Understanding emotional abuse

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Arch Dis Child 2010 95: 59-67
doi: 10.1136/adc.2008.143156

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ABSTRACT

Emotional abuse lacks the public and political profile of physical and sexual abuse, despite being at their core and frequently their most damaging dimension. Difficulties in recognition, definition and legal proof put children at risk of remaining in damaging circumstances. Assessment of the emotional environment is necessary when interpreting possible physical or sexual abuse and balancing the risks and benefits of intervention. This article considers factors contributing to professional difficulty. It is suggested that understanding emotional abuse from the first principles of the causes and implications of the dysfunctional parent–child relationships it represents can help prevention, recognition and timely intervention. It may facilitate the professional communication needed to build up a picture of emotional abuse and of the emotional context of physical and sexual abuse. Doing so may contribute to the safety of child protection practice. The long-term cost of emotional abuse for individuals and society should be a powerful incentive for ensuring that development of services and clinical research are priorities, and that the false economy of short-term saving is avoided.

Emotional abuse is profoundly damaging but readily overlooked. Whereas bruises and fractures often heal quickly and fully, the damage of uncorrected emotional abuse is lifelong. It compromises development of relationship-dependent areas of the brain, influences programming of neuroendocrine function, and has lifelong implications for physical and mental health, including major causes of mortality. It is relevant to children’s behaviour problems, substance abuse, aggression, criminality and intergenerational parenting problems.

Physical abuse and intrafamilial sexual abuse are generally the tip of an iceberg of dysfunctional relationships: their emotional context is often their most sustaining and damaging component, yet relatively infrequently the principle grounds for protective intervention. There is commonly delay in both recognition and action. It may be self-limiting physical injury which leads to safety after years of emotional abuse on which professionals have struggled to act: such difficulties warrant consideration amongst possible contributory factors to serious failures of child protection.

SERVICES TO PROTECT CHILDREN: WRONG SOLUTIONS FOR EMOTIONAL ABUSE?

The child protection system has been moulded by its history. Although physical, sexual and emotional abuse have been recognised over generations and across cultures, they were rediscovered in the 1960s, 70s and 90s, respectively. Legislation, guidance and practice consequently evolved around immediate, episodic, definable problems, rather than the chronic pattern characteristic of emotional abuse. Legislative landmarks have been prompted by public reaction to children’s deaths and media analysis of professional shortcomings. Emotional abuse has lagged behind physical and sexual abuse in paediatric practice and training, resource allocation and political priority. It readily slides down priority lists shaped by media attention and political pressure.

The drift of responses to service failures has been to tighten regulation and external control. Although possibly helping physical protection, this does not necessarily enhance emotional safety: by reducing opportunity for independent thought it may compromise it. Recognition and management of emotional abuse depend on detailed observation, lateral thinking, initiative and adequate freedom to work creatively, whereas regulation tends to narrow the focus. Measurable targets may be poor proxies for the overall picture, yet divert resources disproportionately: key outcomes are often difficult to measure, and manifest only years later. If time and funding are inadequate, check-lists determined by regulation and pulled by targets readily become ends in themselves.

If emotional abuse is inadequately understood it is readily overlooked, because it lacks specific physical manifestations. Suboptimal professional care is, likewise, readily overlooked, and comes in many guises. These include insufficient attention to emotional wellbeing because of inadequate time, training or provision to learn from results of practice, disregard of the risk of delay, and the false economy of short-term saving. Separation of paediatrics and child and adolescent mental health services (CAMHS) is particularly hazardous. It can affect paediatricians’ confidence in managing emotional and behavioural difficulties, and may influence their sense of responsibility for doing so. Assessment of the emotional environment must be fully integral to safeguarding children, and all paediatricians need to feel equipped to contribute to this.

Pursuing a robust “evidence base” is not necessarily the overriding priority. All areas of medicine are not necessarily equally amenable to, nor equally enhanced by doing so. The status of evidence-based practice reflects its importance in areas of medicine where the relationship between cause, manifestation, consequence and management is straightforward. However, emotional abuse is multifactorial in all these respects, and rarely entirely clear-cut. Evidence achieved by squeezing the unmeasurable into quantifiable moulds (eg, by artificially subdividing a continuum) may be a poor proxy for the overall picture, and difficult to apply to practice. Research is generally too blunt a tool to provide answers to
complex individual decisions. It guides them, but does not safely override detailed assessment, experience and wisdom. Services become vulnerable if the pressure of economy encourages evidence to determine funding.

Laming identified communication as a key problem underlying child protection failures. For emotional abuse, effective communication involves exchange as much of understanding as of fact. Unanalysed information has little value, creating a mere illusion of comprehensive assessment.

Unless safety requires children’s immediate removal from home, parental change must be regarded as possible and gaining trust a priority. However, acute, reactive services readily feel judgmental. The conflicting position in which social workers are placed distances families from support which they may both need and welcome. The right solution for physical protection may be the wrong one for managing its emotional context.

DEFINING THE UNDEFINABLE?
Emotional abuse, like a well-known painting, may be described, but not “defined” such that others can recognise it. Attempted definition has produced consensus largely about the difficulty of the task. Since untrained people across cultures recognise emotionally abusive behaviour, pressure to define, not recognition, may underlie professional difficulty in doing so. Attribution of difficulty working with emotional abuse to definitional problems presupposes that practically usable definition is possible and necessary, which is not necessarily so: conceptual understanding is the greater priority.

We are, however, signed up to a professional ethos which, in emphasising guidelines, protocol and regulation, increasingly creates pressure to define and label, particularly when working with an adversarial child protection system. While important to much of medicine, a definitional focus may constrain understanding when categories are arbitrarily demarcated. Artificial distinctions help research, but can disadvantage practice by oversimplifying, or by creating complexity, as, for example, in differentiating between “emotional abuse”, “emotional neglect” and “psychological abuse”. Starting from observation rather than definition, however, allows unconstrained description, but observation must be made through informed lenses.

Behaviours which are deemed emotionally abusive include overprotection, threat, terrorising, excessive punishment, denigration, rejection, isolation, scapegoating, manipulation, giving inappropriate roles or responsibilities, and allowing witnessing of inappropriate adult activity. These descriptions do not, however, generate practically definable thresholds, so remain difficult to translate into action in an evidential system. Each falls on a spectrum merging with what might be considered “normal”, if not desirable, parenting. It is a matter, perhaps, of stepping back to consider the origins and implications of these behaviours, of understanding why they cause harm rather than struggling to define them.

The dynamic nature of emotional abuse affects recognition. Parents’ circumstances and their parenting change. Children are usually at some level attached to the most dysfunctional parents, whose care is rarely uniformly inadequate. Formulation of parenting as abusive necessarily involves value judgement, influenced by cultural norms.

Assessment of emotional abuse often involves several professions of disparate ethos: communicable, common understanding of core principles is essential, common definition perhaps less so.

BACK TO BASICS
Emotional abuse can be understood broadly as failure to provide children with an emotional environment conducive to adequate psychological, developmental and physical progress to achieve safe independence. It is intimately related to the quality of attachment, and to the assumptions, learning and physiological responses which follow from it.

Principles of how healthy attachments are made, and their consequences, give a framework for understanding inadequate emotional care (table 1). On to this core, detail can be built, constructing a jigsaw which includes contributory factors, manifestations and consequences, enabling recognition and simultaneously generating therapeutic opportunities.

Although variably defined, for practical purposes attachment can be understood as the sustaining emotional closeness which binds families together. Its particular significance for children relates to their immaturity, and their consequent dependence on relationships for safety, instruction and role model to prepare for independence. The quality of early attachment establishes foundations for functioning both through relationships and independently. As in a wall, the quality of foundations remains important whatever is added: children’s early parenting establishes preconceptions of relationships which persist as a template for those which follow, albeit ameliorated by subsequent experience.

Healthy foundations are established by parents’ sensitive, timely and predictable attunement to their babies’ feelings and needs, responding through speed, tone and pitch of voice, vocabulary, facial expression, touch and movement. In doing so, they provide a mirror in which children see their inner world reflected, giving meaning to emotions and body signals, and teaching verbal and non-verbal indicators of these. The timeliness, manner and consistency with which they do so establishes children’s assumptions about the value, safety and reliability of relationships, and their foundations for communication, trust, and ability to relinquish control. Sensitive parenting teaches children that attention is valuable, readily achieved and held, and restored by moderate behaviour. Ineffective, unpredictable, confusing or frightening parenting distorts children’s preconceptions of the desirability, reliability and safety of attention, the extent to which they seek it and the way they do so.

Attunement – sensitive awareness of, and response to the feelings and needs of the other – is the core of attachment in any relationship. It allows effective recovery after separation and disagreement, and a sense of unconditional acceptance and emotional safety. It is adversely affected by, for example, stress, anxiety, fatigue and distractibility, and by inadequate time together: simple measures may readily help attachment.

Because infants lack self-regulatory capacity, they depend on attuned parents to handle their stress. The effectiveness and promptness with which they do so influences the programming of the stress regulation systems, ameliorating the consequences of intrauterine stress.

Sensitive attunement depends on parents having acquired, through their own early parenting, the ability to respond intuitively to their children’s needs, and the ability to regulate their own stress and emotions effectively. The quality of their childhood attachment is therefore a key consideration in anticipating or assessing their capacity for good emotional care, and the help needed to achieve it. Many whose own emotional needs are unmet cannot put their children first, or trust sufficiently to accept help. Effective attunement requires physical and emotional availability: the impact on these of,
Emotionally abusive parenting affects perceptions of relationships and self, and programming of stress regulation; it both reflects and promotes dysfunctional attachment. Quality of attachment is always relevant to children’s wellbeing – the question is how, not whether it is significant.

### Table 1: Core principles of attachment and attachment styles*

<table>
<thead>
<tr>
<th>Attachment style*</th>
<th>Parenting</th>
<th>Perception of relationships</th>
<th>Developmental implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>Reliably well attuned; breaks effectively repaired</td>
<td>Valuable; attention worth seeking and readily achieved</td>
<td>Competent in functioning independently and in using relationships to learn</td>
</tr>
<tr>
<td>Insecure</td>
<td>Intermittently well attuned; breaks unpredictably repaired</td>
<td>Valuable but unreliable; attention worth seeking but unpredictably achieved. Depend on attention/approval for self-worth</td>
<td>Attention-seeking may impair learning, or anxiety to please may accelerate it</td>
</tr>
<tr>
<td>Anxious*</td>
<td>Variably attuned and antagonistic; breaks unpredictably repaired</td>
<td>Confusing: valuable, frightening, unpredictable. Crave relationships but fear closeness</td>
<td>May learn better at school than through close relationships. Craving for attention/approval may impair or enhance aspects of learning</td>
</tr>
<tr>
<td>Ambivalent*</td>
<td>Consistently non-attuned or often aggressive</td>
<td>Unhelpful or frightening. Attention not worth seeking, or feels unsafe</td>
<td>Social learning impaired. Cognitive development affected until independent learning is possible. May selectively develop non-personal abstract skills (eg, computing)</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Unpredictably but pervasively abusive</td>
<td>Confusing, unhelpful, unusable</td>
<td>Ineffective independently and in using relationships; unable to integrate effectively in school</td>
</tr>
</tbody>
</table>

*Understanding from first principles is more important to practical application than labelling. Terminology used to describe attachment styles varies and can therefore be confusing. Some do not differentiate between “anxious” and “ambivalent” patterns.

For example, learning difficulties, substance abuse and mental illness is particularly great for those whose early parenting was inadequate. Associated difficulties with self-esteem, social skills, empathy and negotiation, and in regulating stress, emotion, temper and impulse, contribute to emotionally abusive behaviour, which both results from and generates poor attachment.

### WHY DOES IT MATTER?

Emotional abuse insidiously damages the developing brain. The brain develops according to how it is used, and for infants, vital stimulus comes through attuned parenting. During the first 18 months of life this promotes development of the right hemisphere and its connections with the limbic system and autonomic nervous system, affecting stress regulation, and the right prefrontal cortex which mediates executive functions. Delayed brain growth is demonstrable following neglect and becomes increasingly irreversible with age. Emotional abuse affects neuroendocrine function, physical health, growth and development. It frequently underlies behavioural difficulties. It represents dysfunction of the relationships on which children depend for safety, guidance and role model, to learn everything necessary for safe maturity, including preconceptions of relationships, self and the world. It influences the extent of self-sufficiency or dependency. Unmet needs teach children to take control, affecting their ability to learn from adults. Dysfunctional programming of stress regulation, including the hypothalamic-pituitary-adrenal (HPA) axis (reflected in salivary cortisol levels), dopamine and serotonin systems, has potentially life-long implications. Overactive responses produce over-reaction to threat, and adversely affect social relationships, physical and mental health (predisposing, for example, to depression and post traumatic stress disorder), concentration, and behaviour regulation. Trauma may sometimes, conversely, cause autonomic down-regulation, and fearlessness, a pattern linked with avoidant attachment behaviours.

The implications of emotionally neglectful parenting depend on its nature, variability and predictability. Its effects may be tempered by any good relationship, and by individual resilience. Any aspect of development may be affected, though particularly those relating to use of relationships, or directly acquired through them. The pattern of abuse influences its developmental consequences. For example, avoidance of relationships, taught by aggressive parenting, may selectively accelerate self-help, while impairing communication. Intermittently “unavailable” parenting may encourage skills which achieve attention. The way skills are used may be as significant as whether or not they have been acquired. Quality and content of play, imagination, and ability to risk failure influence progress. Children’s difficulty relinquishing control can give the false impression of delayed development when they resist instruction.

Behaviour serves a purpose, and is determined by its anticipated effect, learnt through experience. Perceptions of the value, predictability and safety of attention are at its core. For example, fear of attention because of associated violence, or...
Review

Table 2  Why emotional abuse matters

<table>
<thead>
<tr>
<th>Perceptions of relationships</th>
<th>Self-perception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affects foundations for understanding the value, safety, reliability and associations of relationships</td>
<td>Affects understanding of the “inner world”: body signals (e.g., hunger, pain), emotion, sense of self</td>
</tr>
<tr>
<td>Establishes assumptions concerning the use of relationships for:</td>
<td>Affects perception of personal roles and responsibilities</td>
</tr>
<tr>
<td>Comfort, calming, friendship, intimacy, guidance, learning, cooperation</td>
<td>Affects perception of ability to influence own destiny</td>
</tr>
<tr>
<td>Emotional regulation</td>
<td>May distort the distinction between reality and fantasy</td>
</tr>
<tr>
<td>Distorts perceptions of roles and responsibilities:</td>
<td>Damages self-esteem (e.g., perceived blame, sense of deserving rejection)</td>
</tr>
<tr>
<td>Parent–child, adult–child, gender, sibling relationships</td>
<td></td>
</tr>
<tr>
<td>Authority, hierarchy</td>
<td></td>
</tr>
<tr>
<td>Sexual boundaries</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of relationships</th>
<th>Adaptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes the extent of self-sufficiency or dependency, leading to:</td>
<td>Dysfunctional stress system programming:</td>
</tr>
<tr>
<td>Craving attention</td>
<td>Overactive (e.g., excessive anxiety)</td>
</tr>
<tr>
<td>Avoidance of attention (including autistic-like patterns)</td>
<td>Under-active (e.g., fearlessness)</td>
</tr>
<tr>
<td>Fluctuating use of attention because of ambivalence</td>
<td>Limited danger awareness</td>
</tr>
<tr>
<td>Use of relationships affected by:</td>
<td>ADHD-type problems</td>
</tr>
<tr>
<td>Inattention, affecting “reading” of relationships</td>
<td>Inadequate cognitive coping strategies</td>
</tr>
<tr>
<td>Difficulty regulating emotion and temper</td>
<td>Anxiety concerning change, clinging to “sameness”</td>
</tr>
<tr>
<td>Vulnerability to rejection</td>
<td>Poor negotiation and repair strategies</td>
</tr>
<tr>
<td>Over-reading of disapproval or threat</td>
<td>Hypervigilance to threat</td>
</tr>
<tr>
<td>Limited empathy</td>
<td>Underdevelopment of executive function (e.g., response inhibition, concentration, planning, problem solving)</td>
</tr>
<tr>
<td>Anxiety, stress, depression</td>
<td>Dysfunctional coping strategies (e.g., substance abuse, self-harm)</td>
</tr>
<tr>
<td>Lack of intuitive attunement</td>
<td>Mood disorder, anxiety, post-traumatic stress disorder</td>
</tr>
<tr>
<td>Intolerance of touch</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affects foundations for communication:</th>
<th>Transition to independence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal communication</td>
<td>Difficulties with:</td>
</tr>
<tr>
<td>Non-verbal communication</td>
<td>Functioning effectively independently or through relationships</td>
</tr>
<tr>
<td>Emotional communication</td>
<td>Regulating stress, emotion, anger</td>
</tr>
<tr>
<td>Pragmatic language</td>
<td>Negotiation and conflict resolution</td>
</tr>
<tr>
<td>Strategies learnt for using relationships:</td>
<td>Self-esteem</td>
</tr>
<tr>
<td>Means of achieving and holding attention</td>
<td>Identity</td>
</tr>
<tr>
<td>Constant smiling, always helping</td>
<td>Inadequate foundations for intuitive attunement</td>
</tr>
<tr>
<td>Incessant chat, intrusion, following, clinging</td>
<td>Vulnerability to rejection</td>
</tr>
<tr>
<td>Behaviour which is difficult to ignore (e.g., eating and toileting problems, endangerment, hurting others, sexualised behaviour)</td>
<td>Risk of early pregnancy</td>
</tr>
<tr>
<td>Control of others</td>
<td>Attraction to familiar but dysfunctional patterns of relationships (e.g., violence)</td>
</tr>
<tr>
<td>Hypervigilance</td>
<td>Parenting difficulty</td>
</tr>
<tr>
<td>Over-reaction to threat, over-reading of disapproval</td>
<td></td>
</tr>
<tr>
<td>Over-adjustment to others’ expectations</td>
<td></td>
</tr>
<tr>
<td>Avoidance of risk of failure, over-compliance</td>
<td></td>
</tr>
<tr>
<td>Pre-empting rejection by negative behaviour</td>
<td></td>
</tr>
<tr>
<td>Acceptance of discipline affected by:</td>
<td></td>
</tr>
<tr>
<td>Expectations of discipline (e.g., violence, isolation)</td>
<td></td>
</tr>
<tr>
<td>Perceptions of authority</td>
<td></td>
</tr>
<tr>
<td>Difficulty relinquishing control (e.g., oppositional behaviour)</td>
<td></td>
</tr>
<tr>
<td>Exaggerated sense of rejection</td>
<td></td>
</tr>
<tr>
<td>Underactive stress responses (indifference to reprimand)</td>
<td></td>
</tr>
</tbody>
</table>

Indifference because of consistently poor attentiveness can cause aloofness. Anxiety that valued but unpredictably available attention may be lost causes any behaviour (desirable or otherwise) which achieves it to flourish. Emotionally neglected children’s behaviour is often further coloured by unregulated stress and emotion, impulsivity, craved attention, oversensitivity to disapproval, failure and rejection, lack of social skills, and difficulty relinquishing control.

Difficulties resembling attention deficit hyperactivity disorder (ADHD) are complexly related to emotional abuse, as cause and effect. Overactive HPA axis programming, hypervigilance and anxiety contribute. Familial risk of ADHD is also high, since parents’ symptoms may underlie their substance abuse or temper problems and consequent parenting difficulties. For many children, intrauterine exposure to drugs, alcohol, smoking and violence compound the risk.

Well-established strategies for living with dysfunctional relationships leave children ill-equipped for healthy ones, like negotiating London with a map of Paris. Learnt self-protective behaviour may, perplexingly, provoke discipline and rejection. Children’s hypervigilance and over-adjustment to others’ expectations can make a snapshot view of their behaviour deceptive and professional continuity particularly important.

The relationship between suboptimal emotional care and physical health is multifaceted and often imprecisely attributable. It includes neglect of the practicalities of prevention,
CONSTRUCTING THE JIGSAW

Recognition of emotional abuse resembles the construction of a jigsaw of a familiar painting, made up of pieces of varying clarity. Interpretation depends on understanding how risk relates to parental behaviour, how parental behaviour relates to children’s understanding of relationships, and how children’s understanding of relationships relates to their development, stress regulation and behaviour (box 1 and table 3).

The task is to build a picture of the current and future implications of the preconceptions of relationships, self and the world which the child is acquiring from their emotional environment. It involves considering the developmental, physical, emotional and behavioural implications of these preconceptions, identifying contributory factors, sources of resilience and therapeutic opportunities, and assessing the likelihood of change. The priority is description, not definition. Consideration of how children see and use relationships should be integral to, and inform interpretation of developmental assessment, including patterns of advanced and delayed skills.

Fragments of the jigsaw include what is known or can be assumed about the child’s genetic inheritance, antenatal and postnatal experience, and experiences at home and of moves into and within the care system. They include the behaviour of parents and children, individually and together, described and observed. They include factors conveying resilience – particularly any effective relationship. Assessment of what, judging from identified fragments, might be expected, is considered alongside the child’s observed use of relationships and developmental pattern in interpreting the overall picture. For example, poor parental foundations of attachment increase the significance of behaviour consistent with emotional abuse; parental violence is likely to contribute to autistic-like avoidance of relationships.

The more pieces which are missing, the less reliable the image constructed. Many fragments look individually insignificant or ambiguous: understanding the causes, manifestations and consequences of emotional abuse enables their relevance to be judged. The picture is dynamic, and of complexly interrelating parts. The greater the professional continuity and attention to detail, the greater the opportunity to test it from alternative perspectives, in different settings and over time, and the greater the likelihood of accurate interpretation: photographs of moving objects readily give an inaccurate impression.

Information gathering without analysis has little value and contributes to delay in achieving emotional and sometimes physical safety. Working effectively with emotional abuse requires attention to detail, focused on consideration of what the child needs to achieve to be equipped for adulthood (box 2).

The central question is how, judging from the child’s behaviour and development, they appear to see themselves, relationships and the world, and the implications of these perceptions, if uncorrected, for physical and emotional health, stress regulation, and their transition to independence.

A SERVICE FOR EMOTIONAL ABUSE

The fundamental purpose of a service for emotional abuse is to promote the effective attachment on which children depend for sustained physical, developmental and emotional wellbeing, while addressing consequences of its previous shortcomings.

Since children should, according to the Children Act, remain at or return home unless it is irretrievably unsafe, the belief underpinning services must be that change is possible. Emotional abuse does not mean intent to harm: most struggle to parent because of their own inadequately remedied dysfunctional parenting. Many are consequently mistrustful, vulnerable to rejection and failure, and lack self-worth, agency and negotiating skills. Many cannot regulate stress, fear and emotion effectively. Parents need to feel valued, safe, and understood to engage with services and achieve change. Their behaviour, like children’s, responds best to empathetically imposed boundaries and reinforcement of positives. Interventions which generate stress may encourage the outcomes they aim to prevent, adversely affecting attunement, tolerance, temper regulation and behaviour management, encouraging substance abuse, and distancing families from support. Services need to be encouraging, optimistic and empowering, and to allow early non-confrontational intervention. Approaches such as family group conferences, pedagogy, and charitable and voluntary schemes such as Action for Children and Community Service Volunteers warrant further development and evaluation.

A smooth transition is needed from risk recognition to support, with help integral to assessment. Factors which ultimately lead to children’s removal and adoption usually long predate pregnancy. Education about parenting, attachment, stress regulation and temper management should be routine, but specifically offered by adolescence to those at known risk. Inadequate early support is a false economy, the cost, financial and otherwise, of unaddressed emotional abuse being considerable. Joint funding of public services would avoid the problem of anticipated cost falling within others’ budgets.

Because consequences of dysfunctional emotional care characteristically interrelate, vicious circles and escalating problems are typical if difficulties remain unaddressed. Support must therefore be pragmatic and timely, addressing remediable elements as they are identified. Parental self-care and stress regulation are priorities. Parents need help with attunement, and in understanding and managing behaviour reflecting its inadequacy. Many need support with temper problems, untreated ADHD, depression, anxiety or substance abuse. Professional continuity helps trust and reduces the risk that a snapshot view allows inaccurate interpretation.

Paediatricians need to feel equipped to recognise, describe and contribute to addressing emotional abuse. Training involves bridging gaps between disciplines of differing professional ethos. Mental health should be integral to paediatric training from undergraduate level onwards, and adequate supervision ensured to allow routine practical application. All need to understand the mechanisms through which unsatisfactory parenting
influences emotional wellbeing and the natural history of inadequate emotional care. This enables the relevance of risk factors to be understood, and therapeutic opportunities identified promptly. All need realistic knowledge of the efficacy of alternative parenting, its difficulties, professional responsibilities to support it, and the risks of delay. Opportunity is needed to learn from outcomes of practice. Consultant job plans should allow adequate time to address children’s emotional needs, and, recognising the cost of failure to do so, be funded accordingly.

Understanding is needed of the decision-making process, roles, responsibilities and hierarchies: “no evidence of physical abuse” may, for example, be misinterpreted as “no abuse” if roles are unclear. Expert opinion readily overrides others’ views, creating an onus to interpret it alongside the detailed knowledge of frontline staff. The risk of separation of CAMHS and paediatric services must be fully addressed in local organisation and training.

Emotional abuse needs a higher research profile, while recognising that the relationship of research to practice differs

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**Box 1 Jigsaw pieces for assessing emotional wellbeing: history**

Parental risks to attachment
- Poor quality early parenting (eg, in care, abuse, inappropriate sexual boundaries)
- Unregulated temper, stress, emotion; ADHD, drugs, alcohol, mental health problems, learning difficulties

Perinatal risk
- Intrauterine drugs, alcohol, smoking, stress, malnutrition
- Perinatal experience (eg, neonatal intensive care, drug withdrawal, multiple carers)

Child’s early foundations for attachment
- Pattern of care
  - Consistently good
  - Initially adequate (eg, substance abuse starting beyond infancy)
  - Intermittently good (eg, drug or alcohol abuse)
  - Consistently poor (eg, poor parental foundations of attachment, learning difficulties)
  - Confusing: variably adequate and antagonistic (eg, temper control problems)
  - Often aggressive
  - Consistently abusive

Experiences in the family care
- Quality, consistency and appropriateness of observed parental physical affection
- Consistency, sensitivity, quality of observed parental attunement (eg, voice modulation)
- Child’s observed use of attention at home (unusually little, average, excessive)
- Child’s strategies for achieving attention (positive and negative)
- Parental approach to stress, emotion and temper regulation, negotiation and reconciliation
- Parental mental health (eg, depression affecting mirroring of emotions, psychosis affecting sense of reality)
- Parents’ ability to put children first
- Multiple carers
- Any good relationship
- Violence, child’s response (eg, “frozen”, protecting others)
- Sexual boundaries (sexual abuse, witnessing sexual activity/abuse, exposure to inappropriate material)
- Discipline (means, consistency, effectiveness, child’s response)
- Perceptions of authority
- Physical care (eg, hygiene, toileting, feeding, day/night routines, stimulation)
- Position and role in family (eg, competing for attention, scapegoat, favourite, protector, parental role, “parented” by siblings)
- Siblings’ experiences and behaviour, extended family function (eg, substance abuse, violence)

Experience of moves into and within care
- Preparation and introductions, or not
- How moves happened (eg, traumatic removal, accompanied by trusted adults, accompanied by siblings)
- Behaviour on arrival (eg, seeking affection from the outset, “frozen”, distressed, angry)

Experience of foster care
- Family structure, number of children, genders
- Quality of attunement by carers, 1:1 time
- Response to care: change over time
- Family relationships (eg, response to contact, discussion of circumstances, content of discussion about birth family)

Physical health
- Delayed growth (head circumference, height, weight)
- Injuries (accidental or non-accidental), constipation, soiling, enuresis, infections, missed immunisations

Change over time
- Attachment behaviour
- Emotional awareness/regulation, concentration, behaviour, development

*These will be of variable certainty – known, assumed, probable or possible.
Current use of relationships

**Attachment**
- Does he seek affection? Appropriately? Of whom?
- Behaviour with strangers (eg, seeking affection or excessive attention)
- Behaviour in public places (eg, running off without turning)
- Does he seek attention too much/too little/appropriately?
- How does he react to sharing attention?

**Purpose: use of relationships for:**
- Closeness. Does it feel appropriate?
- Calming, comfort
- Support, guidance, learning, play

**Strategies**
- How does he seek attention? Does he use positive or negative behaviour?
- What is the worst he will do to achieve attention?
- Does he adjust to different expectations?
- Response to discipline
- Can he relinquish control? How does he react to confrontation?
- Aggression
- Sexualised behaviour

**Specific relationships: quality of relationships with:**
- Parent figures
- Other adults (eg, teachers)
- Siblings (eg, roles, rivalry, jealousy, warmth)
- Peers (eg, sharing attention, controlling, popularity, social confidence)

**Communication**
- Does he understand non-verbal communication? Is this selective (eg, anger)?
- Language skills (eg, receptive, expressive, pragmatic)
- Does he communicate emotion? (verbally, non-verbally)

**Effect on others**
- How does it feel to parent him?
- How does he affect family relationships?
- Do carers feel "needed"?
- What is the most difficult aspect of caring for him?
- What are the particular positives of caring for him?

Current indicators of child’s “inner world”

**Emotional awareness**
- Does he show a normal range of feelings, appropriate to circumstances? Do they seem real or acted?
- Does he show excessive temper?
- Does he show empathy?
- Does he have words for feelings?

**Body signals**
- Eating pattern (eg, does he recognise hunger, satiety?)
- Toileting pattern (eg, does he know he needs the toilet? Wetting, soiling – when and where?)

**Response to pain/discomfort**
- Does he seek comfort or just attention; does he accept offered comfort?
- Does he show that he feels unwell?

**Self-worth**
- Does he accept praise? Show pride? Want to please excessively?
- Does he value achievement, personal possessions, appearance?

Developmental picture

- Profile of advanced and delayed skills
- Does he use acquired skills consistently?
- How does use of skills relate to attention use?
- Does he pretend? Get in roles? What sort of content?
- Control issues (eg, deliberate error, resistance to instruction)
- Does he wish to please? Is he motivated by praise?
- Does he show confidence? Will he risk failure?
- Can he comply with quiet play, sitting still, routine?
- Does he use adults to support play?
- School progress (eg, milestones, social integration, opportunity for success, behaviour, concentration, sharing attention, turn taking)

Adaptability and regulation

- Temperament
- ADHD-type features: inattention, impulsivity, hyperactivity
- Mood (eg, affect, mood swings)
- Emotional regulation, temper control, aggression
- Self-calming, using others’ help for calming
- Sleep pattern (eg, settling, waking, nightmares)
- Response to change in routine
- Sense of agency: ability to make choices
- Sense of danger (eg, is he cautious in climbing? Does he startle?)
- Resilience
- Ability to adjust to expectations
- Any good emotional relationships?
- Intelligence

Observed behaviour during assessment

- Attachment behaviour (seeking physical affection, response to offered comfort, eye contact, reference back to carers during play)
- Relative response to parents, foster carers, strangers
- Stranger awareness (eg, does he readily leave the room with a stranger, check with carer before approaching a stranger, seek affection of strangers?)
- How much, and how does he seek/hold attention?
- How does he behave if the carer’s attention is diverted from him?
- How does he handle instruction?
- How does he react to discipline?
- Concentration, “fitting”, impulsivity
- Play pattern (eg, pretend play, affection to dolls, persistence, interest)
- Parental attunement (eg, sensitivity and consistency, voice modulation, facial expression, eye contact), physical affection, discipline
- Reaction to assessment (eg, cooperative, passive, resistant)
- Is his behaviour appropriate to the circumstances?

Physical health

- Dysmorphic features (eg, foetal alcohol syndrome)
- Height, weight, head circumference proportions and trends
- Eyes: brightness, dark rings under the eyes, focus, eye contact
- Skin: ready bruising and blotching, peripheral temperature, eczema, excoriation, infection
- Autonomic function (eg, pulse, blood pressure, skin perfusion, gastrointestinal function)

*These will be of variable certainty – known, assumed, probable or possible.

from that applicable to many areas of medicine. Research brings the challenge of integrating the approaches of diverse professional groups. The established body of social work and psychology literature needs to be matched by a greater clinical focus, including consideration of the predictive value of risk factors, and the relevance to assessment of, for example, head growth and manifestations of autonomic function. Clinical application of the neurochemistry and neuropharmacology of trauma and attachment (eg, the role of oxytocin and vasopressin in promoting bonding and social understanding) warrant exploration.

Circumspection and determination are needed to ensure that systems developed primarily for physical protection are suitable for emotional care, particularly since inadequate services readily go unnoticed. Over-regulation is to be resisted, because it stunts creativity and lateral thinking. Experience and wisdom should be valued, alongside regulation which sets reasonable limits rather than determining practice.
Review

Box 2 Assessing emotional wellbeing: analysis*

<table>
<thead>
<tr>
<th>What are the risk factors to attachment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Is it likely that the parents had satisfactory foundations for attachment?</td>
</tr>
<tr>
<td>▶ What pattern of attunement would the parental risk factors be likely to cause? (eg, initially good, consistently poor, inconsistently good, antagonistic, consistently frightening, unpredictable)</td>
</tr>
</tbody>
</table>

What would be the expected effects of the risk factors?

▶ What would be the child’s expected foundations of perceptions of:
  - Relationships: Valuable, reliable, safe?
  - Attention worth seeking, safe, readily restored?
  - Close relationships different from others?
  - Self: Worthwhile, unconditionally wanted?
  - Awareness of body signals and emotion?
  - The world Safe, predictable?

▶ How might early experiences be expected to have affected stress regulation programming (exaggerated, underactive, normal)?
▶ How would early experiences be expected to affect behaviour? (emotional regulation, concentration, use of attention, ability to relinquish control)
▶ How would early experiences be expected to affect development? (social skills, communication, self-help, physical activity)

How does the current picture fit with what would be expected?

▶ Development
▶ Use of relationships
▶ Regulation of emotion, temper, stress
▶ Concentration
▶ Behaviour
  - How does the observed behaviour pattern relate to parenting style?
  - How does the behaviour suggest that he sees relationships?
    - Valuable (eg, making eye contact, using relationships)?
    - Safe (eg, seeking and sustaining attention)?
    - Reliable (eg, sharing attention, able to relinquish control)?

If there is mismatch between expected and observed development and behaviour:

▶ Does he have other sustaining relationships?
▶ What, despite risk factors, enables the parents to parent adequately?

What would be the probable impact of moves into and within care, considering:

▶ How they happened (eg, traumatic removal, lack of preparation)
▶ How he responded (eg, indifference, withdrawal, immediate seeking of affection)

What factors may be contributing to emotional abuse?

▶ Parents: temper, stress, ADHD, learning difficulties, mental health problems
▶ Child: ADHD, learning difficulties, autistic spectrum disorder
▶ Lack of support; inappropriate accommodation

Which contributory factors can be changed? How? How soon?

▶ How can the parents be helped to change? (Do they acknowledge the problem? Can they accept help? Has help been offered regarding parental ADHD, temper, stress regulation, etc?)
▶ Can the parents prioritise the children? What might help them to do so?

How likely is adequate change? (Likely? Possible? Unlikely?)

What other factors are likely to affect the consequences of risk factors?

▶ To whom/what are the child’s key relationships?
▶ Have the parents been given advice concerning behaviour management? Has ADHD been treated?
▶ What is the child’s probable understanding of his circumstances?

What factors may contribute to resilience?

▶ High intelligence, any supportive relationship, means of success
▶ How can resilience be used and developed?
▶ What professional work is needed?

What work would be needed with birth parents, child, carers, teachers:

▶ To enable the child to remain at home?
▶ To establish and sustain a new home?
▶ To develop adequate attachment?
▶ To remedy the consequences of previous poor attachment?
▶ To support education?
▶ To pre-empt future problems? (eg, stress regulation, ADHD-type problems, understanding of relationships)

What are the consequences of lack of change, now and for the future?

▶ Is the child likely to be able to use relationships adequately for learning, support, friendship?
▶ Is he likely to make effective peer relationships? (eg, ability to share attention, pretend, read social cues, manage temper, relinquish control?)
▶ What are the risks of delay in achieving change?
▶ Implications for learning, social integration, self-esteem; effect on brain growth and its reversibility
▶ Likelihood of achieving an alternative home and effective attachment

*From what is known, is likely or can be assumed.

CONCLUSION

Emotional abuse has lagged behind physical and sexual abuse in paediatric training, practice and research. Recognition of the damage it causes to the developing brain, with potentially lifelong and intergenerational implications, should prompt a sense of urgency in improving services, training and supervision. Assessment of the emotional context is a necessary safeguard for all child protection decisions and their implementation, reducing the risk of leaving children in unsafe circumstances, of delay in establishing alternative parenting, and of achieving physical safety at the cost of emotional harm.

Paediatricians need to be as confident in assessing inadequate emotional care as physical and sexual abuse. Service models must suit its chronic, multifactorial nature, and ensure that paediatricians are fully equipped to work to the edge of CAMHS services and cooperatively alongside them. Understanding emotional abuse in terms of the causes and the physical, developmental, emotional and behavioural consequences of the distorted parent–child attachment it represents can offer a practical, communicable means of working with families, in seeking to prevent, identify and remedy it.
Acknowledgements: I am grateful to Caroline Mercier, Lynn Brown and Emma Bradley for their helpful comments.

Competing interests: None.

Provenance and peer review: Commissioned; externally peer reviewed.

REFERENCES