

Deprogramming abuse

Professor Christine Wekerle outlines a study investigating determinants of the outcomes of the adolescent survivors of childhood trauma and the means by which their prospects can be improved

To begin, what drew you to study the fields of parenting and family violence?

A high school English literature essay question on Shakespeare's Hamlet and Dickens' Great Expectations asked us to articulate what was the most important gift a parent could give to their child. This led me on a 'thought mission': what might be given, and what it might be important to not give.

Why have you focused on adolescent maltreatment? How does your work feed

into the International Resilience Project?

When people think about child abuse and neglect, they likely think about younger children. However, adolescents also come to the attention of child welfare, perhaps because they are finding a voice.

Adolescence is a time of normative risk-taking that may be heightened without attentive parenting and monitoring. As a time of transition into novel behaviours – eg. romantic relationships, work, or driving – it is a prime period for initiating and enhancing resiliency.

The International Resilience Project has primarily focused on qualitative research and small samples. Our work identifies that in-depth study of child welfare-involved adolescents is achievable. We also identify some candidate resilience factors: romantic relationships, relationships with child welfare caseworkers, self-compassion and links to community resources, including school.

How can resilience promote healthful behaviours?

The more we learn, the more we understand that healthful habit-setting is something with which we can assist the young directly in many locales – the doctor's office, the school, the community.

Your work centres on child welfare-involved youths. Is it possible for a teenager to engage in resilience processes without safety networks such as child welfare services?

In adolescents, the main maltreatment-related death is suicide and child welfare-involved adolescents are at greater risk. The issue

for these youths is that resources are shut down and the biological family may not be optimal to turn to. Past 16, as a maltreated adolescent, you are supposed to take yourself to school counsellors or police, because the child welfare system may not protect you any longer. If you are a ward of the state, and the government is your legal guardian, your guardian will abandon you at the age cut-off point.

Could you elaborate on the measurement of emotional maltreatment levels in teens?

Measuring emotional maltreatment has been a challenge because it is tricky to establish the threshold of emotional abuse. A self-report measure that taps both emotional abuse, like verbal attacks, and emotional neglect, such as feeling unloved or unwanted, captures the adolescent's voice in how they experienced their parenting. Exposure to domestic violence is also an index of emotional abuse, because it is painful to watch an attachment figure being beaten, say, or see the injury of parent-to-parent violence.

Youths with higher self-compassion scores are more likely to have better outcomes. How does self-compassion correlate to maltreatment?

Understandably, those with higher self-compassion – the ability to experience love, kindness and tolerance towards self – appear to be less distressed and less prone to self-harming behaviours. It is a mental state and we measured it through self-reporting, using Neff's self-compassion scale. When other factors were taken into account, emotional abuse seemed to be the maltreatment most germane to self-compassion, with lower levels of emotional abuse relating to higher levels of self-compassion.

Have you observed any significant gender differences in your research?

Males scored higher on the self-compassion score than females did. Males are more likely



Teenage resilience

The long-term effects of childhood abuse can devastate lives. A multi-site study of adolescents receiving help from social services because of prior abuse, led by **McMaster University** in Canada, is analysing the factors that point to resilience in these survivors



to commit suicide and females are more likely to engage in non-fatal self-harming, like cutting behaviours. In partner violence, it is the females who die.

In terms of translational research, how could your studies contribute to developments in health innovation?

Health innovation can address the child welfare adolescent group by providing standardised checks that screen for mental health, substance abuse and dating violence. It can draw attention to health planning prior to the child exiting the welfare system at 16. There is potentially no facilitation and advocacy for the child's transition to adult living – the adult services system starts at age 18.

There is room for greater collaboration between child welfare services and healthcare. To my knowledge, child welfare-involved adolescents are not targeted for prevention of self-harm through smoking, obesity, substance abuse and suicide.

Ultimately, the biggest health innovation would be dedicated to preventing child maltreatment: no child maltreatment = no child welfare system.

ACCOUNTS OF CHILDHOOD abuse that reveal great suffering or culminate in death are headline news, but there are many more victims and survivors than the small number that come to public attention: globally, it is estimated that 40 million children are maltreated, mostly through neglect or exposure to domestic violence. In the US alone, the annual cost of interventions where child abuse is found is over \$120 billion – about \$200,000 per surviving victim and \$1 million per death.

Child abuse, whether sexual, emotional or physical, is generally conducted in what should be a safe place, within what should be a loving or guiding relationship. The child learns that home is a place without safety and security, where injury is likely and care is inadequate and inconsistent; that they are unworthy, unlovable and worthless; that they have no rights. To survive this 'training' and make something positive of their lives requires resilience, and it is this quality that is being considered in an epidemiological study focused on the mindsets and coping abilities of randomly-selected adolescents who are receiving support from child welfare services. The project lead is Dr Christine Wekerle, Associate Professor in Paediatrics and Associate Member of the Offord Centre for Child Studies at McMaster University in Hamilton, Ontario.

The project is linked to the International Resilience Project, which is analysing the resilience of youth all over the world, taking into account the conditions of their prevailing environments and circumstances, and, among others, a project on homelessness in Ontario. The project focuses on adolescence as a critical time of transition to independent living, but for maltreated adolescents the transition can be more challenging: "One homeless youth pointedly observed that homelessness was the ultimate test of independence," recalls Wekerle.

Resilience is evidenced by outcome: a successful outcome implies the ability to cope and adapt. The questions are why and how some people cope and adapt better than others after suffering overwhelming deprivation, adversity or danger, as victims of childhood abuse do. Some survivors will cope and build comparatively successful lives, but resilience to the stress of abuse depends on each child or adolescent and each situation, the nature of the stress and its severity.

AFTERMATH OF ABUSE

Childhood abuse is indicated to increase the chances of depression and post-traumatic stress disorder in adolescence and later life. Survivors of childhood abuse display dysregulation as a result of an overstressed defence system: a bias towards processing information negatively, a tendency to overreact to emotions, violence in close relationships and disregard for their own health. In adolescence and adulthood this manifests in an increased likelihood of psychiatric disorder, self-harming in response to stress – disordered eating, cigarette smoking, binge and heavy drinking, substance abuse – lung, liver or heart disease, impaired financial health and premature death. "The child psychologically carries the burden well past the actual experiences in how it impacts their sense of self," Wekerle reflects.

Evidence of resilience in adolescence therefore is measured by success in terms of educational or employment performance, personal attitudes such as optimism, the nature and durations of social relationships and mental health. As Wekerle points out, the prerequisite is feeling safe: "Safety needs to be established so that their focus can shift from apprehensively monitoring others and their environment, to themselves, as in normal development. When children feel safe, resilience starts to become realisable".

INTELLIGENCE

GENDER-BASED RESILIENCE IN CHILD WELFARE: LINKING TO THE INTERNATIONAL RESILIENCE PROJECT

OBJECTIVES

To develop international resilience initiatives that focus on at-risk youth, seeking to: (1) consolidate evidence-based resilience factors, and (2) mobilise, develop, and evaluate resilience programming. In part, this is based on the team's work with child welfare-involved youths, and their transition from system support to independent living.

KEY COLLABORATORS

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• **Dr Lil Tonmyr**, Public Health Agency of Canada • **Drs Harriet MacMillan; Donna Stewart; Nadine Wathen**, Prevention of Violence Across the Lifespan (PREVAil) Centre
• **Marlyn Bennett; Dr Cindy Blackstock**, First Nations Child and Family Caring Society of Canada • **Peter Dudding; Gordon Phaneuf; Kelly Stone**, Child Welfare League of Canada • **Dr Nico Trocmé; Dr Barbara Fallon**, Canadian Incidence Study of Reported Child Abuse and Neglect, Child Welfare Research Portal • **Dr Deborah Goodman; Bruce Leslie; Brenda Moody; Bernadette Gallagher**, Ontario Association of Children's Aid Societies • **Dr Michael Ungar**, Resilience Research Centre & the Networks of Centres of Excellence – Children and Youth in Challenging Contexts Knowledge Mobilization Network

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Wekerle's project indicates that adolescents continue to experience trauma even when their maltreatment is historical and they are receiving support, evinced by a predisposition to violence in their romantic relationships and also to substance abuse. While the spread of intelligence of the adolescents in the study was shown to be in line with the norm, being average to above average, fewer of the adolescents would go on to complete high school or it might take them longer: welfare-involved teenagers tend to experience bullying more than others and they are less likely to receive extramural tuition.

The project has found that adolescents receiving child welfare support report higher levels of distress than those who are not, even though the incidence of medication and counselling for anxiety or depression among them was higher; self-compassion is therefore an important aspect that the project measures. Wekerle believes self-compassion is teachable and that these adolescents would benefit from coaching, since they continue to feel guilt and shame, and the study has found that higher self-compassion leads to better outcomes: "The first point of resilience is staying alive," she affirms. "Sometimes, it's a conscious decision to stay alive, to keep trying, to not let the emotional pain and having been abused become you, rather than simply a historical feature of you. Perhaps in that are the seeds of self-compassion, deciding you have a right to live and a life to lead."

PROJECT STATUS

Most adolescents in the study elected to be assessed where they were living, or nearby, and as Wekerle recalls, the team were keen to accommodate such preferences for timing, sometimes also travelling long distances to meet with participants: "A child welfare adolescent population can be hard to find, hard to reach, and hard to keep".

Among their results and findings, the researchers have so far identified measures of maltreatment history and distress; confirmed that some adolescents with historical child welfare involvement will be found among the urban homeless; found that emotional maltreatment

levels may explain later impairment; discovered that these teenagers espouse an avoidant emotional attachment style and are dismissive of relationships, possibly to avoid risk in experiencing emotions; and revealed that post-traumatic stress disorder symptoms among these adolescents link to relationship violence and problem drug and alcohol use. Sex differentiation is an area yet to be explored: "We are still at the stage of understanding sex, as opposed to gender, differences, such as same-sex or opposite-sex modelling depending on the sex and the attachment relationship of the perpetrator of maltreatment".

The project is currently analysing evidence-based, readily portable resilience programming for teenagers involved with child welfare; and the next studies will include community resources, school engagement, verbal fluency, positive identification with child welfare caseworkers and length of caseworker support.

FUTURE INITIATIVES

Improved training for medical students and residents in child maltreatment is already in the pipeline, funded by the Ontario Centre of Excellence for Child and Youth Mental Health: "With Anne Niec and Joyce Zazulak, we are developing and pilot testing an arts-based curriculum to present maltreatment content in a novel and accessible way," notes Wekerle. "We hope to standardise this evidence-based knowledge, since maltreated people are increasingly being recognised as presenting a wide range of clinical conditions and requiring emergency treatments."

Wekerle would like to see large-scale studies of resilience accommodated in existing public health research initiatives; she would also like to see more input from neuroscience on resilience to better direct epidemiological studies. She feels that health education for teenagers could be a low-cost option for improving health outcome, including the importance of regular exercise, hygiene and meditation or yoga or T'ai-Chi: "The childhood to young adult years are the largest growth period in a lifetime. The investment in these years to ensure healthy development is an investment for the long term," she asserts.

The first point of resilience is staying alive

