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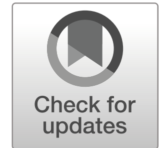

Is Emotional Abuse As Harmful as Physical and/or Sexual Abuse?

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Abstract

This article discusses risk factors for adults who have suffered early childhood trauma, specifically focusing on emotional abuse, and discusses the negative long-term consequences from childhood trauma such as depression, anxiety, stress, and neuroticism personality. This research study predicts that those who report emotional abuse will have higher sores for depression, anxiety, stress, and neuroticism personality compared to those who reported only physical, only sexual, or combined physical and sexual abuse. Using the NEO Five-Factor Inventory, Depression Anxiety and Stress Scale, and Childhood Trauma Questionnaire, 748 college students participated in an on-line survey at a Southeastern university. As predicted, this study found those who reported emotional abuse had higher scores for depression, anxiety, stress, and neuroticism personality compared to those who reported only physical, only sexual, or combined physical and sexual abuse. Studies show emotional abuse may be the most damaging form of maltreatment causing adverse developmental consequences equivalent to, or more severe than, those of other forms of abuse (Hart et al. 1996). Therefore, this article discusses the need for public awareness campaigns to raise public and community awareness and evidenced based treatments that help with the psychological consequences resulting from emotional abuse.

Keywords Early childhood trauma · Emotional abuse · Consequences of trauma · Treatment for trauma

Research shows that early childhood trauma can significantly alter a child's normal development which can cause long-term impairments, even into adulthood. According to Teicher and Samson (2013), researchers have found that childhood trauma is associated with physical, mental, sexual, and emotional symptoms that can persist into adulthood. According to the American Academy of Pediatrics (APA), psychological maltreatment of a child is "the most challenging and prevalent form of child abuse and neglect" (Hibbard et al. 2012, p. 372) because it is more subtle to detect. Emotional abuse can be allusive, and its very nature allows it to hide in plain sight (Hart and Glaser 2011). Emotional abuse is often a misunderstood form of trauma, perhaps the most damaging type of abuse, that leads to long-term consequences for adults (Heim et al. 2013). Therefore, this article will examine robust relationships among variables that exist due to early childhood trauma, particularly focusing on emotional abuse.

The Children's Bureau reports that nearly 3 million U.S. children experience some form of maltreatment annually, predominately by a parent, caregiver, or family member. According to the U.S. Department of Health and Human Services, an estimated 1670 children died from abuse and neglect in the United States in 2015 (https://www.acf.hhs.gov/media/press/2017/child-abuse-neglect-data-released). In 2015, it was estimated the Children's Advocacy Centers around the country served more than 311,000 child victims of abuse. Statistics show that nearly 700,000 children are abused in the U.S. annually and approximately 3.4 million Child Protective Service cases regarding children were investigated and 2.3 million of those children receive prevention services. According to Jenny (2011), neglect (failure to provide for the basic needs of a child), physical abuse (physical injury inflicted by a parent or caregiver intentionally or in the course of excessive discipline), sexual abuse (sexual act inflicted by parent, caretaker, or other), and emotional abuse (verbal abuse, cruelty, and threats) are all specific forms of trauma that have long-term consequences. In fact, according to the U.S. Department of Health and Human Services, the children who experienced maltreatment or abuse, three-

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quarters suffered neglect; 17.2% suffered physical abuse; and 8.4% suffered sexual abuse. Many children have suffered more than one form of maltreatment or abuse.

According to the American Psychiatric Association (APA 2000), trauma is described as a perceived experience that threatens injury, death, or physical integrity and causes feelings of fear, terror, and helplessness. Exposure to traumatic experiences are widespread and do not discriminate against gender, age, race, ethnicity, or sexual orientation. According to Myers et al. (2002), childhood maltreatment includes sexual abuse (generally involving sexual acts against children with age-related power imbalance for the sexual gratification of the offender), physical abuse (physical acts against a child, typically by an adult, parent, caregiver, or other authority figure, which results in some level of tissue injury, ranging from bruises or lacerations to broken bones or teeth, or even death), emotional abuse (verbal aggression that affects the welfare or morale of the child, or any conduct that humiliates, embarrasses, or threatens the child), physical neglect (failure of caretakers to provide for basic physical needs, such as feeding, home, security, supervision, and health), and emotional neglect (failure of caretakers to provide for basic emotional and psychological needs, such as love, motivation, and support). Early childhood traumas, such as these types of abuses, have negative effects throughout childhood and continue into adulthood. Exposure to childhood trauma has been linked to childhood and adult psychopathology, including depression, anxiety, personality traits (Cummings et al. 2012), and negative effects on cognitive, social, and emotional competencies (Enoch 2011), and an increase risk for chronic diseases (Dong et al. 2003). Briere and Jordan (2009) report that trauma survivors suffer from depression anxiety, anger, sensitivity to rejection, abandonment issues, unstable relationships, and difficulty with trust issues.

Emotional Abuse

This research will focus on the relationships particularly in regard to those who report emotional abuse. Psychological maltreatment, or emotional abuse and neglect, has been theorized to cause adverse development consequences equivalent to, or more severe than, those of other forms of abuse (Hart et al. 1996). Emotional abuse may be the most damaging form of maltreatment due to causing damage to a child's developing brain affecting their emotional and physical health as well as their social and cognitive development (Heim et al. 2013). According to Barnett et al. (1993), emotional abuse is "persistent or extreme thwarting of the child's basic emotional needs [such as] parental acts that are harmful because they are insensitive to the child's development level" (p. 67). The American Professional Society on the Abuse of Children (APSAC; Myers et al. 2002) defines emotional abuse as "a repeated pattern of caregiver behavior or a serious incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (p. 81). According to Heim et al. (2013), emotional abuse not only causes low self-esteem but also impacts the nervous system. These authors report emotional abuse causes changes in the brain, specifically in regions associated with understating and controlling emotions and recognizing and responding to the feelings of others. Their study found thinning in the tissue of the brain that helps with self-awareness and emotional regulation, particularly in the prefrontal cortex and medial temporal lobe. Individuals who report a history of emotional abuse often have memories of the abuse which elicits negative feelings and tense physical sensations that are difficult to regulate and control due to the nervous system and brain changes. Those who report emotional abuse suffer with depression, anxiety, low self-esteem, moodiness, and extreme or dulled emotional responses (Heim et al. 2013).

Personality Issues

According to Edwards et al. (2003), childhood is a formative time for the development of healthy personality traits. Traumatic events during childhood can cause long lasting effects, even into adulthood, because children are still learning how to develop cognitions and emotions; therefore, they have more difficulty understanding the meaning of trauma. Edwards et al. (2003) report that children who suffer childhood abuse by a caregiver or close family member are likely to feel a sense of betrayal, disrupted developmental processes, negative conceptualizations of self and others, and a perception of the world as unsafe. When children experience relationships as rejecting or unsafe, these experiences can alter a child's perception of self, trust in others, and perception of the world. Bakker et al. (2006) reports that early childhood trauma leads to personality traits such as neuroticism.

According to Collins and Read (1990), early childhood trauma can effect adult relationships. Adults who report a history of trauma are more likely to report feeling somewhat uncomfortable being close to others, finding it difficult to trust others, and not wanting to depend on others or have others get too close. These individuals can also report feeling that others are reluctant to get close to them, often worry that they are not loved, and struggle with fear of rejection or abandonment. Research has demonstrated that forming successful relationships and attachments in childhood can lead to one having a higher quality of life in adulthood, especially in regard to having a healthy sense of self, others, and overall healthy relationships.

Goldberg (1993) introduced the Big-Five model to help categorize five diverse personality factors: neuroticism,

extraversion, openness to experience, agreeableness, and conscientiousness. This research study will focus on the personality of neuroticism. Neuroticism (N) personality is known as the tendency to be overly emotional, anxious, distressed, and worrisome (Goldberg 1993). Adults who have characteristics of this personality are more vulnerable to suffering from low self-esteem and feelings of guilt and frustration. These individuals tend to set excessively high goals that can be unrealistic and are more likely to focus on negative aspects of conversations when receiving social support (Bakker et al. 2006; Cummings et al. 2012).

Depression and Anxiety

According to Enoch (2011) and Teicher and Samson (2013), psychiatric problems are common among survivors of trauma, including depressive disorders, anxiety disorders, self-injurious behaviors, and eating disorders (Yates et al. 2008), attachment disorders, conduct disorders, personality disorders, aggression, crime, and suicidal behavior (Gilbert et al. 2009). The psychological disruptions for trauma survivors are severe and can have persistent, chronic long-term effects. Many children exposed to trauma suffer from developmental regressions; emotionally, cognitively, and behaviorally (Enoch 2011). According to DeBellis et al. (2005), early childhood trauma is more detrimental than trauma experienced later in life due to the developmental processes that are occurring, neurologically and psychologically.

According to Teicher and Samson (2013), those who were depressed with a history of abuse had neurological and psychological changes in their brains in comparison to those who were depressed and did not have a history of abuse. They also found that those who suffered from a history of abuse developed the depression at an earlier age, were more severely depressed, more anxious, more suicidal, and responded to treatment differently, including antidepressant treatments, than those who were depressed and did not have a history of abuse.

According to Teicher and Samson (2013), "Some of the strongest evidence for an association between exposure to childhood maltreatment and the development of major depression can be found in the Adverse Childhood Experiences study…" (p. 1115). Teicher and Samson report that exposure to these early childhood experiences accounted for 54% of the population's current episodes of depression and 67% for suicide attempts. The National Comorbidity Replication Study by Cougle et al. (2010) showed that childhood sexual or physical abuse was associated with an increase in risk for specific phobias, social anxiety disorder, general anxiety disorder (GAD), and panic disorders. According to Green et al. (2010), childhood adversity accounted for 32.4% of the populations risk fraction for anxiety disorders. Therefore, it is imperative to understand how trauma experiences can interfere with these processes and have long lasting effects. Condly (2006) reports "Traumatic events effect great damage not so much because of the immediate harm they cause but because of the lingering need to re-evaluate one's view of oneself and the world" (p. 211).

Overview of Study

This research focused on examining the negative long-term consequences and risk factors for adults who have suffered early childhood trauma i.e. depression; stress; anxiety; and neuroticism personality. This study used The Childhood Trauma Questionnaire (CTQ) to measure physical, sexual, and emotional abuse. The Depression Anxiety Stress Scale (DASS) was used to measure depression, anxiety, and stress. The NEO-Five Factor Inventory (NEO-FFI) neuroticism (N) subscale was used to measure for neuroticism personality. This study predicts that those who report a history of emotional abuse will score higher on depression, anxiety, stress, and neuroticism personality compared to those who reported only physical, only sexual, or combined physical and sexual abuse.

Hypotheses

Hypothesis 1: Those who report a history of childhood trauma (physical, sexual, and emotional abuse) will have a moderate positive correlation with depression, anxiety, stress, and neuroticism personality.

Hypothesis 2: Those who reported emotional abuse will more likely report higher scores for depression, anxiety, stress, and neuroticism personality compared to those who reported only physical, only sexual, or combined physical and sexual abuse.

Method

Participants

This study utilized an existing data set with data collected from college students between August 2015 and June 2016 through an online participant management system at a Southeastern university. Participants were given the option to decline to answer each question, were offered the opportunity to resign from the study at any time and were given contact information for mental health resources in the unlikely event that emotional distress was experienced. Participants received course credit for completing the online self-report surveys. The study was reviewed by and received approval from the university's Institutional Review Board prior to data collection.

A total of 748 college students responded to the online survey, however, some participants failed to answer some of the questions. There was a total of 737 participants who reported their gender; 466 females (63.2%) and 271 males (36.8%). In regard to race, 732 participants responded to the question; 586 (80.1%) reported being White/Caucasian, 58 (7.9%) reported being Black/African-American, 23 (3.1%) reported being Hispanic/Latino, and 65 (8.9%) reported other. Out of these participants, there were 730 (99%) who reported being undergrads; there were 5 (1%) participants who reported being a graduate student or non-degree seeking student.

Instruments

Depression Anxiety and Stress Scale (DASS21) The DASS21 is a 21-item measure that is widely used to assess for negative emotionality within the past week. This scale consists of three subscales; the depression subscale (DASS-D) which measures hopelessness, low self-esteem, and low positive affect; the anxiety subscale (DASS-A) which assesses autonomic arousal, musculo-skeletal symptoms, situational anxiety, and subjective experience of anxious arousal; and the stress subscale (DASS-S) which assesses tension, agitation, and negative affect. All three subscales consist of 7 items rated on a 4-point scale from 0 "Did not apply to me at all" to 3 "Applied to me very much or most of the time." The minimum range for all subscales used is 0 and the maximum range is 63. An example item from the depression subscale is: "I felt that I had nothing to look forward to" (Lovibond and Lovibond 1995, b). This scale was determined to have validity (Ng et al. 2007) as well as high internal consistency (Cronbach's alpha scores of > .7). The internal consistency was .72 for the depression subscale, .77 for the anxiety subscale, and .70 for the stress subscale (Tran et al. 2013). The overall score, which includes all items, also had high consistency alpha's of .88 (Tran et al. 2013).

Childhood Trauma Questionnaire (CTQ) This is a 28-item measure that assesses childhood experiences of maltreatment including: emotional, physical, and sexual abuse, as well as emotional and physical neglect. The CTQ consists of six subscales, three assessing abuse (emotional, physical, and sexual), two assessing neglect (emotional and physical), and one assessing responses in socially desired manner (minimization/denial subscale). The subscales of emotional, physical, and sexual abuse were used in this study. Each of these subscales consists of five items on a 5-point Likert-scale ranging from 1 "Never True" to 5 "Very Often True." Higher scores signal a higher extent of traumatic experience. The minimum range for each subscale used is 5 and the maximum range is 25. An example item from the sexual abuse subscale is: "When I was growing up: I believe that I was sexually abused" (Bernstein and Fink 1998). Internal consistency of the three subscales is moderate to high (alphas between .70 and .92). The test-retest reliabilities are strong with testing over a 2- to 6-month interval which yielded an interclass correlation of .88 (Bernstein et al. 1994).

NEO Five-Factor Inventory (FFI) This is a 60-item measure that assesses the Big-5 personality traits. This scale consists of five subscales (i.e., neuroticism, extraversion, openness, agreeableness, and conscientiousness). The extraversion subscale measures specific traits such as talkative, energetic, and assertive; the agreeableness subscale measures traits like sympathetic, kind, and affectionate; the conscientiousness subscale measures traits like organized, thorough, and planful; the neuroticism subscale measures traits like tense, moody, and anxious; and the openness subscale measures traits like having wide interests, and being imaginative and insightful. These five subscales are measured on a 5-point scale, ranging from 1 "Strongly Disagree" to 5 "Strongly Agree." This study only used the 12-item subscale neuroticism (N). The minimum range for this subscale is 12 and the maximum range is 60. A sample item from the neuroticism subscale is: "I often feel inferior to others" (Costa and McCrae 1992). The Cronbach alphas for the neuroticism subscale is .85 (Costa and McCrae 1992). This scale is a well validated measure that has been used in numerous studies (Thalmayer et al. 2011).

Demographic Information Participants completed demographic information such as gender, age, race, student classification, and other demographic questions.

Results

Hypothesis 1

The correlation analysis found moderate positive relationships for those who reported emotional abuse with DASS-D ($r = .387$, $p < .01$), DASS-A ($r = .355$, $p < .01$), DASS- S ($r = .393$, $p < .01$) and N ($r = .309$, $p < .01$). There were only slight to low correlations for those who reported other types of abuse (physical abuse and/or sexual abuse) with all DASS subscales. There were low to no relationships for those who reported physical or sexual abuse regarding neuroticism personality (N). No relationship was large enough (i.e., greater than .80) to cause concerns of multicollinearity. As predicted, emotional abuse had moderate positive correlations with depression, anxiety, stress, and neuroticism personality. The null hypothesis is rejected. See Table 1 for correlations. See Table 2 for descriptive statistics.

Hypothesis 2

As discussed in hypothesis 1 and shown in Table 1, the correlations for emotional abuse and DASS-D ($r = .387$, $p < .01$),

Table 1 Correlations

	CTQ-EA	*CTQ-PA*	*CTQ-SA*	*DASS-D*	*DASS-A*	*DASS-S*	*N*
CTQ-EA	–	–	–	–	–	–	–
CTQ-PA	.669**	–	–	–	–	–	–
CTQ-SA	.437**	.528**	–	–	–	–	–
DASS-D	.387**	.212**	.170**	–	–	–	–
DASS-A	.355**	.212**	.203**	.749**	–	–	–
DASS-S	.393**	.188**	.156**	.766**	.801**	–	–
N	.309**	.093*	.056	.567**	.447**	.530**	–

Note. * $p < .05$, ** $p < .01$; CTQ = Childhood Trauma Questionnaire; EA = Emotional Abuse; PA = Physical Abuse; SA = Sexual Abuse; DASS = Depression Anxiety and Stress Scale; D = Depression; A = Anxiety; S = Stress; NEO = NEO Personality Five Factor Inventory; N = Neuroticism

DASS-A (r = .355, p < .01), DASS- S (r = .393, p < .01) and N (r = .309, p < .01) were stronger in comparison to those who reported physical or sexual abuse.

The independent variables (emotional, physical, and sexual abuse) were split into two categories; Absent or present. This allowed the researcher to examine the interaction effects between those who reported emotional abuse absent (EA) and those who reported emotional abuse present (EP) along with the other categories of sexual abuse absent (SA), sexual abuse present (SP), physical abuse absent (PA), physical abuse present (PP). See Table 3 for the descriptive statistics for depression, Table 4 for the descriptive statistics for anxiety, Table 5 for the descriptive statistics for stress, and Table 6 for the descriptive statistics for neuroticism personality.

A factorial multivariate analysis of variance (MANOVA) was performed using the independent variables emotional abuse, physical abuse, and sexual abuse with the dependent variables DASS-D, DASS-A, DASS-S, and N. The MANOVA revealed a significant multivariate main effect for emotional abuse, Wilks' $\lambda = .98$, $F(4,737) = 2.94$, $p = .02$, partial eta squared = .016. Power to detect the effect was .79.

Table 2 Descriptive Statistics

	N	*M*	*SD*
CTQ- EA	748	3.76	4.69
CTQ-PA	748	2.52	3.55
CTQ-SA	748	1.30	3.66
DASS-D	748	9.22	10.31
DASS-A	748	8.24	8.25
DASS-S	748	11.64	9.36
N	748	35.05	10.28

Note. CTQ = Childhood Trauma Questionnaire; EA = Emotional Abuse; PA = Physical Abuse; SA = Sexual Abuse; DASS = Depression Anxiety and Stress Scale; D = Depression; A = Anxiety; S = Stress; NEO = NEO Personality Five Factor Inventory; N = Neuroticism

There were no significant main effects regarding those who reported only physical abuse, only sexual abuse, or combined physical and sexual abuse.

The univariate between-subjects tests showed no interaction effects between the independent variables physical abuse,

Table 3 Descriptives for Depression

	N	*M*	*SD*
EA	260	5.54	8.32
EP	488	11.18	10.73
SA	623	8.36	9.94
SP	125	13.48	11.07
PA	291	7.93	9.82
PP	457	10.04	10.54
SPEPPP	104	14.17	10.58
SPEAPP	6	9.50	15.56
SAEPPP	245	10.31	10.66
SAEAPP	102	5.21	7.69
SPEPPA	12	12.50	12.99
SPEAPA	3	1.33	.577
SAEPPA	127	10.28	10.42
SAEAPA	149	5.69	8.46

Note. EA = Emotional Abuse Absent; EP = Emotional Abuse Present; SA = Sexual Abuse Absent; SP = Sexual Abuse Present; PA = Physical Abuse Absent; PP = Physical Abuse Present; SPEPPP = Sexual Present Emotional Present Physical Present; SPEAPP = Sexual Present Emotional Absent Physical Present; SAEPPP = Sexual Absent Emotional Present Physical Present; SAEAPP = Sexual Absent Emotional Absent Physical Present; SPEPPA = Sexual Present Emotional Present Physical Absent; SPEAPA = Sexual Present Emotional Absent Physical Absent; SAEPPA = Sexual Absent Emotional Present Physical Absent; SAEAPA = Sexual Absent Emotional Absent Physical Absent

Table 4 Descriptives for Anxiety

	N	*M*	*SD*
EA	260	5.43	7.20
EP	488	9.74	8.39
SA	623	7.59	7.81
SP	125	11.46	9.57
PA	291	7.23	8.12
PP	457	8.88	8.27
SPEPPP	104	12.11	9.58
SPEAPP	6	9.33	13.35
SAEPPP	245	8.91	7.51
SAEAPP	102	5.50	6.93
SPEPPA	12	8.50	8.09
SPEAPA	3	5.33	2.08
SAEPPA	127	9.50	8.70
SAEAPA	149	5.23	7.15

sexual abuse, or combined physical and sexual abuse and the dependent variables. As predicted, those who reported emotional abuse reported higher scores for depression, anxiety, stress, and neuroticism personality compared to those who reported only physical, only sexual, or combined physical and sexual abuse. Therefore, the null hypothesis was rejected. See Table 7.

Discussion

This study focused on examining the negative long-term consequences and risk factors for adults who have suffered from early childhood trauma, particularly focusing on the trauma of emotional abuse. As predicted, those who reported emotional abuse scored higher for depression, anxiety, stress, and neuroticism personality. The correlation analysis and MANOVA supported both hypotheses and found that those who reported emotional abuse scored higher for the risk factors of depression, anxiety, stress, and neuroticism personality.

As stated in the literature, emotional abuse has been theorized to cause adverse development consequences equivalent to, or more severe than, those of other forms of abuse (Hart et al. 1996). The psychological disruptions for trauma survivors are severe and can have persistent, chronic long-term effects. Many children exposed to trauma suffer from developmental regressions; emotionally, cognitively, and behaviorally (Enoch 2011).

According to Heim et al. (2013), emotional abuse may be the most damaging form of maltreatment due to causing damage to a child's developing brain affecting their emotional and physical health, as well as their social and cognitive development. Emotional abuse causes changes in the brain associated with understating and controlling emotions and recognizing and responding to the feelings of others. These long-term consequences effects individuals' self-awareness and emotional regulation, causing depression, anxiety, low self-esteem, moodiness, and extreme or dulled emotional responses. This emotional trauma during childhood can cause long lasting effects, even into adulthood, because children are still learning how to develop cognitions and emotions (Edwards et al. 2003). Children who suffer emotional trauma, especially by a caregiver or close family member, are likely to feel a sense of betrayal, disrupted developmental processes, negative conceptualizations of self and others, and a perception of the world as unsafe. When children experience relationships as rejecting or unsafe, these experiences can alter a child's perception of self, trust in others, and perception of the world (Bakker et al. 2006).

Table 5 Descriptives for Stress

	N	*M*	*SD*
EA	260	7.72	8.28
EP	488	13.74	9.23
SA	623	11.03	9.18
SP	125	14.69	9.68
PA	291	10.16	9.10
PP	457	12.59	9.40
SPEPPP	104	14.95	9.61
SPEAPP	6	14.50	11.74
SAEPPP	245	13.40	9.12
SAEAPP	102	8.11	8.33
SPEPPA	12	13.75	10.95
SPEAPA	3	9.67	1.52
SAEPPA	127	13.39	8.97
SAEAPA	149	7.13	8.10

Table 6 Descriptives for Neuroticism

	N	*M*	*SD*
EA	260	30.71	10.99
EP	488	37.36	9.08
SA	623	34.63	10.55
SP	125	37.12	8.57
PA	291	34.05	11.64
PP	457	35.68	9.27
SPEPPP	104	37.39	8.39
SPEAPP	6	35.50	12.26
SAEPPP	245	36.80	9.23
SAEAPP	102	31.26	8.77
SPEPPA	12	36.75	9.39
SPEAPA	3	32.33	4.93
SAEPPA	127	38.48	9.30
SAEAPA	149	30.10	12.32

Bakker et al. (2006) reports that early childhood trauma leads to personality traits such as neuroticism. According to Goldberg (1993), who introduced the Big-Five model to help categorize personality factors such as neuroticism, reports that neuroticism personality is known as the tendency to be overly emotional, anxious, distressed, and worrisome. Individuals with this personality are more likely to have negative cognitive thinking, trouble regulating their emotions, feeling depressed, overanxious, stressed, and relationship issues (Bakker et al. 2006). These individuals are also more likely to report a history of childhood abuse (Cummings et al. 2012).

Limitations and Implications

This study utilized an existing data set with data collected from college students through an online participant management system at a Southeastern university. Participants received course credit for completing the online self-report surveys. Therefore, the researcher must take into account the weakness of relying on self-report measures. Questionnaires are generally strong on reliability but weak on validity. The artificiality of the questionnaire format puts a strain on validity. An individual's real opinions on issues seldom take the limited form of strongly agree, agree, disagree, or strongly disagree. Another limitation is using questionnaires such as the CTQ, which requires memory of historical data from childhood and could elicit different interpretations at present than when experiencing the events as a child.

Despite the growing awareness of childhood emotional abuse as a societal problem, many individuals are not aware of the nature and seriousness of emotional abuse. Therefore, public awareness campaigns must be launched to raise public and community awareness regarding the negative life-long consequence of emotional abuse. This is important in order to raise awareness to protect children's development, health, and safety as well as prevent emotional abuse and any other childhood trauma abuse (Hart et al. 1996; APSAC; Myers et al. 2002).

For individuals who have suffered from emotional abuse, research shows several evidence-based treatments that help the psychological consequences of such abuse. According to Najjar et al. (2008), one of the most researched and evidenced based treatments used for trauma symptoms is cognitive behavioral theory (CBT). CBT focuses on addressing and alleviating dysfunctional thoughts, behaviors, and emotional responses by teaching clients to regulate their feelings by changing their thoughts and behaviors (Najjar et al. 2008). Trauma Focused CBT (TF-CBT) is a psychosocial treatment that includes psychoeducation, parent skill development, relaxation, affective modulations, cognitive reprocessing, and creation of trauma narratives. This evidenced based treatment has been validated for children and parents (Cohen and Mannarino 2008). TF-CBT has shown significant improvement with symptoms of PTSD, depression, behavioral problems, shame, and abuse-related attributions. van der Kolk (2006) argues that traumatic memories and emotional pain are programmed within the mind and body, which require somatically oriented therapies to address symptoms of hyperarousal, dissociation, and body awareness.

Eye movement Desensitization and Reprocessing (EMDR) is a treatment modality that focuses on the brain's information system and desensitizing the traumatic memory through bilateral stimulation (BLS) and short imagined exposure (Shapiro 1989). In EMDR processing, all dimensions of the memories including the image, the thoughts, the emotions, and the body sensations are accessed through BLS (Shapiro 1989). BLS, with either eye movements, auditory tones, tapping, or music activates the right and left hemispheres of the brain to access traumatic memory; therefore, causing duel attention to BLS while at the same time paying attention to the traumatic memory (Rodenburg et al. 2009). The dual attention that is required during EMDR facilitates left and right hemispheric connection and disrupts the traumatic memory network.

Dialectical Behavior Therapy (DBT) is a cognitive behavioral treatment developed by Marsha Linehan for individuals diagnosed with Borderline Personality Disorder (BPD). Linehan (1993) developed the four skills sets of DBT to help relieve BPD symptoms; affect regulation, mindfulness, interpersonal effectiveness, and distress tolerance. The affect regulation skill set helps clients develop and maintain better control over reactive emotions associated with the trauma. Mindfulness skills teach clients to be in the present moment, take a nonjudgmental stance, and encourage body awareness. Interpersonal effectiveness skills help clients interact more effectively in relationships and helps with self-esteem and self-identity issues. Distress tolerance skills help clients learn more effective coping strategies to decrease anxiety, depression, and self-destructive behaviors. Research shows that DBT has been proven to help improve symptoms of trauma (Wagner et al. 2007).

Table 7 Descriptives for MANOVA

Effect	Λ	*F*	*df1*	*df2*	*Sig*	*Square*	*Power*
Emotional Abuse	.98	2.94	4.00	737.0	.02	.016	.79
Physical Abuse	.99	.42	4.00	737.0	.79	.002	.15
Sexual Abuse	.99	.68	4.00	737.0	.60	.004	.22

Conclusion

This study found that the participants who reported emotional abuse reported higher scores for depression, anxiety, stress, and neuroticism personality compared to the participants who reported only physical, only sexual, or combined physical and sexual abuse. This study, along with other research, shows that individuals who have suffered from emotional abuse during childhood have long-term consequences that can persist into adulthood. Emotional abuse has been found to cause adverse development consequences equivalent to, or more severe than, those of other forms of abuse including physical and sexual abuse (Enoch 2011; Hart et al. 1996; Heim et al. 2013). Emotional abuse is just as damaging as physical and/or sexual abuse. The exposure to emotional abuse during childhood can interrupt the developmental processes and cause life-long physical, mental, and emotional deficiencies. Research shows that emotional abuse survivors can suffer from depression, anxiety, low self-esteem, abandonment issues, and unstable relationships. Therefore, it is important to raise awareness regarding the consequences of emotional abuse in order to prevent other children from exposure to such trauma. It is also important to raise awareness for those who have suffered emotional abuse to seek help to alleviate symptoms that they may be suffering from. Clinicians must work collaboratively with patients regarding treatment preferences to ensure that the outcomes will be more effective and successful.

Compliance with Ethical Standards

Conflict of Interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical Standards and Informed All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [institutional and national] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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