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Received: 1 June 2022 | Revised: 22 September 2022 | Accepted: 6 October 2022

DOI: 10.1002/car.2796

ORIGINAL ARTICLE

Association of Child Protection Professionals

Development of a framework for classifying threat and neglect in childhood: A qualitative study

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Funding information
The lead author (JB) was the recipient of a postgraduate research scholarship awarded during the period of 2019–2021, provided in support of candidature in the Doctor of Philosophy in Clinical Psychology in the School of Applied Psychology, Griffith University. Fifty per cent of this scholarship was funded by the Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Services and Models of Care Grant Opportunity (H1617G038), Commonwealth Government, Australia.

Abstract

Quantification of childhood adversity has typically involved a cumulative risk approach in which total number of discrete adversities serves as an index of overall risk. However, this approach fails to account for the growing evidence of differential outcomes following exposure to childhood adversities. An alternative approach adopts a dimensional perspective, with growing evidence for distinct developmental impacts associated with exposure to threat (violence/abuse) and deprivation (neglect). This study developed a framework for the classification of these dimensions through a thematic analysis of health practitioners' views and accounts of different forms of childhood adversity. Ten health practitioners experienced in working with children with challenging behaviours and neurodevelopmental disorders participated in semi-structured interviews regarding definitions and examples of six categories of adversity: physical/emotional/sexual abuse, physical/emotional neglect, and domestic and family violence. The qualitative analysis identified 23 themes across the six categories of adversity, along with two overarching themes regarding ambiguity of classifying exposures and non-specific outcomes of exposures. Themes were integrated to provide a framework and checklist for classifying indicators of exposure to threat and deprivation. The findings offer a framework and checklist for the assessment of threat and deprivation that will allow for further testing of the dimensional risk model.

KEYWORDS
abuse, childhood adversity, deprivation, dimensional, neglect, threat

Key Practitioner Messages

- This paper provides details of construction of a framework and an associated checklist for identifying and classifying childhood adversity.
- Despite some ambiguity in distinguishing types of threat and deprivation, distinct characteristics were identified for each exposure type.
- This framework and checklist can be used to classify exposure to forms of deprivation and neglect as distinct types of adversity, thus supporting greater uniformity in classifying childhood adversity in research and practice.

INTRODUCTION

Exposure to childhood adversity has been clearly linked to a range of poor developmental outcomes across childhood and adulthood. The extent of adversity has typically been measured using a cumulative risk approach in which different types of adversity are summed to arrive at a total risk score (Felitti et al., 1998). Extensive evidence links cumulative exposure to adverse outcomes, including drug abuse, depression, suicide attempt, smoking, poor self-rated health, sexually transmitted disease, physical inactivity and severe obesity, behaviour problems, panic/anxiety, low levels of exercise and overall poor health (Felitti et al., 1998; Liming & Grube, 2018).

However, there is growing concern that the utility of this cumulative risk approach is limited. Implicit in this model is the assumption that all forms of adversity function through the same mechanism – wear and tear resulting from chronic activation of stress response systems or 'allostatic load' (Evans et al., 2013; Mclaughlin & Sheridan, 2016). However, there are inconsistent results regarding changes to stress-response systems following prolonged exposure, with some studies observing lower reactivity (McLaughlin et al., 2015) and others observing heightened reactivity (Fries et al., 2008) of systems. Further critiques of the cumulative risk approach have also highlighted concerns with the identification of particular adversities within widely used measures (McLennan et al., 2020). Thus, while it is certainly the case that understanding exposure to childhood adversity has both clinical and policy implications, screening and routine assessment using a cumulative risk approach has been questioned (Finkelhor, 2018). There is a clear need for the field to adopt a model informed by developmental neuroscience, which allows for exploration of the potential differences in trajectories which, in turn, may have specific impacts on neurobiological mechanisms.

A DIMENSIONAL APPROACH TO UNDERSTANDING EXPOSURE TO CHILDHOOD ADVERSITY

A dimensional approach to childhood adversity has been proposed, that classifies adversities into core dimensions: exposure to threat (i.e., direct threat of harm), and deprivation (i.e., absence of expected developmental inputs) (Mclaughlin & Sheridan, 2016). The model emphasises the central role of learning in shaping outcomes following exposure to childhood adversity. Specifically, children exposed to threat are proposed to demonstrate altered emotional learning due to heightened neural sensitivity in brain areas like the amygdala, ultimately leading to hypersensitivity to cues of danger. Conversely, deprivation promotes an absence of evolutionarily expected inputs during development. This reduced input constrains a child's learning opportunities, ultimately leading to difficulties with abilities like language and executive functioning (Mclaughlin & Sheridan, 2016).

Evidence to support this model is mounting. Sheridan et al. (2017) demonstrated a positive association between a measure of deprivation (lower parental education) and outcomes such as behavioural inhibition and global executive function (EF) difficulties in a sample of adolescents. This relationship was not found for a measure of threat (exposure to community violence). This preliminary evidence of differential mechanisms and outcomes following different forms of adversity exposure has since been replicated in multiple studies showing that deprivation indices predicted poorer performance on cognitive and EF measures, while threat exposure predicted alterations in emotional responding (Lambert et al., 2017; Machlin et al., 2019; McNeilly et al., 2021; Miller et al., 2018; Sheridan et al., 2017). This body of literature supporting the dimensional model helps to address the significant limitations of cumulative approaches, by positing testable predictions following exposure to childhood adversity. Considering all adversities equal clearly obscures important information regarding mechanisms of impairment, and invariably hinders efforts to develop clear targets for intervention (Mclaughlin & Sheridan, 2016).

SEEKING RIGOROUS CLASSIFICATION OF CHILDHOOD ADVERSITY

While advances in the field have allowed for better understanding of the mechanisms and impact of different adversities, challenges remain. Despite developments in the formulation of different types of exposures, conceptualisation of constructs has varied across studies. For example, early work exploring the dimensional model defined neglect using self-report measures such as the Childhood Trauma Questionnaire (Sheridan et al., 2017), structured approaches to determining neglect based on home observations (Miller et al., 2018), or metrics such as income-needs ratios (Lambert et al., 2017). Difficulties with standard conceptualisations have also been noted more broadly in the abuse and neglect field (Mathews et al., 2020). This leads to concerns regarding the comparability of results between studies.

While considering different dimensions of childhood adversity can provide a more complex rendering of the impact of adversity on functioning, a model is only as informative as operational definitions allow. Thus, to improve utility of the dimensional model, further research is needed to develop clear operational definitions of exposures. A well-

established approach for developing operational definitions is through expert consultation. This involves collecting data from individuals experienced in a particular area (Pinilla-Roncancio et al., 2021) and has been used previously to develop operational definitions of important concepts in primary healthcare (Haggerty et al., 2007), and to clarify inconsistencies around international definitions of child poverty (Pinilla-Roncancio et al., 2021).

The aim of this study was to utilise an expert consultation approach to identify health practitioners' definitions and characterisation of adverse childhood exposures with a view to developing a framework that reflects the dimensional model proposed by Mclaughlin and Sheridan (2016). Semi-structured interviews were conducted with allied health practitioners seeking their views on definitions and examples of different forms of childhood adversity.

METHOD

Participants

A convenience sample of multidisciplinary health practitioners with experience working with children with fetal alcohol spectrum disorder (FASD) and other neurodevelopmental disorders was recruited. Of 12 practitioners contacted, 10 consented to participate. Two practitioners declined to participate citing time constraints as the reason. The sample comprised health professionals who varied in their professional background, gender and years of experience (see Table 1 for details).

Data collection

Institutional approval from the relevant Human Research Ethics Committee was obtained. Interviews were conducted by lead author (JB; a 33-year-old male completing a PhD in Clinical Psychology). He had experience conducting qualitative research in a previous analyst role in central government and received additional training/supervision in qualitative interviews and thematic analysis by his supervisory team (content expert: SD; and methodology expert: TO). Practitioners were eligible if they worked in a medical or allied health field and had experience working with children with neurodevelopmental disorders for a minimum of two years. Convenience sampling was supported by snowball sampling with the aim of recruiting practitioners with a mix of professional background, gender and years of experience (Ghaljaie et al., 2017). Initially, practitioners were contacted through the researchers' existing networks in the field. These practitioners were asked to recommend other prospective participants according to the eligibility criteria. Practitioners were contacted via telephone or email and sent information sheets. Informed consent was obtained verbally at the outset of all interviews. Six of the 10 participants were known to the researcher via previous collaborations in professional contexts. Participants were informed that the aim of the study was to explore their definitions and examples of different forms of childhood adversity, and that the study formed part of the interviewer's PhD research.

A semi-structured, audio-recorded interview was undertaken with two major sections: (i) demographics of practitioner and (ii) discussion of adversity. The categories of childhood adversity were informed by Felitti et al. (1998) original categorisation of adverse experiences. Practitioners were asked to provide definitions and examples of each type of adversity (see Supplementary Notes 1: Interview Topic Guide). The topic guide was constructed by the authors and pilot-tested with a colleague experienced in assessment and treatment of children with neurodevelopmental difficulties. Six categories of exposure were included in interview questions (physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect and exposure to domestic violence). The four remaining adversities (caregiver mental illness, parental incarceration, caregiver substance abuse and parental divorce) were not discussed in interviews. These were considered easily operationalised without the need for expert consultation due to being more identifiable exposures.

Interviews were conducted via Zoom videoconferencing (June–September 2021). Interview duration ranged from 18 to 31 min ($M = 24.5$, $SD = 3.80$). Interviews were conducted confidentially, with no additional people present. Field notes were taken during each interview. Transcripts were not returned to participants for comment.

TABLE 1 Characteristics of health practitioners interviewed ($n = 10$)

Background/profession	N	Female (%)	Years of experience in field (mean)
Psychology/criminology	5	60%	10.0
Occupational/Speech Therapy	3	100%	13.3
Paediatrics	2	50%	19.5

Data management and statistical methods

Interviews were audio recorded and transcribed verbatim using professional transcribers. All transcripts had identifying information removed. Thematic analysis was undertaken using procedures provided by Braun & Clarke (2006). The interview was theoretically driven by drawing on the dimensional model of childhood adversity (Mclaughlin & Sheridan, 2016), while an inductive approach was used to extract themes within existing categories of adversity exposure. Data familiarisation and code generation were conducted by lead author (JB). This involved highlighting meaningful segments of information in transcripts and producing condensed meaning units, followed by coding. The lead author and content expert (SD) collaboratively completed theme searching (gathering codes into potential themes), theme reviewing (checking that constructed themes were internally valid) and defining and naming themes. Meetings at the early, midpoint and final stage of coding were conducted with methodology expert (TO) to check that the codes and constructed themes were consistent with data. All data were stored and organised in Microsoft Excel. The final organisation of data was converted into a framework which included codes and themes nested within relevant types of exposures.

Previous literature was consulted to validate the relevance and specificity of each theme to each type of adversity in the framework. As themes were designed to reflect indicators of the presence of a specific exposure, any themes which emerged across multiple exposures, or which evidence suggested can be an indicator of multiple exposures, were reported for completeness but excluded as indicators from the framework.

Quality and rigour

Manuscript preparation was guided by the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007). The lead researcher kept a reflexive journal throughout data collection and produced a positionality statement prior to beginning interviews. Prior to analysis, a team meeting was led by the methodology expert (TO) to develop the procedures for coding to enhance rigour. Preliminary coding was conducted by the lead author, who then met with the methodology expert (TO) to refine the coding practice. The lead author collated and organised codes within each type of adversity, and the thematic analysis was completed in conjunction with the content expert (SD). A final team meeting was held to discuss the audit trail to ensure that results were an accurate reflection of the data. An example of the process of analysing raw data through to development of themes is given in Appendix C.

RESULTS

Data were analysed within and across the six categories of exposure (physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, and domestic and family violence). Themes were identified for each type of exposure following qualitative analysis of participant responses, as exemplified by Appendix C. Tables 2-4 present the themes nested within each type of exposure, along with codes and quotes. Codes reflect exemplars, rather than an exhaustive list of all possible experiences under an exposure. See Note S2 for an analysis.

Physical abuse

The first theme within physical abuse was ‘intentional physical acts that are associated with bodily harm’ (see Table 2). Participants described actions such as hitting, shaking, grabbing, burning and stabbing, among others. A second theme was ‘injuries in children that are a consequence of physical abuse’. Examples included broken bones, bruises and other physical marks, head injuries and skull fractures.

A final theme for physical abuse was ‘needing evidence of abuse through medical or other reports’. This theme acknowledged the difficulty inherent in accurately identifying instances of physical abuse and included examples of needing reports from child safety, X-rays, questioning caregivers and concerns around young children being unable to report their own injuries.

Emotional abuse

Within the exposure category of emotional abuse, there was a main theme of ‘overtly hostile statements directed at a child’. This included swearing, bullying, insulting and threatening violence towards children. Participants tended to

TABLE 2 Quotation examples for themes within exposure to threat: Physical, emotional and sexual abuse

Abuse type	Theme	Codes	Quotation [participant number]
Physical abuse	Intentional acts	Hit with car; stabbed	'… *you know, like, I've had one his, um … his mum ran him over with a car. She hit him with a car. Um, you know, stabbed him through his back …'* [P02]
	Injuries that are consequences of physical abuse	Bruising; physical marks; handprints; fingerprints; patterns of bruising	'… *And so, you know, they are bruises that occur over soft parts of the body. Um, things that, uh, are conformed to particular patterns of, um, uh, you know, handprints, fingerprints, or… or the imprints of in… instruments or implements …*' [P08]
	Needing evidence through reports or scans	Investigation for injury; X-rays for injuries; infants cannot report	'… *And that's how we have to go investigate and look for those sorta injuries. So, that's why, um, if a baby presents like that, um, a lot of times we will do X-rays of the whole body. You know, to make sure we are not missing a fracture. Because babies cannot tell us, right? They cannot talk.'* [P10]
Emotional abuse	Overtly hostile statements	Threats of calling child safety	'… *and that emotional abuse, though, especially of a child who's been removed by Child Safety before, using that threat of, well, Child Safety's going to come back and get you. I'm going to call them. They can just come and take you.*' [P04]
	Statements that contribute to negative self-concept	Belittling child in front of child	'… *I think it's really common language for people to belittle the kids. Like, 'Oh …' And talk about them when they are there or whatever. Be like, 'Oh, they are just so difficult.' You know? And they just … 'And they never get it right …'* [P02]
	Caregiver-child relationship	Child not meeting parent needs; parental expectations not informed by development	'… *So, sometimes you have parents who think that a child is being lazy or not doing things that they want them to do, not meeting their needs. And I guess it's that that's based on their perception, not on the developmental capabilities of that child. So, you know, expecting a young child, you know, to get themselves up in the morning, get their breakfast, right? And if you are three, how do you do that, right? And then being upset that the child did not do that sort of thing.*' [P10]
Sexual abuse	Physical sexual acts	Sexual acts; fondling; groping; penetration; child being forced	'… *But it's usually um, physical kind of sexual behaviours that are unwanted or … by the other party and/or they are unable to provide consent for those behaviours. So that might be fondling, groping um, penetration um, you know, making the child engage in those behaviours with the abuser'* [P05]
	Exposed to sexual content	Pornography: online; paper; magazine; DVD	'… *[child] exposure to pornography, I guess whether it's online or in kind of paper, magazine, sort of versions and videos, DVDs, all that sort of stuff. So, any exposure to those sorts of things*' [P06]
	Acts to increase compliance	Grooming; time spent with family friend; no other adults around	'… *grooming behaviours are things that you'd be kinda looking out for, I suppose in clinical notes, too. A…A child saying I am…that friend of our family keeps coming around, and, you know, we end up spending time together alone …'* [P06]
	Sexualised behaviours	Observed sexualised behaviour; finger penetration of other children; masturbating in company	'… *if a child's displaying sexualized behaviour at six years of age, so that is that they are, you know, fingering other children um, you know, masturbating in the classroom, then um, then these are behaviours that you …* [P04]
	Age/power imbalance	Age difference; abuse of responsibility; power imbalance	'… *Yeah, so I think about sexual abuse as when, um, an older person or a person that has care responsibilities for a child, um, where they use their, I guess, power or authority to involve a child in a sexual activity'* [P07]
	Complexities around reporting	Video evidence; most difficult exposure to prove; child court testimony	'… *these days sometimes there's video evidence because people like taking videos of themselves doing this. Uh, but it's, you know, of all the different sorts of abuse, it's probably the one that is the most difficult to prove. Particularly if it comes down to the child having to give, um, testimony about it against an adult'* [P08]

TABLE 3 Quotation examples for themes within exposure to deprivation: Physical and emotional neglect

Neglect type	Theme	Codes	Quotation [participant number]
Physical neglect	Failure to respond to needs	Unfulfilled needs: physical, food, shelter, clothing	'… *neglecting the child or person's physical needs, their environmental kind of needs. So whether that be they are, um, they are not being provided with adequate, um, food, shelter, clothing'* [P09]
	Failure to provide adequate development	Excreta on floor; dirty environment; bad smell	'… *So you have got excrement in the house. Um, you have got um, dirty dishes in the … in the sink … Um, and kids may, you know, um, just smell of the house maybe either, you know, smell of damp or smell of uh, urine and faeces …'* [P03]
Emotional neglect	Unable to respond to child cues	Withholding affection; ignoring child while upset	'… *the classic example of emotional neglect would be, you know, withholding affection um, ignoring a child when they are experiencing emotions that they are not capable of managing themselves'* [P05]
	Poor-quality relationship	Silent treatment	'… *the child saying, um, 'Mom stopped talking to me, or dad stopped talking to me, and they have not spoken to me for five days or a week because of something that I did.' So, that…that kind of silencing … Silent treatment'* [P05]
	Absent carer	Absent carer; child fending for self; child left to look after siblings	'… *But parents are just absent. Um, yeah. And they just, you know … Ki … kids are left to make their own lunches, to look after their siblings. To, you know, um … no validation of, like, yeah, this is really hard for you, or no love'* [P02]

TABLE 4 Quotation examples for themes within domestic and family violence

Theme	Codes	Quotation [participant number]
Witnessing physical violence	Property damage; punching doors; shooting walls; throwing objects; hurting pets	'… *and I guess, property damage. So, I've had cases where, um, you know, children have reported that dad's punched holes in the bedroom door that they have shot or through the wall, or, you know, thrown things. Uh, you know, hurt pets'* [P06]
Witnessing verbal violence	Non-physical; violent language; swearing; non-physical aggression	'… *I would not discount someone being exposed to domestic violence just because their parents did not beat each other up all the time. I would still consider, like, pretty strong, um, like, language like violence. Like swearing and kind of, um, aggression even if it wasn't physical'* [P02]
Coercive control	Coercive control: isolation, belittling, worthlessness	'… *So coercive control would be … examples would be um, situations where a partner tries to isolate the other person so that they have fewer and fewer networks in order to … to run. It's a constant state of kind of belittling um, the person so that they are basically kind of, you know, reduced to feeling like they have no worth'* [P05]
Complexities around reporting	Other reports of concerns; suspicion	'… *it's really hard. And unless you have got someone who's directly reporting concerns, um, often there's lots of suspicion there' [P03]*

describe these as intentional statements towards the child, and multiple participants reported these as the 'most obvious' forms of emotional abuse. The second theme was 'exposure to statements or behaviours likely to contribute to a negative self-concept'. This included actions which promote guilt and shame in children, belittling children indirectly in their presence, comments which harm a child's identity, isolating children or withholding love or affection. Participants typically described these examples as harmful whether intentional or unintentional, and often reported them as occurring during conversations between caregivers and others while a child is present.

The third theme was 'caregiver-child relationship factors in emotional abuse'. This theme depicted relational factors between a caregiver and child that may increase the likelihood of emotional abuse occurring. This included caregivers' unawareness or intolerance of child distress, unrealistic expectations, maladaptive attempts to gain compliance, poor quality attachment, and poor attunement or ability to identify emotional needs.

Sexual abuse

This category of exposure broadly encompassed six themes (see Table 2). The first theme characterising sexual abuse was 'physical sexual acts involving children'. Participants tended to report that this as the most overt and obvious type

of sexual abuse. Examples included behaviours such as sexual penetration of children, genital touching, oral sex with children, groping, fondling and asking a child to touch someone sexually.

The second theme depicted 'children being exposed to sexual content'. This theme distinguished exposure to sexual content or actions as opposed to explicit participation. Examples included exposure to pornography, inappropriate text messaging, sexual talk or having a child observe sexual acts between others.

A third theme encompassed 'acts that aim to increase the likelihood that a child will engage in interaction that has a sexual component'. This theme included behaviours relevant to grooming, such as attempting to build child compliance, unnecessary invasions of privacy while dressing/grooming or adults posing as children online. The fourth theme was 'sexualised behaviours that are atypical for a child's developmental age'. Participants reported these behaviours as potential indicators that a child had previously been exposed to sexual abuse. Examples included sexualised behaviour with other older or younger children or in the company of others.

Participants discussed issues around 'age and/or power imbalances' as being key to sexual abuse (the fifth theme). These included reports of sexual abuse being more likely from an older to younger person, engaging in behaviours beyond the child's ability to understand, or where an individual uses power or control to facilitate abuse. The sixth and final theme was 'difficulties and complexities around reporting for sexual abuse'. Participants commented that the presence of abuse was sometimes ambiguous, or difficult to determine. Complexities were also reported around difficulties eliciting information from victims or obtaining evidence to corroborate even if reports had been made. Example quotations for all themes within abuse are shown in Table 2.

Physical neglect

Within the exposure to deprivation categories, a major theme was 'survival – failure to recognize and/or respond to child's physical needs for survival'. Examples included not making adequate medical care available for children, a lack of food, bathing, inadequate room for physical movement, shelter and safety.

The second theme was 'thriving – failure to provide a physical environment that allows for adequate development'. This theme included not providing books to read, areas to play in, properties being cluttered/smelly or parents being distracted from providing responses that meet physical needs (e.g. by substance misuse, gambling or phones/gaming).

Emotional neglect

The first major theme for emotional neglect was 'parental responding – carer is present but fails to recognize and/or is unable to respond to child's emotional cues'. This included unfulfilled child needs of attention, parental contact, praise, connection, teaching and nurturance. Examples also included parents not understanding a child's needs, being unable to emotionally contain the child, displaying a lack of responsivity or ignoring a child when upset.

A second major theme was evidence of a 'poor-quality relationship – noticeable absence of warmth from carer to child'. This theme included examples such as parents withholding affection or love from a child, isolating a child or invalidating a child's needs.

As a third theme, participants reported examples of 'absent carer/child being left with developmentally inappropriate responsibilities'. This included parents being regularly intoxicated, misusing substances, children being left at home alone at a young age, children being left to look after siblings or parents prioritising meeting their own needs above their child's. Example quotations for all themes within deprivation are shown in Table 3.

Domestic and family violence

The first theme for this type of adversity was 'child witnessing physical violence within the family unit'. This included a child witnessing physical violence directed towards a parent, sibling or other family members. It included a child witnessing specific acts such as choking, murder, punching holes in walls, property damage, hurting family pets or children being used in violence.

The second theme was 'witnessing acts of verbal violence within the family unit'. This included verbal abuse such as parents shouting at each other, violent language, emotional and passive aggression, caregivers making threats to self and others in the family unit and any other form of non-physical conflict.

The third theme was 'coercive control – child exposed to a pattern of behaviour aiming to limit agency between carers'. This included examples such as controlling the finance of others, restricting movements or cars, and intentional isolation, manipulation or 'gaslighting' of family members.

The fourth theme was 'difficulties/complexities around reporting/identification of domestic and family violence'. This referred to a general lack of hard evidence, reports of concerns and suspicions, generational issues or reluctance around reporting acts and parental attempts to cover up domestic and family violence. Example quotations for each theme within domestic and family violence are provided in Table 4.

Overarching themes

There were two overarching themes that emerged across exposure types. The first was 'outcomes following exposure to adversity'. Participants regularly discussed the developmental/psychological outcomes they had observed following different exposures:

> '*… Um, so, they had sort of welts and they had a flattened head from never being stimulated or moved or fed regularly. Um, so, that…for me, that's an example of physical neglect'* [P01]

A final overarching theme underpinning all exposure types was 'ambiguity/difficulty of neatly classifying exposures'. Participants acknowledged grey areas in which categorisation was unclear or depended on additional context. Participants also commonly reported that defining exposures clearly was difficult. To illustrate, one participant noted:

> '*… That's hard because I guess when I think of emotional neglect, I…I think there's an overlap between the two* [emotional neglect and physical neglect]' [P01]

DISCUSSION

This study aimed to identify health practitioner's definitions and accounts of different childhood adversities with a view to developing a framework that reflects the dimensional model of adversity proposed by Mclaughlin and Sheridan (2016). The qualitative analysis identified 23 themes across the six categories of adversity, along with two overarching themes regarding ambiguity of classifying exposures and non-specific outcomes of exposures. The pattern of overarching and specific themes is broadly consistent with previous research, as some characteristics and outcomes appear similar across different exposure types (Assed et al., 2020; Sanjeevi et al., 2018).

While discussing physical abuse, participants reported diverse behaviours classified as intentional physical acts that are associated with bodily harm, and common types of injuries identified as consequences of physical abuse. These themes are consistent with the American Psychological Association's (APA) definition of physical abuse, which emphasises physical injury and intentional physical acts (VandenBos, 2007). Further, these indicators are consistent with previous research on the dimensional model, where physical abuse was defined as reports of harsh physical discipline and/or observed negative physical actions towards a child (Miller et al., 2018), or being hit hard enough by a family member to be hospitalised (Busso et al., 2017; Sheridan et al., 2017). Given the consistency with previous literature and specificity among exposures (i.e. themes did not occur under any other categories), these two themes were included in the framework as indicators of physical abuse. The integration of multiple previous definitions of physical abuse provides a comprehensive classification of physical abuse.

A third theme depicted the need for evidence through medical or other reports. This theme highlights how identification of physical abuse can be limited by lack of caregiver reporting. This is consistent with research which tends to emphasise the importance of thorough medical and other history taking to help identify possible abuse (Hornor, 2005); however, it was not included in the checklist as an indicator of abuse as reporting difficulties were not specific to this category.

Two major themes underpinning emotional abuse were overtly hostile statements being directed at the child, and the child being exposed to statements or behaviour that is likely to contribute to negative self-concept. These are consistent with the APA definition (VandenBos, 2007) which emphasises caregivers verbally insulting or threatening a child. This theme was also consistent with definitions employed by research on the dimensional model, including family members directly calling children 'stupid, lazy or ugly' (Sheridan et al., 2017), or family members saying hurtful or insulting things to children (Busso et al., 2017). The second theme underscores the potential impact of these interactions on self-concept. The self-concept concerns a person's image of themselves as an individual (Spencer, 1988) and negative self-concept has been previously linked to childhood exposure to abuse (Lopez & Heffer, 1998). Given the evidence suggesting these themes as direct indicators of emotional abuse, and their specificity in the current analysis, they were both included in the framework. The inclusion of impacts on self-concept is a

strength of the framework, as it captures a less intentional but damaging aspect of emotional abuse perhaps missing from previous research.

A final theme in this category was parent–child relationship factors. This theme recognises that emotional abuse often arises from dysfunctional relational patterns between parent and child. This is consistent with reports that emotional abuse is more likely when parents lack self-regulatory capacity or the attunement to respond adequately to their child (Rees, 2010). Further, interactional models of child maltreatment suggest that abuse tends to occur as a result of adverse interactions between parent and child (Thompson & Kaplan, 1996). While this theme helps to account for some possible causes of emotional abuse, these factors are known to also underlie other various forms of child maltreatment (Thompson & Kaplan, 1996). As such, this theme was excluded from the checklist.

Sexual abuse was comprised of the broadest set of themes in this study. The first was physical sexual acts involving children. This theme firmly echoes previous research, which tends to focus heavily on the theme of actual sexual acts involving children in defining sexual abuse (Busso et al., 2017; Felitti et al., 1998; Sheridan et al., 2017). Two additional themes specific to this category were identified: child exposure to sexual content (i.e. pornography or witnessing sexual acts), and acts that aim to increase the likelihood that a child will engage in interaction with a sexual component (i.e. 'grooming' behaviours). Both of these themes are broadly consistent with the APA definition of sexual abuse: 'violation of exploitation by sexual means' (VandenBos, 2007), and as such were included in the framework.

Remaining themes in this category were not included in the framework due to a lack of specificity to this exposure in the data (complexities around reporting) or evidence suggesting a lack of specificity in the literature (age/power imbalance, sexualised behaviour) (O'brien, 2011).

Two major themes for physical neglect were failure of a caregiver to recognise and/or respond to a child's physical needs for survival, and failure of a caregiver to provide a physical environment that allows for adequate development of a child. The first theme pertains to providing resources necessary for survival e.g. food, shelter, safety, medical appointments. The second theme refers to a physical environment not conducive to optimal development e.g. lack of cognitive stimulation, chaotic, unhygienic home or poor child grooming. These themes are consistent with previous dimensional research, which has defined neglect/deprivation as living in poverty (Busso et al., 2017), parents not bathing children, providing children clothes, clean environment, healthy diet (Machlin et al., 2019), children missing medical check-ups (Sheridan et al., 2017), the absence of a play area in the home, or children's books and toys in the home environment (Miller et al., 2018). Inclusion of both themes related to survival and thriving is a strength of this framework, as they offer an integration of definitions of physical neglect across multiple previous studies.

Emotional neglect yielded three specific themes: a caregiver being present but failing to recognise or respond to child's emotional cues, poor-quality relationship (the absence of warmth from carer to child) and distracted/absent parent and/or child being left with developmentally inappropriate responsibilities. The first of these themes reflects parents not providing appropriate emotional support in response to child cues. The second theme refers to instances in which caregivers isolate a child, invalidate a child's needs or withhold interaction on purpose (i.e. the 'silent treatment'). These themes are consistent with some ACEs research (Dube et al., 2001) and more recent work using the dimensional model (Sheridan et al., 2017). Consistent with these two themes, this definition includes items related to a child feeling loved, supported, important or special and like their family felt close and looked out for each other.

The third theme (distracted/absent parent) refers to indicators of emotional neglect such as parents being intoxicated at home regularly, distracted by gaming/mobile phones, and/or children are left to raise siblings or to meet their own emotional needs. While absent from previous research using the dimensional model, this theme is consistent with previous work which referenced children being left by inattentive caregivers to independently complete tasks inappropriate for their developmental needs as a form of neglect (Ramachandran, 2012). Consequently, all three themes were included in the coding framework. This classification represents a combination of multiple forms of emotional neglect used in previous research, allowing for more comprehensive identification of this exposure than has been used previously.

Domestic and family violence generated four themes overall. The first theme was children witnessing acts of physical violence within the family unit. Examples of this included a family member being hit, having objects thrown or family pets being intentionally hurt. This is consistent with traditional definitions of domestic violence (Felitti et al., 1998) and was included in the framework.

Two additional themes were children witnessing acts of verbal violence within the family unit (shouting, swearing, threatening others or themselves, or persistent criticism of family members) and exposure to a pattern of behaviour aiming to limit carer agency – referred to as 'coercive control' in the literature (Stark, 2013). This included adult members of the family unit having restricted access to finances, vehicles, movement, or overprotective romantic partners. Both were reported as specific to this category by participants. Clear definitions of domestic and family violence are not included in previous dimensional adversity research. However, nonphysical abuse (Mazza et al., 2020) and coercive control (Stark, 2013) are included in more recent definitions of domestic and family violence. Given their consistency

with current evidence and specificity to domestic and family violence, these two themes were also included in the framework. Similar to previous exposures, the combination of multiple themes consistent with previous literature nested within the single category of sexual abuse represents a significant strength of the model. This allows for a more comprehensive conceptualisation of this exposure.

An additional theme in this category was difficulties around reporting. Evidence suggests that this difficulty is not specific to this exposure (Assed et al., 2020; Sanjeevi et al., 2018). Similarly, difficulties around reporting are consistent with estimates that only 20 per cent of victims report sexual abuse (Voce & Boxall, 2018). Consequently, this theme was excluded from the checklist.

Eligible themes were collated to form a preliminary framework for the classification of the dimensions of childhood adversity (See Figure 1). See Supplementary Notes 3: Adversity Identification Checklist for the full version of the framework with coding exemplars.

Limitations

Interviews were conducted within a specific context and socio-cultural setting, (e.g. practitioners working in neurodevelopmental disorders). While care was taken to ensure perspectives were gathered from a range of professional backgrounds, selection of participants undoubtedly influences the applicability of results to other settings. Interviews were also only conducted over a single round without additional rounds to arrive at consensus. These factors need to be considered when determining the transferability of the findings and relevance of the adversity framework to other contexts.

Implications for practice

This research provides a framework and standardised checklist for identifying and classifying different forms of childhood adversities in clinical populations. This framework can be used to support practitioners from a range of fields in accurately classifying exposures which may be relevant to formulation of client presentations and in determining treatment methods. The framework also has utility for researchers looking to accurately classify different forms of childhood adversity in samples. Future research exploring mechanisms of change using the dimensional model of adversity could use this framework to improve the rigour in classification of sample exposures.

Conclusion

Overall, participants reported multiple distinct themes across six different types of childhood adversity. Eligible themes were combined to create a framework and checklist which specify different experiences as adversities. The findings offer a framework to aide in the assessment of dimensions of adversity, which will allow for further testing of the dimensional risk model.

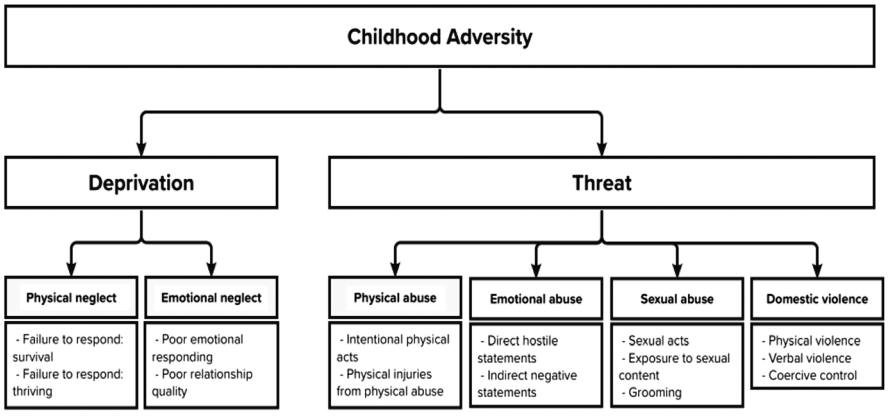

FIGURE 1 Framework derived from thematic analysis

ACKNOWLEDGEMENTS

Open access publishing facilitated by Griffith University, as part of the Wiley - Griffith University agreement via the Council of Australian University Librarians. This project was completed under a PhD scholarship co-funded by the Australian Government and Griffith University.

CONFLICT OF INTEREST

There are no conflicts of interests for listed authors.

ETHICS STATEMENT

Ethical approval for this project was obtained from the relevant Human Research Ethics Committee at Griffith University (GU Ref No: 2019/397).

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REFERENCES

Assed, M.M., Khafif, T.C., Belizario, G.O., Fatorelli, R., De Ameida Rocca, C.C. & De Pádua Serafim, A. (2020) Facial emotion recognition in maltreated children: A systematic review. *Journal of Child and Family Studies*, 29(5), 1493–1509. Available from: https://doi.org/10.1007/s10826-019-01636-w

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative research in psychology*, 3, 77–101. Available from: https://doi.org/10.1191/1478088706qp063oa

Busso, D.S., McLaughlin, K.A. & Sheridan, M.A. (2017) Dimensions of adversity, physiological reactivity, and externalizing psychopathology in adolescence: Deprivation and threat. *Psychosomatic Medicine*, 79(2), 162–171. Available from: https://doi.org/10.1097/PSY.0000000000000369

Dube, S.R., Anda, R.F., Felitti, V.J., Croft, J.B., Edwards, V.J. & Giles, W.H. (2001) Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. *Child abuse & neglect*, 25, 1627–1640. Available from: https://doi.org/10.1016/S0145-2134(01)00293-9

Evans, G.W., Li, D. & Whipple, S.S. (2013) Cumulative risk and child development. *Psychological Bulletin*, 139(6), 1342–1396. Available from: https://doi.org/10.1037/a0031808

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. & Marks, J.S. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245–258. Available from: https://doi.org/10.1016/S0749-3797(98)00017-8

Finkelhor, D. (2018) Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect*, 85, 174–179. Available from: https://doi.org/10.1016/j.chiabu.2017.07.016

Fries, A.B.W., Shirtcliff, E.A. & Pollak, S.D. (2008) Neuroendocrine dysregulation following early social deprivation in children. *Developmental Psychobiology: The Journal of the International Society for Developmental Psychobiology*, 50(6), 588–599. Available from: https://doi.org/10.1002/dev.20319

Ghaljaie, F., Naderifar, M. & Goli, H. (2017) Snowball sampling: A purposeful method of sampling in qualitative research. *Strides in Development of Medical Education*, 14, Available from: https://doi.org/10.5812/sdme.67670

Haggerty, J., Burge, F., Lévesque, J.-F., Gass, D., Pineault, R., Beaulieu, M.-D. & Santor, D. (2007) Operational definitions of attributes of primary health care: Consensus among Canadian experts. *The Annals of Family Medicine*, 5(4), 336–344. Available from: https://doi.org/10.1370/afm.682

Hornor, G. (2005) Physical abuse: Recognition and reporting. *Journal of Pediatric Health Care*, 19(1), 4–11. Available from: https://doi.org/10.1016/j.pedhc.2004.06.009

Lambert, H.K., King, K.M., Monahan, K.C. & McLaughlin, K.A. (2017) Differential associations of threat and deprivation with emotion regulation and cognitive control in adolescence. *Development and Psychopathology*, 29(3), 929–940. Available from: https://doi.org/10.1017/S0954579416000584

Liming, K.W. & Grube, W.A. (2018) Wellbeing outcomes for children exposed to multiple adverse experiences in early childhood: A systematic review. *Child and Adolescent Social Work Journal*, 35(4), 317–335. Available from: https://doi.org/10.1007/s10560-018-0532-x

Lopez, M.A. & Heffer, R.W. (1998) Self-concept and social competence of university student victims of childhood physical abuse. *Child Abuse & Neglect*, 22(3), 183–195. Available from: https://doi.org/10.1016/S0145-2134(97)00136-1

Machlin, L., Miller, A.B., Snyder, J., McLaughlin, K.A. & Sheridan, M.A. (2019) Differential associations of deprivation and threat with cognitive control and fear conditioning in early childhood. *Frontiers in Behavioral Neuroscience*, 13, 80. Available from: https://doi.org/10.3389/fnbeh.2019.00080

Mathews, B., Pacella, R., Dunne, M.P., Simunovic, M. & Marston, C. (2020) Improving measurement of child abuse and neglect: A systematic review and analysis of national prevalence studies. *PLoS ONE*, 15(1), e0227884. Available from: https://doi.org/10.1371/journal.pone.0227884

Mazza, M., Marano, G., Lai, C., Janiri, L. & Sani, G. (2020) Danger in danger: Interpersonal violence during COVID-19 quarantine. *Psychiatry Research*, 289, 113046. Available from: https://doi.org/10.1016/j.psychres.2020.113046

Mclaughlin, K.A. & Sheridan, M.A. (2016) Beyond cumulative risk: A dimensional approach to childhood adversity. *Current Directions in Psychological Science*, 25(4), 239–245. Available from: https://doi.org/10.1016/j.neubiorev.2014.10.012

McLaughlin, K.A., Sheridan, M.A., Tibu, F., Fox, N.A., Zeanah, C.H. & Nelson, C.A. (2015) Causal effects of the early caregiving environment on development of stress response systems in children. *Proceedings of the National Academy of Sciences*, 112(18), 5637–5642. Available from: https://doi.org/10.1073/pnas.1423363112

McLennan, J.D., MacMillan, H.L. & Afifi, T.O. (2020) Questioning the use of adverse childhood experiences (ACEs) questionnaires. *Child Abuse & Neglect*, 101, 104331. Available from: https://doi.org/10.1016/j.chiabu.2019.104331

McNeilly, E.A., Peverill, M., Jung, J. & McLaughlin, K.A. (2021) Executive function as a mechanism linking socioeconomic status to internalizing and externalizing psychopathology in children and adolescents. *Journal of Adolescence*, 89(1), 149–160. Available from: https://doi.org/10.1016/j.adolescence.2021.04.010

Miller, A.B., Sheridan, M.A., Hanson, J.L., McLaughlin, K.A., Bates, J.E., Lansford, J.E., Pettit, G.S. & Dodge, K.A. (2018) Dimensions of deprivation and threat, psychopathology, and potential mediators: A multi-year longitudinal analysis. *Journal of Abnormal Psychology*, 127(2), 160–170. Available from: https://doi.org/10.1037/abn0000331

O'brien, W. (2011) Challenges redoubled: Contexts of risk and compromised access to services for children with sexualised behaviours. *Child Indicators Research*, 4(4), 697–706. Available from: https://doi.org/10.1007/s12187-010-9086-y

Pinilla-Roncancio, M., Ritterbusch, A.E., Sanchez-Franco, S., González-Uribe, C. & García-Jaramillo, S. (2021) Conceptual debates on poverty measurement: The use of qualitative expert consultation to guide methodological decision-making in designing a multidimensional child-poverty measure. *Child Indicators Research*, 1-21(6), 2449–2469. Available from: https://doi.org/10.1007/s12187-021-09852-x

Ramachandran, V.S. (2012) *Encyclopedia of human behavior*. Academic Press.

Rees, C. (2010) Understanding emotional abuse. *Archives of Disease in Childhood*, 95(1), 59–67. Available from: https://doi.org/10.1136/adc.2008.143156

Sanjeevi, J., Houlihan, D., Bergstrom, K.A., Langley, M.M. & Judkins, J. (2018) A review of child sexual abuse: Impact, risk, and resilience in the context of culture. *Journal of Child Sexual Abuse*, 27(6), 622–641. Available from: https://doi.org/10.1080/10538712.2018.1486934

Sheridan, M.A., Peverill, M., Finn, A.S. & McLaughlin, K.A. (2017) Dimensions of childhood adversity have distinct associations with neural systems underlying executive functioning. *Development and Psychopathology*, 29(5), 1777–1794. Available from: https://doi.org/10.1017/S0954579417001390

Spencer, M.B. (1988) Self-concept development. *New Directions for Child and Adolescent Development*, 1988(42), 59–72. Available from: https://doi.org/10.1002/cd.23219884206

Stark, E. (2013) Coercive control. In: Lombard, N. & McMillan, L. (eds.) *Violence against women: Current theory and practice in domestic abuse, sexual violence and exploitation*. London; Philadelphia, PA: Jessica Kingsley, pp. 17–33.

Thompson, A.E. & Kaplan, C.A. (1996) Childhood emotional abuse. *The British Journal of Psychiatry*, 168(2), 143–148. Available from: https://doi.org/10.1192/bjp.168.2.143

Tong, A., Sainsbury, P. & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357. Available from: https://doi.org/10.1093/intqhc/mzm042

Vandenbos, G.R. (2007) *APA dictionary of psychology*. American Psychological Association.

Voce, I. & Boxall, H. (2018) Who reports domestic violence to police? A review of the evidence. *Trends and Issues in Crime and Criminal Justice*, 1–16, Available from: https://doi.org/10.3316/informit.982229837445814

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Betts, J.L., Ownsworth, T. & Dawe, S. (2022) Development of a framework for classifying threat and neglect in childhood: A qualitative study. *Child Abuse Review*, e2796. Available from: https://doi.org/10.1002/car.2796