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**Sticks and stones may break my bones: the effects of emotional
abuse.**

Journal of Aggression, Maltreatment & Trauma

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Sticks and stone may break my bones.

Abstract

The relationship between psychological maltreatment in childhood and adult well-being has previously been established via the statistical modelling of psychometric data. This study examines a set of statistical data regarding abuse alongside personal accounts. One hundred and sixty five participants completed several psychometric scales, including a measure of childhood emotional abuse. Several participants were then invited to interviews exploring issues in more depth. Statistical analysis supported previous findings, but the interviews exposed themes pertinent to the examination of long-term effects of emotional abuse, such as acknowledgement of abuse. The findings support the use of a mixed methodology, as statistical measurements alone did not reveal some detail. The implications of this finding for psychological research and practice are discussed.

Introduction

If your child has been called names, how do you comfort her? The saying *sticks and stones may break my bones, but words will never hurt me* is one that dates from at least the 19th century and possibly it is much older than that (Northall, 1894). However, the efficacy of this axiom for someone who is suffering verbal abuse is questionable; the reassurance that taunts and insults cannot hurt does not make the pain go away. It is received wisdom that there is a distinction between physical pain and emotional or social pain; physical hurt is seen as the more damaging. This may not be the case, and ignoring the pain can be hazardous. James (1890/1950) suggested that those who experience social ostracism or emotional mistreatment find it more disturbing than a physical punishment. Chen, Williams, Fitness & Newton (2008) also discovered that social pain is remembered long after physical pain has faded in memory and would appear to have far reaching consequences for mental health, relationships and adaptation to change. Moreover, social or emotional pain, embarrassment or ostracism can be relived, time after time, whereas it is difficult to mentally recreate physical pain. This paper examines current thinking about the potential consequences of non-physical pain experienced in childhood, and reports on empirical research exploring these consequences together with the recollections of non-physical pain in a group of adults.

Non-physical pain and its outcomes

Physical or sexual abuse in childhood is an established risk factor for adult health problems (Kendall-Hackett, 2002; Clark, de Bellis, Lynch, Cornelius and Martin, 2003). A particular form of non-physical abuse, childhood emotional abuse, may have even more far-reaching consequences, due to its insidious and unremitting nature. Abuse is any behaviour that is designed to control and subjugate another human being through the use of fear, humiliation, and verbal or physical assaults. Emotional abuse is any kind of abuse that is psychological rather than physical in nature, including verbal abuse, constant criticism,

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intimidation, manipulation, and refusal to be pleased. Riggs & Kaminski (2010, p6) asserted the notion that emotional abuse harms children is unequivocal, and suggested that it is responsible for some of the lasting effects of sexual and physical abuse, as well as being destructive in its own right. An examination of how these effects manifest themselves in adults who do, and who do not, report such childhood abuse is therefore a valid objective.

Irving & Ferraro (2006) demonstrated that abusive experience during childhood affected self-rated health, with emotional abuse by parents having the largest negative contribution to perceived adult health. This finding was irrespective of the sex of the participant, but the largest single predictor of low health ratings in women was emotional abuse by the mother. This may go some way to explaining the findings of Long & Mullen (1994) who reported on a study of women who abused alcohol, exploring the factors they perceived as being contributory to their behaviour. They found that emotional pain was a major factor in female alcohol abuse, with emotional abuse by parents contributing to that pain in over 34% of those interviewed. As this study did not make comparisons to men who abuse alcohol, it is difficult to determine the precise contribution of gender, but it is clear that emotional pain is a major factor of concern for later health and perceived health.

Other mental health issues may also be affected by early experience. Gibb et al (2007) found a relationship between emotional abuse, together with verbal victimisation by peers (bullying), and the likelihood of adult depression. Depression is experienced by large numbers of people and is characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration (WHO, 2008). In adulthood, there are twice as many women receiving a diagnosis and/or treatment for depression than men (Hyde, Mezulis & Abramson, 2008). This gender discrepancy starts to show itself in puberty and reaches adult levels of difference at around 15 years of age. Similarly, some anxiety disorders, such as phobias, and social anxiety, affect

women disproportionately to men (Halbreich & Kahn, 2007). Other physical conditions with a psychological element, ones that we are only just beginning to understand, such as idiopathic headache, fibromyalgia and irritable bowel syndrome, are also suffered predominantly by women, and are clearly linked to psychosocial risk factors (see Walker et al, 1997 and Ali et al, 2000). Some researchers, such as Ferraro & Nuriddin (2006), go further and suggest that women are more likely to suffer health-related consequences due to experiencing childhood psychological stress than men, including higher risk of physical and mental illnesses. Due to such sex differences, biological and genetic models of all the above conditions are compellingly convincing. However, biology alone does not account for these differences, as they would be much larger if there was a solely gender based solution. In addition, depression or anxiety would respond to gender based education/therapy. Hence, the medical field is moving towards more integrative theories and models, suggesting that the differences emerge due to a set of factors that include the hormonal, genetic and psychological. It is also proposed that negative life events impact more on those with a predisposition to depression or anxiety. For example, Maciejewski & Mazure (2006) suggest that there are particular cognitive styles, such as fear of criticism and rejection, that predict adult onset of major depression, and which are associated with emotional abuse. What does not appear to be explained is why such factors might be present or why such styles might be adopted, what these negative life events might be, or why women and girls may be more vulnerable. Integrative explanations such as that proposed by Hyde et al are valuable, but ignore the individualistic nature of development, and the robustness of some individuals who experience such factors but who do not develop difficulties. This is one element the present study seeks to address, by examining the accounts of people who do report such abuse in their childhood, and comparing them with those who do not.

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Emotional abuse does not, of course, only happen in isolation to other forms of maltreatment. Survivors of sexual abuse also report that, in addition to any long lasting physical effects of the abuse itself, the betrayal and loss of innocence has a profound consequence for later life. Such effects may extend to other forms of abuse. Irving and Ferraro (2006) found that reported emotional abuse experiences in childhood were associated with lower personal control, which, in turn, leads to lower ratings of adult health. The major period for development of personal control is during childhood and early adolescence, when the individual should begin to feel empowered and to have influence over their own life events (Zimmerman, 1995). Irving & Ferraro suggest that abuse during this age period alters this development and this is subsequently reinforced by, and makes one more susceptible to, negative experience in later adolescence and adulthood. Their findings imply that this adverse effect can result in poorer health, or at the very least, a perception of poor health. There is also a clear relationship between childhood abuse and the probability of being exposed to later trauma, thus compounding the effects (Classen, Paresh, & Aggarwal, 2005). Surviving abuse can therefore mean, not only recovery from abusive episodes, but also continuing to experience disadvantage in terms of psychological adjustment and adaptation in later life. This effect is described in the cumulative disadvantage theory, which has broad implications for health research, as well as social and criminological outcomes.

Cumulative disadvantage theory

The impact of one set of negative experiences is not just immediate, but compounds throughout the life course, as individuals are more likely to have developmental issues, encounter negative experiences or perceive events in a negative light. Hence, a person who is abused in childhood will tend to choose relationships that are themselves abusive in nature. Indeed, emotionally abused individuals are more likely to exhibit mistrust and high rejection expectancy towards new people than those who have experienced little or no abuse (Berenson

& Anderson, 2006). This viewpoint has had a major impact on health related issues, and the study of individual characteristics that might be involved in ill health versus robustness. The finding of Ferraro and Nuriddin's study (2006), of a sex difference in poor health outcomes due to emotional distress, is attributed to the different forms of cumulative disadvantage experienced by the men and women in their sample. Criminological research also suggests that early experience of delinquency can translate into inappropriate transitions from anger to depression, and problems with alcohol abuse (Hagan & Foster, 2003). Hence, the disadvantage of growing up in a delinquent group accumulates due to the adverse effect of the early experiences. Therapies that lead the individual to higher personal control and empowerment could therefore be more effective in several situations, but such efficacy has yet to be fully explored (Carbone, 2010). Such models also link the accumulation of negative experience to the development of learned helplessness, which in turn is linked to the likelihood of depression, even in young children (Cole et al, 2007). It would be pertinent to suggest then, that any examination of how childhood emotional abuse affects the adult should address the individual propensity for adaptation or coping in those who have been abused, compared to those who do not develop such strategies.

What is emotional abuse?

As mentioned above, emotional abuse is any kind of behaviour that is designed to psychologically subjugate, control and/or harm the recipient. As such, it can erode self-confidence, sense of self-worth, and self-concept. It is insidious, as perpetrators disguise it as advice or guidance, but constant berating and belittling leads to the loss of personal value, leaving victims with deep and long lasting, but invisible, scars (Glaser, 2002). Emotional abuse does not have the same visibility as sexual or physical abuse (Rees, 2010) but clinicians agree that it is a core element of both, and may even be the more damaging. Emotional abuse also manifests itself in several guises, such as aggressing, denying and

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minimising. Aggressive forms of abuse include insults, threats, blaming and ordering, which all undermine the equality and autonomy of the victim. However, aggression can also be indirect ó criticism, advice, help, but all with the intent to belittle and control the recipient. Denying is a potent aspect of the abuse and means that the recipient's perception of their world becomes distorted or invalidated. For example, a victim confronts the abuser with an example of aggressive behaviour, but the abuser refuses to acknowledge the event or the victim's account of it. Another form of denial is to withhold, when the abuser refuses to listen or communicate, or to acknowledge that the victim has any valid viewpoint or feeling beyond the abuser's own. Minimising is a less extreme form of denial, simply countering the accusation of abuse with attempts to question the victim's experience as exaggeration or over-sensitivity, or trivialising the acts of the victim (Lantz & McMurray, 2009)

If such behaviour takes place in a child's relationship with an adult, when the victim becomes an adult in turn, they may find that their relationships mirror or expand on this. If there has been little opportunity to set personal standards, develop viewpoints and validate feelings and perceptions, the developing child experiences the abusive environment as normal. Therefore, even destructive relationships feel familiar and possibly comfortable, with recipients of abuse struggling with feelings of powerlessness, hurt, fear, and anger and interpreting even positive interactions in negative ways (Iwaniec, Larkin & Higgins, 2006). For example, a woman who always encountered criticism of her appearance in childhood may interpret her friends' or partner's compliments as sarcastic, or may continually seek reassurance.

Negative impact on adult relationships is only one outcome of experiencing emotional abuse in childhood. For example, in 2005, Hund & Espelage proposed a model that linked childhood emotional abuse to alexithymia, general distress, and disordered eating. Their study of a non-clinical sample of five hundred and eighty-eight women showed a

complex relationship between emotional abuse and the psychological and physiological outcomes measured. They concluded that childhood emotional abuse could have more of a negative impact on its survivors than other factors alone. This was supported by Kennedy et al (2007), who found a direct effect on eating pathology in non-clinical participants, even when taking into account other forms of abuse, self-esteem, depression and anxiety. They went on to suggest that any examination of health issues in terms of abuse outcomes would be incomplete without considering emotional abuse as a factor.

The studies detailed above all suggest that the events of childhood form a lasting impression throughout the life course, and have major consequences for adult physical and mental health. Before accepting this, there are some underlying implications from some of the literature that require examination. Some give the impression of a difference in the outcomes of childhood experience between men and women, with women at higher risk of developing problems such as alcoholism (Long & Mullen 1994) or eating disorders (Hunt & Espelage, 2005) if they were subjected to psychological maltreatment as children. Ferraro & Nuriddin (2006) accept that this difference is inherent, and that this is the outcome of the accumulation of different experiences, or adaptation to them. This position is not as safe as it would seem however, as many studies demonstrating the effect of abuse on women do not include direct comparisons with male participants.

A second demographic factor emerging in the literature is that this is a life course issue, and that negative events have a compounding effect. Age would therefore seem be a contributory factor in some way, in that more negative events will have been experienced in an older person. This is bolstered by a stereotype of older people being more concerned about their health and exhibiting health anxiety (Boston & Merrick, 2010). There is evidence to suggest that research has irrevocably linked cumulative disadvantage to age, but, according to Dannefer (2003), only when addressing gerontological inequalities in robustness. Whilst

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many studies affirm that the life course perspective is an important one, none addressed this directly, examining whether age has a mediating effect, except for people who are, for example, over 65 years of age . If age is a contributing factor, then it might be expected that older people would demonstrate more disparity in health or perceived health as a consequence of difference in positive and negative experiences and the accumulated effects of these. Any such research should then include age as an aspect to be confirmed as contributory or not.

A further point to note is that great deal of the research has been based on predominantly quantitative methodology, making inferences from the examination of relationships in data drawn from measures of health and abuse. Previous quantitative research typically used samples of thousands, although that linking childhood emotional abuse to specific physical outcomes such as fibromyalgia, or psychological well-being such as the propensity for depression, are much smaller, e.g. Walker et al. Additionally, some studies have concentrated on female participants only, or on specific professions, a methodological limitation acknowledged clearly in the literature (see Reyome, Ward, and Witkiewitz, 2010). It is possible, therefore, that some issues are being overlooked. In the same way that we assume there is an inevitability that survivors of sexual abuse will themselves become abusers, we are in danger of assuming that childhood emotional abuse will result in an unhealthy and abusive adult. There seems to be little emphasis on those that survive abuse, but who then do not go on to abuse others or experience abusive relationships. The points raised are therefore the basis for the study reported in this paper.

Objectives of this study.

The current study was designed to attempt to discover whether there are any factors that can mitigate the non-clinical negative impacts of childhood events. Identifying adults with reported childhood abuse, but whose adult health, well-being & personal control scores

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are high, and comparing those with lower scores, together with adults who do not score highly on the abuse scales, would seem to be a fruitful course to take. If adults report emotional (or other) abuse, but are robust enough to have positive adult experiences, the differences between these people and those who do not have the same perspective in life might identify the psychological adjustments, and hence therapeutic process, which would help current and future survivors of abuse. However, quantitative measurement alone would not be sufficient, and this study utilised a mixed methodological format - a psychometric approach to profiling participants with high or low levels of abuse and differentially reported difficulties in adult hood, together with analysis of personal accounts.

The major objectives for this study are, therefore, to identify adult men and women with and without reported childhood emotional abuse, and to measure several variables in which emotional abuse is implicated as leading to lower health or perceived health levels. Statistical analysis of the scores on these measures comparing in terms of sex of the participants, and levels of reported abuse (or lack of abuse) will determine whether this sample demonstrates the expected relationship between childhood abuse and adult health and adaptation. If this is the case, participants will be categorised, on the basis of a profile of their scores, into high and low abuse and high and low health outcomes. A sub-sample will be drawn in order to provide a detailed examination of the adults' reported accounts. In this way, a mixed methodological approach will be used and evaluated for efficacy in the examination of these issues.

Method

Ethics

All research protocols adhered to British Psychological Society codes of conduct with respect to research with human participants. Participants were given information about the study at all points of data collection, and asked to sign a consent form indicating they were

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providing permission to use the data collected for the purpose of the study. They were assured that all personal information would be anonymised and kept securely, and that only the researcher had access to any of this data. They were also told that they could withdraw from the study at any time (up to dissemination of findings) with no explanation and no consequence. Data was coded in order to provide anonymity, and the identification codes were kept in secured files stored separately to the data file.

In the event of a participant wishing to discuss issues raised by the questionnaires or interviews, sources of support were identified and provided along with all other information.

Participants

Participant recruitment was via a poster campaign on a University campus and nearby residential, suburban areas. This broadened the potential participant pool, but did not extend to catchment areas beyond what may be identified as a reasonably affluent district.

The posters advertised the study as examining childhood experiences and the effect they have on adult outlook. There were no exclusion criteria beyond age (over 18 only).

35 men and 130 women, ranging in age from 22 to 45 (mean 31.77) answered the advertisements and none were excluded. All completed several questionnaires designed to elicit experience of childhood abuse, personal control levels, and current perceived health. Potential participants were not recruited on the basis of any other criteria, such as mental health issues or stress related illnesses, even though these appeared in the literature. Therefore, some participants may have had such problems, but the study did not seek comparisons between groups on these factors.

Participants were also asked to indicate whether they would be willing to go through to a second stage of the study, involving interviews with the researcher. All participants indicated they were willing to be interviewed. Once the psychometric scale scores were entered into the data file, and initial descriptive statistics were compiled, participants were

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categorised on the basis of their sex, and whether their abuse was high or low. The random selection of participants for the second stage of the study was carried out using these classifications (see data plan below).

Instruments

- The **Child Abuse and Trauma Scale (CATS)** is a 38-item scale initially designed to give scores of sexual abuse, negative home environment/neglect and punishment. It has high internal consistency (Cronbach's $\alpha = 0.63$ to 0.90) and test-retest reliability $r = 0.71$ to 0.91). It shows significant positive correlation with outcome measures of dissociation, depression and interpersonal difficulties (Sanders and Becker-Lausen, 1995). Kent & Waller, (1998) further extracted a fourth construct that can be measured by the scale, that of emotional abuse. They found high internal consistency ($\alpha = 0.9$) between this construct and the other subscales. They note further however, that correlational analyses showed that the emotional abuse subscale was not independent of the other subscales, but that this is not an issue of concern. The scores for this construct range from 0-28
- The **Health Perceptions Questionnaire (HPQ)**, Ware, 1976) provides scores on subscales of current health (scored 9-45), prior health (3-15), susceptibility/resistance (4-20), health outlook (4-20), health worry (4-20), sickness orientation (2-10), rejection of sick role (4-20), and attitude toward going to doctor (2-10). These subscales show good internal consistency: $\alpha = 0.9$ (current health) to 0.45 (health worry). There is also good test-retest reliability ($r=0.59$ to 0.86). Ware also reports high construct validity for measurement of past/present health, future health, and sick role propensity.
- The **Internal Control Index (ICI)**, Duttweiler, 1984) is an indicator of cognitive processing, autonomy, resistance to social influence, self-confidence and delay of gratification. It has high reliability (a Cronbach's α of 0.85) and tests indicate the presence of a strong principal component, two replicable factors, and evidence for convergent

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validity. It has been used to measure the relationship between perceived control and recovery (or likelihood for depression) from traumatic events such as rape (Regehr et al, 1999). Scores can range from 28 to 140 with higher scores indicating high internal locus of control.

- The **Satisfaction with life scale** (SWLS, Diener, 1985) measures the self-reported level of satisfaction in general terms, and it is not related to any specific aspect such as health, income, relationships etc. Satisfaction with life is one factor of the construct of subjective well-being, the others being positive affective appraisal and negative affective appraisal. Life satisfaction is distinguished from affective appraisal in that it is more cognitively than emotionally driven. Internal consistency and alpha coefficients are above 0.8 and test-retest reliability was reported as 0.82. Face validity was established by factor loadings greater than 0.6, and construct validity is reported as being good, with research finding demonstrating a change over time as expected, and distinctions between groups as predicted. The scale is scored 7-35, with higher scores denoting higher satisfaction.

Participant profile

Using the scoring on the various scales/subscales together, participants could be profiled in terms of the negative or positive experiences in childhood, and the relationship that had with the reported satisfaction with life, perception of own health, and level of internalised control. Along with the completion of scales, the participants were asked to indicate if they would be willing to participate in further interviews with the researcher. They were told these interviews would include questions about childhood, relationships with other people now, and the effect childhood experiences the participant thought may have had on adult life.

In order to choose which participants would be included in the interview stage, the scales that showed correlation with emotional abuse scores were examined. The scores were separated into upper and lower quartiles on both their emotional abuse scores and which of the other scales appeared to be related. Hence, those with scores on the scales that indicated that they

had experienced high or low levels of emotional abuse formed the inclusion into the next stage, in combination with high or low scores on scales of interest. The intention was to include people in four categories, indicated by the upper and lower quartiles.

- High emotional abuse + high scores on other scales
- High emotional abuse + low scores on other scales
- Low emotional abuse + high scores on other scales
- Low emotional abuse + low scores on other scales

The selection criteria for this stage included measurements of low and high emotional abuse, as the study objectives were to identify any points of difference between people in these groups in terms of adult levels of health (see data analysis plan)

These participants were then interviewed by the researcher, following a semi-structured interview schedule incorporating questions as outlined above.

Of the participants who agreed to participate in interviews, four men and four women were selected on the basis of the profile.

Interview schedule

The interview schedule was developed by combining the questions from the emotional abuse construct of the CATS with other issues derived from the literature around relationships and adaptability.

Emotional abuse construct

The questions below form the measurement of the emotional abuse construct within the CATS.

- Did your parents ridicule you?
- Did your parents insult you or call you names?
- Did you feel disliked by either of your parents?
- How often did your parents get really angry with you?
- Did your parents ever verbally lash out at you when you did not expect it?

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- Did your parents yell at you?
- Did your parents blame you for things you didn't do?

These were the core issues covered by the interview. Each interviewee was given a written list of these questions, and the interviewer asked him/her if the above had occurred and whether they had put this down on the questionnaire stage of the study. They also had the following as topics to be discussed:

- How would you describe your relationship with your parents (carers or stepparents) now? What do you think you may have learned from these?
- Is there anything in those relationships that you try to emulate or avoid in relationships with your own children or partner?
- How do you view your health?

This portion of the interview was interviewee led, but with reference to these questions.

Interview procedure

The interview started with neutral questions. Once the interviewee was comfortable, the interviewer moved onto questions about relationships with parents/carers when a child, eliciting examples of interactions to illustrate the subject being discussed. The interview then moved on to current/recent relationships with parents and the effect that relationship may have had. If appropriate, the interviewee was asked if s/he thought there was anything about the parental relationship that affected current situations. This last was interviewee-led, with some probes being prepared if necessary, but the interviewee's comfort about speaking on these subjects was carefully monitored. If there were any signs of distress the line of questioning would have been paused or abandoned (or the interview would have been terminated if necessary). This only happened with one interviewee, who chose to carry on with the interview after a short rest.

Thematic analysis exposed several themes in the interviews, which emerged in different ways depending on various factors.

Data analysis plan.

The study was in two parts, a quantitative design using several psychometric scales and a qualitative interview stage. Once participants had been given information and a consent form to sign, they were asked to complete the four scales, and to indicate if they were willing to participate in stage 2. The scale data was placed in an SPSS file and statistical analysis was performed in order to determine several pieces of information:

1. Descriptive statistics were compiled for all of the score variables with respect to sex and age of the participant.

Although the reviewed literature did not directly examine any effect of age on the health outcomes, there is evidence to suggest that the effect of negative experiences accumulate over the life course (Dannefer, 2003). It is also thought that concern for health increases, and the perception of good health decreases with age, but that this is only seen in older adults (Boston & Merrick, 2010). This sample contained young and middle age adults, not older adults, but the opportunity to explore any mediating effect of age was seen as important.

2. Correlational analysis of all the score variables was carried out to determine the strength and direction, if any, of the relationship between the measured variables. In order to determine any effect of the demographic variables, partial correlation was also carried out.
3. Any sex differences in each set of scores

As the literature reviewed indicated clear sex differences in both the incidence of health concerns and the response to emotional abuse (Ferraro & Nuriddin,

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2006), sex differences were computed using independent t-tests in order to identify any such differences in this sample.

4. Any effect of age

The descriptive statistics implied that there might be an effect of age, therefore one-way ANOVAs (with three categories of age) were performed on the scores.

5. A correlation matrix of all bivariate Pearson correlation coefficients was produced in order to determine the relationship amongst all of the measures, and then the same matrix was produced controlling for sex, as age had been shown to have no significant effect or covariation effect.

6. An examination of these analyses allowed a participant profile to be drawn up, in order to select interviewees for the next stage of the study.

7. Interview transcripts were analysed using thematic analysis (see below)

Results

Quantitative results & selection of interviewees

As described in analysis stage 1 above, the scale scores were examined via descriptive statistics and a correlation matrix.

Table 1 Descriptive statistics of scores with respect to sex. Table 1 Descriptive statistics of scores with respect to sex.

Sex		Satisfaction with life	Emotional abuse	Internal control index	Current health	Prior health	Susceptibility resistance	Health outlook	Health worry	Sickness orientation	Reject sickness role	Attitude to doctor
Male	Mean	30.54	3.66	89.00	14.77	9.29	11.43	10.23	11.34	6.11	13.03	7.49
	SD	6.002	3.325	34.777	7.549	3.945	4.698	4.312	5.145	2.233	4.322	2.020
	Min	13	0	32	1	4	4	4	4	3	5	4
	Max	35	12	137	26	15	20	20	19	10	20	10
female	Mean	20.68	13.64	90.65	9.87	9.68	14.87	11.34	11.57	6.22	11.47	6.74
	SD	7.757	8.119	32.547	4.955	3.505	6.525	4.345	4.411	2.373	4.390	1.915
	Min	8	1	29	0	4	4	4	4	3	5	4
	Max	35	28	139	20	15	29	19	19	10	19	10
Total	Mean	22.77	11.52	90.30	10.91	9.59	14.14	11.10	11.52	6.20	11.80	6.90
	SD	8.436	8.420	32.930	5.931	3.594	6.329	4.349	4.561	2.338	4.409	1.956
	Min	8	0	29	0	4	4	4	4	3	5	4
	Max	35	28	139	26	15	29	20	19	10	20	10

Table 2 Descriptive statistics with respect to age.

Age		Satisfaction with life	Emotional abuse	Internal control index	Current health	Prior health	Susceptibility resistance	Health outlook	Health worry	Sickness orientation	Reject sickness role	Attitude to doctor
18-25	Mean	23.33	9.63	92.48	10.11	9.93	14.37	10.15	12.63	6.09	11.96	6.91
	SD	8.295	8.470	29.444	6.148	3.289	6.806	4.336	4.419	2.475	4.115	2.064
	Min	9	0	39	0	4	4	4	4	3	5	4
	Max	35	28	139	25	15	29	20	19	10	19	10
26-35	Mean	23.06	11.92	90.82	9.94	9.52	14.66	11.34	10.95	6.37	11.58	6.84
	SD	7.948	8.365	34.413	5.371	3.556	6.049	4.073	4.836	2.278	4.847	1.909
	Min	8	0	29	0	4	5	4	4	3	5	4
	Max	35	28	138	23	15	27	19	19	10	20	10
36+	Mean	22.00	12.61	87.98	12.60	9.40	13.39	11.61	11.25	6.11	11.91	6.95
	SD	9.130	8.332	34.343	6.062	3.900	6.270	4.597	4.277	2.320	4.202	1.950
	Min	8	0	30	0	4	4	4	5	3	5	4
	Max	35	28	138	26	15	27	19	19	10	20	10
Total	Mean	22.77	11.52	90.30	10.91	9.59	14.14	11.10	11.52	6.20	11.80	6.90
	SD	8.436	8.420	32.930	5.931	3.594	6.329	4.349	4.561	2.338	4.409	1.956
	Min	8	0	29	0	4	4	4	4	3	5	4
	Max	35	28	139	26	15	29	20	19	10	20	10

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Table 3 Correlation matrix of all scores

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

		Emotional abuse	Internal control index	Current health	Prior health	Susceptibility resistance	Health outlook	Health worry	Sickness orientation	Reject sickness role	Attitude to doctor
Satisfaction with life	r	-.244**	-.040	.163*	-.119	-.135	-.019	.069	-.043	-.001	.162*
	p	.002	.613	.036	.129	.085	.812	.376	.580	.991	.038
Emotional abuse	r		-.080	-.143	-.025	-.375**	.090	-.012	.002	-.117	-.007
	p		.308	.066	.746	.000	.250	.880	.982	.134	.924
Internal control index	r			-.036	-.128	.131	.065	.081	-.079	.004	-.200**
	p			.646	.102	.093	.409	.303	.312	.956	.010
Current health	r				.009	-.166*	.006	.081	-.081	.164*	.118
	p				.906	.033	.939	.299	.302	.035	.131
Prior health	r					.040	-.032	.027	.062	-.081	.050
	p					.612	.683	.729	.429	.304	.520
Susceptibility resistance	r						-.030	-.016	.095	.080	-.027
	p						.702	.838	.225	.306	.727
Health outlook	r							-.162*	-.136	-.004	-.073
	p							.037	.081	.962	.354
Health worry	r								-.036	-.086	-.172*
	p								.645	.270	.027
Sickness orientation	r									.066	-.085
	p									.400	.279
Reject sickness role	r										-.070
	p										.370

Significant ($p < 0.01$) negative correlations were observed between Emotional abuse & Satisfaction with life ($r = -0.244$) and Susceptibility/resistance to ill-health ($r = -0.375$).

Susceptibility/resistance & current health were significantly ($p < 0.05$) negatively correlated ($r = -0.166$), as were Internal control index & Attitude to going to doctor ($r = -0.2$), Health outlook & Health worry ($r = -0.162$) and Health worry & attitude to going to doctor ($r = -0.172$). Significant ($p < 0.05$) positive correlations were observed between Satisfaction with life & Current health ($r = 0.163$), Satisfaction with life & Attitude toward visiting doctor ($r = 0.162$), Current health & Rejection of sickness role ($r = 0.64$).

However, most of these correlations became non-significant when partial correlation, controlling for sex, was performed. Performing a correlation matrix on just the female participants showed that there were clear negative correlations between emotional abuse and susceptibility ($r = -0.625, p < 0.01$), and internal control and attitude to going to the doctor ($r = -0.244, p < 0.01$).

One major issue highlighted in the literature is that women appear to be more susceptible to the influences of negative life events. To determine if this was reflected in the sample, the scale scores were subjected to independent samples t-tests for samples with unequal variances (due to the disparity in sample sizes). Significant differences were found between men and women on the following variables.

Table 4 Significant mean differences between men and women on scale scores.

* women scored higher.

Measure	t (p<0.01)	Mean difference
Emotional abuse	11.003	9.981 *
Satisfaction with life scale	8.077	9.866
Perceived current health	3.640	4.907
Susceptibility resistance	3.515	3.441 *

Univariate analysis of variance found the only variable to be affected by age was perceived current health ($F_{(2,162)} = 3.681, p < 0.05, MSE = 34.063$). There were no interaction effects between age and sex for any of the scale scores.

It appears then, that the only variable to systematically affect scores on any of the scales is sex, but this finding must be treated with caution due to the disparity in numbers of men and women. However, this substantiated the decision to interview both men and women in more depth. As age did not appear to be a contributory or distinguishing factor, the selection of participants for interviews was not based on age, simply their sex and scores on the scales of interest (those shown as having significant mean differences in the t-test results).

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Table 5. Upper and lower quartiles (and minima/maxima) for the scores for emotional abuse and satisfaction with life.

		Emotional abuse	Satisfaction with life
Mean		11.52	22.77
		3.66 (male)	30.54 (male)
		13.64	20.68 (female)
Min		0 (male)	13(male)
		1 (female)	8(female)
Max		12 (male)	35 (both)
		28 (female)	
Percentiles	25	1 (male)	26 (male)
		6 (female)	14 (female)
	75	5 (male)	35 (male)
		20 (female)	26.25 (female)

Table 6. Interviewees and selection criteria

Sex	Emotional abuse (EA) range	Satisfaction with life (SWLS) range	Category	Selected participants (EA score/SWLS score)
M	0-1	35	Low abuse/high satisfaction	M1 (0/35)
M	0-1	13-26	Low abuse/ low satisfaction	M2 (1/13)
M	5-12	35	High abuse/high satisfaction	M3 (11/35)
M	5-12	13-26	High abuse/low satisfaction	M4 (12/35)
F	1-6	8-26	Low abuse/high satisfaction	F1 (1/33)
F	1-6	8-26	Low abuse/low satisfaction	F2 (2/9)
F	20-28	26.25- 35	High abuse/high satisfaction	F3 (28/14)
F	20-28	26.25-35	High abuse/low satisfaction	F4 (28/31)

Once all the above analyses had been performed, the participant sample was categorised on the basis of their sex and scores on two variables, emotional abuse and satisfaction with life. The SWLS were chosen as the scale encompasses a range of issues of concern, and it showed significant negative correlation with emotional abuse. Each of the score variables was examined for quartiles and participants who fell into the combination of top and bottom quartiles of the two scores were considered for inclusion. A random number corresponding to the participant number in the file was then generated and that participant contacted. Four male and four female participants were selected for interview, and all agreed.

Participants were assured that all data was treated with confidentiality and anonymity, and that only the interviewer would know their identity. Some participants expressed concern at being selected for the second stage, but they were reassured that this was simply a research procedure and that it had no bearing on any mental or physical health aspect. Each participant was assigned a code to identify their transcript and to allow any quotes used as evidentiary information to be linked to the characteristic of interest.

Interviews.

Semi-structured interviews were carried out to explore issues around emotional abuse and current life status, such as satisfaction and perceived health. The interviews were transcribed verbatim and examined using a thematic analytical approach (Gavin, 2008). Thematic analysis is a process of making explicit the structures and meanings that the participant or reader embodies in a text. The transcripts were subjected to analysis by two readers who highlighted text and noted regularly occurring and/or atypical themes. This resulted in a thematic overview in which each reader had identified types of response, highlighting the occurrence on each transcript. These were exchanged and each read the other's commentary, indicating agreement or otherwise. This process went on in several iterative instances, until consensus was achieved. In this way, a set of overarching themes with subsidiary themes was identified. Confirmatory or exclusionary evidence was sought across all transcripts.

Interpretation

Psychometric examination of childhood emotional abuse and adult perceptions of personal control, health and well-being was carried out. The statistical analysis obtained suggests that there is a contributory relationship between recollected levels and type of abuse in childhood and adult health and adaptation as measured by personal control and ratings of perceived health. This supports the previous findings from the relevant research literature.

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There also seems to be a clear sex difference in the experience of abuse, together with the relationship of this to the other measures. However, interpretation of these results should be treated with caution, due to the small sample size. It should also be noted that the scales were primarily used to check that this sample could be compared to previous research, and to profile and identify suitable participants for inclusion in the interview portion of the study.

Interview themes

Several themes emerged from the transcribed interviews. After iterative checking and refinement from the two judges' notations, the following primary themes were identified:

- Memory (Memories of abuse or lack of abuse)
- Rejection (of abused state)
- Responses (Recollected responses to abusive episodes)
- Replication (of behaviour)

Each of the themes had relationships with each other, depending on the characteristics of the interviewees (see below). However, there were items that did not appear across all participants, and further iterative examination exposed secondary themes

- Abuse (type)
- Child (Happiness in childhood)
- Adult (Happiness in adulthood)
- Intensity (of abuse)
- Vulnerability
- Resilience

Memories of abuse or lack of abuse

According to the scale scores, four of the interviewees (M3/M4/F3/F4) had experienced emotional abuse, but the other four (M1/M2/F1/F2) did not, or only indicated very low levels. The interviewees with higher levels of abuse recalled several instances in which a parent or carer (in this case all recalled examples involving the mother or stepmother) had performed one or more of the actions described in the emotional abuse

construct of the CATS, but many also recalled accompanying physical chastisement. This suggests a link between memory for abuse and abuse type, identified as a secondary theme.

F4 ö...she (*mother*) used shout at me a lot, usually because I wasn't doing something the way she wanted it done, but it was always accompanied by a slap.ö

M3 öWe learned pretty quickly to recognise when she (*stepmother*) was in a bad mood, it wasn't difficult, and we'd just stay out of the way. No-one wanted to bear the brunt of her displeasure, or the paddle (*interviewer question*). She had this big wooden thing like a large table tennis bat, and she would hit us with itö

These statements were made in response to questions about parents getting angry with the interviewee as a child, or blaming the child. F4 expanded on this by suggesting she could never do anything right in her mother's eyes, a clear indication of abuse as noted by Lantz & McMurray (2009). It is noteworthy that the interviewees who did not record emotional abuse could all recall examples of the actions described as emotionally abusive, but did not regard them as such, but merely as appropriate punishment or behaviour. For example, when asked about parental ridiculing, one interviewee said:

M1 öWell, my mum used to always try and embarrass me in front of relatives, or even my school friends. She did it to my brother too. He used to wet the bed and she nicknamed him 'Soppy' and told everyone what it meant. I was glad she didn't do anything like that to me!ö

This could be interpreted as humiliation, but the interviewee remembered this as an example of his mother being funny and outgoing:

M1 ö... no, this was mum's way of having a laugh. She did those sorts of things with everyone. ö

Additionally, when discussing the question of parental dislike, one interviewee showed how a parent's disinterest of the child's accomplishments can affect the child.

F1 öMy parents were always a bit dismissive about things that they didn't think important. I once got the lead in the school play, it was a massive thing for me, I was so shy, but my mum just said they wouldn't be coming to see me in it, it was a waste of time, because I'd make a mess of it. So, I gave up the part to my best friendö (*short silence*) öbut I'm sure she loved me really...ö

Blame was also mentioned by several interviewees, but all insisted this was not abusive, simply mistakes on the parent's part, or a sibling trying to shift blame.

F2 öI once got blamed for breaking a glass, when my sister had actually dropped it. It was her (*mother's*) favourite and she walloped me, but I think she was just upset, you know? I used to take the blame a lot for my sister's misbehaving, she was older and no-one expected her to behave badly.ö

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All interviewees reiterated that they were not abused in any way, and that any punishment received was merited. They also suggested that punishment was an acceptable form of control in dealing with children. For example:

F4 "I think that parents don't punish kids enough, I see little brats are rude and noisy, and the parents let them run riot."

Memory of abuse then is never clear cut for these interviewees; they recall incidents that are possibly aggressive, humiliating, dismissive, or denying, but do not acknowledge them as such. This supports Glaser's (2002) assertion that the abuser is adept at hiding behaviour in another form, and that the scars of emotional abuse are, indeed, invisible, even to the victim.

Rejection (of abused state)

The lack of memories of abuse appeared to be linked to a rejection of an abused state; participants who scored low on emotional abuse, but who were relating episodes of identified actions, rejected any suggestion that they had been abused. There appears to be a disparity between how participants viewed the incidents, which is independent of any of the other constructs examined.

F2 "No, I wouldn't say we were abused, just she (*mother*) was a bit strict, but you have to be with kids don't you? I get annoyed when I see children misbehaving without being told off"

F4 "I must have been a horrible kid, I never did anything right for her, and I expect I deserved everything she (*mother*) dished out"

M3 "We ran riot after my dad remarried, it can't have been easy on her (*stepmother*) taking five kids on. We learned quickly that if she was grouchy we'd get what we deserved. I wonder now if she had mental problems, you know, depression or something"

Such statements demonstrate reflection on the interviewees' own behaviour, never an acceptance of the parent as abuser. Rejection is not simply a lack of recall about incidents, as the section above shows that interviewees do remember interactions of this nature. This is unmistakably a refutation of any abused state. This then begs the question, is our definition of emotional abuse at fault, or is there some rationalising function happening with respect to

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recall of a childhood experience? Perhaps a productive strategy would be to consider what the responses to the parental behaviour were.

Responses (Recollected responses to abusive episodes)

Interviewees were asked to recall what their response had been when they recounted abusive episodes, irrespective of whether they defined them as such. Most indicated that they responded by avoiding the behaviour that led to the episode, or avoiding the abusive parent.

M2 ÷ I never knew what would set her (*mother*) off so I just stayed out of her way as much as possible.ö

M4 ÷ I just avoided being alone with her (*mother*).ö

Such reactions appear to be avoidant in nature. Where such a strategy was not possible, the described action is despondent.

F3 ÷ I tried as hard as I could to be good, do all the things she (*mother*) wanted, but it was never enough, she always criticised everything.ö

This does seem to be indicative of learned helplessness, itself closely implicated in the development of depression and other illnesses (Cole et al ,2007) and associated with the accumulation of negative developmental experiences (Evans et al, 2005)

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Replication (of behaviour)

Some interviewees, particularly those who scored high on emotional abuse, suggested that their adult behaviour was affected by the memory of childhood experience.

F4 "Both me and my sister have no kids. I know I decided fairly early that I wouldn't have any, as I wouldn't want to be responsible for putting a kid through that, you know. And I feel I wouldn't be able to stop myself. Not sure about how my sister felt, but I'm guessing it's the same underneath."

M1 "Well, no-one behaves the same way with their own kids as their parents did, do they? My children don't see granny very often, she's old now, and a bit cantankerous. She did insult my eldest once, and she was very upset... *(did not give details)*"

Secondary themes emerged, linked to the primary themes discussed above. Abuse type and rejection of abused state were clearly expressed in relation to memory of abuse. Whilst interviewees were distinguished on the basis of whether they had experienced abuse or not, and whether they identified behaviour as abusive, another distinction appears to be the intensity of the abuse. Those who reported high levels of abuse were divided on whether these happened frequently or not, and whether they were consistent behaviours. This is defined here as intensity. Female participants reported regular episodes, but also stated that there appeared to be little consistency of what would trigger the abuse, and/or that it was a constant experience. Male participants did not express their recollections in this way.

F3 "I think something like that happened every day or so, but I can't really say so, because sometimes I'd get punished, and sometimes she *(mother)* didn't bother with me."

M4 "I generally knew what would set her *(mother)* off, so learned to avoid her."

Parents' behaviour clearly impacted on whether participants recalled being happy as children, and whether they declared themselves happy now. Some of this was bound up with the impact parental behaviour had on childhood friendships:

F4 "I didn't bring friends home, they were deemed either too young for me, or older, and therefore 'boy mad' *(interviewer question)* I was about 8 or 9 when I realised that I shouldn't, or rather couldn't, have friends."

M1 "My friends loved coming to our house, mum was always making cakes and stuff, we'd play all day if it wasn't for tea-time. I like to think we're the same with our lot, they've always got other kids over."

F4 "Happy? Oh no, I wasn't a happy kid. (*Probe*). I spent my childhood being afraid, I never wanted to go home after school, but there was nowhere else to go..."

For some interviewees the impact went further than childhood. In addition to distancing themselves from the abusive parent, or deciding not to perpetuate abusive behaviour (see above), some participants suggested that they blamed the parent for negative feelings in adulthood.

F3 "I still can't relax if I'm doing something she (*mother*) would have disapproved of, like staying out late. Or spending money on myself, something frivolous maybe, she'd have hated that"

A major issue in the literature was the impact that childhood abuse had on the perceived health in the adult child. While no interviewee made direct links between abuse and health, there were references to the way in which individuals approached their own health, interpreted as vulnerability and resilience:

F3 "She (*mother*) used to say we were attention seeking if we tried to say we were ill. My sister once had a bad cough, and was slapped every time she made a noise. She ended up being diagnosed with asthma. I'm always worried that if I ignore something small I'll end up really ill"
M3 "I don't worry about my health, which is odd, because we'd get shipped off to the doctor if we had the slightest sniffle. I tend to downplay things like that as I hate having to go to the GP"

One group of participants of particular interest were those who had reported high levels of childhood emotional abuse, but who were also high scorers on the other scales indicating a healthy adaptation to adult life. These individuals were M4 and F4. Whilst not necessarily typical of the population of people in these circumstances, a further analysis of their answers was conducted. It was interesting that they talked about the abuse in very detached terms. M4 in particular described his response to his abusive parent as avoidance, he learned to keep out of his mother's way. F4 conversely, reported that she felt trapped ("nowhere else to go"), but also that she had made explicit adjustments, such as choosing not to have children, and not making friends. Later in the interview, she stated that she had severed ties with her family, and felt better for it.

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Interviewees in the converse position, declaration of no or low levels of abuse (M1/M2/F1/F2), are also of interest in terms of adaptation. Although recording no episodes of emotional abuse in the questionnaire responses, and, during the interviews, denying that any abuse had taken place, their interviews did expose recollections of behaviour that were abusive. The current health and personal control scores for two of these interviewees (M2/F2) were as low as their high abuse counterparts, suggesting that acknowledgement of abuse might be a factor in its effect.

Discussion

Statistical analysis of the measures collected from this sample supported some of the literature concerning childhood experience of emotional abuse and its long lasting effects. Previous research outlined above, such as that reported by Irving & Ferraro (2006), suggests that there is a clear link, possibly a causal relationship, between emotional abuse and later maladjustment in adult life. Such adjustments seem to be poor levels of personal control and high levels of susceptibility to illness. Some researchers, for example, Riggs & Kaminski (2010) have even asserted that it may be the emotionally abusive components of physical and sexual abuse that are responsible for long-lasting negative consequences into adulthood. The sample examined here showed significant negative relationships between emotional abuse and satisfaction with life and resistance to illness, suggesting that abuse has effects throughout the life course. However, the link between abuse and personal control was not exhibited by this sample.

The research literature also makes a case for sex differences in the experience and consequences of emotional abuse. Halbreich & Kahn (2007) have suggested the sex disparity for anxiety disorders is due to differential experience of emotional abuse and Hyde et al (2008) propose the same for depression. Whilst there is no suggestion of such illnesses being present in this sample, there are clear sex differences in both experience of abuse and

the relationship of that experience to adult characteristics. However, the numbers of male and female participants was unequal, and the interpretation here must be cautious. Taking this difference into account showed that women were more likely to report having experienced abusive episodes and be more susceptible to illness, and reported lower levels of satisfaction with life than men, and have a more negative perception of their current health.

However, the quantitative measures were administered in order to check that this sample showed the same trends seen in the literature, and to identify potential interviewees. The sex differences shown confirm that it would be appropriate to interview both men and women, and interview candidates were categorised on the basis of this and other data, then one interviewee selected randomly from each category.

Interview analysis showed several themes emerging, both in terms of how interviewees recalled childhood experiences and their response to them, and the current state of perceived health. There were differences in how interviewees remembered the experiences, as some denied that they had been abused, but some of their recounted episodes could have been interpreted as abusive. This position was interpreted as a rejection or denial of the abused state. The interviewees in this category clearly did not think they had been abused, but also did not show as healthy an adaptation to adult life as either of the other non-abused individuals or the abused but healthy individuals.

An interesting outcome appears to be that even if an individual does not recall their childhood as being abusive, there are events that could be interpreted as such. In some cases, individuals reporting low abuse but also low health perception and internal control scores (it appears that this may still have the potential for a negative effect, as these individuals (M2/F2) did show a profile of lower health perceptions and internal control. In interviews, these two participants also described incidents that did appear to be abusive, but also expressed no blame for the parent. The converse is also of note, as those who had

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experienced abuse, but who had a healthy adult life, appeared to use the strategy of distance and avoidance in adulthood, even if this is not explicitly acknowledged.

This does have implications for an application of cumulative disadvantage theory to emotional abuse. A hypothesis that experiencing childhood abuse will lead to an accumulation of more negative experiences as a result of maladaptations does not appear to hold for individuals who adopt family avoidant strategies. The reverse is true for people who do not acknowledge their childhood events or atmosphere as abusive, and they may indeed experience an accumulation of disadvantageous encounters and outcomes. If the cumulative disadvantage theory and hypotheses generated from it are to be of practical use in research and practice, the possibility of unacknowledged abuse will need to be taken into account. A state of denial in a client is one of the first barriers encountered by counsellors (Mearns & Thorne, 2007). This issue would appear to be pertinent here. Additionally, adult survivors of childhood physical and sexual abuse often assert that the emotional aspects of the abuse, such as betrayal, are as important as any other (Willows, 2009). The individuals in this study experienced physical abuse (slapping, paddling etc.) in addition to the emotional abuse discussed, but there were several instances of psychological ill treatment alone. No individual described sexual abuse.

Limitations of the study

The mixed methodological approach to the research questions appears to have been appropriate, in that previous research findings were confirmed and extended, but also used as the basis for selection of interviewees and construction of an interview schedule. However, the sample included in the quantitative stage was relatively small, and a wider range of experiences may have been captured with a larger sample. Additionally, although the qualitative stage of the study exposed rich and detailed material, it is still unclear whether this sample of eight provides a typical depiction of a wider set of experiences. Having

established a process of research and analysis, it is proposed that a similar study be carried out with larger samples.

In addition to repeating the study on a larger sample, there are further items to be considered in future research. Here, the interviews were carried out on individuals randomly selected on the basis of the scores from a variety of psychometrically validated scales. Targeting particular aspects from a larger sample may be more fruitful, and gain more pertinent comparison. For example, the sex difference in the quantitative measures was not in particular evidence through the interviews. Possibly including more men in the first stage will allow for the inclusion of participants with more extreme scores, leading to a wider range of experiences to be examined.

A second issue that emerged during analysis, but yet to be fully explored, is that the recollected abuse was always carried out by the female parent, i.e., mothers or stepmothers. This may not be surprising, as women still bear the primary responsibility for child care, and the episodes recalled appear to fall within that category of interaction. However, the question of differences in the sex of the parent in terms of emotional abuse would bear scrutiny.

Conclusion

This study was intended to be an exploratory investigation into the effects of emotional abuse, and to determine the efficacy of a mixed methodological approach. Using both statistical analysis of psychometric scores, and interpretive analysis of semi-structured interviews, has led to a set of rich data from which issues not previously examined can be sought. Statistical analysis of scores on measures of childhood emotional abuse, satisfaction with life, perceived health and personal control demonstrated that the link between abuse and adaptation was present in the research sample. Further discussion of elements contained in the emotional abuse construct with several participants revealed themes pertinent to the long-term effects of a virtually invisible form of maltreatment. Of particular interest were two

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groups of participants. Firstly, those who denied experiencing any abuse of this nature, but who described incidents that could be interpreted as such, and who were also reporting difficulties in adult life that appear to be indicative of poor health or perceived health. In these individuals, the denial or non-recognition of abuse seems to be a contributory factor to dissatisfaction in later life. The second group of interest are those whose reported childhood memories were of abusive relationships with parents, but who were robust in adult life. The mediating factor here appears to be the use of avoidant strategies, as they reported distancing themselves from the abusive family members either in childhood or later.

Findings from this relatively small sample suggest that there is a wider range of effects that can be measured to determine how childhood experiences contribute to accumulated psychological disadvantages throughout the life course. One major point exposed is that participants who did not acknowledge childhood experiences as abusive were just as likely to have issues in adult life as those who did. Implications for adjustment to adult life have been proposed. As such, the study's objectives have been met, and further examination of the issues raised is proposed.

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Table 2 Descriptive statistics with respect to age.

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