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SOCIAL WORK STUDENTS' UNDERSTANDING OF CHILDHOOD PSYCHO-EMOTIONAL MALTREATMENT BY CAREGIVERS

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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ABSTRACT

Child psychological, emotional maltreatment (CPEM) presents to the social work profession as one of the most challenging to detect, prevent and intervene. The consequences of CPEM have been equally devastating to a child's development compared to all other forms of childhood maltreatment. The purpose of this study is to assess graduate social work students' knowledge of CPEM as a determinant of their clinical preparedness to work with families in practice. The rationale for this study is to explore how the lack of focus on CPEM in university education, field experience, and field supervision impacts a social worker's ability to prioritize the right of every child to live free from abuse.

The research method used for this study involved a quantitative exploratory design with a self-reported survey developed by the researcher. The survey was distributed and administered through a Qualtrics link and was open to a convenient sample of all graduate social work students enrolled in the MSW program. The independent variables included clinical comfort, clinical preparedness, and education/field experiences. The dependent variable was the level of knowledge of CPEM as demonstrated through a vignette score. Pearson correlations were evaluated for significant relationships. The most significant findings of this research were that MSW students' knowledge of CPEM was related to their experiences with assessing the level of trauma in CPEM exposed children.

The implication of this study is to develop a globally accepted and uniform definition of CPEM. In addition, the academic curriculum should be expanded to address full scope of CPEM by integrating clinical reasoning and decision-processing early in the curriculum layout. Furthermore, field agencies and supervisors should adopt leadership roles for learning and disseminating knowledge about CPEM. Accommodation for future research regarding CPEM would include the development of a specific screening tool for early detection of CPEM in children.

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DEDICATION

To my wife Karen who has given me love, support, and patience throughout this project. To my son's Jacob and Jared whose enthusiasm for university study and setting high standards have influenced me to do the same. To my mom who encouraged me to receive this master's degree and is proud I will be a psychotherapist.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

The assessment of social work students' knowledge of Childhood Psycho-Emotional Maltreatment (CPEM) can be a determinant of their clinical preparedness to competently assess caregiver(s) and the child in practice. For the purpose of this study, CPEM is being defined as a non-contact abuse perpetrated by the specific caregiver behaviors of verbal belittling, spurning, ignoring, prolonged isolation, outbursts of anger, denial of emotional responsiveness, and lack of loving affection (Arruabarrenca et al. 2013). These caregiver behaviors may be intentional or non-intentional and are consistently repetitive over an extended period of time. The end result of CPEM is to diminish a child's inner sense of self-worth (Hibbard et al. 2012), with subsequent long-term impairments in the cognitive, psychological, neurological, and behavioral domains (Shaw et al. 2012).

CPEM is one of the most challenging maltreatments to detect and prevent, even for experienced professionals in child welfare services. Professional-level education and field experience adequately prepare social work students to address the more common forms of childhood maltreatment and neglect. Until recently, CPEM perpetrated by a caregiver has received little attention both in the professional curriculum and out in the field. This lack of attention on CPEM is reflective of the broader challenges of child protection in

the national underreporting of CPEM at 11% (USDOHHS, 2018), absence of a uniform definition of CPEM (Debowska et al. 2017), and poor agreement among professionals regarding unacceptable caregiver parenting (Tonmyr et al. 2011). The primary reason for social workers to focus on CPEM is the abundance of research illustrating the consequences of CPEM to be as devasting, or more so, to a child's development when compared to other forms of child abuse and neglect (Teicher et al. 2006). Furthermore, several meta-analytic studies have elucidated independent caregiver personality traits (Tonmyr et al., 2011; Mulder et al., 2018), independent child factors (Santhosh, 2016), and parent-child interactive factors (Santhosh, 2016), which have a strong statistical correlation to the perpetration of CPEM. These research studies are suggestive of the kind of personality profile of a caregiver who might be at risk, under certain circumstances, with a child of particular vulnerabilities to perpetrate CPEM.

Social workers are among the front-line professionals to assess caregivers' personality and mental health status using clinical discretion, experience, and knowledge. CPEM occurs in a wide range of families, regardless of socioeconomic level (Bernard, 2009) and in homes with family conflict or violent aggression (Tonmyr et al., 2011). Since CPEM interferes with a child's developmental trajectory, there is a preponderance of evidenced based literature linking CPEM disorders of attachment, educational challenges, socialization dysfunction, and an assortment of disruptive behavior and emotional issues (English, et al., 2015). This study, and additional research, can effectively

support the urgent need for social workers to be proficient in assessing caregivers who are at risk to perpetrate CPEM. In order ensure the welfare of children, social workers need to be cognizant of the possibility of CPEM exposure when faced with a child with psychological and behavioral issues.

Purpose of the Study

The purpose of the research study is to investigate social work students' knowledge in addressing CPEM in caregiver-child situations. This research seeks to provide an understanding of the clinical preparedness held by social work students (future social workers) to evaluate whether their current education and field experiences have adequately supplemented their competence to address the challenges of CPEM. CPEM is considered to be a crime in the United States (Bernard, 2018). Unfortunately, any caregiver can potentially perpetrate CPEM. Research supports that specific caregiver personality traits, specific vulnerabilities, and exposure to violence in the home can have an additive risk for exposure to CPEM (Bernard, 2018). By gauging the student's knowledge, experience, and clinical preparedness to identify CPEM, this study aims to create an understanding which can influence additional CPEM training for social workers, increase support services for caregiver(s) at risk to perpetrate, and advocate for the right of a child to live free from abuse.

The research method used for this study was a quantitative study design consisting of twenty yes/no questions. This research design was selected because data were collected from a large sample size. This self-administered

survey questionnaire has the advantage of ascertaining that the biases of the researchers would not interfere with the participant responses nor data interpretation.

Significance of the Project for Social Work Practice

There is limited research in the area of social work students' knowledge regarding CPEM, and their clinical preparedness to competently assess children and caregivers in practice. This research study may influence the restructuring of professional social work programs to incorporate CPEM and all evidence-based issues related to CPEM. Furthermore, students entering the professional workforce can become more informed about how CPEM impacts families. Through this clinical perspective, caregiver(s) support services and child interventions can be offered earlier in the process. This study also informs child welfare policy to adopt a new comprehensive definition CPEM. With a new, uniformly acceptable definition, all professionals who work with children can communicate consistently. In addition, this study brings the necessary attention to CPEM as a devastating form of childhood maltreatment.

The findings of this research may also contribute to the enhancement of the field experience for students in professional social work programs. This study aims to investigate the following research question: What are social work students' knowledge of CPEM and their clinical preparedness to competently work with caregiver(s)-child appropriately?

CHAPTER TWO

LITERATURE REVIEW

Introduction

Social workers are among the front line of professionals assessing sensitive cases involving exposure to CPEM. It is crucial for social work students to receive adequate education and field experiences to achieve clinical competency in addressing situations with CPEM. Several factors related to CPEM and social work education with field experience may be contributing to clinical preparedness to work with CPEM in client populations. This chapter consists of relevant research articles to improve our understanding of how social work education regarding CPEM contributes to clinical preparedness when working through cases. The literature applicable to CPEM and the theory guiding the conceptualization of this research are discussed. This literature review also justifies this research project.

Relevancy of Childhood Psycho-Emotional Maltreatment in Social Work Education and Field Experience

The history of child maltreatment and social work practice is a long one. Social work practice has recognized that the foundation for appropriate emotional development begins in infancy and is dependent upon the quality, frequency, and nurturance of a primary caregiver's responses (Bowlby, 1969; O'Hagan, 1993; Oates 1996). In the United States, confirmed cases of child maltreatment are at the one million mark (CDC, 2018) and increasing. Of the child victims, 78% were

victims of neglect, 18% of physical abuse; 11% of sexual abuse; and 9% of CPEM (U.S. DOHHS, 2018). The true incidence of CPEM is unknown, and the precision of reported incidence depends on the diligence of the reporting source, verifiable methodology, and unambiguous definitions.

Until recently, CPEM has received less research attention, less social work curriculum focus, and insignificant field experience priority (Teicher et al., 2006). When the definition of CPEM varies among states, there are challenges in measuring the actions which constitute CPEM. Additionally, misconceptions regarding the seriousness of CPEM have also led to less attention amongst educational administrators and clinical instructors. Finally, the challenges of delineating CPEM from other co-occurring types of abuse and neglect may also influence clinical substantiation and reporting (Hart et al., 1996).

Most parents, regardless of sociodemographic status, have used emotionally aggressive discipline at some time (Status et al., 2003). Although CPEM does not result in observable physical findings, it is associated with impairment in a broad range of behavioral, emotional, psychological, and social problems (Bremmer et al., 2000; Teicher et al., 2006). It has also been suggested the outcomes of CPEM may be more serious compared to other types of maltreatment (Glaser et al., 2012). It is also challenging to identify the critical cut-off for what constitutes psycho-emotionally abusive levels of behavior or acts. This lack of behavior criteria data makes it challenging to examine precise impairments associated with each part of CPEM.

Due to the elusive nature of the consequences of CPEM, CPEM tends to be placed in a residual category of all of the child maltreatment. Consequently, the professional response's effectiveness to children exposed to CPEM has been minimized by social workers. Since the concept of CPEM is relatively imprecise to be used for state intervention with families (Melton, 1987), some social workers minimize their intervention to resolve this chronic problem (Garbarino, 1986),

Faced with these facts, the under-reported incidence of CPEM, an ambiguous definition of CPEM, misconceptions about CPEM, it is uncertain whether a social work student perceives themselves as an effective and prepared clinician to navigate CPEM in families. Social work education and field experience focus more on common advanced topics and current social welfare trends such as social injustice, immigration, neglect, sexual abuse, geriatrics, suicide prevention, substance abuse, gender identity, discrimination, and homelessness (Willson, 2020). Lack of preparation has the potential for negative outcomes for both social workers (e.g., feeling incompetent, unethical behaviors, avoiding, compassion fatigue) and clients (improper referral, inadequate intervention, further abuse) (Adams & Riggs, 2008). Proper training in CPEM can equip future social workers to identify risks in a caregiver, exposure of a child, and initiate supportive services. Specific areas for CPEM education include: (a) inquiring about the personality and mental health status of a caregiver, (b)

exploring the caregiver-child relationship, (c) evaluating the child for vulnerabilities for abuse, (d) evaluating details of CPEM exposure,

(e) conveying empathy, (f) implementing evidence-based approaches, (g) self-care, and (f) supervision. Each of these components is discussed briefly below.

First, proper training prepares students to assess client personality, mental health status, and abuse history. Proper training allows students to ask about CPEM directly and respond in a supportive manner. Some clients may omit, answer falsely, or avoid the topic because they do not perceive their parenting experiences as problematic. Social work students must learn how to communicate that CPEM can be discussed openly in the therapeutic relationship's safety.

Along with an assessment of the caregiver, student social workers need to be ready to openly explore the caregiver-child relationship. A social worker may be hesitant to do this because of the discomfort in hearing about the details of a dysfunctional or abusive relationship (Ventura, 2010). Training is essential to increase a student's ability to explore trauma histories, which may be painful or frightening (Foster et al., 2014).

Student social workers with proper training will be able to assess a child privately, away from the caregiver. Verbal and non-verbal cues can be notated in the context of the interview. Specific vulnerabilities such as physical disabilities, medical issues, and special needs place a child in a potentially precarious

position. Besides up-to-date medical, dental, and school-related information, a prepared student social worker will inquire about peer relationships and home-life.

The ability to convey empathy is another essential component of social worker training. While listening to the details of CPEM, unprepared social workers may unintentionally withdraw empathy as a way to self-protect (McGreggor et al., 2006). Withdrawal of empathy may hinder the family's progress. Social work students can be trained to offer the opportunity of hope, understanding, and empathy (Jenmorri, 2006).

In addition to the ability to convey empathy, student social workers must be knowledgeable about CPEM intervention and evidence-based approaches. Another key part of social work training is to discuss the necessity of self-care. Unfortunately, many student social workers receive minimal self-care training (Culver, 2011). In order to maintain clinical effectiveness without compassion fatigue, social workers should be trained to engage in activities such as a wellness plan. Additionally, proper education about ways to work with compassion fatigue can increase students' readiness to work effectively with CPEM.

Finally, supervision is an essential element to CPEM for emerging social workers (Foster, 2011; Sommer, 2008). Novice social workers often experience a variety of challenges, including questioning their perspectives and assumptions. Supervisors with expertise in the area of CPEM guide inexperienced social

workers to explore the personal impact of working with potential perpetrators of CPEM and survivors. Supervisors will model special skills to assist the learning process.

Factors of Vulnerability

After a careful and thorough review of literature related to the perpetrators of CPEM from 1994 to 2018, it was revealed that every individual, in a caregiver role, has the propensity to perpetrate CPEM. On a positive note, this probability is not activated in every caregiver. Therefore, certain factors exist which stimulate the vulnerability to act as a perpetrator. There are two classes of triggering factors behind the act of perpetration. First, extrinsic factors such as demographics, social, familial, and environmental. Second, intrinsic factors such as personal and interpersonal characteristics. These factors will be briefly discussed below. Age is a prominent demographic factor of vulnerability to perpetrate CPEM. For males (Flaherty, 2006) and females (Yampolskaya et al., 20019) the age range for perpetrators is between 20 and 30. CPEM incidence was also found to be a function of the family climate (Schnitzer et al., 2005). A child crying and home alone with a non-biological caregiver-perpetrator (Yampolskaya et al., 2009) on the weekend could trigger CPEM behaviors in the perpetrator. In addition, uncooperative and undisciplined behavior in children (Wiehe, 2003) could provoke perpetrators to engage in CPEM.

Personality is a prominent intrinsic factor of vulnerability to perpetrate CPEM. Personality traits such as lack of self-confidence, poor impulse

control (or hyper-reactivity), narcissism, deficiency in empathy, and egocentricity (Wiehe, 2003) have been associated with known and confessed perpetrators of CPEM. Caregivers struggling with post-traumatic stress disorder (PTSD), depression, psychiatric disorders, and substance abuse were also more likely to perpetrate CPEM due to a disengaged parenting style (Yampolskaya et al., 2009). Also, perpetrators of CPEM usually self-report themselves as “failures” in peer and marital relationships (Wiehe, 2003). Often, but not always, their existing relationships were abusive, dysfunctional, or distressed. Another statistically significant predictor for the perpetration of CPEM is a prior history of adverse childhood experiences (Zurbriggen, 2013). Perpetrators of CPEM, who did not have a prior history of adverse experiences, were individuals who usually were able to ignore their feelings of guilt surrounding their action of CPEM and embrace the derived pleasure from the CPEM to gain control, discipline, and inflicting emotional pain on a child (Zurbriggen, 2013).

In summation, given the serious consequences of CPEM, scientific knowledge and clinical awareness of risk factors for CPEM are essential. From a scientific perspective, insight into risk for vulnerability to perpetrate CPEM may shed more light on the etiology of CPEM. From a clinical perspective, risk and care need assessment procedures may be improved. The proper care needs of vulnerable children and caregivers can be better targeted to prevent CPEM. Additionally, careful tracking and comprehensive documentation of all adult caregivers living with a child will allow for effective intervention strategies.

Gaps in the Literature

While the defining features of childhood Psycho-Emotional Maltreatment (CPEM) have been explored in the literature (English et al., 2015), the consensus of a uniformly adopted definition with agreed-upon terminology has not been described in the literature. To address this gap in understanding of CPEM, this research project designed a new definition of CPEM. The new definition comprehensively included specific caregivers' behaviors, time periods of perpetration, and the outcomes of such behaviors on a child. With a nationally accepted definition of CPEM, research can identify the characteristics of families in which CPEM is present and how those characteristics interact as a part of a causal chain of events (Pecora et al., 2018).

An abundance of literature, research, and meta-analytic effort has focused on CPEM related parental behaviors (Arruaharrena et al., 2013; Mulder et al., 2018) and parental risk factors that increase vulnerability to perpetrate (Stith et al., 2009; Johnson et al., 2001). However, the appropriate professional response, clinical training, intervention studies and education and field experience have not been investigated to date. The current research project seeks to examine how social work students' education, clinical experience, professional response, and intervention choices reflect their clinical competency and preparedness to assess for CPEM in families in practice.

Theories Guiding Conceptualization

Several theories guided this research project: interactive theory, and attachment theory. Each will be discussed briefly. The interactive theory explains CPEM as a symptom of how a caregiver is dysfunctional in a complex in a complex family setting and with many interacting variables. In fact, according to this theory, certain personality traits make an individual more sensitive to certain kinds of environmental stressors.

Attachment theory concerns itself with feelings of sensitivity and responsiveness of a caregiver toward their child. The early caregiver-infant relationship is internalized by the child and forms a template in which all future relationships are formed. These kinds of attachments are crucial for adaptive development. Disturbances in attachments and bonding lead to insecure attachments in childhood. Insecure attachments in childhood can lead to abusive caregivers as a parent. Some children, who have experienced CPEM, may have difficulties forming close interpersonal relationships with their peers, partners, and offspring.

CHAPTER THREE

METHODS

Introduction

This chapter discusses the methods and research design used to explore and investigate MSW students' perceptions of clinical comfort and clinical preparedness to address a client exposed to child psychological, emotional maltreatment (CPEM) by their caregiver. The study design, sample characteristics, data collection, instruments, procedures, participant confidentiality, and data analysis are described, and this methods section establishes how the researcher conducted it.

Study Design

The purpose of this study is to explore the relationship between levels of clinical comfort and preparedness to serve a client exposed to CPEM and demonstrable knowledge of CPEM, academically and through field experiences. MSW students completed self-reports regarding their educational preparation, field training, and quality of supervision. In addition, MSW students self-reported how clinically comfortable and clinically prepared they perceive themselves to be when with clients experiencing CPEM. The data collected were used to show the relationship between clinical preparedness and comfort on the ability to recognize CPEM using several short vignette questions.

When looking at clinical preparedness and comfort as a predictor for recognition of CPEM in vignettes, a related facet is an academic foundation MSW students receive. The coursework and curricular content devoted to CPEM could play a role in how students self-report clinical preparedness and comfort. Enhanced professional development in CPEM training would, potentially, better prepare social workers to address CPEM in child welfare.

This study used a quantitative study design with a survey questionnaire that the researcher developed. The survey gathered information regarding MSW students' perceptions of clinical preparedness and clinical comfort in serving clients in different aspects of CPEM. This study used an exploratory design with self-reported surveys distributed and administered through a Qualtrics link that assessed knowledge of CPEM using short vignette questions. The link was sent via email after receiving approval from the Director of the School of Social Work. All MSW social work students were eligible to participate in the study. This self-reported survey design best fits the study based on sample size, time limitations, and the university setting. The researcher collected data from a convenience sample of graduate students enrolled in the MSW program during the 2020-2021 academic year.

A limitation of using this quantitative research design with a survey questionnaire was that the indices of preparedness and comfort are not standardized. The reliability, validity, and internal consistency among items of this scale are unknown. The researcher limited the choice of questions and the

format of the answers. Another limitation was that different respondents could interpret the same question differently. A quantitative survey did not allow participants to elaborate on their answers, as done in a qualitative research design. Furthermore, the respondents' level of honesty or thoughtfulness in completing the questionnaire was not assessed.

The research questions for this study were: Are graduate social work students sufficiently academically knowledgeable to address CPEM in society? Are graduate social work students comfortable in their clinical abilities to manage CPEM in society? Are graduate social work students clinically prepared to perceive, process, assess, and intervene in situations involving CPEM?

Sampling

The sample used in this study was collected from MSW students attending a university in Southern California both online and in person. This study sample was a non-probability sample assembled through convenience sampling.

Initially, eighty participants took part in and began this research study. Of that number, only 62 participants completed the survey. Over fifty percent were advanced year students in the MSW program (n=80), including part-time (n=29), full-time (n=20), and online students (n=32). The researcher chose the sample due to its convenience.

The descriptive statistics describe the survey sample, as presented in Table 1. The majority of participants were female (92.5%), identified as Hispanic/Latino(a) (59%) or Caucasian (24%). The mean age was 32 years.

When looking at the educational level of the sample, the predominant undergraduate major was sociology (31%) followed by psychology (25%), whereas at the graduate level, the majority of respondents were Online students (40%). The majority of respondents were employed (84%), with 16% unemployed. Regarding the area of specialization, the majority of respondents chose mental health (39%) followed by child welfare (21%).

Besides demographical data, respondents were asked specific questions related to perceived clinical preparedness to address the CPEM trauma-exposed population. More than half of respondents (58%) have had experience with assessing the level of abuse in clients and had 1-to 9 months of clinical child welfare experience (57%). When asked whether or not the university academically prepared the respondent for work with the CPEM population, (63%) indicated inadequate preparation by the academic curriculum. In contrast, 64% of the respondents indicated their field placement and 54% indicated their field supervision adequately prepared them clinically to work with the CPEM population.

Table 1. Demographic Characteristics of the Study Sample

		N	(%)	M	S.D.
Age				32	8
Sex	Male	6	7.5		
	Female	74	92.5		
Race/Ethnicity					
	African American	4	5.0		
	Caucasian	19	23.8		
	Hispanic/Latino(a)	47	58.8		
	Asian/Pacific Islander	5	6.3		
	Multiracial	5	6.3		
Education- BA degree					
	Human services	5	6.3		
	Psychology	20	25.0		
	Sociology	25	31.3		
	Social work	17	21.3		
	Criminal justice	1	1.3		
	Other	12	15.0		
Education- MSW program					
	2-year F.T.	28	35.0		
	3-year F.T.	20	25.0		
	3-year Online	32	40.0		
Current student status					
	1st year F.T.	13	16.3		
	2nd year F.T.	13	16.3		
	1st year P.T.	2	2.5		
	2nd year P.T.	12	15.0		
	3rd year P.T.	29	36.3		
Area of specialization					
	Child welfare	17	21.3		
	Mental health	31	38.8		
	Gerontology	3	3.8		
	Medical social work	7	8.8		
	School social work	8	10.0		
	Substance abuse	2	2.5		
	other	9	11.3		
Employment status					
	Full time	39	48.8		
	Part time	25	31.3		
	Self-employed	3	3.8		
	Unemployed	13	16.3		
Personal experience CPEM caregiver					
	Yes	36	45.0		

No	44	55.0
Months of child welfare experience		
0	8	10.0
1-3	23	28.7
4-9	23	28.7
10-24	15	18.8
25+	11	13.8
Level of assessment		
Yes	46	57.5
No	34	42.5
Adequate curriculum		
Yes	30	37.5
No	50	62.5
Adequate field placement		
Yes	51	63.7
No	29	36.3
Adequate field supervision		
Yes	43	53.8
No	37	46.3

Data Collection and Instruments

The self-administered survey questionnaire was collected by emailing MSW students an approved invitation with a Qualtrics link. The data collected included demographic data, clinical preparedness data, clinical comfort data, and clinical knowledge vignettes. In addition, data were collected regarding education received, field placement, and quality of supervision. Furthermore, data were collected regarding whether the respondent had any personal experiences of CPEM by their caregiver. The survey was worded with cultural sensitivity in mind.

The researcher observed patterns and relationships between data. The independent variables were the composite scores for clinical comfort and clinical

preparedness. The composite score for clinical comfort was made up of 6 dichotomous (yes/no) questions, where a “yes” response was assigned a score of 1 and a “no” response assigned a score of 0. The composite score for clinical comfort generated a quantitative scale which ranged from 0 to 6. The respondents were instructed to think about “clinically comfortable” in terms of the ability to objectively approach the unpleasant aspects of a client (in terms of a CPEM exposed child or known CPEM accused caregiver), while maintaining empathy and lack of judgment.

Similarly, the composite score for clinical preparedness comprised of 9 dichotomous (yes/no) questions, where a “yes” response received a score of 1 and a “no” response received a score of 0. The composite score for clinical preparedness ranged from 0 to 9. The respondents were instructed to think about “clinically prepared” in terms of the ability to develop a clinical approach to clients involved with CPEM through the use of appropriate assessment tools, documentation, intervention, and critical responding. Clinical comfort and processing were the indicators selected to assist the researcher in understanding their impact on MSW students’ demonstrable knowledge of CPEM to correctly process vignettes addressing (or not addressing) CPEM in children. Correct processing of the vignette questions demonstrated a foundation of CPEM knowledge. The composite knowledge score was the dependent variable, ranging from 0 to 8, depending on how many correct answers were obtained on the eight vignettes assessing CPEM knowledge.

Procedures

The research was conducted through the support from California University San Bernardino's MSW research program director, Dr. Armando Barragan as well as the committee chair, Dr. James Simon. A letter of approval from the IRB permitted the researcher to distribute a survey through a Qualtrics link, and the survey took between fifteen and twenty minutes to complete. Participation was not a requirement, and no incentives were offered to participants. All responses were anonymous because no identifying information was collected. The data were exported to the Statistical Package for the Social Sciences (SPSS) version 28. Data analysis commenced after all surveys were completed.

Protection of Human Subjects

The Institutional Review Board of California State University San Bernardino approved this study. The researcher used Qualtrics, which protects participant confidentiality and the data obtained through the survey. No identifiable information such as name and date of birth was required. Students were informed that participation in the survey was voluntary. The survey included a debriefing statement towards the end, which discussed the purpose of the study and provided contact information in case of concerns or questions.

Data Analysis

Analysis for the data collected used SPSS software version 28. Descriptive statistics were used to describe the sample, and Pearson correlation analyses were used to evaluate the association between future social workers' clinical preparedness and comfort level with the ability to clinically recognize CPEM in vignettes. A series of Pearson correlations were performed where the independent variables of interest (e.g., education/field training obtained, demographic information, perceived preparedness, and perceived clinical comfort) were correlated with the knowledge of CPEM identified in the vignettes.

Summary

This methods section operationalized how the perceptions of clinical comfort and preparedness of MSW students that served clients exposed to child psychological emotional maltreatment (CPEM). Ethical research methods were employed, and research was conducted in order to provide knowledge and understanding of MSW students' level of preparedness to serve this vulnerable population group. This chapter described the sample, the variables of interest, as well as the data analyses that were utilized to answer the research questions. Last, this chapter described the procedures as well as the human rights protections.

CHAPTER FOUR

RESULTS

Introduction

This chapter describes the results of the statistical analysis conducted. The chapter includes the results of inferential statistics. The presentation of the findings summarizes the results of correlation analysis between students' perceived comfort, preparedness, educational/training received, and composite CPEM knowledge.

Presentation of Findings

The composite for clinical comfort, clinical preparedness, and knowledge reflect how respondents perceived their ability as a social worker to make determinations about CPEM in hypothetical situations. Table 2 shows how average clinical comfort and preparedness levels enabled respondents to demonstrate slightly above average CPEM knowledge. The average score of the clinical comfort scale was 4 (*SD* = 1.8) and 4 on the clinical preparedness scale (*SD* = 3.1) indicating moderate levels of both clinical comfort and clinical preparedness. On average, participants answered 6 of 8 the vignette questions correctly (*SD* = 1.3).

Table 2. Descriptive Results of Clinical Comfort, Clinical Preparedness, and Childhood Psycho-Emotional Maltreatment Knowledge

	N	M	S.D.
Clinical Comfort Scale	62	4.05	1.83
Clinical Preparedness Scale	62	4.21	3.15
Knowledge of CPEM from vignettes	62	6.67	1.26

Note. As indicated in the methods section, the total range of composite scores was from 0 to 8.

Table 3 describes the percent of respondents indicating “Yes” to specific questions. While field placement (63.7%) and field supervision (53.8%) were sources of adequate preparation to address CPEM, the university curriculum was a source of inadequate preparation (27.5%). Respondents indicated prior experiences with assessing the level of trauma (57.5%), and the ability to discuss (90.3%) and question (71%) a child and caregiver involved in known CPEM. The ability to assess and intervene with cases of known CPEM was notably lower (49%).

Table 3. Percentage of Respondents Indicating Yes

Question	%
Assessed level of trauma	57.5
University curriculum adequately prepared	27.5
Field placement adequately prepared	63.7
Field supervision adequately prepared	53.8
Personal CPEM experience by own caregiver	45.0
Comfortable to discuss unloving parent	90.3
Comfortable to question CPEM suspect	71.0
Prepared to respond to CPEM disclosures	69.0
Prepared to assess/intervene in CPEM cases	49.0

When analyzing the results of the respondents' abilities to process the vignettes, Table 4 below indicates the distribution of correct responses. Respondents were most accurate with cases of no CPEM and less successful with cases dealing with defining features of CPEM (e.g., non-acceptance 58%, verbal belittling 73%, unstable behaviors 75%).

Table 4. Percentage of Respondents Answering Each Vignette Correct

Question		%
1.	Unstable parent behaviors	75.0
2.	No CPEM	95.0
3.	Caregiver verbal belittling	73.0
4.	Caregiver non-acceptance	58.0
5.	Over-controlling parent	87.0
6.	No CPEM	96.0
7.	No CPEM	98.0
8.	Emotional belittling	83.9

As indicated in Table 5, the experience of assessing the level of abuse clients are exposed to was positively correlated with the total knowledge composite score ($r = .26$, $p \leq 0.05$). That is, having personal experience of assessing maltreatment was associated with a higher score when correctly identifying CPEM on the vignettes. Also, having assessed the level of trauma was negatively correlated with clinical comfort meaning that people that had personally assessed the level of trauma had lower scores on the composite score measuring clinical comfort ($r = -.31$, $p \leq 0.05$). Last, there was a positive

relationship between clinical comfort and clinical preparedness indicating that participants' higher clinical comfort also had higher clinical preparedness and vice versa ($r = .52$, $p \leq 0.01$)

Table 5. Correlation Matrix

	1	2	3	4
1.Knowledge composite	1			
2. Clin. Comfort composite	-.04	1		
3. Clinical preparedness	-.07	.52**	1	
4. Assessed level of trauma	.26*	-.31*	-.2	1

Note. ** denotes p ≤ 0.01 level (2-tailed); * p ≤ 0.05 (2-tailed).

As indicated in Table 6, it was found that the quality of the university curriculum was negatively correlated with clinical preparedness ($r=-.57$, $p \leq 0.01$).

Table 6. Correlation Matrix

	1	2	3	4
1. Knowledge composite	1			
2. Clin. Comfort composite	-.04	1		
3. Clinical preparedness	-.07	.52**	1	
4. Quality of curriculum	-.05	-.24	-.57**	1

Note. ** denotes p ≤ 0.01 level (2-tailed); * p ≤ 0.05 (2-tailed).

Age was found to be negatively related to the total knowledge composite score (r = -.38 p = 0.05, see Table 7). Thus, an increase in age was correlated with lower scores on the vignettes.

Table 7. Correlation Matrix

	1	2	3	4
1. Knowledge composite	1			
2. Clin.comfort composite	-.04	1		
3. Clin. Preparedness	-.07	.5**	1	
4. Age	-.4**	-.1	.02	1

Note. ** denotes p ≤ 0.01 level (2-tailed); * p ≤ 0.05 (2-tailed).

As indicated in Table 8, it was found that the quality of the field placement was negatively correlated to the clinical preparedness composite (r = -.57, p ≤ = 0.01. Thus, students indicating that the quality of their field placements prepared them for CPEM had lower scores of clinical preparedness.

Table 8. Correlation Matrix

	1	2	3	4
1. Knowledge composite	1			
2. Clin. Comfort composite	-04	1		
3. Clinical preparedness	-.07	.5**	1	
4. Quality of field placement	-.04	-.21	-.57**	1

Note. ** denotes p ≤ .01 level (2-tailed); * p ≤ 0.05 (2-tailed).

With respect to field supervision, it was found that the quality of the field supervision was negatively related to the clinical preparedness composite (r =-.66, p ≤ .05) and the clinical comfort composite (r = -.36 p ≤ .01). Thus, field supervision was correlated with lower preparedness and comfort to address CPEM (See Table 9). This finding would imply the quality of supervision was not sufficient to assist with clinical preparedness and comfort.

Table 9. Correlation Matrix

	1	2	3	4
1.Quality of supervision	1			
2. Knowledge Composite	.02	1		
3. Clinical Comfort	-.4**	-.04	1	
4. Clinical Preparedness	-.7*	-.07	.5**	1

Note. ** denotes p ≤ .01 level (2-tailed); * p ≤ .05 (2-tailed).

Finally, there was a positive relationship between the quality of field supervision and field supervisor demonstrated assessment tools (r = .44, p ≤ .01, Table 10) and field supervisor used client cases to demonstrate presence or absence of CPEM (r = .29, p ≤ .05, Table 9).

Table 10. Correlation Matrix

	1	2	3	4
1. Quality supervision	1			
2. Supervisor demonstrates assessment tools	.44**	1		
3. Supervisor used cases to demonstrate	.29*	.52*	1	
4. Supervisor modeled interventions	.24	.58**	.47**	1

Note. ** denotes p ≤ .01 level (2-tailed); * p ≤ .05 (2-tailed).

Summary

The results of the statistical analysis highlight the perceptions of respondents regarding clinical preparedness, clinical comfort, and demonstrable knowledge of CPEM. 27.5% indicated the university curriculum did not adequately prepare future social work students to address CPEM. Respondents indicated prior experience with assessing the level of CPEM related trauma was the main source for knowledge of CPEM. Despite positive field experiences, respondents' abilities to clinically process vignettes were best in cases without CPEM but mixed in cases with CPEM.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter presents the conclusions drawn from the collected surveys of the sixty-two Southern California University MSW students. The discussion includes answers the following research questions: Are MSW students sufficiently academically knowledgeable to address CPEM in society? Are MSW students comfortable in their clinical abilities to manage CPEM in society? Are MSW students clinically prepared to perceive, process, assess, and intervene in situations involving CPEM? Furthermore, this chapter describes the limitations of this research study and includes recommendations for social work practice, implications for policies and research, and the conclusions gained from the research data.

Discussion

This study aimed to assess social work students' knowledge of CPEM as a determinant of clinical preparedness to work with families in practice. The results indicated that perceived clinical preparedness, clinical comfort, university education, and field experiences are significantly associated with MSW students' ability to clinically process CPEM in a professional setting, such as an agency. To answer the first research question, MSW students' perceived the university did not adequately prepare them to address the scope of CPEM in society. To

this point, the literature has shown on-line distance learning in social work education to effectively enable students to achieve the required learning competencies established by the NASW (Crisp, 2018; Gillingham, 2009; Goldingay & Bobb, 2014; McAuliffe, 2018), and state licensing goals (McAuliffe, 2018). However as graduate MSW students transition into fully immersive professional service delivery, the literature concurs with the findings of this current research project regarding the lack of academic preparedness (Bundy-Fazioli et al., 2010; Martin, 2016; Baum, 2016). While the primary academic focus of child welfare for generalist social worker educators is the more common forms of child neglect and maltreatment, CPEM receives minimal graduate level curricular attention. This minimal level of academic emphasis on CPEM reflects the broader perspective in the field of social work regarding CPEM (Crisp, 2019; Hibbard et al.,2012). The literature highlights how, as child welfare issues becomes more complex, the specific aspects of each abuse expand at a rate faster than social work theory, social work research, and social work education can evolve (Tham & Lynch, 2019). To this point, graduate MSW students have, retrospectively reported, the lack of clinical preparedness to address the trauma of CPEM in children (Tham & Lynch, 2019; Tham & Lynch, 2014; Poso et al., 2013), the inability to ask appropriate questions when there is no disclosure (Tham & Lynch, 2019), and the hesitancy to use intuition to adapt current trauma protocols for specific cases (Manthorpe et al., 2015).

Another aspect of graduate social work education is an enriched field experience with a qualified field supervisor. To answer the second research question, this study showed MSW students perceived themselves as clinically comfortable and clinically prepared to manage CPEM in society. The respondents' perceptions of preparedness/comfort were attributed to the quality of field supervision, in terms of demonstrating tools to assess the level of CPEM-related trauma. Although results in this study indicated that quality of supervision was negatively correlated with clinical comfort and clinical preparedness, this may be related to student self-doubt. The literature supports this idea of self-doubt and lack of confidence, as common among graduate MSW students (Tham & Lynch, 2019; Bralla, 2020). Some research has attributed this "impostor syndrome" (Clance & Imes, 1978) in graduate MSW students as due to either feeling of being clinically unprepared, having anxiety surrounding clinical confidence, and being overwhelmed by the idea of successful clinical competency (Tham & Lynch, 2019). Despite this contrary finding, field experience of assessing the level of trauma involved in CPEM also emerged as a variable significantly associated with an MSW students' ability to process cases to distinguish presence of CPEM, clinically. Based on these findings, it can be inferred that MSW student direct experiences in learning assessment tools are the foundations that influence MSW students' knowledge of CPEM. Furthermore, Ketner (2017) explains how field experience is important because it puts academic theory into practice. Furthermore, quality field supervision facilitates

the transition into the social work workforce (Tham & Lynch, 2019). In other words, the literature supports both a strong foundational education integrated with quality field experiences and supervision to prepare students for real-world client assessments (Lynch, 2019).

To address the third research question regarding appropriate clinical processing of CPEM, this research showed a positive relationship between perceived clinical preparedness and processing of CPEM. Respondents attributed field placement and supervision as the sources for their preparedness. These findings are in alignment with the literature, which indicates that quality supervision in quality field placements is crucial in MSW students' development of a sense of "ableness" (Pehrson et al., 2009), confidence (Alschuler et al., 2015) and integration of specific knowledge (Cooper-Bolinskey et al., 2016). Additionally, this research showed that students who reported quality of supervision to prepare them to address CPEM, also reported their supervisors demonstrated CPEM-specific assessment tools. To a lesser degree, quality of supervision to prepare was also associated with supervisors who used cases to differentiate between CPEM and other mental health issues. These findings are supported by the literature (Tham & Lynch, 2019; Fook et al., 2000) which highlights how graduate MSW students transition from a "novice" professional to "expert". Supervision which included specific skill acquisition to assess and case reviews to illustrate the "critical reflective process" (Fook et al., 2000) shaped how the novice professional can interpret, process, and decide to intervene

(Preston-Shoot & McKimm, 2012). This implies that universities and social work agencies should ensure that MSW students receive high quality supervision, as it can improve their levels of service delivery. Ultimately, this elevates the social work profession, overall. The noteworthy factors about the quality of field supervision included having a field supervisor who demonstrated how to assess trauma and analyze clinical cases for CPEM involvement.

To address the larger issue of limited CPEM in research, limited graduate school curriculum attention on CPEM (Brenner, 2004), and limited scope in field education (Saltzburg et al., 2010), the literature offers several suggestions. In order to expand the graduate social work curriculum to include the scope of CPEM in society, the literature suggests bringing social work practice on to a situational-based learning platform (Gillingham, 2011; Fook et al., 2000) so students can develop critical reflection skills about CPEM early in their academic learning. This situational-based learning would be accomplished by arranging on-going visits by experienced CPEM field supervisors to the classroom (Gray & McDonald, 2006) to review the cognitive processes needed in professional reasoning with regards to CPEM. This could take the form of role playing, case reviews, modeling assessment tools, and discussions about when clinical intuitions are to be looked at. To expand the field experience to include the scope of CPEM in society the literature suggests shifting social work organizations towards developing supportive learning environments for all newly hired social workers (Manthorp et al., 2015). The literature definitely wrestles with the

question of where the line between the responsibility of social work educators and social work agencies should be drawn (Healy & Meagher, 2007; Wilson, 2013).

To broaden the profession of social work, regarding the social problem of CPEM, the literature suggests an overall prioritization of the right for a child to live free from all forms of abuse (Convention on the Rights of the Child, 2018), including the covert forms of CPEM and neglect. The social work profession can move forward into the future at a rate commensurate with the broader needs of society. The literature also suggests a need for field supervisors to actively advocate for the profession as leaders who propel CPEM knowledge forward and disseminate this knowledge (Asakura & Maurer, 2018; Miehls et al., 2013; Schamess, 2012). Last, there is also a need for an expansion of collaborative research and motivated curiosity among academia and field practitioners (Staudt et al., 2003) regarding CPEM.

Another important result was the significant percentage of respondents who acknowledged personal CPEM experiences with a caregiver. Trauma history among social work students could be guiding their accurate ability to identify the negative outcome of a trauma on a child (Zerubavel, & Wright, 2012). Care should be taken by students and social workers to ensure these trauma histories do not vicariously re-traumatize them and interfere with clinical abilities. Another critical result is that while academics were perceived as inadequate to prepare students clinically, their field experiences appeared to compensate their hands-

on learning. This highlights the importance of field to complement social work student' clinical learning, as mentioned before which has been found in other studies (Crisp, 2018; Ketner et al., 2017; Saltzburg et al., 2010; Travis et al., 2016).

Limitations

There were some limitations that were encountered during the process of this research study. One of the limitations was the lack of a standardized questionnaire to measure clinical preparedness and comfort. Thus, the reliability, validity, and internal consistency among questionnaire items are unknown considering that the researcher chose the questions and the format of the answers. Another significant limitation of the research is that the questionnaire did not allow participants to elaborate on their answers which impeded us from understanding some of their quantitative data. Also, the respondents' level of honesty of thoughtfulness in completing the questionnaire was not assessable, so it is possible that some respondents were not honest or forthcoming while answering questions. Last, the sample is from one university in a large, diverse Southwestern state and thus the results may not generalize to other jurisdictions.

Recommendations for Social Work Practice, Policy and Research

This research study sheds light on the factors which influence MSW students' knowledge of CPEM, such a perceived preparedness, comfort, education, and field experiences. As mentioned previously, the results revealed

that the quality of field supervision and field placement significantly influenced how prepared and comfortable MSW students felt to deal with CPEM clients. Due to these results, one recommendation that could be made is to continue educating social work students and social workers already in practice about the best practices, research findings, and factual material regarding CPEM. This may be done through the enhancement of the online training curriculum by universities to offer free trainings to unlicensed social workers and continuing education units for licensed social workers.

On a macro level, the development of CPEM educational training courses (webinars) and continued education and professional development presented by agencies and experienced child welfare professionals could be integrated into the required MSW educational curriculum. Additionally, large statewide child welfare agencies and organizations which employ social workers working with children and families may use this information to establish policies, procedures, and guidelines surrounding CPEM and disseminate information and education to standardize acceptable practices and awareness by which social workers may gain and evaluate their competency in practice. An example of a successful model for CPEM practice is The Frontline Model in England (Maxwell et al., 2016), trains social work students intensively for two years, with qualified supervision. This model is focused on experiential learning first, which includes relationship-building, conflict resolution and conversational skills considered

important. The intensive coaching and responsive supervision allow for a bridge between university programs and agencies (Maxwell et al., 2016).

A recommendation for future research regarding CPEM would include a prioritization of the development of more specific screening tools to be used in schools, for early detection of intervention. Workforce development models for educators, such as The National Child Traumatic Stress Network Toolkit for Educators (Loomis, 2018) could be expanded or adapted to address CPEM in children. Parent engagement effects on child outcomes of CPEM-trauma is another avenue of potential research. The impact of parent-teacher and parent-child support can be assessed with regards to CPEM outcomes on cognition and behavior.

Conclusion

Daily, social workers worldwide serve as faithful warriors in the lives of children to protect, support and guide their self-determination to live a life free of abuse. This freedom of abuse is an ultimate professional victory for a social worker, the ability to competently practice in these impactful moments in a child's life due to the preparedness and comfort obtained from one's academic and field experiences. The confusion and misunderstanding of CPEM adds a new layer of complexity for social workers. By providing future social workers specific education and training in CPEM, there is an increased level of knowledge, competence in practice, and an elevated feeling of clinical preparedness and

comfort. Ultimately, the result is an improved quality of care MSW students will provide to their clients experiencing CPEM.

APPENDIX A

INSTITUTIONAL REVIEW BOARD LETTER

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

April 26, 2021

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2021-177

James Simon Todd Rubin
CSBS - Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear James Simon Todd Rubin:

Your application to use human subjects, titled "SOCIAL WORK STUDENTS' UNDERSTANDING OF CHILDHOOD PSYCHO-EMOTIONAL MALTREATMENT BY CAREGIVERS" has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study to ensure the protection of human participants. Important Note: This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at https://www.csusb.edu/academic-research.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

Important Notice: For all in-person research following IRB approval all research activites must be approved through the Office of Academic Research by filling out the Project Restart and Continuity Plan.

Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.
Submit a study closure through the Cayuse IRB submission system once your study has ended.
If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2021-177 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair
CSUSB Institutional Review Board

ND/MG

APPENDIX B

RESEARCH INVITATION

CSUSB WE DEFINE THE Future

School of Social Work

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
5500 University Parkway, San Bernardino, CA 92407
909.537.5501 | fax: 909.537.7029
http://socialwork.csusb.edu

Dear Prospective Research Participant,

My name is Todd Rubin, and I am conducting a research study for my MSW degree. Research studies are done to answer important social science questions. This study is being conducted to learn more about future social worker's clinical preparedness regarding childhood psychological-emotional maltreatment. The reason I am conducting this research is to ensure future social workers are fully prepared to face a client in a clinical setting who has experienced childhood psychological-emotional maltreatment.

Taking part in this study is optional. The criterion to participate are:

1. To be 18 years of age or older
2. To be enrolled in a social work program such as BASW program full and part-time; MSW full and part-time; Pathway MSW full and part-time, and Title IV-E program.

Your participation will take approximately 15 minutes of your time and is conducted completely anonymously. The research study has been approved by the International Review Board (IRB) and the project's supervisor is Dr. James Simon.

Questionnaire Link: (To be placed here)

Informed Consent: (To be placed here)

At the survey's conclusion, there will be a random raffle for a $50.00 Amazon Gift Card.

Thank you in advance for your support and participation in helping me make this study a success.

Thank you,
Todd Rubin

Phone: 845 826 3598

Email: 007072748@coyote.csusb.edu

or toddrubin81@gmail.com

Developed by Todd Rubin

APPENDIX C

INFORMED CONSENT

CSUSB
WE DEFINE THE Future
School of Social Work
CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
5500 University Parkway, San Bernardino, CA 92407
909.537.5501 | fax: 909.537.7029
http://socialwork.csusb.edu

INFORMED CONSENT The study in which you are asked to participate is designed to evaluate knowledge about child psycho-emotional maltreatment. The study is being conducted by Todd M. Rubin, a graduate student, under the supervision of Dr. James Simon, Adjunct Professor of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to evaluate the knowledge of Child Psycho-Emotional Maltreatment (CPEM) among social work students.
DESCRIPTION: Participants will be asked a series of questions on various aspects of CPEM for which they can choose from five choices.
PARTICIPATION: Your participation is completely voluntary and refusal to participate or discontinue participation is permitted at any time without consequences.
CONFIDENTIALITY: Participation information and answers remain anonymous. Data is reported in group form only.
DURATION: It will take twenty minutes to complete the survey.
RISKS: Although not anticipated, there may be some discomfort in answering some of the questions. You can omit, skip or end participation of uncomfortable.
BENEFITS: There will not be any direct benefits to the participants.
CONTACT: If you have any questions about this study please feel free to contact Todd M. Rubin at (845) 826 3598 and James D. Simon at James.Simon@csusb.edu
RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after July 2022.

****

I agree to have this interview be audio recorded: _____ YES _____ NO

I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

_____ _____
Place an X mark here Date

Developed by Todd Rubin

APPENDIX D

DEMOGRAPHIC SURVEY

Developed by Todd Rubin

Demographics Questions. The following questions ask information about you. Please answer each as best as you can.

1. What is your age? _____ (1)
2. Gender: _____ (1) Male
   _____ (2) Female
   _____ (3) Other (Please Specify: _____)
3. Racial/ Ethnic Identity:
   _____ (1) African American
   _____ (2) Asian/Pacific Islander
   _____ (3) Caucasian/European American
   _____ (4) Latino (a)/Hispanic
   _____ (5) Native American
   _____ (6) Multiracial (Please specify: _____)
4. Bachelor's Degree:
   _____ (1) Human Services
   _____ (2) Psychology
   _____ (3) Sociology
   _____ (4) Social Work
   _____ (5) Criminal Justice
   _____ (6) Other (Please specify: _____)
5. MSW Program
   _____ (1) 2 Year Full-time
   _____ (2) 3 Year Part-time
   _____ (3) 3 Year Pathway
6. Current MSW Status
   _____ (1) 1st Year Full-Time
   _____ (2) 2nd Year Full-Time
   _____ (3) 1st Year Part-Time
   _____ (4) 2nd Year Part-Time

_____ (5) 3rd Year Part-Time

7. Area of Specialization

_____ (1) Child Welfare

_____ (2) Mental Health

_____ (3) Gerontology

_____ (4) Medical Social Work

_____ (5) School Social Work

_____ (6) Substance Abuse

_____ (7) Physical & Mental Disabilities

_____ (8) Correctional Services

_____ (9) Social Work in the workplace

_____ (10) Other (Please specify: _____)

8. Field Placement:
   What is your current field placement?
   _____ (1)

   If you are an advanced MSW student, please indicate your first year field placement:

   _____ (2)

9. Employment Status:
   _____ (1) Full-Time
   _____ (2) Part-Time
   _____ (3) Self-Employed
   _____ (4) Unemployed

10. Have you had any personal experiences with psychological or emotional abuse by a caregiver?

    _____ (1) No

    _____ (2) Yes (Please elaborate on this response: _____)

11. Months of experience in a child clinical setting.
    _____ (1) 0
    _____ (2) 1-3
    _____ (3) 4-9
    _____ (4) 9-24

_____ (5) 25+

12. Have you ever assessed the level of trauma or abuse an individual has been exposed to?
    _____ (1) Yes
    _____ (2) No

13. Do you feel your university's academic curriculum has adequately prepared you to work with child psychological and emotional maltreatment at the clinical level?
    _____ (1) Yes
    _____ (2) No

14. Do you feel the quality of professional field placement(s) has adequately prepared you to work with child psychological and emotional maltreatment at the clinical level?

    _____ (1) Yes

    _____ (2) No

15. Do you feel the quality of professional supervision has adequately prepared you to work with child psychological and emotional maltreatment at the clinical level?

    _____ (1) Yes

    _____ (2) No

APPENDIX E

RESEARCH QUESTIONNAIRE

Developed by Todd Rubin

Questionnaire

For the following set of questions, the phrase "clinically comfortable" is used for the purpose of this questionnaire; we define "clinically comfortable" as the ability to deal objectively with unpleasant aspects of the client before you while maintaining empathy and lack of judgment. Please answer (1) Yes (2) No

1. I feel clinically comfortable discussing the nature of an unloving parent with a child.
   _____(1) Yes
   _____(2) No
2. I feel clinically comfortable to ask questions of a caregiver suspected of child psychological, emotional maltreatment.
   _____(1) Yes
   _____(2) No
3. I feel clinically comfortable assessing the level of trauma in a child with known exposure to psychological-emotional maltreatment.
   _____(1) Yes
   _____(2) No
4. My field supervisor demonstrated appropriate social worker assessment tools for child psychological-emotional maltreatment.
   _____(1) Yes
   _____(2) No
5. My field supervisor used clinical examples of client cases to differentiate between emotional abuse and mental health issues.
   _____(1) Yes
   _____(2) No
6. My field supervisor modeled specific intervention practices appropriate for child psychological, emotional maltreatment.
   _____(1) Yes
   _____(2) No

For the following set of questions, the phrase "clinically prepared" is used. For the purpose of this questionnaire, we define "clinically prepared" as the ability to assess your client by developing a clinical approach to the case, utilizing assessment tools, performing documentation, and implementing interventions.

7. I feel clinically prepared to respond to disclosures of child psychological, emotional maltreatment.
   _____(1) Yes
   _____(2) No
8. I feel clinically prepared to assess and intervene in families with known child psychological-emotional maltreatment. _____
   _____(1) Yes
   _____(2) No

9. I feel clinically prepared to assess the level of trauma or abuse an individual has been exposed to.
   _____(1) Yes
   _____(2) No

10. Based on my **university's academic curriculum,** I feel clinically prepared to work with child psychological and emotional maltreatment?
   _____(1) Yes
   _____(2) No

11. Based on the **quality of my professional field placement(s),** I feel clinically prepared to work with child psychological and emotional maltreatment?

   _____(1) Yes

   _____(2) No

12. **Based on the quality of my professional supervision,** I feel clinically prepared to work with child psychological and emotional maltreatment?

   _____(1) Yes

   _____(2) No

For the next section, please answer please answer Yes or No.

13. Your 14-year-old client tells you "I can't predict how my parents will react as they often are yelling at me one minute then the next minute they aren't" Is this an example of psychological-emotional maltreatment?
   _____(1) Yes
   _____(2) No
14. Your 13-year-old client tells you, "my mom is willing to let me take chances in order to grow." Is this an example of psychological-emotional maltreatment?
   _____(1) Yes
   _____(2) No
15. Your 14-year-old client tells you, "my dad purposely embarrasses me in front of my friends." Is this an example of psychological maltreatment?
   _____ (1) Yes
   _____ (2) No
16. Your 17-year-old client tells you, "my parents are always trying to change me because they don't want me to express myself." Is this an example of psychological-emotional maltreatment?
   _____(1) Yes
   _____(2) No
17. Your 12-year-old client tells you, "my mother expects me to excel in everything I do; otherwise, she sees me as a complete failure." Is this an example of psychological-emotional maltreatment?
   _____(1) Yes
   _____(2) No

18. Your 15-year-client tells you, "my parents often acknowledge my school achievements." Is this an example of psychological-emotional maltreatment?
    _____(1)Yes
    _____(2) No
19. Your 10-year-old client tells you, "when my dad knows I have been treated unfairly by someone else, he speaks up for me." Is this an example of psychological-emotional maltreatment?
    _____(1) Yes
    _____(2) No
20. Your 23-year-old client tells you, "Throughout my childhood, whenever I expressed any emotions, I was told I was 'being too dramatic or 'you're a drama queen' by my mother." Is this an example of psychological-emotional maltreatment?
    _____(1) Yes
    _____(2) No

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