CHILDHOOD PSYCHOLOGICAL MALTREATMENT AND ITS RELATIONSHIP WITH ADULT ADJUSTMENT

By

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ABSTRACT

This research examined the relationship between childhood psychological maltreatment (CPM) and adult maladjustment. This research also investigated the ability of CPM to predict maladjustment (depression, low self-esteem, and anger) over and above physical abuse and sexual abuse. Participants consisted of 160 (50 men, 109 women, 1 no response) undergraduate college students. The participants completed the Comprehensive Childhood Maltreatment Scale (CCMS), Center for Epidemiologic Studies Depression Scale (CES-D Scale)**,** Multidimensional Anger Inventory (MAI), and the Rosenberg Self-Esteem Inventory (RSE). Significant correlations emerged between CPM and symptoms of depression, anger, and self-esteem in adulthood. When controlling for physical abuse alone and physical and sexual abuse together, CPM was significantly correlated to symptoms of depression and anger. When controlling for sexual abuse alone, CPM was significantly correlated to all of the adjustment variables.

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CHAPTER I

INTRODUCTION

Child maltreatment has been the focal point of numerous research studies (e.g., Mills et al., 2013; Trickett, Kim, & Prindle, 2011). Within the field of child maltreatment, a considerable amount of attention has been given to researching sexual abuse and physical abuse (e.g., Mills et al., 2013). Many researchers have focused on the outcomes of maltreatment for children and adults. Some of these outcomes include post-traumatic stress disorder (Spinazzola et al., 2014), internalizing and externalizing symptoms (Hagan, Roubinov, Mistler, & Luecken, 2014), and the perpetration of violence in adulthood (Milaniak & Widom, 2015). Research in child maltreatment has evolved to address the psychological components of abuse and neglect and how to define this form of maltreatment (Brassard & Donovan, 2006).

The American Academy of Pediatrics has identified child psychological maltreatment (CPM) as "the most challenging and prevalent form of child abuse and neglect" (Hibbard et al., 2012, p. 372). This particular form of abuse is a challenge due to the very nature of the abuse. For over three decades, professionals have worked to adequately define CPM as a form of abuse (Brassard & Donovan, 2006). As cited by Brassard and Donovan (2006), the term *mental injury* was initially used in 1974 as a means of labeling this form of abuse. Even though mental injury was presented as a form of abuse, it was not adequately defined at that time (Hart, Brassard, Binggeli, & Davidson, 2002). The lack of an operational definition stunted the progress of research

and the ability of professionals to identify this form of abuse and address it in clinical settings (Hart et al., 2002).

The American Professional Society on the Abuse of Children (APSAC, 1995) has defined CPM as "a repeated pattern of caregiver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (p. 2). Emotional abuse, psychological abuse, emotional neglect, and psychological maltreatment have been used over the years as the terminology to describe this form of maltreatment (Baker, 2009). Emotional abuse is identified as acts of commission, whereas emotional neglect is identified as acts of omission (Glaser, 2011). Early research conducted on this form of child maltreatment identified both acts of abuse (commission) and neglect (omission) as being the defining features (Brassard & Donovan, 2006). Some researchers, however, only study emotional abuse (acts of commission) and do not differentiate between physical and emotional neglect (e.g., Feng, Chang, Chang, Fetzer, & Wang, 2015; Finkelhor, Vanderminden, Turner, Hamby, & Shattuck, 2014). Within the United States, the term psychological or emotional maltreatment is used to address the acts of omission and commission that affect a child's emotional development (Glaser, 2011).

APSAC (1995) grouped the behaviors of psychological maltreatment into six categories: spurning (e.g., making the child seem unimportant), terrorizing (e.g., being frightening towards the child), isolating (e.g., restricting the child's environment), exploiting/corrupting (e.g., engaging in antisocial or negative actions in front of the child), denying emotional responsiveness (e.g., being emotionally disconnected from the

child), and unwarranted denial of health care or education (e.g., not providing for serious physical/mental health or educational needs). The difficulty with these categories and descriptions of behaviors is that there is not a specific definition as to when these behaviors are considered severe enough to warrant intervention and would then be labeled as maltreatment (Glaser, 2011). Numerous studies on the prevalence of child maltreatment (e.g., Sedlak et al., 2010; Shi, 2013) have been conducted to measure the various behaviors that comprise child maltreatment, including CPM.

One of the major studies on child abuse and neglect, The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), estimated that 1,256,600 children had been maltreated during the year of 2005-2006 (Sedlak et al., 2010). It was estimated that 148,500 children were emotionally abused and 193,400 children were emotionally neglected (Sedlak et al., 2010). It is important to note that these numbers only included children who had been harmed or were in danger of being harmed by emotional abuse or neglect. In addition to these limitations, the only children counted were those who were being abused or neglected by a parent or caregiver (Sedlak et al., 2010).

Finkelhor et al. (2014) conducted a household survey on 4,503 children in 2011 and found that 5.6% experienced emotional abuse in the past year with a rate of 10.3% reporting emotional abuse in their lifetime. Emotional abuse was measured by the question "Did you/your child get scared or feel really bad because grown-ups in their/your life called this child/you names, said mean things to this child/you, or said they didn't want this child/you?" (Finkelhor et al., 2014, p. 1425). The caregiver of the child answered the question for children under 10 years old. Children 10 years old to 17 years

old answered the questions on the survey concerning their own experiences. Overall neglect was measured using screeners concerning what would be considered neglectful behavior (e.g., "parental drinking and drug use, being left alone, living in a broken down home, unsafe or unhealthy conditions, allowing unsafe people to be around and lack of personal hygiene care" p. 1426), and they found overall neglect was reported at a rate of 4.7% for the past year and 11.6% over the life of the child (Finkelhor et al., 2014).

In another study with children, Taiwanese high school students (N = 5,236) completed questionnaires, with 4,788 indicating at least one form of maltreatment among the options provided (Feng et al., 2015). Using the ISPCAN Child Abuse Screening Tool Children's Home Version, Chinese, psychological abuse (e.g., screaming, threatening to hurt or kill, threatening to abandon) was found to represent 69.2% and neglect (e.g., felt not cared for, felt unimportant, inadequate support/help) was found to represent 54.6% of the individuals who reported some form of abuse (Feng et al., 2015). In addition to the prevalence of CPM in samples of children and adolescents, the occurrence of CPM has been assessed in adult retrospective studies (e.g., Shi, 2013).

Data collected with adults at a clinic on a Midwestern university campus found that, out of 497 individuals assessed, 370 (74.4%) of the individuals had experienced some form of childhood abuse and neglect (Shi, 2013). The sample included individuals living in the community, along with faculty from the college, undergraduate students, graduate students, and their spouses. The Childhood Trauma Questionnaire revealed that, among those who experienced abuse, the most common types of abuse were emotional neglect (54.9%) and emotional abuse (52.1%) (Shi, 2013). Additionally, in a Portuguese

retrospective sample of 1,200 adults, Dias, Sales, Hessen, and Kleber (2015) administered the Childhood Trauma Questionnaire-Short Form to measure the prevalence of child maltreatment. Dias et al. (2015) found that, among participants who had indicated that they had been abused, the most common types of abuse were emotional abuse (60.8%) and emotional neglect (91.0%). Furthermore, research concerning prevalence also has provided evidence that CPM is often present with other forms of child maltreatment (e.g., Dias et al., 2015; Feng et al., 2015).

Researchers have begun to place more emphasis on investigating the co-occurrence of CPM with other forms of abuse (e.g., Schneider, Ross, Graham, & Zielinski, 2005; Silva, Graña, & González-Cieza, 2014). APSAC (1995) noted that CPM can be found in all types of child maltreatment. Further, current research on CPM with children supports the concept that different forms of abuse are interconnected (e.g., Finkelhor et al., 2014; Schneider et al., 2005; Shi, 2013). Finkelhor et al. (2014) found that experiencing one type of maltreatment was a risk factor for experiencing other forms of maltreatment.

Schneider et al. (2005) completed an analysis of 806 LONGSCAN children from birth to 8 years old. The analyses compared children who had a Child Protective Services' (CPS) record that contained reports of emotional maltreatment with children whose records did not indicate emotional maltreatment. The results revealed that when there were reports of emotional maltreatment there were more reports of physical abuse and neglect compared to when emotional maltreatment was not reported (Schneider et al., 2005).

Shi (2013) found there was a significant association between the level of severity of experienced abuse and the number of co-occurring abuse experiences. The levels of severity were rated by the researchers based on the subscale scores of the Childhood Trauma Questionnaire (CTQ; Shi, 2013). Those who were rated as severe to extreme were more likely to have experienced all five types of abuse (i.e., emotional abuse, physical abuse, sexual abuse, physical neglect and emotional neglect) than those who were rated in a lower category (e.g., low to moderate, moderate to severe; Shi, 2013). With more research providing evidence to support CPM occurring with other forms of abuse (Schneider et al., 2005), it has become important to identify the long-term correlates that may develop due to experiencing this form of abuse.

Psychological Maltreatment Outcomes

In summarizing the literature, Binggeli, Hart, and Brassard (2001) concluded that the impact of psychological maltreatment may have more serious implications for survivors when compared to the impact of the other forms of abuse. Additionally, it was found in the literature that many of these correlates continued to be present into adulthood (e.g., Allen, 2008; Gross & Keller, 1992). Hart et al. (2011) found, in their review of the literature, that CPM has been linked to depression, delinquency, and negative views of life. Different children may experience similar forms of CPM, but may not have the same negative correlates from the experience (Glaser, 2011). Although research has been conducted to investigate the various correlates of CPM in adults and children (e.g., Leeson & Nixon, 2011; Wright, Crawford, & Del Castillo, 2009), the

current research investigated its relationship with depression, self-esteem, and anger in adults.

Depression

Many studies have linked the experiences of CPM to internalizing disorders in children and, in particular, depression (e.g., Leeson & Nixon, 2011; Schneider et al., 2005). English, Thompson, White, and Wilson (2015) isolated the subtypes of CPM to identify the outcomes that were linked to the specific subtypes. English et al. (2015) linked symptoms of depression, among other symptoms, to behaviors that related to psychological safety (e.g., threats of injury/homicide, marital violence, exposure to extreme behaviors), which are similar to the terrorizing and corrupting subtype of CPM.

Similarly, de la Vega, de la Osa, Granero, and Ezpeleta (2013) found that children who experienced emotional maltreatment through exposure to intimate partner violence were identified as having internalized symptoms and anxiety-depression. Furthermore, those who reported having experienced different forms of CPM (e.g., terrorizing, spurning, denying emotional responsiveness, and corrupting), as compared to those who only experienced one form of CPM, scored higher on the Child Behavior Checklist (CBCL) for depression and other related internalizing symptoms (de la Vega et al., 2013). In addition to the correlates in children, there are many correlates of CPM that are present in adulthood (e.g., Lee, 2015).

Research concerning the correlates of CPM in adulthood is most often analyzed using retrospective data (e.g., Coates & Messman-Moore, 2014; Hyman, Paliwal, & Sinha, 2007; Wright et al., 2009). Retrospective data allow the researcher to obtain

information concerning childhood experiences while obtaining information concerning adult adjustment (e.g., Coates & Messman-Moore, 2014; Hyman et al., 2007; Wright et al., 2009). Samples used in research to investigate CPM and adult outcomes have come from clinics (e.g., Crow, Cross, Powers, & Bradley, 2014; Shi, 2013), communities (e.g., Dias et al., 2015), and colleges (faculty and/or students; e.g., Allen, 2008; Coates & Messman-Moore, 2014; Diaz, Lizardi, Qian, & Liu, 2008).

Clinical samples have provided evidence of internalizing symptoms being associated with CPM (e.g., Crow et al., 2014; Gibb, Chelminski, & Zimmerman, 2007; Harvey, Dorahy, Vertue, & Duthie, 2012). Specifically, in a clinical sample that included mostly low income African Americans, it was found that childhood emotional abuse was correlated with symptoms of depression in adults (Crow et al., 2014). Additionally, Gibb et al. (2007) found, in a clinical sample, that childhood emotional abuse was correlated with major depressive disorder. Contrary to the evidence provided by the majority of the research, using bivariate correlations, Cadmus-Romm (2004) found in a community archival study that emotional abuse and emotional neglect were not correlated to symptoms of depression. The current research focused on the undergraduate college population, and research with that population was reviewed (e.g., Allen, 2008; Coates & Messman-Moore, 2014; Muller, Thornback, & Bedi, 2012).

A review of the literature that focused on the undergraduate population supported the findings from the clinical samples concerning CPM's relationship to symptoms of depression (e.g., Allen, 2008; Coates & Messman-Moore, 2014; Harper & Arias, 2004). Specifically, Allen (2008) investigated the relationship between the defining behaviors of

CPM, as described by APSAC (1995), and emotional adjustment. He found that behaviors of CPM were related to symptoms of depression in college students who were between the age of 18 years old and 22 years old. Additionally, Coates and Messman-Moore (2014) assessed CPM in adults using the Computer Assisted Maltreatment Inventory (CAMI), and they found that CPM was correlated to adult symptoms of depression. Thus, research has provided evidence of the correlation between CPM in childhood and adult symptoms of depression.

Self-Esteem

The current research also investigated the correlation between CPM and self-esteem. Research conducted concerning CPM has provided evidence that there is a correlation between experiences of CPM and lower levels of self-esteem during childhood (e.g., Chan, Brownridge, Yan, Fong, & Tiwari, 2011) and later on into adulthood (e.g., Cadmus-Romm, 2004; Gross & Keller, 1992). Harvey et al. (2012) completed individual interviews with six participants, identified as having experienced CPM as children, to assess past and present perceptions of themselves. These individuals were both self-identified and identified by a therapist as having experienced CPM as a child. Harvey et al. (2012) found evidence that the individuals used the experiences of abuse to define themselves. The individuals perceived themselves as being less worthy, and they blamed themselves for being abused (Harvey et al., 2012). These individuals accepted this perception of themselves, and it affected multiple aspects of their lives.

There is a limited amount of research available that specifically addresses the correlation between CPM and self-esteem in children and adults. Leeson and Nixon

(2011) found, in a sample of 50 children ages 6 years old to 17 years old, that CPM was negatively correlated to levels of self-esteem during childhood as reported by the children. The levels of self-esteem were measured using the Self-Esteem Inventory (Leeson & Nixon, 2011). Parental reports of internalizing symptoms were collected using the CBCL. The results from the parental reports were consistent with the children's reports and identified internalizing symptoms as correlates of CPM (Leeson & Nixon, 2011).

Chan et al. (2011) investigated child maltreatment along with witnessing parental intimate partner violence and their correlations with self-esteem in children. Chan et al. (2011) found that 72% of the children reported psychological abuse. It was revealed that children who reported experiencing any type of abuse (i.e., physical abuse, psychological aggression, and neglect) had statistically significant lower self-esteem than those who only received corporal punishment. Additionally, it was found that those who witnessed intimate partner violence had significant lower self-esteem as compared to those who did not witness intimate partner violence (Chan et al., 2011). There were similar findings in an archival study with longitudinal data of adolescents who were followed into young adulthood (Cadmus-Romm, 2004). The results of the analysis revealed that emotional abuse and emotional neglect during adolescence were correlated with lower self-esteem in young adulthood. The findings from the previous research conducted with children (e.g., Chan et al., 2011; Leeson & Nixon, 2011) are essential to investigating the relationship between CPM and low self-esteem in adults. The current research was focused on adult correlates of CPM. Previous research has revealed that the correlates of

CPM in adults (Festinger & Baker, 2010) are similar to those in children (de la Vega et al., 2013).

Adult retrospective studies concerning CPM found that it correlated with self-esteem in adulthood (e.g., Brodski & Hutz, 2012; Festinger & Baker, 2010). Specifically, in a sample of adults between the age of 21 years old and 72 years old, Festinger and Baker (2010) found that CPM was correlated with lower self-esteem in adulthood. Additionally, in a college sample, Gross and Keller (1992) found that individuals who reported psychological abuse in childhood had lower self-esteem scores than those who did not report being psychologically abused. Self-esteem was measured using the Rosenberg Self-Esteem Scale (Gross & Keller, 1992).

In a sample of college students, Brodski and Hutz (2012) examined individuals' memories of emotional abuse as it related to specific parenting styles, as well as the correlation between emotional abuse and levels of self-esteem. The definition of emotional abuse used by these researchers included acts of omission and commission, as opposed to solely acts of commission (Brodski & Hutz, 2012). It was revealed that there were overall differences in responses to the Childhood Trauma Questionnaire concerning emotional abuse, based on parenting style. For example, there were significant differences between authoritative and negligent maternal parenting, authoritative and authoritarian maternal parenting, negligent and indulgent maternal parenting, and authoritarian and indulgent maternal parenting (Brodski & Hutz, 2012). Additionally, there were overall differences in responses concerning emotional abuse based on paternal

parenting style (Brodski & Hutz, 2012). Concerning self-esteem, Brodski and Hutz (2012) found that emotional abuse was negatively correlated with self-esteem.

The review of previous literature provided evidence of similar results concerning the correlation between CPM and self-esteem (e.g., Festinger & Baker, 2010; Gross & Keller, 1992). Thus, research provides evidence that self-esteem is negatively correlated with CPM. Higher levels of CPM were correlated with lower levels of self-esteem in children (e.g., Chan et al., 2011), as well as in adults (e.g., Cadmus-Romm, 2004; Festinger & Baker, 2010). The current research further investigated the relationship between CPM and self-esteem, along with investigating the relationship between CPM and anger in adulthood.

Anger

Research has revealed that children who experience maltreatment have a higher risk of becoming perpetrators of violence as adults (e.g., Mersky & Reynolds, 2007; Milaniak & Widom, 2015). In this regard, studies have often examined the related concepts of aggression (e.g., Allen, 2011; Logan-Greene & Jones, 2015) and anger (Harper & Arias, 2004). Anger has been correlated with child maltreatment (e.g., van Vugt, Lanctôt, Paquette, Collin-Vézina, & Lemieux, 2014), with limited research specifically on the correlation between adult anger and CPM.

van Vugt et al. (2014) conducted longitudinal research with female adolescents in a residential community. The research indicated that emotional neglect and emotional abuse were positively correlated with anger during adolescence. Additionally, van Vugt et al. (2014) followed up with the women during early adulthood and found that

emotional abuse and emotional neglect were positively correlated with anger during this time period as well. Additional research with adults, that has been conducted retrospectively, has found similar results concerning anger and its relationship to child maltreatment (e.g., Harper & Arias, 2004; Sudbrack, Manfro, Kuhn, de Carvalho, & Lara, 2015).

Harper and Arias (2004) found that higher levels of distress from CPM were correlated with higher levels of anger. Furthermore, Sudbrack et al. (2015) found that higher levels of emotional abuse and emotional neglect were correlated with higher levels of anger. In addition to research on emotional abuse and neglect, parallel research concerning child sexual abuse related to anger found that women who reported experiencing child sexual abuse indicated more anger suppression, using the State-Trait Anger Expression Inventory (STAXI) (Luterek, Harb, Heimberg, & Marx, 2004).

Aggression has been studied more often than anger, and the research suggests that aggression is a correlate of child maltreatment in adults (e.g., Allen, 2011). Using zero-order correlations, Allen (2011) found that CPM was positively correlated with aggression (e.g., verbal aggression, physical aggression). Additionally, parallel research concerning neglect (i.e., lack of supervision and failure to provide) found that there was a statistically significant positive correlation between neglect and aggression as well as emotional abuse and aggression (Logan-Greene & Jones, 2015). The collective research concerning anger (e.g., Harper & Arias, 2004) and aggression (e.g., Allen, 2011) as correlates of CPM has provided support for continued research in this area.

Psychological Maltreatment's Relationship to Other Forms of Abuse

The co-occurrence of maltreatment types (Spinazzola et al., 2014) leads to difficulties in investigating the outcomes of CPM, without considering the influence of other types of maltreatment (e.g., Spinazzola et al., 2014). Trickett, Mennen, Kim, and Sang (2009) contributed to the body of research concerning the overlap of maltreatment types in their examination of Los Angeles County Department of Children and Family Services' (DCFS) reports. During their examination of the records, Trickett et al. (2009) were able to link the reports of emotional abuse to the APSAC (1995) subtypes of abuse including spurning, terrorizing, isolating, and exploiting/corrupting. The definition used for this study did not include any acts that would be considered emotional neglect.

Using the subtypes of emotional abuse, Trickett et al. (2009) found considerable overlap among the types of abuse reported in the DCFS records. Specifically, children who experienced emotional abuse (exploiting/corrupting subtype) also experienced physical abuse at a rate of 80.4%, which was the highest occurrence of physical abuse for all the emotional abuse subtypes (Trickett et al., 2009). Furthermore, children who experienced emotional abuse (isolating subtype) also experienced sexual abuse at a rate of 30%, which was the highest of the emotional abuse subtypes (Trickett et al., 2009). The rates of overlap in maltreatment types imply that it would be beneficial to investigate the different types of abuse together rather than separately. When these types have occurred together, research has revealed that CPM may be a better predictor (Sudbrack et al., 2015) of maladjustment than other forms of abuse. Furthermore, CPM may predict maladjustment above other forms of abuse (e.g., Butaney, Pelcovitz, & Kaplan, 2011).

Spinazzola et al. (2014) investigated the outcomes of CPM with children. The researchers found that there was an overlap with CPM and other types of abuse. The presence of CPM was found to be a comparable, if not stronger, predictor of maladjustment than the presence of physical and sexual abuse occurring concurrently (Spinazzola et al., 2014). Specifically, CPM had a significantly higher odds ratio of predicting depression over physical abuse, as well as physical abuse and sexual abuse together. Furthermore, CPM was associated with over half of the 27 adjustment outcomes that were measured.

Butaney et al. (2011) found, with adolescents, that the occurrence of CPM was able to predict adjustment above the effects of physical abuse. Specifically, results from a two-step hierarchical multiple regression model revealed that, in the second step, CPM accounted for an additional 7% of the variance, in CBCL scores, above that which was explained by age, IQ, gender, and physical abuse, in the first step (Butaney et al., 2011). This research has revealed that, when investigating the correlates of CPM along with other forms of maltreatment, CPM has predictive power above physical abuse (Butaney et al., 2011).

Sudbrack et al. (2015) investigated the relationship among various types of childhood maltreatment (i.e., emotional abuse, emotional neglect, physical abuse, physical neglect, and sexual abuse) and adult adjustment. Sudbrack et al. (2015) obtained a sample of 10,800 participants and found, using a linear regression model, that emotional abuse and neglect had a strong relationship with adult maladjustment. Other forms of abuse were related to specific areas of adjustment (e.g., anxiety, sensitivity), but

emotional abuse and neglect were strong predictors of maladjustment in multiple areas (e.g., anger, coping, stability). Higgins and McCabe (2000) completed similar research, but obtained somewhat different results.

Specifically, Higgins and McCabe (2000) used multiple regression models to assess which maltreatment types (i.e., sexual, physical, CPM, neglect, and witnessing family violence) contributed to maladjustment in adults. The researchers found that sexual abuse and psychological maltreatment were both unique predictors of overall maladjustment (Trauma Symptoms Checklist-40) in adults who had experienced maltreatment as children (Higgins & McCabe, 2000). Additionally, Higgins and McCabe (2000) found that sexual abuse and psychological maltreatment were both unique predictors of lower scores on the Rosenberg Self-Esteem Scale. The different sample sizes in Higgins and McCabe (2000, $N = 175$) and Sudbrack et al. (2015, $N = 10{,}800$) could have contributed to the differences in the results.

Logan-Greene and Jones (2015) found that chronic neglect (i.e., failure to provide and lack of supervision) was correlated with aggression when isolated from other types of maltreatment. Chronic neglect, in this instance, referred to repeated occurrences of any and all forms of neglect and was not limited to emotional neglect. When the other forms of abuse (e.g., chronic emotional maltreatment, chronic physical abuse) were entered into the regression model, the relationship between chronic neglect and aggression remained significant, but the correlation coefficient was smaller than when chronic neglect was in the model alone. Furthermore, when other forms of abuse were entered into the model,

chronic emotional abuse was not found to be correlated to aggression (Logan-Greene & Jones, 2015).

Summary

Psychological maltreatment has not been the topic of research studies as often as other forms of child abuse. A review of the literature, however, has revealed that CPM is a prevalent (e.g., Finkelhor et al., 2014; Shi, 2013) form of child maltreatment that occurs concurrently with other forms of maltreatment (e.g., Schneider et al., 2005; Spinazzola et al., 2014). The correlates of CPM have been researched in children (e.g., de la Vega et al., 2013; Leeson & Nixon, 2011), adolescents (e.g., Chan et al., 2011), and adults (e.g., Coates & Messman-Moore, 2014). Previous research has revealed correlations between CPM and symptoms of depression (e.g., Allen, 2008; Gibb et al., 2007), symptoms of low self-esteem (e.g., Cadmus-Romm, 2004; Chan et al., 2011), and symptoms of anger (e.g., Harper & Arias, 2004; van Vugt et al., 2014) in adults. Two of the variables that have not been addressed as often, or as in-depth, as other variables include self-esteem and anger. Thus, although some studies have examined these variables, it is important to further investigate their correlation with CPM.

In addition to the limitations concerning the depth of the literature, there also has been limitations in the research concerning CPM's ability to predict maladjustment over and above other forms of abuse. The co-occurrence of multiple forms of maltreatment (Schneider et al., 2005) makes it difficult to address the correlates of CPM without examining how the other forms of abuse contribute to the prediction of adult correlates. Research has been inconsistent in its findings concerning CPM's ability to predict adult

correlates over and above other forms of abuse. Therefore, in addition to addressing the adult correlates of CPM, this research addressed CPM's ability to predict maladjustment over and above physical and sexual abuse.

Another restriction in the research involves the research conducted with the clinical and community samples, which do not generalize to the college population. The undergraduate population is different than other populations (i.e., clinical and community) that have been used in some of the samples. The research conducted with the college population consisted of samples inside and outside of the United States, including Brazil (Brodski & Hutz, 2012) and Belgium (Raes & Hermans, 2008). These samples also limit the generalizability of the research to the undergraduate population of the United States.

Therefore, the current research, with an undergraduate college sample, investigated depression, self-esteem, and anger as adult correlates of CPM. Additionally, the research examined CPM's ability to predict maladaptive correlates over and above physical and sexual abuse.

Hypotheses

1. Experiencing CPM would correlate with more symptoms of depression, more symptoms of lower self-esteem, and more symptoms of anger.
2. Experiencing CPM would correlate with more symptoms of depression, more symptoms of lower self-esteem, and more symptoms of anger when controlling for sexual abuse alone, physical abuse alone, and sexual and physical abuse together.

CHAPTER II

METHOD

Participants

At a midsized university in the southeast, participants were recruited during the summer (from undergraduate psychology classes) and during the fall (using the psychology research pool). The participants received course credit or extra credit for their participation in the research. The sample consisted of 160 students. There were 109 women, 50 men, and one participant who chose not to answer the question about his or her sex. The sample was ethnically diverse with 43% of the sample identifying as Caucasian and 38% of the sample identifying as African American. The majority of the sample was between 18 years old and 21 years old (84%). Descriptive statistics of the demographic variables are presented in Table 1. Before data collection began, approval was obtained from the Middle Tennessee State University's Institutional Review Board (See Appendix A). An addendum (See Appendix B) was received after the initial approval.

Measures

Demographic form. The participants were given a demographic form prior to completing the measures. The demographic form asked about sex, age (18 to 21 years old, 22 to 25 years old, 26 to 29 years old, and 30 years old and over), and race/ethnic group (Caucasian, African-American, or "Other"). The ages were divided into groups of ages to help preserve the anonymity of participants; this prevented those who represented

Table 1

Frequency of Demographic Variables

Variables	*N*	*%*
Sex		
Men	50	31.25
Women	109	68.13
No response	1	0.63
Age		
18-21	135	84.38
22-25	12	7.50
26-29	6	3.75
30 & older	7	4.38
Ethnicity		
Caucasian	68	42.50
African American	60	37.50
Other	32	20.00

the extreme (i.e., older, nontraditional students) from being more easily identifiable. See Appendix C.

Center for Epidemiologic Studies Depression Scale (CES-D Scale). The CES-D Scale (Radloff, 1977) is a self-report depression scale validated for use with the general public. The items are rated as *rarely or none of the time* to *most or all of the time* for each of the 20 items, with four of the items being reverse scored. The scores range from 0 to 60 with the higher scores indicating greater symptoms of depression. The scale has good concurrent and divergent criterion-related validity (Radloff, 1977). The internal consistency of the CES-D scale in the general population was approximately .85. The test-retest correlations were moderate and were better for shorter periods of time (4 weeks = .67) than longer periods (8 weeks = .59). The CES-D was designed to measure symptoms in the moment, which are expected to change with time and will affect the test-retest reliability (Radloff, 1977). The CES-D has been found to have good internal reliability with college students (e.g., Harper & Arias, 2004; Webb, Heisler, Call, Chickering, & Colburn, 2007). Webb et al. (2007) found an internal reliability of .88, and Harper and Arias (2004) found an internal reliability of .91.

Rosenberg Self-Esteem Inventory (RSE). The RSE (Rosenberg, 1965) is a measure of global self-esteem, which contains 10 items measured on a 4-point Likert scale (*strongly agree* to *strongly disagree*). Five of the items were reverse scored, and all of the items were summed for a total score of 10 points (minimum) and 40 points (maximum), with 40 suggesting high self-esteem (e.g., Festinger & Baker, 2010). In a review of the literature, Festinger and Baker (2010) found the RSE to have good

construct validity and test-retest reliability. The RSE was shown to have an internal consistency of .85 (Festinger & Baker, 2010)

Multidimensional Anger Inventory (MAI). The MAI was developed by Judith Siegel (1986) to assess multiple dimensions of anger. The MAI contains 38 items measured on a 5-point scale ranging from *completely undescriptive* to *completely descriptive.* The 38 items also can be divided into subcategories to measure specific dimensions of anger (anger-arousal, range of anger-eliciting situations, hostile outlook, anger-in, and anger-out; Siegel, 1986). The internal consistency of the total scale is .88, and the test-retest reliability is .75 over a 3 to 4 week period. Specific dimensions of the MAI were significantly correlated with the Novaco Anger Inventory, Buss-Durke Hostility Inventory, and the Harburg scale, suggesting criterion-related validity (Siegel, 1986).

Comprehensive Child Maltreatment Scale (CCMS). The CCMS (Higgins & McCabe, 2001) was developed for use with adults and assesses their experiences of negative interactions and possibly abusive situations during childhood. The measure contains 22 questions, which have been divided into subgroups to cover physical abuse, neglect, psychological maltreatment, witnessing family violence, and sexual abuse (Higgins & McCabe, 2001). The ratings for the responses were *never* to *very frequently* for items in all the categories other than sexual abuse. The items in the sexual abuse scale were on a 6-point scale (0 = *never*, 1 = *once*, 2 = *twice*, 3 = *3-6 times*, 4 = *7-20 times*, and 5 = *more than 20 times*). The items within each abuse category (i.e., physical abuse, sexual abuse, neglect, and psychological maltreatment) were asked three different

times, with the exception of witnessing family violence, to account for the relationship of the individual (mother, father, other adult/adolescent) that may have been involved with the abuse experience during childhood. The relationships (mother, father, other adult/adolescent) from each scale (i.e., physical, sexual, and psychological maltreatment) were summed to obtain a total score for each scale.

The CCMS has an overall alpha coefficient of .93 (Higgins & McCabe, 2001). The alpha coefficients for the individual scales were analyzed, and with the exception of physical abuse, all scales had an alpha higher than .70 (Higgins & McCabe, 2001). The physical abuse scale had an alpha of .66. Test-retest reliability, over a 6 to 8 week period, was .92 for the total CCMS (Higgins & McCabe, 2001). The CCMS has shown evidence of concurrent criterion-related validity when compared to similar subscales within the Child Abuse Trauma Scale (Higgins & McCabe, 2001).

Procedure

Approval from the Middle Tennessee State University's Institutional Review Board was obtained prior to conducting any research. Once the research was approved, participants were recruited from undergraduate psychology classes during the summer semester. The psychology research pool was used to recruit participants for the study during the fall semester. Prior to signing up for the research, the participants had to review the exclusionary criteria, which stated that they should not participate if they have had suicidal thoughts or behaviors in the past month. When participants presented for the research study, they were asked to sign an informed consent (See Appendix D), which detailed the procedure, risks, and benefits. Once the participants consented to engage in

the study and their self-reported age was shown to be 18 years or older, they were provided with a packet of surveys along with verbal instructions on how to complete the packet. The packet included the demographic form along with the CCMS (Higgins & McCabe, 2001), CES-D Scale (Radloff, 1977), MAI (Siegel, 1986), and the RSE (Rosenberg, 1965). Due to the chance of reactivity occurring after the abuse questions, the CCMS was presented last in each of the packets. The demographic form was presented first in each packet, and the order of the other three questionnaires was varied. The order of the surveys was adjusted to prevent them from being in the same order for each person who completed the survey and to control for extraneous variables. Once the study was completed, the participants were provided with a debriefing information sheet (See Appendix E).

CHAPTER III

RESULTS

Descriptive Statistics

The means, standard deviations, and internal consistencies for the adjustment and abuse measures are listed in Table 2. As seen in Table 3, there were significant correlations among the adjustment variables. Specifically, depression, self-esteem, and anger were correlated with each other. The correlations among the maltreatment variables are presented in Table 4. All three maltreatment variables (psychological, physical, and sexual abuse) were positively correlated with each other.

Hypotheses Testing

The first hypothesis was whether experiencing CPM was correlated to increased symptoms of depression, anger, and to lower self-esteem. This hypothesis was analyzed using zero-order correlations to measure the strength of the correlation between CPM and symptoms of depression, self-esteem, and anger. As seen in Table 5, there were significant correlations among the maltreatment and adjustment variables. Specifically, CPM was positively correlated with depression and anger, and negatively correlated with self-esteem.

The second hypothesis was that CPM would correlate with greater symptoms of depression, anger, and lower self-esteem, when controlling for physical abuse alone, sexual abuse alone, and then physical and sexual abuse together. This hypothesis was analyzed using partial correlations to measure the strength of the correlation between

Table 2

Descriptive Statistics of the Adjustment Scales and the Maltreatment Subscales of the CCMS

Scales	*M*	*SD*	*α*
Adjustment			
Depression	16.80	9.79	.87
Anger	107.27	21.55	.91
Self-Esteem	31.12	6.46	.92
Maltreatment			
Physical	12.40	4.04	.70
Psychological	17.11	7.19	.82
Sexual	2.41	6.63	.88

Note. Adjustment variables: N =145 to 160. Maltreatment: N = 160. Depression = Center for Epidemiological Studies Depression Scale; Anger = Multidimensional Anger Inventory; Self-Esteem = Rosenberg Self-Esteem Inventory; Maltreatment = Comprehensive Child Maltreatment Scale (CCMS).

Table 3

Zero-Order Correlations Among Adjustment Measures

Adjustment Scales	Depression (N = 145)	Anger (N = 160)	Self-Esteem (N = 160)
Depression			
Anger	.41**		
Self-Esteem	-.49**	-.21*	

Note. Adjustment variables: N = 145 to 160. Depression = Center for Epidemiological Studies Depression Scale; Anger = Multidimensional Anger Inventory; Self-Esteem = Rosenberg Self-Esteem Inventory.
*p < .01. **p < .001.

Table 4

Zero-Order Correlations Among Subscales of the Comprehensive Child Maltreatment Scale

Maltreatment Subscales	Physical	Sexual	Psychological
Physical			
Sexual	.31*		
Psychological	.71*	.40*	

Note. N = 160. *p < .001.

Table 5

Zero-Order Correlations between the CCMS Subscales and the Adjustment Scales

	Adjustment Measures		
Maltreatment Subscales	Depression (*N*= 145)	Anger (*N* = 160)	Self-Esteem (*N* = 160)
Physical	.14	.23**	-.12
Sexual	.27***	.23**	-.05
Psychological	.36***	.32***	-.19*

Note. *N* = 145 to 160. Depression = Center for Epidemiological Studies Depression Scale; Anger = Multidimensional Anger Inventory; Self-Esteem = Rosenberg Self-Esteem Inventory; Maltreatment = Comprehensive Child Maltreatment Scale (CCMS). *$p < .05$. **$p < .01$. ***$p < .001$.

CPM and the adjustment variables, when controlling for physical abuse alone, sexual abuse alone, and physical and sexual abuse together.

In the partial correlation examining the relationship between CPM and anger, when controlling for physical abuse, it was found that anger remained statistically significantly correlated with CPM, $r(160) = .22$, $p < .01$. Similarly, in the partial correlation examining the relationship between CPM and depression, when controlling for physical abuse, it was found that depression remained statistically significantly correlated with CPM, $r(145) = .37$, $p < .001$. When controlling for physical abuse, self-esteem did not remain statistically significantly correlated with CPM, $r(160) = -.15$, $p > .05$.

When examining the partial correlation between CPM and anger, when controlling for sexual abuse, it was found that anger remained statistically significantly correlated with CPM, $r(160) = .25$, $p < .01$. In the partial correlation examining the relationship between CPM and depression, when controlling for sexual abuse, it was found that depression remained statistically significantly correlated with CPM, $r(145) = .28$, $p < .001$. Similarly, self-esteem remained statistically significantly correlated with CPM, $r(160) = -.18$, $p < .05$, when controlling for sexual abuse.

In the partial correlation examining the relationship between CPM and anger, when controlling for physical and sexual abuse together, anger remains statistically significantly correlated with CPM, $r(160) = .18$, $p < .05$. Additionally, depression remained statistically significantly correlated with CPM, $r(145) = .32$, $p < .001$, when controlling for physical and sexual abuse together. Self-esteem did not remain

statistically significantly correlated with CPM, $r(160) = -.15$, $p > .05$, when controlling for physical and sexual abuse together.

CHAPTER IV

DISCUSSION

The purpose of this study was to build upon the extant literature concerning CPM and its relationship with adult adjustment. It was hypothesized that experiencing CPM would be correlated with greater symptoms of depression, great symptoms of anger, and lower self-esteem in adults. Consistent with the hypothesis and existing research (e.g., Allen, 2008; Crow et al., 2014), this current study found that those who had higher scores on the CCMS psychological maltreatment subscale also indicated experiencing greater symptoms of depression. Different explanations have been proposed concerning the factors that may contribute to the relationship between CPM and depression. For example, Coates and Messman-Moore (2014) found that emotional dysregulation mediated the relationship between CPM and depression in adults. Additionally, Harper and Arias (2004) found that shame moderated the relationship between CPM and depression in women. The factors addressed in the existing research have provided insight into the mechanisms that may be involved in the relationship between CPM and symptoms of depression in adults.

Consistent with the hypothesis, the current research found that CPM was significantly correlated with greater symptoms of anger in adults. Different explanations have been suggested concerning the relationship between CPM and anger in adults. Specifically, Harper and Arias (2004) found that shame, which was a moderator for depression in women, also was a moderator for anger in men. The nature of the differences between men and women have not been addressed, but could be considered in future research. Because of the limited research concerning the relationship between

CPM and anger, it is helpful to explore parallel research. Parallel research concerning aggression (Allen, 2011) found that the relationship between CPM and aggression was mediated by dysfunctional self-capacities (e.g., difficulties with interpersonal relationships). The research indicates that the experiences of CPM may cause difficulties in relating with others as children, which then leads to difficulties with interpersonal skills as adults (Allen, 2011).

In accordance with the hypothesis, experiencing CPM was significantly correlated with lower self-esteem in adults. The results from the current study are consistent with previous research (e.g., Festinger & Baker, 2010; Gross & Keller, 1992). In a qualitative study, Harvey et al. (2012) theorized that the experiences of CPM inhibited the emergence of a good sense of self, which may lead to lower self-esteem. It is possible that the words and actions that are associated with CPM are internalized and then used as an internal dialogue as a means to define oneself. Harvey et al. (2012) found that their participants often internalized the messages they received through their experiences of CPM. These internalized messages caused them to compare themselves with others and often times view themselves as not being "good enough."

Existing research has provided insight into the overlap of different forms of maltreatment (e.g., Schneider et al., 2005; Spinazzola et al., 2014; Trickett et al., 2011). The current study adds to the existing research and demonstrates that psychological, physical, and sexual abuse are significantly correlated with each other. The hypothesis in this study was that CPM would correlate with greater symptoms of depression, greater symptoms of anger, and greater symptoms of lower self-esteem, when controlling for

physical abuse, sexual abuse, and then physical and sexual abuse together. This study found that while controlling for sexual abuse all of the adjustment variables (depression, anger, and self-esteem) remained significantly correlated to CPM. Furthermore, when controlling for physical abuse and then physical abuse and sexual abuse together, depression and anger remained significantly correlated with CPM. Consistent with parallel research with adolescents (e.g., Butaney et al., 2011), this research has shown that CPM can predict these particular adjustment variables, in adults, over and above the presence of other forms of maltreatment

The findings from the current study are significant as they support the theory that these specific forms of maltreatment should not be studied alone as they are all intercorrelated with each other. Additionally, the current research provides evidence of the strength of the relationship between CPM and the adjustment variables over and above that of physical and sexual abuse. Research suggests that CPM is embedded in all types of abuse (Schneider et al., 2005), which makes it very difficult to research CPM without considering the other forms of abuse. The findings from this study warrant future research on the relationships among psychological, physical, and sexual abuse and how they may impact adult adjustment. In addition, research concerning CPM should be conducted to better understand how to prevent this form of maltreatment.

There were several limitations to this study, such as with the sample. The sample consisted of college undergraduate students who were predominantly women (68%) between 18 years old and 21 years old (84%). Additionally, the sample was restricted due to exclusionary criteria that informed any individual who had experienced suicidal

thoughts or behaviors in the past month to not participate in the study. The demographics of this sample were not representative of the population at the university, as the sample was ethnically diverse with 60% of the sample consisting of ethnic minorities. These variables impact the ability of this study to generalize to this university's population as well as to the general population. Furthermore, this was a relatively small sample obtained at one university in the southeast.

There also were limitations concerning the maltreatment scales. The CCMS has been used in previous research (e.g., Higgins & McCabe, 2003) and had good internal consistency overall and for the subscales. This research used three subscales (physical, sexual, and psychological maltreatment) rather than the whole scale. The physical and psychological abuse scales only contained three questions each. Using scales that contained more items would have been preferable and may have added to the validity of the measure.

Additionally, there were limitations concerning the cross-sectional design of the study. This design analyzed information collected at one point in time, rather than across time, which would be a longitudinal study. The cross-sectional design did not allow for the consideration of other factors that may have impacted adult adjustment. For example, the college experience itself could have contributed to whether or not an individual experienced difficulty with adjustment. Longitudinal studies are the preferred option for this type of research, but due to the time and expense of conducting that type of research, it is not always feasible.

The nature of this research (childhood maltreatment) and the design (cross-sectional) made it necessary to collect retrospective data. Retrospective data are dependent upon the memories of the participants, which may not be reliable. Memories may be distorted as the length of time from the actual incident increases. Furthermore, the presence of current symptoms of depression or anger may impact the memories of their childhood. It may be that individuals who are experiencing emotional maladjustment remember their childhood in a more negative light than those who are not currently experiencing emotional maladjustment (Festinger & Baker, 2010).

Despite these limitations, this research provided important information concerning the association of CPM with adult adjustment. Specifically, it provided insight concerning the correlation among CPM and depression, anger, and self-esteem. Experiencing CPM appears to be a risk factor for developing symptoms of depression, anger, and lower self-esteem in adults. This research also provided information concerning the ability of CPM to predict maladjustment over and above physical, sexual, and then physical and sexual abuse together. Research concerning CPM's predictability is limited, but this study adds to the growing body of literature concerning CPM's role in adult maladjustment over and above the impact of physical and sexual abuse.

Future research in this area should be conducted using a longitudinal design. This would allow researchers to consider the variables outside of maltreatment that could contribute to adult maladjustment. Furthermore, research concerning the underlying factors of the different forms of abuse would help in understanding the relationships among psychological, physical, and sexual abuse. Additionally, when investigating the

correlates of CPM, research on the role of mediators in the development of correlates to CPM would help to provide more understanding concerning how to prevent these outcomes.

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APPENDICES

APPENDIX A

Middle Tennessee State University Institutional Review Board Approval Notice

IRB
INSTITUTIONAL REVIEW BOARD
Office of Research Compliance,
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2269 Middle Tennessee Blvd
Murfreesboro, TN 37129

MIDDLE TENNESSEE STATE UNIVERSITY

IRBN008 - PROTOCOL APPROVAL NOTICE

Wednesday, May 11, 2016

Investigator(s): Danielle Nowlin & Mary Ellen Fromuth
Investigator(s') Email(s): *den2g@mtmail.mtsu.edu*
Department: Psychology

Study Title: ***Child Psychological Maltreatment and its Relationship with Adult Adjustment***
Protocol ID: **16-3256**

Dear Investigator(s),

The above identified research proposal has been reviewed by the MTSU Institutional Review Board (IRB) through the **FULL COMMITTEE REVIEW** mechanism under 45 CFR part 46 and 21 CFR part 56. This protocol was reviewed by the IRB at a convened meeting which was conducted in accordance with the HHS requirements on 5/3/16. The IRB has determined that this study poses minimal risk to the participants or that you have satisfactorily worked to minimize the risks, and you have satisfactorily addressed all of the concerns brought up during the review. A summary of the IRB action and other particulars in regard to this protocol application is tabulated as shown below:

IRB Action	APPROVED for one year	
Date of expiration	5/17/2017	
Sample Size	300	
Participant Pool	**MTSU Psychology Research Pool and classes chosen**	
Exceptions	None	
Restrictions	**ONLY MTSU PSYCHOLOGY RESEARCH POOL STUDENTS OR STUDENTS IN CLASSES RECRUITED TO PARTICIPATE, PARTICIPANTS SHOULD COMPLETE SCREENING AS PART OF THE SIGN-UP PROCESS**	
Comments	None	
Amendments	**Date**	**Post-approval Amendments**
		Click here to enter text.

During its convened meeting on 5/3/16, the IRB also determined, through a majority vote, that the continuing review (CR) can be approved through the EXPEDITED process as this study meets the requirement criteria.

This protocol can be continued for up to THREE years (5/17/2019) by obtaining a continuation approval prior to 5/17/2017. Refer to the following schedule to plan your annual project reports and be aware that you may not receive a separate reminder to complete your continuing reviews. Failure in obtaining an approval for continuation will automatically result in

cancellation of this protocol. Moreover, the completion of this study MUST be notified to the Office of Compliance by filing a final report in order to close-out the protocol.

Continuing Review Schedule:

Reporting Period	Requisition Deadline	IRB Comments
First year report	5/17/2017	Not received
Second year report	5/17/2018	Not received
Final report	5/17/2019	Not received

The investigator(s) indicated in this notification should read and abide by all of the post-approval conditions imposed with this approval. Refer to the post-approval guidelines posted in the MTSU IRB's website. Any unanticipated harms to participants or adverse events must be reported to the Office of Compliance at (615) 494-8918 within 48 hours of the incident. Amendments to this protocol must be approved by the IRB. Inclusion of new researchers must also be approved by the Office of Compliance before they begin to work on the project.

All of the research-related records, which include signed consent forms, investigator information and other documents related to the study, must be retained by the PI or the faculty advisor (if the PI is a student) at the secure location mentioned in the protocol application. The data storage must be maintained for at least three (3) years after study completion. Subsequently, the researcher may destroy the data in a manner that maintains confidentiality and anonymity. IRB reserves the right to modify, change or cancel the terms of this letter without prior notice. Be advised that IRB also reserves the right to inspect or audit your records if needed.

Sincerely,

Institutional Review Board
Middle Tennessee State University

Quick Links:

Click here for a detailed list of the post-approval responsibilities.
More information on expedited procedures can be found here.

APPENDIX B

Middle Tennessee State University Institutional Review Board Addendum

IRB
INSTITUTIONAL REVIEW BOARD
Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd
Murfreesboro, TN 37129

MIDDLE TENNESSEE STATE UNIVERSITY

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Comments	None	
Amendments	**Date**	**Post-approval Amendments**
	9.6.16	Added investigators: Angelina Anselmo; Kin Leong Chan

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Sincerely,

Institutional Review Board
Middle Tennessee State University

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APPENDIX C

Demographic Form

Part A

Please complete the follow questions regarding demographic information.

1. Are you?
    1. Male
    2. Female
    3. Other
    4. I do not wish to answer this question.

2. How old are you?
    1. 18-21
    2. 22-25
    3. 26-29
    4. 30 & older
    5. I do not wish to answer this question.

3. What is your ethnicity?
    1. Caucasian
    2. African American
    3. Other
    4. I do not wish to answer this question.

APPENDIX D

Informed Consent

Principal Investigator: Danielle Nowlin
Study Title: Child Psychological Maltreatment and its Relationship with Adult Adjustment.
Institution: Middle Tennessee State University

Name of participant: _____ Age: _____

The following information is provided to inform you about the research project and your participation in it. Please read this form carefully and feel free to ask any questions you may have about this study and the information given below. You will be given an opportunity to ask questions, and your questions will be answered. Also, you will be given a copy of this consent form.

Your participation in this research study is voluntary. You are also free to withdraw from this study at any time. In the event new information becomes available that may affect the risks or benefits associated with this research study or your willingness to participate in it, you will be notified so that you can make an informed decision whether or not to continue your participation in this study.

For additional information about giving consent or your rights as a participant in this study, please feel free to contact the MTSU Office of Compliance at (615) 494-8918.

1. **Purpose of the study:**
   The purpose of this study is to examine the relationship between experiences of maltreatment during childhood and adjustment in adulthood.

2. **Description of procedures to be followed and approximate duration of the study:**
   We would like to ask you to participate in this study examining the relationship between childhood experiences of maltreatment and adjustment during adulthood. The demographic form will ask questions about age, sex, and ethnicity. You may skip any of the demographic questions or other questions that are asked. This study will ask about abuse experiences including physical, sexual, and psychological maltreatment. Questions will be asked about current adjustment including depression, self-esteem, and anger. The study will take about 45 minutes to complete. You will receive two research credits for your participation. The whole questionnaire is anonymous, and your name will not be included on the survey.

3. **Expected costs:**
   There will not be any monetary costs to you for your participation. The only cost will be your time.

4. **Description of the discomforts, inconveniences, and/or risks that can be reasonably expected as a result of participation in this study:**
   Some participants may experience some psychological stress due to the nature of the questions. Some of the items ask explicit questions about sexual and other forms of child abuse. This may trigger some stress and feelings of discomfort in some individuals.

5. **Compensation in case of study-related injury:**
   MTSU will not provide compensation in the case of study-related injury.

6. **Anticipated benefits from this study:**
   a) The potential benefit to science and humankind that may result from this study is that we will be able to learn about the relationship between specific childhood experiences and adult adjustment.
   b) The potential benefit to you from this study is learning about the research process.

7. **Alternative treatments available:**
   No alternative treatments available.

8. **Compensation for participation:**
   The compensation for participation will include two research credits or extra credit in your course.

9. **Circumstances under which the Principal Investigator may withdraw you from study participation:**
   None

10. **What happens if you choose to withdraw from study participation:**
    Participants who choose to withdraw from the study will still receive credit for their participation.

11. **Contact Information.** If you should have any questions about this research study or possible injury, please feel free to contact Danielle Nowlin at den2g@mtmail.mtsu.edu or my Faculty Advisor**,** Mary Ellen Fromuth at 615-898-2548, Maryellen.Fromuth@mtsu.edu.

12. **Confidentiality.** All efforts, within reason, will be made to keep the personal information in your research record private but total privacy cannot be promised. Your information may be shared with MTSU or the government, such as the Middle Tennessee State University Institutional Review Board, Federal Government Office for Human Research Protections, if you or someone else is in danger or if we are required to do so by law.

13. **STATEMENT BY PERSON AGREEING TO PARTICIPATE IN THIS STUDY**

I have read this informed consent document and the material contained in it has been explained to me verbally. I understand each part of the document, all my questions have been answered, and I freely and voluntarily choose to participate in this study.

_____ _____

Date Signature of patient/volunteer

Consent obtained by:

_____ _____

Date Signature

Danielle Nowlin, BS, Graduate Student Researcher
Printed Name and Title

APPENDIX E

Debriefing Information

Please keep for your own use.

Psychological maltreatment is a form of child abuse that has only recently become the focus of much research. This form of abuse is defined as actions directed towards the child and, it includes name calling, threatening, and isolating the child. Maladjustment in children and adults (e.g., depression, anxiety, and eating disorders) has been correlated to the experiences of psychological maltreatment. The purpose of this study was to investigate the relationship between psychological maltreatment and depression, self-esteem, and anger. In addition to investigating those relationships, this research was designed to investigate if psychological maltreatment has a stronger relationship with later maladjustment than physical or sexual abuse.

Sometimes people feel distress when thinking about past experiences of abuse of any kind. If you would like to talk to someone about your experience or feelings, counseling services are available by contacting the following:

On Campus: **MTSU Counseling Services**, ext. 2670

Off Campus: **MTSU Center for Counseling and Psychological Services** (615) 898-2271 (open Fall/Spring; free for students)
The Guidance Center, (615) 895-6051 (fee based)
Centerstone of Tennessee, (888) 291-4357 (fee based)
Mental Health Cooperative, (615) 743-1555 (fee based)
Suicide Prevention Lifeline (800) 273-8255

If you would like more information about this study or your rights as a participant, please feel free to contact me at den2g@mtmail.mtsu.edu or my faculty advisor. Dr. Mary Ellen Fromuth, at MaryEllen.Fromuth@mtsu.edu. The results from this study will not be immediately available, but arrangements can be made for you to obtain the results of the study once they become available.

Thank you for your time and patience in helping me with this project.

Danielle Nowlin
Graduate Student, Clinical Psychology
den2g@mtmail.mtsu.edu