CHILDHOOD EMOTIONAL ABUSE AND NEGLECT IN HONG KONG

Abstract

Background: Adverse childhood experiences are an important public health issue. It is well documented that they are associated with many health problems. Nevertheless, little is known about childhood emotional abuse and neglect (CEA and CEN) among Hong Kong people.

Objective: This study aimed to explore the demographic and mental health correlates of CEA and CEN in a Hong Kong sample.

Methods: A total of N = 418 Hong Kong adults completed an online survey that included questions regarding demographic information and measures of adverse childhood experiences, depression, anxiety, borderline personality disorder, post-traumatic stress disorder and somatoform dissociation.

Results: The rates of CEA and CEN were 43.3% and 44.5% respectively in this convenience sample. Both CEA and CEN were associated with poor socioeconomic status. They were also associated with psychiatric service usage and all five types of mental health problems. Both CEA and CEN increased the chance of having mental health problems even after taking into account the effects of other forms of childhood abuse and neglect.

Conclusions: This study is the first to show that CEA and CEN are significantly associated with poor socioeconomic status and mental health problems in the Hong Kong context. Implications are discussed. Further studies are needed.

Keywords: Adverse childhood experiences; Emotional abuse; Emotional neglect; Child protection; Mental health; Hong Kong

Demographic and mental health correlates of childhood emotional abuse and neglect in a Hong Kong sample

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Introduction

Childhood maltreatment is associated with unfavorable mental health effects

It has long been suggested that childhood experiences are crucial to personality development and mental health (e.g., Erikson, 1950; Fromm, 1956). In that regard, adverse childhood experiences have been said to be an important public health issue because of their significant relationships with subsequent physical and mental health problems (Dallam, 2001; van der Kolk, 2017). In the empirical literature, it is well-documented that childhood adversities are associated with a variety of mental health problems, including depression (Chapman et al., 2004; Kessler & Magee, 1994), suicidal tendencies (Dube et al., 2001; Kwok, Chai, & He, 2013), borderline personality disorder (BPD) (Ball & Links, 2009), eating disorders (Johnson, Cohen, Kasen, & Brook, 2002), substance abuse (Levenson, 2016), pathological dissociation (Fung, Ross, Yu, & Lau, 2019; Irwin, 1999) and psychosis (Read, van Os, Morrison, & Ross, 2005). Stressful or traumatic experiences can profoundly affect one's psychophysiological development (for example, the hypothalamic-pituitary-adrenal axis, and brain structures such as the amygdala, hippocampus and frontal lobes) (van der Kolk, 2014). In particular, child maltreatment is common across different countries and regions, although research has been dominated by studies on childhood sexual abuse (Stoltenborgh, Bakermans-Kranenburg, Alink, & IJzendoorn, 2015). Childhood maltreatment has been found to be associated with both physical and mental health problems (Leeb, Lewis, & Zolotor, 2011). Such experiences can have psychological impacts, such as low self-esteem, anxiety, self-blame and other cognitive behavioral problems (McLean & Foa, 2011; D. A. Ross et al., 2017; Steele, Van der Hart, & Nijenhuis, 2009). For example, after childhood maltreatment, a child may feel that the world is not safe and people are not predictable, or believe that he or she is not loveable and deserves to be abused (Fung & Ross, 2019; C. A. Ross & Halpern, 2009).

Childhood emotional abuse and neglect are as important issues as other forms of childhood maltreatment

The harmful effects of childhood maltreatment are obvious in the literature. However, some people may believe that some forms of childhood maltreatment (e.g., physical and sexual abuse) are more harmful than other forms, even though it has been found that childhood physical abuse, sexual abuse, emotional abuse and emotional neglect are all associated with mental health problems (Vachon, Krueger, Rogosch, & Cicchetti, 2015). Unlike other forms of childhood maltreatment, childhood emotional abuse (CEA) and neglect (CEN) are more difficult to define and measure as there may be no physical indicators of them. Nevertheless, Glaser (2002) provides five criteria for defining CEA and CEN and suggests that childhood emotional abuse and neglect are defined as "a carer-child relationship that is characterized by patterns of harmful interactions, requiring no physical contact with the child" (p. 697). It is said that there are at least two dimensions to emotional maltreatment: the abuse dimension (acts of commission)(hostile parenting) and the neglect dimension (acts of omission)(indifferent parenting) (Baker & Festinger, 2011; Iwaniec, 1995). In fact, the literature indicates that CEA and CEN are as important issues as other forms of childhood maltreatment. Norman et al. (2012) conducted a systematic review and meta-analysis and suggested that non-sexual child maltreatment including CEA and CEN are significant risk factors for a range of mental health problems. Other studies also indicate a link between CEA and CEN and mental health problems (e.g., Kimber et al., 2017; Taillieu, Brownridge, Sareen, & Afifi, 2016; Young, Lennie, & Minnis, 2011). In addition, some studies also reported that childhood emotional maltreatment is associated with certain demographic variables, such as gender and education level (Baker & Festinger, 2011; Scher, Forde, McQuaid, & Stein, 2004), although no causal relationships have been established.

Knowledge gaps in the Hong Kong Chinese context

While the consequences of CEA and CEN have been increasingly recognized, more effort is needed to better understand the situation in the Chinese context, specifically in Hong Kong. Since Chinese parents may be generally less accepting, less consistent, less warm and more restrictive/hostile/rejecting/neglecting than parents from other cultures (e.g., North America) (Chen et al., 1998; Kelley & Tseng, 1992; Putnick et al., 2012), CEA and CEN may be significant public health issues in the Chinese context. Previous studies have suggested that CEA and CEN are fairly common

in Chinese populations. For instance, in a sample of 202 Hong Kong mental health service users, 43.1% of participants reported CEA and 38.6% reported CEN (Fung et al., 2019). Li et al. (2014) found that the rates of CEA and CEN were 18.76% and 49.48%, respectively, in a sample of Chinese adolescents (N = 485). Another study reported that the rates of CEA and CEN were 10.5% and 27.9%, respectively, in a sample of 552 Chinese adolescents (Wang et al., 2017). More importantly, it is possible that cultural differences may influence the impacts of childhood maltreatment (Korbin, 1991; Kwok et al., 2013). For example, the relationship between childhood emotional maltreatment and mental health problems may be less obvious in some specific culture.

Although CEA and CEN have been investigated in a few Chinese studies (e.g., Huang et al., 2012; Wang et al., 2017), more research is needed to examine their relationships with different demographic and mental health variables in both clinical and non-clinical Chinese populations, and specifically in Hong Kong.

In particular, there are some major knowledge gaps. First, previous studies that looked at the psychosocial correlates of CEA and CEN in non-clinical Chinese settings (e.g., Li et al., 2014; Wang et al., 2017) did not include measures of trauma-related mental health problems (i.e., post-traumatic stress disorder and somatoform dissociation). Second, little is known about the mental health correlates of CEA and CEN in the Hong Kong Chinese context - given the historical and political context, there are cultural differences between different Chinese cultures (e.g., Hong Kong is different from China), including perceptions of parenting (Berndt, Cheung, Lau, Hau, & Lew, 1993) and adolescent-parent conflicts (Yau & Smetana, 2003), filial piety, parent-child interaction and intergenerational relationships within families (Yeh, Yi, Tsao, & Wan, 2013), and maternal child-rearing practices (Lai, Zhang, & Wang, 2000). In fact, child maltreatment studies in Hong Kong (e.g., Chan, 2011; Lau, Liu, Cheung, Yu, & Wong, 1999) rarely focus on emotional abuse and emotional neglect, and have rarely measured trauma-related mental health problems together with them. To our knowledge, there are only two recent studies that investigated adverse childhood experiences (including CEA and CEN) in Hong Kong. One study was conducted in a clinical setting and only included measures of one mental health problem (i.e., dissociation) (Fung et al., 2019); while the

other study was conducted a non-clinical sample, it primarily looked at the patterns of childhood adversities and did not include any mental health measure (Ho, Chan, Chien, Bressington, & Karatzias, 2019). Given that Hong Kong is a big city with a population of more than 7.4 million and that the number of Hong Kong people migrated to other countries (e.g., Canada, United States) is huge and keep increasing, childhood emotional maltreatment among Hong Kong people is an important issue that requires more attention.

Keeping the above-mentioned issues in mind, this study aimed to explore the demographic and mental health correlates of CEA and CEN in a sample of Hong Kong adults. The major hypothesis was that CEA and CEN would be significantly associated with all types of mental health problems even after taking into account the effects of other forms of childhood abuse and neglect.

Methods

Participants

This study used data from a project that examined adverse childhood experiences and mental health problems in Hong Kong, which was approved by the institutional review board of the City University of Hong Kong. The project recruited Hong Kong adults through Hong Kong based online channels (e.g., social networking sites and online groups) to participate in a web-based mental health survey that included measures of adverse childhood experiences, depression, anxiety, post-traumatic stress disorder (PTSD), BPD and somatoform dissociation. During the period from November 2018 to January 2019, a total of 420 individuals gave informed consent and completed the online survey using a password-protected Google Form. Two participants were excluded because they indicated that they had not lived in Hong Kong for at least one year.

A total of N = 418 participants were included in the analysis. All participants indicated that they had lived in Hong Kong for at least 7 years. Most participants were female (67.5%), 31.6% were male, and four participants (1%) described themselves as transgender. Their ages ranged from 18 to 64 (M = 27.3, SD = 8.80). Only 15.3% reported that they were currently using psychiatric services.

Instruments

The online survey included questions regarding demographic information (this included gender, age, individual monthly income, education level, and previous/current use of psychiatric services), in addition to measures of the following variables:

Childhood emotional abuse and neglect (CEA and CEN) were assessed with the 10-item Adverse Childhood Experiences Questionnaire, which was developed by the Centers for Disease Control and Prevention, US. This questionnaire includes 10 yes/no items that assess ten different types of adverse experiences before the age of 18 (Bruskas & Tessin, 2013; Esaki & Larkin, 2013; Reavis, Looman, Franco, & Rojas, 2013). In particular, there is one item about CEA ("*Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?*") and one item about CEN ("*Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?*"). These two items operationalize CEA and CEN and are consistent with the above-mentioned definition suggested by Glaser (2002). The Chinese version of the 10-item Adverse Childhood Experiences Questionnaire has been used in a previous study (Fung et al., 2019). The Cronbach's α of the Questionnaire was 0.657 in the present sample.

Depression was assessed with the 9-item Patient Health Questionnaire (PHQ-9), which is a widely-used self-report measure that can be used to screen for depression (Kroenke & Spitzer, 2002; Kung et al., 2013). An example of the items is "*feeling down, depressed, or hopeless*." The psychometric properties of the Chinese version of the PHQ have been examined in Yeung et al. (2008) – a cutoff score of 15 can detect major depressive disorder with a sensitivity of 81% and a specificity of 98%. The Cronbach's α of the PHQ-9 was 0.924 in the present sample.

Anxiety was assessed with the Generalized Anxiety Disorder 7-item Scale (GAD-7), which is a brief, reliable and valid screening tool for generalized anxiety disorder (GAD) (Löwe et al., 2008; Spitzer, Kroenke, Williams, & Löwe, 2006). An example of the items is "*feeling afraid as if something awful*

might happen." The Chinese version of the GAD-7 is also reliable and valid – a cut-off score of 10 can detect GAD with a sensitivity of 86.2% and a specificity of 95.5% (see He, Li, Qian, Cui, & Wu, 2010). The Cronbach's α of the GAD-7 was 0.937 in the present sample.

Post-traumatic symptoms were assessed with the PTSD Checklist, which is a 17-item self-report assessment tool for PTSD (Weathers, Litz, Herman, Huska, & Keane, 1993). An example of the items is "*repeated, disturbing dreams of a stressful experience from the past*." In a preliminary study, Wu, Chan, and Yiu (2008) indicated that the Chinese version of the PTSD Checklist is reliable and valid and that a cut-off total score of 50 can detect DSM-IV PTSD with a sensitivity of 100% and a specificity of 98%. The Cronbach's α of the GAD-7 was 0.963 in the present sample.

Borderline personality disorder (BPD) symptoms were assessed using the self-report version of the Borderline Personality Disorder Section of the Dissociative Disorders Interview Schedule (DDIS-BPD). The DDIS is a well-validated structured interview for a number of DSM disorders, including dissociative disorders, major depressive disorder and BPD (C. A. Ross & Ellason, 2005; C. A. Ross et al., 1989). There is a 9-item section for BPD, which corresponds to the nine DSM-5 diagnostic criteria for BPD. An example of the items is "*frantic efforts to avoid real or imagined abandonment*." According to DSM-5 rules (American Psychiatric Association, 2013), a positive diagnosis of BPD requires the endorsement of at least 5 out of 9 items. The Chinese version of the DDIS-BPD has been used as a self-report measure (SR-DDIS-BPD) in previous studies (e.g., Fung & Chan, 2019; Fung, Ho, & Ross, 2018). In a pilot study, the Chinese version of the SR-DDIS-BPD had a sensitivity of 87% and a specificity of 77% to detect clinically diagnosed DSM-5 BPD (area under the curve = .861) in a sample of 56 psychiatric outpatients (unpublished data). The Cronbach's α of the DDIS-BPD was 0.800 in the present sample.

Somatoform dissociation was assessed with the 5-item Somatoform Dissociation Questionnaire (SDQ-5). Somatoform dissociation, sometimes understood as somatization or medically unexplained physical symptoms, is regarded as a major feature of dissociative disorders (Nijenhuis, 2001). The SDQ-5 is a brief, reliable and valid screening tool for dissociative disorders (Nijenhuis, Spinhoven, van Dyck, Van der Hart, & Vanderlinden, 1996, 1997). An example of the items is "*It is as if my body,*

or a part of it, has disappeared." The Chinese version of the SDQ-5 proved to be reliable and valid; using 9 as the cut-off score, it can detect dissociative disorders with a sensitivity of 81.3% and a specificity of 96.3% (Fung, Choi, Chan, & Ross, 2018). The Cronbach's α of the SDQ-5 was 0.739 in the present sample.

Data analysis

The SPSS 22.0 was used for statistical analysis. Chi-square and one-way ANOVA were used to explore differences in demographic backgrounds, other adverse childhood experiences and mental health variables between participants who reported CEA and/or CEN and those who did not. Point-biserial correlations and partial point-biserial correlations were used to assess the individual associations of CEA and CEN (dichotomous variables: yes or no) with the five mental health screening scores (continuous variables).

Results

In this sample, 43.3% participants reported childhood emotional abuse (CEA) and 44.5% reported childhood emotional neglect (CEN).

It was found that CEA and CEN were associated with age, financial dependence, individual monthly income, education level and psychiatric service usage (see Table 1).

In addition, CEA and CEN were associated with other types of adverse childhood experiences, except for household substance abuse and the presence of a criminal household member (see Table 2).

Mental health screening scores indicated that participants who reported both CEA and CEN scored significantly higher than participants who reported only CEA or only CEN, while participants who reported only CEA or CEN scored significantly higher than participants who reported no CEA or CEN; the only measure for which this pattern did not apply was SDQ-5 scores (see Table 2). Participants who reported both CEA and CEN did score significantly higher on the SDQ-5 than the

two other groups of participants (see Table 2), but those with only CEA or CEN did not differ from those with neither.

Partial point-biserial correlations revealed that both CEA and CEN had significant associations with all five types of mental health problems, even after controlling for childhood physical abuse, sexual abuse and physical neglect (see Table 3). Even when more variables were controlled for, CEA was still associated with three types of mental health problems while CEN was still associated with all five types of mental health problems (see Table 3).

In order to further understand whether CEA and CEN increased the chance of having mental health problems after taking into account the effects of other forms of childhood abuse and neglect, we conducted chi-square tests to examine the differences in mental health between those with and without CEA and CEN among participants who reported no childhood physical abuse, sexual abuse or physical neglect. Participants with CEA or CEN but no physical or sexual abuse or physical neglect were significantly more likely to screen positive for major depressive disorder, GAD, PTSD and BPD; no statistically significant findings were observed regarding the dissociative disorders ($p = .050$ to .058) (see Table 4).

Discussion

This study contributes to the child abuse and neglect literature by investigating the demographic and mental health correlates of CEA and CEN in a sample of Hong Kong Chinese adults. First, we found significant associations of CEA and CEN with poor socioeconomic status (financial dependence, lower monthly income, lower education level) in a sample of Hong Kong adults. Second, we found that CEA and CEN were also associated with many other types of adverse childhood experiences in this sample. Third, we provide further evidence of the associations of CEA and CEN with psychiatric service usage and mental health problems (depression, anxiety, PTSD symptoms, BPD symptoms and somatoform dissociation) in the Chinese context. Fourth, we found that participants who reported CEA and/or CEN were still more likely to screen positive for major depressive disorder, GAD, PTSD

and BPD even after taking into account the effects of other forms of childhood abuse and neglect. Taken together, our results indicate that CEA and CEN are significantly associated with poor socioeconomic status and mental health problems even in less individualistic cultures. In addition, although self-selection bias may have taken place, CEA and CEN appear to be common in this convenience sample (the rates are 43.3% and 44.5% respectively). For cross-cultural comparison, we may look at the figures in other places: A meta-analysis indicated that the prevalence of CEA and CEN is 36.7% (25.1% to 49.1%) and 60.0% (45.0% to 74.0%) respectively among mainland Chinese college students (Fu et al., 2018); another study reviewing the global prevalence of childhood emotional maltreatment found that the rates of CEA and CEN are 41.6% and 30.1% respectively in Asia, 11.3 % and 40.0% respectively in Australia, and 36.5% and 14.5% respectively in North America (Stoltenborgh et al., 2015). The high rates of CEA and CEN in this study imply that childhood emotional maltreatment may also be a serious issue in Hong Kong and should receive more attention. Our findings highlight the necessity of examining the prevalence of CEA and CEN among Hong Kong people using a representative sampling method in future studies.

This study is preliminary and suffers from several limitations. For example, although the mental health measures are well-validated in the Chinese context, only single items were used to assess CEA and CEN. In addition, we found that CEA and CEN are less associated with somatoform dissociation (which should be strongly related to childhood trauma) – this finding may be due to methodological issues; future investigations are needed in this regard. Additionally, the data was not representative of the general population in Hong Kong as the participants were recruited through online channels and may have been affected by a self-selection bias. Therefore, it is difficult to use the data to estimate the prevalence of CEA and CEN in Hong Kong and the generalizability of the results may be limited.

Despite its limitations, this study provides the first data regarding the demographic and mental health correlates of CEA and CEN in a sample of Hong Kong adults. Within-sample analysis also reveals some interesting findings that may have significant implications for the fields of health care and social services, especially for practitioners who work with Hong Kong people and immigrants from Hong Kong around the world.

Child care, protection and prevention

While some may think that CEA may not be a serious problem in collectivistic cultures due to cultural differences and that parental emotional abuse may be perceived as normal in such contexts (e.g., shaming is a common parenting strategy)(Kwok et al., 2013; Rudy & Grusec, 2006), our findings revealed that both CEA and CEN are closely associated with mental health problems in our sample, although no causal relationships can be confirmed. The findings are consistent with the literature and imply that the feelings and emotional needs of children should not be overlooked in Hong Kong. Parents and caregivers should be mindful of their responsibility for the emotional needs of children and should employ parenting strategies that are not emotionally abusive. Health care and social service providers should be aware of the signs of CEA and CEN when working with Hong Kong people. If parents and caregivers have difficulty in being consistent, accepting and warm in front of their children because of their own emotional problems, they should seek professional help. Future studies should further investigate parental risk factors for CEA and CEN in order to prevent inappropriate parenting styles among Hong Kong parents. Future studies should also develop child protection programs that aim at preventing CEA and CEN and evaluate whether such programs could reduce mental health problems during adulthood.

In addition, it appears that child emotional maltreatment is underreported or underrecognized in Hong Kong (Cross, 2014). During the period from January to June 2019, there were 532 newly reported child abuse cases captured by the Social Welfare Department database, but only 4 cases (0.8%) involved emotional maltreatment (Social Welfare Department of The Government of The Hong Kong Special Administrative Region, 2019), suggesting that many cases of child emotional maltreatment may remain unreported in this large city. Given the high rates of CEA and CEN reported in our sample, we recommend better identification of child emotional maltreatment in Hong Kong.

Timely assessment and support for CEA and CEN survivors

As participants with CEA and/or CEN were more likely to report mental health problems in our sample, it implies that Hong Kong people who have experienced CEA and/or CEN should receive

timely mental health assessment and support. Practitioners working with survivors of CEA and CEN should be knowledgeable about the assessment and treatment of mental health problems. On the other hand, mental health service providers should be sensitive to the psychosocial needs of mental health service users who have encountered CEA and/or CEN. This group of service users may tend to have more interpersonal or attachment-related difficulties (e.g., BPD symptoms, trust issues), and therefore trauma-informed care is essential to prevent re-traumatization and ensure a sense of safety when working with survivors of CEA and/or CEN. In addition, since poor socioeconomic status was found to be associated with CEA and CEN, trauma screening may be important in service settings for Hong Kong people with disadvantaged backgrounds too.

Policymaking to prevent CEA and CEN

If CEA and CEN are as harmful as other forms of abuse and neglect, policymakers should also make efforts to prevent CEA and CEN. In many places, such as in Hong Kong, criminal law protects children well from physical abuse, physical neglect and sexual abuse, but children are not yet well protected from CEA and CEN (Sin, 1999). Further public discussion is needed regarding how to better protect children from CEA and CEN at the social and political levels; for example, a so-called "Cinderella law" was introduced to criminalize emotional abuse of children in the United Kingdom. Additional social resources may be required to support and educate parents and caregivers in the community. Based on the findings from the present study, we urge different stakeholders to make efforts to prevent CEA and CEN, even in less individualistic cultures.

Concluding remarks

This preliminary study is the first to explore the demographic and mental health correlates of CEA and CEN in a Hong Kong sample. Although there are several limitations, out study showed that CEA and CEN are not uncommon in Hong Kong and have significant associations with poor socioeconomic status and a variety of mental health problems. The findings are consistent with those in other cultures. Although no causal relationships can be demonstrated, the impacts of CEA and CEN on Hong Kong people should receive more attention and their service needs should not be ignored.

This study draws attention to the problems of CEA and CEN in the Hong Kong context. Implications are discussed. Future studies should develop programs that aim at preventing children from CEA and CEN and evaluate whether such programs can reduce mental health problems during adulthood.

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