



Effects of child abuse on general health and personal beliefs in adulthood: A case study

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Abstract

The aim of this study, involving one General Hospital in the North of England, was to investigate how adult survivors from a hospital sample of children previously diagnosed as abused compared on standard psychological measures of Locus of Control, Self Esteem and General Health when matched with controls who attended hospital for paediatric assessment or investigation. Our findings suggest that, overall, abuse survivors do not differ significantly on standard psychological measures from controls. Possible reasons for this are discussed. Hospital records provide an important database for further study of the long-term effects of identified abuse and health problems in childhood.

Key words: child abuse, health, beliefs, retrospective study

Child abuse has been the centre of much media and political interest over the years, raising public awareness and concerns regarding its occurrence and effects, both short and long term. However, the problem of definition is a central theme for much research. It seems there is no absolute definition of abuse; its concept is an evolving one and is based on social interpretations of events. Gough (1993) suggests that definitions of child abuse have two things in common: that the child is harmed and that someone intended that harm. However, even this general definition raises problems. Distinctions are hard to make, since there is no agreement on what is harmful, responsibility for the harm or whether it is abusive. In practice, the distinctions are even more difficult because the full details of what, how and why abuse happens are often only partially known. Gelles (1975) pointed out that there is no objective phenomenon that can automatically be recognised as child abuse. For practical purposes, the definitions of physical injury, sexual abuse, emotional abuse and neglect given in the Children Act 1989 are widely accepted.

Creighton (1992) found that physical abuse accounted for most of Child Protection registrations in this country, followed by sexual abuse and then emotional abuse and neglect. Browne et al (1988) characterised abuse into 'passive' and 'active' forms but pointed out that victims were unlikely to be subjected to only one type of abuse; sexual and physical abuse were always accompanied by emotional abuse (Browne and Herbert 1995). It is worth noting that the long-term effects of physical abuse, neglect and emotional abuse have received rather less attention from researchers than sexual abuse. Most recent clinical research tends to be on the effects of sexual abuse only (see, for example, the study by Frothingham et al. 2000). This needs to be taken into consideration when comparing studies. With the exception of some

sexual abuse, maltreatment is seldom a single event or incident. Studies that look at maltreatment in the general population also play an important part in enlarging understanding (Cawson et al. 2000; Cawson, 2002).

Research has helped with the definition of abuse and abnormal treatment by examining what normally happens in families and what the long-term outcomes of different kinds of parenting and family events may be (see Schaffer's 1998 review). This in itself is not without problems, as what is seen as 'normal' in one generation is often 'abnormal' in another, and 'normal behaviour' as exhibited by the majority of parents does not mean it is 'optimal' (Department of Health, 1995). The Newsons' survey of child upbringing in the 1960s found that 95% of parents hit their children. Out of these, 80% thought it was right to do so (Newson, & Newson 1968). Later, when they repeated the study, 81% of parents said they hit their children but half thought they should not do so (Newson, & Newson, 1989).

Dingwall (1986) argued that the 'diagnosis' of 'child abuse' was a last resort when all other explanations had been rejected, that only some kinds of maltreatment tended to get labelled as abuse, and only some kinds of parents and carers tended to be suspected of abusing their children. This point has also been explored by, among others, Creighton (2002).

Care must be taken when looking at statistics because the definition of child abuse is socially constructed and changes over time. Among the many methodological problems in research is the fact that statistical data are often contradictory; we need to be sure to compare like with like before making any evaluation. In Britain, until the early 1980s, the category of sexual abuse was not included on local authority child abuse registers. The number of sexual abuse cases on registers held by the NSPCC in 1981 was only 27, but by 1986 had risen to 527. By 1991, sexual abuse accounted for 16% of registrations in England and Wales (Department of Health, 1991a). Creighton (1992) observed that the attention it received overshadowed work on other forms of abuse to the extent that some used the terms 'child abuse' and 'child sexual abuse' interchangeably: another difficulty when comparing statistical data.

If professionals are faced with a severe incident where there are no mitigating circumstances and which, left unchecked, will lead to significant harm, they have a duty to protect the child. In other circumstances it may be concluded that no abuse has occurred and that no action to protect the child or support the family is necessary. However, most cases that come to the notice of agencies involved in child protection fall between these extremes. Deciding whether child abuse has occurred in these – the most common – cases is often very difficult (Bannister, 1989; Corby, 2000; Department of Health, 1995; Parton, 1997).

Downes and Orr (1980) pointed out that, despite the increasing number of reports, little was known about the immediate and long-term psychological effects of abuse on children and adolescents, although it was generally thought that the effects of abuse might play an important part in shaping the way a child develops into adulthood. Prevalence studies on the general population reveal that large numbers of adults abused as children appear to suffer long-term adverse consequences (Cawson et al., 2000; Creighton, 2002); whereas in earlier follow-up studies Toro (1982) and Finkelhor (1988) found that about one-third of survivors showed no symptoms of abuse in the short term and a larger number none in the long term.

Bowlby (1951) claimed that the first relationship was crucial for healthy development as it acted as a model for all other relationships: see Helfer and Kempe's (1987) study of poor attachments of mothers who abuse. Cicchetti and Lynch (1995), using traditional classification schemes, demonstrated that approximately two out of three maltreated children showed atypical, insecure attachments to their mothers. The high rates of such attachments found in maltreated children put them at risk of non-adaptive outcomes in interpersonal development and are associated with the presence of externalising and internalising behavioural problems (Cicchetti & Lynch, 1993). It seems, therefore, that suffering abuse as a child can have long-term effects that interfere with day-to-day functioning. However, Toth and Cicchetti (1996) found that the quality of attachments might moderate the effects of maltreated children's perceived competence and depressive symptomatology.

Information on the adverse psychological effects of abuse comes mostly from clinical case descriptions of abused children and retrospective studies of adults abused as children. Some research has also attempted to differentiate between types of abuse, age and sex of victims and the type of abusive relationship that are associated with different adult outcomes. For instance, Hall and Lloyd (2001) claimed that factors found to be statistically associated with the experience of sexual abuse in childhood include anger, sleep disturbance, dissociations, sexual difficulties, guilt, depression, anxiety, substance abuse and eating disorders. These claims are backed by further studies of the sequelae in adulthood of child sexual abuse (Beitchman et al., 1992; Briere, 1992). The work of the NSPCC in studying the experience of maltreatment in a non-clinical sample of young people (18-24) found that those with a history of maltreatment were more likely to report feeling depressed and unhappy as adults (Cawson, 2002).

In the search for moderators of negative life events, the locus of control (LoC) is thought to be one of the more potentially important personality variables. Rotter (1966) used the term locus of control to refer to the extent to which people believed they were in control of their life events. He proposed that the concept explained our beliefs about what controlled events in our everyday lives and how we were reinforced by our actions. As children grow, they may learn that some actions result in similar consequences, while others do not. If the child comes to distinguish actions resulting in predictable consequences from those that do not, this learning will generalise across situations. Thus individuals will develop a tendency to believe they are, or are not, in control of events.

Rotter (1966) devised the Internal-External (I-E) Scale. This assesses a person's position on a bipolar continuum, Internal-External. Internal-External control has to do with expectancy. Those with a mainly internal locus expect their own input to lead to required goals. They tend to take responsibility for their own actions and try hard to implement their plans. Such people believe that they can create their own successes and failures, whereas those with an external locus believe in chance happenings. This latter group tends to rely on luck, and when things go badly, they tend to blame the outside world (Lefcourt et al., 1981). Most occupy a position somewhere between the two extremes. As the LoC construct seems to reflect the extent to which individuals believe themselves capable of exerting personal control over environmental events, one might expect 'internals' and 'externals' to respond differently to particular life experiences.

Lefcourt et al. (1981) found that locus of control measures interacted with recalled negative life events in predicting mood states. Positive life events, on the other hand, were found to have relatively little effect on subsequent mood disturbance. LoC has also been closely linked with studies looking at learned helplessness. Seligman (1975) suggested that people suffering from depression often did not take actions that could improve their circumstances, because they saw this as pointless; previous life experiences placed them in a position where they felt unable to act and thus led to the learned helplessness response, even when circumstances changed. He maintained that this response resulted from any situation where people believed they had no control over events.

The possibility that emotional processes affect short- and long-term health and well-being is of major interest to a variety of academic disciplines and is a central theme of psychosomatic medicine and health psychology. Health status is evaluated on the basis of two sources of information: laboratory evidence and pathology; and patient-reported symptoms and illness history. Lazarus (1991) pointed out that, to the extent that illness depended, in part, on subjective reports, there was room for confusion between the emotional process and health status.

There are a number of problems that make it difficult to obtain definitive answers about the emotion-health relationship. These include confounding subjective-objective measures, the multivariate causation of health outcomes and the stability of health status over long periods of time (Lazarus, 1990). Lazarus claimed that because all measures of somatic health depended on self-reports, the confounding inherent in subjective data could not be completely overcome. Exposure to traumatic events can be associated with a wide variety of subsequent

psychological symptoms and disorders, including anxiety, depression and cognitive symptoms such as low self-esteem and psychosomatic symptoms (Boney-McCoy & Finkelhor, 1995). Bremner, Southwick and Charney (1994) found that a history of exposure to extreme stress (such as childhood physical abuse) increased the risk for stress-related symptomatology when individuals were re-exposed to traumatic stress later in life. There is also evidence that children sexually abused at a young age are more vulnerable to the development of post-traumatic stress symptoms and depression (Wolfe, 1987). Research results indicated that abused children had lower self-concepts than non-abused children; and that the experience of abuse was generally associated with lowered self-concepts in children of all ages. Abuse victims are often less confident, have fewer friends, are less ambitious and lower in self-esteem (Oates, Forest, & Peacock, 1985). A more recent study by Vondra, Barrett and Cicchetti (1990) using the Lipsitt (1958) self-concept scale for children found that children from maltreating families were less realistic in their self-ratings than their peers from non-maltreating families. Although they scored lower than their peers on objective measures of physical and cognitive competence, they gave themselves higher ratings of competence and self-acceptance than those assigned to them by their peers. Self-concept can be thought of as the individual's belief or perception about his or her personality. Negative or positive attitudes and values by which a person views him or herself, and the judgements they make about these, form their self-esteem, which is made up of a set of personal attitudes and beliefs. In turn, this provides a mental set that prepares the person to respond to life events.

Objectives of the present study

The aim was to investigate the effects of childhood abuse by using standard psychological measures on adult survivors and matched controls. The study, based on the records of a large general hospital, was intended as a pilot for future research in this area to determine how adult survivors of childhood abuse (physical, sexual, emotional and neglect) perceived the amount of control they had over their life events compared with children attending hospital outpatients for paediatric assessment where no abuse was suspected. A further aim was to determine whether there were any significant differences in general health (somatic symptoms, anxiety and insomnia symptoms, social dysfunction or severe depression symptoms) between survivors of abuse and controls. The relationship between the participant's self-esteem as an adult and previous childhood abuse was also investigated.

It was predicted that those participants who had experienced childhood abuse would have significantly higher scores on the LoC Scale than the outpatient (control group) participants, suggesting the former have a more external locus of control. This would be consistent with a number of previous follow-up research studies in childhood abuse (see above). It was also predicted that participants who had experienced abuse as children would have a poorer self-image and a lower self-esteem. Finally, it was predicted that participants who had experienced abuse in childhood would feel significantly worse about their state of health and suffer more symptoms of ill health.

Method

Design

This study, which was originally intended as a pilot, was an unrelated design, using groups of participants who were examined in hospital as children, matched on a number of criteria. The

study used a parametric t-test for unrelated data to measure whether there were significant differences between the mean scores from these groups on standard questionnaires used for self-esteem, locus of control and general health. Chi-square 'goodness of fit' was also used to test for any significant difference between the expected frequency of replies received and the actual number of replies received from each group.

Sample selection and procedures

Approximately 2500 medical records for all children seen by the Child Protection Consultant were studied. The criterion for inclusion in the study was: patients attending between 1989 and 1999. All patients under 17 years of age at the time of study were also excluded, as this would involve further complicated ethical issues. The research specifically targeted the follow-up of survivors older than 18. Other patients excluded were those suffering from any recorded mental health problem and those with learning difficulties. Details such as current address were checked using the hospital computer system, which revealed a number of patients who had since died or who were in prison. These were then excluded from the study.

Participants were selected from the records of children seen for examination or investigation in a large general hospital in the North of England between 1989 and 1999. Prior clearance for all aspects of the study was obtained from the Ethics Committee of the hospital concerned. One group of participants (the 'abuse' sample) was obtained from medical records of patients seen by the Child Protection Consultant in the Accident and Emergency (A & E) Department; these patients had attended hospital for the investigation of possible child abuse. This group was then subdivided into two: i) abuse confirmed; and ii) abuse not found. Those participants from the 'abuse confirmed' group were patients who were found to have suffered some form of abuse and went on to be involved in child protection proceedings. The second group – 'abuse not found' – also underwent examination for suspected abuse but findings were either inconclusive or the injury judged accidental. These subjects were later eliminated from the study since they did not return the questionnaire.

The control group was obtained from the hospital's radiology database following referral from paediatric outpatients. The patients were matched for age, date of investigation and postcode. They were examined by a Consultant Paediatrician for investigation of a medical condition. None had any history of abuse or record of investigation for non-accidental injury. Initial contact was then made by letter to a total of 231 patients; 95 in the abuse group, 67 in the non-abuse group and 69 in the control group. Letters signed by either the Child Protection Consultant or the Consultant Paediatrician (depending on who had examined the patient as a child) were sent, asking patients if they would be willing to take part in the study. Details of the study were given in the letter but the term 'abuse' was not mentioned; subjects were informed that the study was looking at people who had either been seen as a child in the Accident & Emergency Department or in the Paediatric Department. They were asked to indicate their willingness to complete three questionnaires by returning a tear-off slip in a prepaid envelope. In the interests of patient confidentiality, the return slips had a unique reference for each patient, negating the need for them to give personal details.

In order to maximise response, patients were offered the option of either attending hospital to complete the questionnaire or having it posted with a prepaid return envelope. The researcher's telephone number was given for anyone who wished to discuss the matter or had any concerns about the study. If patients were at all upset by the contact, further support could be offered.

The questionnaire was either posted along with a consent slip or the patient was contacted and a convenient appointment arranged, according to the respondent's wishes. All were again given the details of the study, reassured that they would not be asked for specific details of their hospital attendance and that any information would be held in the strictest confidence. Standard instructions meant that all participants should approach the task in the same way.

The numbers in each group eligible and willing to take part were: 21 (abuse), 8 (abuse not found), 33 (control).

Research participants

Forty subjects took part in the study (32 female and 8 male). Thirteen participants (10 female and 3 male) were from the 'abuse' sample and 27 (22 female and 5 male) from the control sample. It was not always possible from the records to categorise with certainty the type of abuse. The age of all participants ranged from 18 to 27 years at the time of the study with a mean age of 20 years ($SD = 2.8$). The age range at the time of their examination in hospital was 6 to 16 years with a mean age of 13 years ($SD = 3.2$).

Measures

The questionnaires used in this study were standard adult psychometric measures that had been tested for validity and reliability. They are as follows:

- The General Health Questionnaire (GHQ 28)
- The Coopersmith Self Esteem Inventory (SEI) – Adult Version
- The Locus of Control (LoC) Scale – I-E Scale.

The GHQ has 28 questions divided into four sub-scales: somatic symptoms, anxiety and insomnia symptoms, social dysfunction or severe depression, with seven questions in each sub-section. This questionnaire provides information about the participants' current general health as well as their emotional state over the past few weeks. The minimum obtainable score in each section = 0, with a total minimum score = 0. The maximum score in each section = 21, total maximum score = 84. A high score would suggest the individual feels generally much worse than usual and has an overall poorer state of health, whereas a low score would suggest the individual was feeling much better than usual and symptom-free.

The adult version of the Coopersmith Self Esteem Inventory has 25 questions designed to measure the subjects' attitude towards themselves: it is an expression of self-approval or disapproval. The minimum obtainable score on SEI = 0 and the highest score = 25. Low scores correspond to low self-esteem and high scores correspond with high self-esteem.

The Rotter I-E Scale used is an adaptation of Rotter's original scale. It is a 20 item self-report measure, which assesses the extent to which people perceive environmental reinforcers as being under their personal control, following their own actions. The minimum obtainable score on LoC = 20, the maximum score = 120. A low score would suggest the individual was inclined to an Internal view, believing events to be controlled by their own actions. Conversely, a high score would suggest the individual was External, believing life events to be influenced by luck or factors over which they had little influence.

Results

The predictions made in this study were that participants who had experienced childhood abuse would show a significant difference on measures of self-esteem, locus of control and general health when compared with a matched control group who had attended hospital but had no history of abuse or suspected abuse.

The results were not in line with this prediction. Mean scores revealed little difference on all measures between the 'abuse' group and controls. When t-tests for unrelated data were carried out, the null hypothesis could not be rejected, as none of the scores revealed any significant differences between the groups. These results would suggest that abused participants did not feel significantly worse with regard to their overall general health, did not report lower self-esteem and were not significantly different in their locus of control when compared with the control group. Scores suggest that both groups experienced Medium Self Esteem; both had relatively low scores on the General Health Questionnaire, suggesting they felt in good general health and were currently symptom-free. Locus of Control scores did, however, reveal that both 'abuse' and control participants were more external in their outlook, tending to believe they had little influence or personal control over events in their lives.

T-tests on separated male and female groups again revealed no significant differences in SE, LoC, or GH scores except in the male abuse and male control groups, where there was a significant difference between GH scores for abuse and control males. This result contradicts the original hypothesis that abuse survivors would have poorer general health than controls, as it shows that control males reported significantly worse feelings with regard to their current general health (although this is just significant) than 'abuse' males.

The mean score for 'abuse' males on GH is much lower than both 'abuse' females as well as male and female subjects in the control group, which may be due to the small number of abused males taking part in the study. It may be interesting for future research with a larger sample to look for any significant differences between genders within the 'abuse' group. Given the small sample size (female = 10, male = 3), tests for significance were not carried out.

Mean scores would suggest 'abuse' females score higher than control females on all sub-scales and therefore the former may feel worse about their general health. The 'abuse' males, however, score much lower than control males, suggesting they feel in better health than controls. Once again, these results were not further examined for significance due to the small number of participants involved.

Results of an unrelated t-test showed that there were no significant differences in scores between physically and sexually abused subjects on Self Esteem and General Health, but on Locus of Control, participants who had experienced physical abuse were significantly more External than those who experienced sexual abuse (only one participant was categorised under neglect). This may also warrant further study by gender on a larger sample of abused participants.

A chi square goodness of fit test was carried out to examine whether results for this study would closely approximate a normal distribution. Results showed a significant difference between the observed number of responses to the study and the expected number of responses. The overall response rate was 20%. The chi square test shows that, although the 'non abuse' group (subsequently eliminated) contributed considerably to the overall χ^2 -value, the control results made the biggest contribution, showing that more participants than would have been expected replied from this group. It may be useful for further research to look at any significant difference between gender or type of abuse and expected response in this type of study.

Discussion

Because of the high attrition rate and number of subjects excluded, this pilot study should be considered as a case study without claims to represent a wider population.

Lazarus (1990) pointed out that it was widely assumed that a sense of control was tantamount to health and lack of control indicative of, or an inevitable source of, distress. He suggested that this could be challenged in a number of ways. For example, some research suggested that personal responsibility for undesirable conditions might be harmful. Folkman (1984) com-

mented that, although being in control was often evaluated as favourable, there were exceptions in health. Many people would rather someone else, usually a doctor, made decisions.

These factors need to be considered, as attention in this study was focused specifically on the date of initial examination for both the 'abuse' group and the control group. We are aware that the 'abuse' group may have had a high level of involvement with other agencies and a high level of intervention following the diagnosis, and this may be a reason for their external beliefs. However, data was not gathered concerning the amount of follow-up or hospital intervention the control group received. It may be that some, or all, of the control group underwent prolonged treatment for their medical condition, which possibly caused them to feel less in control of their life events. Lazarus (1991) also argued that appraisals do not necessarily remain fixed; rather, they can be tentative or changeable cognitive constructions, which emerge out of ongoing transactions on the basis of conditions in the environment as well as within the person, and more or less subject to modification as conditions and persons change.

Although Rotter (1966) stated that sex differences on the I-E scale appeared to be minimal, studies by Feather (1967, 1968) showed that females obtained significantly higher external scores than males. This factor also might have had some bearing on the current study, as females outnumbered males in both groups by 4 to 1 and this might have been an influential factor in the marked external LoC in the results.

Studies of childhood abuse have often paid particular attention to health. Many retrospective studies report that women with a history of abuse are more prone to clinical depression, suicide attempts, anxiety and somatic complaints (Cunningham, Pearce, & Pearce, 1988; Read, 1998). Browne and Finkelhor (1986) also claimed that child victims of abuse show higher levels of somatic symptoms and anxiety than those not in abuse situations. In the present study, when General Health is broken down into the sub-sections, both 'abuse' and control group scores are low for the following: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. Severe depression scores are particularly low, suggesting that neither group currently suffers from any depressive symptoms, contrary to some previous findings. Scores on somatic symptoms and anxiety or insomnia did reveal some difference between the abuse and control group, with higher scores for the abuse group, although these did not reach a level of statistical significance.

Some children are more resilient than others; and the consequences of abuse do not always lead to the same effects. Several studies uncovered findings similar to this study. Elmer's (1977) study did not find any significant difference in emotional and behavioural ratings of abused and accident or untraumatised controls. Her study included an eight-year follow-up period with subjects matched on a number of demographic variables. Elmer attributed the lack of significant difference between groups to the overall effects of low socio-economic status whereas Toro (1982) argued that small sample size in Elmer's study (abuse $N = 17$) and the use of outcome measures of questionable reliability and validity might account for the majority of non-statistical findings. The present study has a small sample size (abuse $N = 13$) and therefore this might apply, although the measures used were reliable.

Lynch and Roberts (1982) suggested that, as Elmer's sample came from a deprived area, the control sample may have included children with undetected abuse. To counter this, they carried out a study of physically abused children from a wide range of socio-economic backgrounds in an attempt to achieve less bias towards lower social class. We attempted as far as possible to match 'abuse' and control patients' postcodes. Our findings were consistent with Lynch and Roberts' results, in particular although the 'abuse' children fared worse on a number of developmental dimensions, the differences were rarely significant. There is therefore some clinical evidence that is not statistically significant.

One criticism that can be made of Lynch and Roberts' (1982) study is that they used unharmed siblings as a control group. This was an attempt to show that any differences could not be due to environmental factors. However, research in areas such as domestic violence suggests that children in the same environment, while not suffering the same degree of physical abuse, may suffer similar psychological damage. Maker et al. (1998) show in their study on

family violence that, although a child may not be a direct victim, exposure to uncontrollable violence may have negative psychological outcomes similar to experiencing other childhood trauma such as physical and sexual abuse. They emphasised that 'individual acts of abuse and neglect may not be as harmful to the child as the whole pattern of aberrant parenting and family functioning' (p. 416). We would also suggest that the possibility of undetected abuse is a factor needing to be considered in all studies in this field.

Finding studies that directly compare proved difficult and often only tentative associations can be made. It is more a case of 'stand-alone' studies, each contributing differently to a knowledge base. There are, too, problems with retrospective data collection, including possible inaccurate recall of events and cognitive and emotional distortions of how these events are interpreted. Also, if abuse was undetected in childhood, it is difficult to know whether clinical problems are due to the effects of the abuse. Other studies carried out on abused children at the time of examination may not be directly comparable to the current study due to the difference in ages of subjects, although research findings may still be of importance as they may reveal that problems uncovered in childhood have continued into adult life.

Studies often relate to different time periods when definition of abuse or categories for Child Protection Registration may have changed. There might also be problems when trying to compare data relating to different geographical areas, especially between countries with different standards and methods of medical documentation.

Gender is an important factor to consider when comparing studies, which often are carried out on either male or female abuse survivors, since the effects of the psychological impact might differ between the sexes. Nakou et al. (1982) carried out a study on children who had suffered physical abuse or neglect in Greece. They reported that there was a marked sex difference in abuse. Overall, more than twice as many boys as girls were abused. One explanation given for the high percentage of boys in the Greek study was that, as Greece is a very male-dominated culture, abuse might be due to unrealistic expectations of parents with regards to male children. Creighton (1992) reported that in Britain more boys are represented in the 'physical abuse' and 'failure to thrive' categories on the Child Protection Register with more girls in the 'neglect' and 'sexual abuse' categories.

Further studies may need to be designed to gather information on emotional abuse and neglect. These are notoriously hard to detect, often overlapping with other forms of abuse, but Egeland et al. (1983) claimed from their longitudinal study that emotional abuse had the most serious consequences for a child's social and intellectual development (see also Iwaniec, 1995, 1997, 1998).

Once again, we note studies where findings are contradictory. Allen and Tarnowski (1988) carried out research using 18 physically abused and 18 non-abused subjects aged 7-13. Children were excluded if they had an IQ less than 80, had experienced neglect or sexual abuse, had learning difficulties or received treatment for behavioural disturbance. Controls were matched for age, sex and race. The abused group scored significantly higher (more dysfunctional) than controls on depression and hopelessness and significantly lower on measures of self-esteem. Data did, however, show that physically abused children took less responsibility for their own behaviour and tended to feel that outcomes were determined primarily by external factors: see also Barahal, Waterman and Martin (1981). Generalising the findings might be limited, given that most children were from lower socio-economic backgrounds. Poverty is known to produce major consequences for health and expectation of life, as well as for individual opportunity and chances for success (e.g., Bradshaw, 1991; Cawson, 2002). The NSPCC study (Cawson, 2002) of a non-clinical, young adult population looked at resilience in four areas but did not directly include health. Those who reported child maltreatment were more likely to feel depressed and unhappy as young adults.

If we focus on sexual abuse alone, we see that research has shown that a history of child sexual abuse is associated with an increased use of medical services (e.g., Cunningham et al., 1988) and psychiatric services (e.g., Waller, 1991). Among women identified as having various psychosocial problems, histories of child sexual abuse were common. Felice et al. (1978), in a

study of the aftermath of adolescent rape, reported frequent somatic complaints and phobias. Kilpatrick et al. (1979) also found long-standing depression to be a serious problem following rape, while Read (1998) found an association between child abuse and psychiatric disturbance in adults.

In a follow-up study of both physically and sexually abused children, Gibbons et al. (1995) found no evidence to suggest that sexual abuse necessarily led to poor developmental outcomes in cognitive ability or behaviour for children in the longer term, but the sample size was again very small ($N = 8$). They claimed that in some cases victims may have 'localised' the damage caused by abuse so that while one area of their development was impaired, others remained intact. They also found that physical abuse, except in the most extreme cases, caused no long-term harm. However, as the results were so contrary to their expectations (as in our case), they thought, as we do, that information about the context in which events occurred and the meaning of them to the child might be worthy of study.

Variations in research findings may be due to a number of factors. Friedrich et al. (1986) found that 'the frequency of behaviour problems (apparently) subsides with the passage of time' (p. 55). They carried out a study of sexually abused children using self-report measures of self-esteem and depression. Findings were not significant on initial assessment. At six-month follow-up, the only significant factor was that sexually abused girls reported higher self-concept but that at 12 months no significance was found. Their findings suggested that abused children did not manifest more emotional difficulties and that this absence of significant problems continued for at least a year. As with other studies, a problem is that the study involved girls only. The absence of males in maltreatment studies is the subject of a literature review by Haskett et al. (1996).

Johnson and Eastburg's (1992) study found that positive self-concept declined with age in both abused and non-abused samples. The fact that self-concept declined among abused children might support the findings of Vondra et al. (1990) that maltreatment leads to less realistic and inflated ratings of personal competence, though after the age of eight, children developed a less rigid and more realistic picture of their self-worth. This could account for the differences in findings between studies, and is an important factor for follow-up studies like the present. A number of studies have led to the conclusion that sexually abused children do not exhibit 'a single typical pattern' of post-molestation adjustment (Gomes-Schwartz et al., 1985, p. 508).

Tsai et al. (1979) suggested that, while not all sexually molested children would experience adult maladjustment, developmental factors associated with age at the time of the abuse might mediate the psychological response. Hall and Lloyd (2001) suggest that sexual abuse may have an impact on a child's developmental stage, perhaps arresting development or slowing it down while the child tries to cope with the abusive situation. Many children develop ways of coping or, as defined by Summit (1988), 'accommodation'. These processes are like psychological survival mechanisms, which may then become an intrinsic part of the individual's functioning and generalise to other aspects of their psychological development throughout life. As ways of coping might account for the differences between the groups or, more specifically, between gender, it may be useful to carry out further research in this area in order to highlight different coping mechanisms. Leitenberg et al. (1992) have suggested that abused children's coping strategies of suppressing and avoiding emotions are associated with poorer adjustment in adulthood. If abuse has taken place but is not diagnosed at the time, as we suspect happened in a small number of cases in the 'abuse not found' group the chances of adjustment might be worse.

An important factor in the present study as in previous studies is the number of subjects, which, for whatever reason, chose not to participate. Would their scores have had an impact on the overall results? Oates et al. (1984) argued that, as the social characteristics of the 'lost' subjects were similar to those of the sample as a whole, there was no need to be concerned over sample bias. Gibbons et al (1995) observed that, while this point may have some validity, it did not remove the possibility that non-respondents and participants were different in other

ways that might have an important bearing upon outcome. Wodarski et al. (1990) commented that non-participation might be reflective of more serious abuse, with the loss of such families underestimating outcomes for physically abused children.

We do not know the true number of children who experience abuse, as many may never present for treatment or may not be picked up by other organisations; neither are studies based on hospital or agency information necessarily representative of the population at large.

The study of child abuse forces us to look at difficult and uncomfortable issues relating to how some children begin their lives. From the huge but methodologically diverse amount of research that has been carried out in this area, it seems that abuse may be a serious risk factor for adult well-being. Victims of abuse present numerous health problems, especially in the area of depression and anxiety. They often suffer from low self-esteem and feel they have little control over life events.

Results from our study do not reveal many significant differences between those who suffered abuse and others who suffered from health problems. While many abused children do not fare well, there are those who demonstrate a remarkable resilience and this fact may be reflected in the results of our study. The presence or absence of abuse will be likely to interact with other aspects of the child's environment to determine the long-term outcome for the child and adult survivor. Children attending hospital for other reasons may also constitute a vulnerable population in the short and long-term.

The considerable amount of intervention the abused child receives might also be a factor affecting external locus of control. Optimistically, it could also improve life chances, accounting for the finding that 'abuse' participants in this study did not show significant differences from controls. This suggests that the earlier risk factors are detected, the better future chances might be; it is known that early intervention and support are likely to have a significant, positive effect upon maltreated children.

Further research is needed for three main reasons. First, a larger population would add more validity and allow for what is likely to be a high wastage rate, permitting more confident statistical analysis, particularly with regard to significance. Second, a larger study, allowing qualitative as well as quantitative analysis of responses, would throw light on the issues arising from this case study, such as the possible presence of abuse in some cases where this diagnosis had not been made at the time. A prior awareness of this possibility would alert medical staff and researchers to the possibility of an increase in the size of the 'abuse' group. And third, it might also answer other important questions posed in our discussion about both short and long-term effects on children's well-being and their health in adulthood.

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