduced quality of life. Further analysis revealed that the EA only, EN only and EM groups all reported significantly lowered quality of life scores than the 'no maltreatment' group, indicating that either or both (EA/EN) will result in reduced well-being. It is worth noting however that those individuals that reported both forms of maltreatment (EA and EN) experienced the most reduced quality of life. This is suggestive of accumulation effects of experiencing multiple forms of maltreatment. Given that both emotional maltreatment experiences result in a range of detrimental effects, such as on emotion regulation abilities and internalising and externalising behaviours, it is unsurprising that subsequent quality of life is reduced. Although different outcomes were associated with EA and EN (e.g. different impacts on ER abilities and aggression), one outcome was the same, that is, reduced well-being.

4.4 Summary of main findings

This study hoped to address the growing need to separate emotional maltreatment into its component parts of emotional abuse and emotional neglect. The rationale for doing this was based on a very small number of previous studies that had recognised the fundamental differences between these two maltreatment experiences, and had reported unique variance between EA and EN (Shaffer, Yates and Egeland, 2009; Soffer *et al.*, 2008; Wright *et al.*, 2009). Based on the principles of attachment theory, negative interactions, particularly with primary care givers, are detrimental to development of emotional expression and understanding, therefore the impact of EA and EN on emotion regulation (ER) was investigated.

EA and EN have demonstrated both similarities and differences in terms of outcomes and internal processes. EA and EN have both been shown to reduce a young person's quality of life and have both been associated with increased risk of depressive mood. However, significant differences were also noted. Namely, EA resulted in an increase in experience of negative basic emotions, potentially placing the emotion regulatory systems under increased pressure; whereas EN did not result in this increase but was instead associated with reduced experiences of happiness. Increased EA was also predictive of using internal- and external-dysfunctional ER strategies; whereas EN was predictive of reduced ability to use either internal- or external-functional ER strategies.

Although minimisation scores were noted in 50 per cent of the overall sample, indicating possible denial coping, this form of coping cannot be maintained in response to chronic and repeated emotional maltreatment experiences (Rose & Abramson, 1992). Indeed, experiences of EA increase the risks of dysfunctional ER strategies; these findings suggest that although dysfunctional in the longer term, responses are potentially adaptive within a maltreating context. For example, these young people may have learned to cope by bullying others or hurting themselves which aids the management of their emotions in the short-term. What is arguably of greater concern is the finding that the EN only group do not appear to have even dysfunctional means by which to manage their emotions. The EN group have no increase in dysfunctional strategies, but rather become less skilled in functional strategies as EN increases. This is likely to render these individuals very vulnerable and reliant on others to regulate their emotions. As demonstrated in a study of adult outpatients receiving psychotherapy, patients who reported childhood EN required significantly longer treatment than patients who did not report childhood EN (Perry, Bond & Roy, 2007). The researchers report that these patients observe themselves as requiring more therapy, which within the context of this study's findings (that EN reduces the ability to employ functional ER strategies) these patients' IWMs are of themselves as being weak and incapable, therefore requiring more external support. The detrimental effect of EN experiences on reducing the ability to regulate emotional experiences is also demonstrated by previous research that has found associations between EN and dissociation, which were not found for EA (Wright *et al.*, 2009).

The impact of experiencing both EN and EA (i.e. the EM group) appears to have an accumulative detrimental effect on the individuals' risk of depressive mood, aggression and reduced quality of life. Experiencing both EA and EN may be the most detrimental as the care giver is both threatening and unavailable, rendering them unpredictable further increasing the child's distress, seen by an increase in experience of negative emotions (Crittenden, 1992).

4.5 Implications for clinical practice

Emotional maltreatment is a particularly under-estimated and unrecognised form of maltreatment (Barnett, Miller-Perrin & Perrin, 2005). Within a child protection system which is under-resourced and likely to become further stretched due to the current economic climate, the emphasis has fallen on protecting children that are being visibly and physically abused, to the detriment of protecting children from emotional maltreatment (O'Hagan, 1995, 2006). This research highlights high prevalence rates and detrimental effects of EA and EN within the family context. Therefore, clinical services and interventions need to acknowledge and address the need for systemic interventions to reduce EA and EN and combat their effects.

This study has provided further evidence that EA and EN are different in terms of their detrimental impact on the ability to regulate emotions. This highlights the necessity to provide different therapeutic interventions depending on the form of emotional maltreatment experienced (Glaser, 2002). For example, if a child

experiencing emotional neglect as the parent is lacking in confidence on how to interact with their child then this would clearly require a different approach than if a child was being verbally threatened as they were perceived by their parents as being intentionally difficult. Iwaniec, Larkin and McSherry (2007) suggest developmental counselling for parents to help increase their understanding of the appropriate expectations to have of their child. This would aid the reduction of parental misinterpretation of a child being intentionally difficult, as this misattribution can result in parental aggression and frustration. Support and guidance for parents could be offered in order to change the negative interaction styles between parent and child. Video recordings, role plays and/or family therapy could be utilised depending on the families' individual requirements (Iwaniec, Larkin & McSherry, 2007). Previous research has highlighted that when the caregiver is able to positively change their interaction styles, the child's well being and development consequently improves, highlighting the need to work with both caregivers and children (Christoffersen & DePanfilis, 2009).

In terms of tailored interventions for the emotionally abused or emotionally neglected children and young people, different approaches may be required. Based on the findings of the present study it is likely that these young people will have similarities in their presentations, such as lowered mood, but also differences, such as levels of externalising/observable outcomes (i.e. aggression). Both groups of young people may need support in learning to correctly identify emotions, how to adaptively express them and interpret emotional expression in others. These skills constitute basic emotion regulation abilities (Gross, 2007). The clinician may also

model to the young person how to identify and manage both their own emotions and emotional responses of those around them, such as how they manage the emotional responses of the young person in therapy. This modelling and emotional labelling is required as within the maltreating environment these skills were either not available from the parents (as with EN) or maladaptive methods were modelled (as with EA). Similarly, the therapist can engage the young person into a therapeutic relationship based on interactions of mutual respect that are non-abusive, instead being responsive and considerate of the young person. These new interaction styles will help to promote self-esteem and potentially alter negative internal working models of the self and others.

The results of the current study suggest that the young people that have experienced EN will require the most long-term and gradual interventions. Although both groups of young people will require time to develop trust in their therapist (because of the negative internal working models that they will be maltreated by others), the EN young people appear to have the least developed emotion regulation strategies. It should therefore not be assumed that these young people have any skills in even the most basic emotion regulation skills, such as emotion recognition.

Measures such as the CTQ could be applied to initial clinical assessments, in order to screen for all forms of maltreatment. Furthermore, some research indicates that this measure can aid disclosure of maltreatment histories which would not otherwise be identified in a typical clinical interview (e.g. Bernstein & Fink, 1998). This is

particularly important as adolescent patients are often referred for behavioural difficulties which may be the manifestation of maltreatment experiences. The subtle but important additional information gathered by the CTQ will enrich the psychological formulation; conceptualising current difficulties within the context of emotional maltreatment. In combination with the findings of this research, the formulation can then incorporate the effects of EA and EN on emotion regulation. For example, understanding the links between challenging negative behaviours and overwhelming negative emotions and limited abilities to regulate these heightened emotions.

Results from this study suggest that it is the children and young people who experience emotion neglect that are going to be most difficult to identify and support, as they withdraw from people and have significantly reduced emotional coping skills. Unlike the young people who experience EA who may draw attention to themselves via aggression or external-dysfunctional ER strategies and therefore receive support, the EN group are less likely to come to the attention of support services. Although if, as adults, these individuals seek support they are likely to require longer support than individuals who have not grown up with experiences of emotional neglect (Perry, Bond & Roy, 2007).

These findings are not only for the attention of child and family health professionals or social workers but also are of clinical relevance to professionals working in the adult services that may be treating parents with addiction difficulties or other mental

health challenges which impact on their ability to meet the needs of their children. Identification of these additional needs and collaboration with other services may in the long-term reduce the volume of potential adult patients. By increasing the awareness of emotional maltreatment, assessment and interventions can be based on early identification and family support, remembering that EA and EN are often unintentional and potentially maintained by the generational transmission of unhelpful parenting practises.

Emotion regulation is an important form of coping, which if successful aids the development of successful relationships and helps to protect the individual from difficulties, such as becoming over-whelmed by emotions and subsequent psychopathology risks (Gross, 1999). The need to be able to sufficiently regulate our emotions to promote better psychological outcomes has been gaining growing acknowledgement within therapeutic interventions. This can be seen by the ER components of dialectical behavioural therapy (DBT; McKay, Wood & Brantley, 2007) and by the more recent Emotion-Focused Cognitive Therapy (Power, 2010). It is suggested that these forms of emotionally based interventions will become increasingly important, as knowledge of ER and its impact on development and well-being grows. Investment and education into developing and delivering these new techniques should therefore be considered.

4.6 Ethical implications

The current study has highlighted a number of ethical implications. It highlights the need for professionals to be explicit in the assessment of EA and EN as they are less visible than the other forms of maltreatment, but can have substantial negative implications for the individual's development and interactions. It should not be assumed that because these forms of maltreatment do not result in physical marks that they are in any way less important to identify and address. To aid the recognition of EA and EN, clear legal definitions of these terms are necessary to enable staff and the public to identify and intervene with this more subtle form of maltreatment.

The growing research in this field continues to place more emphasis on the need to raise awareness of the negative impacts of EA and EN on young people and how this impacts on their future relationships and mental health outcomes. Only by increasing awareness will it be possible to prevent or intervene. Further resources may be required in order to provide training and support for front line staff (e.g. teachers and social workers), mental health clinicians and generic clinicians who work with families. This field of research would benefit from both more research into the differential effects of EA and EN and also studies which help to develop an evidence base for interventions following these maltreatment experiences.

4.7 Strengths and Limitations

A number of strengths and limitations of this study should be acknowledged to aid interpretation of its findings.

4.7.1 Accumulative effects

As the only forms of maltreatment that were measured in this study were EN and EA, the accumulative impact of other forms of maltreatment on ER remain unknown. Previous research has suggested that the risk of negative outcomes increase following multiple forms of abuse (Messman-Moore & Brown, 2004). The present study's results also indicated that when EA and EN are experienced together there is an increased risk of depressive mood and aggression. As accumulative and multiple forms of abuse and neglect have been highlighted as being of particular concern to an individual's development (Finkelhor, Ormrod & Turner, 2007), it would be helpful to examine not only EA and EN in relation to ER, but also other forms of abuse.

4.7.2 Cross-sectional design

As this study used a cross-sectional study, data was therefore collected at a single point in time, which although advantageous in terms of time and resource, it reduces the amount of interpretation that can be made, that is, no causal relationships can be determined. It is assumed that EA and EN impact on ER, but cause and effect cannot be truly determined. All the self-reports provided were only valid at that time, for

example, a young person may have had a cold when completing the quality of life questionnaire, whereas the following week the same person could report something very different. Although a cross-sectional design is most appropriate for gathering prevalence information, a repeated measures or longitudinal design would provide further information on the relationships described in this study.

4.7.3 Sample

A large sample of community based adolescents was recruited via participating secondary schools. The sample was substantially larger than required in order to gain power for correlations and regressions (Faul *et al.*, 2007). The sample was representative of both private and state secondary school pupils, therefore providing a wide spectrum of socio-economic backgrounds, and it also included both boarders and day pupils. Although a community based sample it is likely that a significant proportion of the sample will have been known to the mental health services. For example, The Office for National Statistics (ONS) reported that in 2004, 10 per cent of young people (aged 5-16 years) were diagnosed with a mental health disorder. As no exclusions were made regarding young people who may be accessing the mental health services, these findings may be representational of an adolescent clinical sample, although replication would be required to determine this.

As there were such high rates of EN and EA reported, this suggests that the young people involved in this study felt secure enough within the experimental procedure (i.e. procedures to ensure confidentiality and anonymity) to be open and honest about

their experiences. Although minimising was noted, within the context of denial coping some minimising would be expected (Wekerle *et al.*, 2001).

4.7.4 Self report measures

Child maltreatment research has often been hindered by the challenges of having no universal definitions (Cicchetti & Toth, 2005). However, this study has attempted to overcome this obstacle by using the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), which has been recommended by Baker and Maiorino (2010), who conducted a recent review of the emotion maltreatment literature, not only because of the CTQ's excellent psychometric qualities but also to enable research to be comparable and replicable. Also, unlike some research in the field, only Bernstein and Fink's recommended cut-off scores have been used in this study, again in order to aid replication and ensure validity.

There are some disadvantages to relying on self-report measures in order to gain understanding of emotional maltreatment. As highlighted by Knuttschnitt and Dornfield (1992) the individual may be so habituated to their chaotic and abusive environment that they do not view themselves, or label themselves, as being "abused". However there has been some evidence to suggest that youth self-report of maltreatment (using the CTQ and Child Maltreatment Form; an adapted version of the Ontario Health Supplement Questionnaire (MacMillian *et al.*, 1997)), significantly overlaps with the reports made about the individual by their social worker, indicating external reliability in using a self report measure (Wekerle *et al.*,

2001). However, caution should be exercised when interpreting this finding, as when specifically examining emotional maltreatment, rates of agreement between the young person and their social worker were extremely low. Possibly highlighting the complex and subtle nature of emotional maltreatment, which does not result in physical injury, and which relies heavily on the subjective views of what is 'normal' for the individual and those people in their environment (for example, family or peers).

This study is also less affected by the difficulties associated with retrospective reports, as the adult based research that has preceded it (see Baker, 2009, for full review). Young people included in this study are relying less on their memory recall, as the difficulties they are experiencing will be either in the present tense or have been within the not distant past. However, the CTQ does not offer any information on the onset or duration of the maltreatment, which may have important implications on findings (Werkerle *et al.*, 2001). The developmental timing of the maltreatment (for example, during critical periods such as infancy or adolescence) is likely to be crucial to the impact of maltreatment on the individual (Iwaniec, Larkin & McSherry, 2007). As the CTQ does not gather this information the developmental context is lost.

4.8 Future research

This study revealed indications of accumulative effects of having experienced multiple forms of maltreatment (EA and EN) however it did not examine other forms of maltreatment (e.g. sexual or physical abuse). It may be of interest to gain further understanding of multiple maltreatment experiences. Similarly, by controlling for other forms of maltreatment a better understanding of the unique impact of EN and EA could be explored (Courtney, Kushwaha & Johnson, 2008). However, significant ethical considerations would be required to be considered before attempting such research with a potentially very vulnerable population. A study conducted by Wekerle and colleagues (2009) did successfully administer the CTQ in its entirety (measuring sexual abuse, physical abuse and physical neglect as well as EN and EA) to an adolescent population (mean age 16 years). The researchers included a measure of how the participants felt before and after completion of the full CTQ, in order to determine if any distress had been caused. Participants reported that they were not distressed by the questionnaire, that the questions were clearly understood and that the questionnaire had not been upsetting to them. These findings are hopeful for enabling further research on accumulative effects in younger populations without causing distress.

As the temperament variables were also shown to be predictive of ER strategies utilised by the individual, this is an important point for future consideration. Future studies may be able to consider if particular temperamental traits are protective against the effects of EN or EA. For example, effortful control (a temperament

component) has been associated with similar attention control as that used in emotion regulation (Rothbart Ellis & Posner, 2004). Or alternatively, which temperament traits result in increased risk of EA or EN (Harrington *et al.*, 1998).

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