ISSN: 2348-4667
Anthropological Bulletin
5 (2), 47-58, 2015

Health and behavioural consequences of child abuse

Daud Salim Faruquie[5]

This paper addresses the serious issue of child abuse which is widespread but understudied in India. The chapter contains descriptions and evaluations of studies and interpretation of data on the physiological and psychological health effects associated with child abuse. Global knowledge has been referred to develop the understanding of the concept and presentation of the evidence of negative effects of abuse. This information is presented to provide public health officials, physicians, psychologists, anthropologists, policy makers, NGOs and other interested individuals and groups with (1) an overall perspective of the problem of child abuse and (2) a description of evidence indicating various damaging health effects.

The discovery of "battered child syndrome" in 1962 by Henry Kempe' and associates saw the beginning of interest of the general public and also serious researchers in the phenomenon of child abuse and its consequences. Later on, sexual abuse was highlighted in Britain during 1980's (Corby, 1993). It was further noted that children are subjected to different kinds of victimization and are particularly vulnerable due to their developmental status (Finkelhor and Dziuba-Leatherman, 1994). In the course of time, cross-cultural studies brought awareness that child abuse is a global problem (Segal and Ashtekar, 1994).

Concept of child abuse is perhaps the most difficult issue to be defined. According to Parke and Collmer (1975), abused child refers to "any child who receives non-accidental physical injury as a result of acts and omissions on the part of his parents or guardians that violate the community standards concerning the treatment of children". But Jill (1981) has taken a wider perspective and included those acts of maltreatment which do not produce an injury but are equally harmful. Jill refers child abuse to all kinds of physical or mental injury, negligent treatment or maltreatment of a child by a person who is responsible for the child's welfare.

It is suggested by literature in the area that abuse may be divided into different categories, according to the type of maltreatment and its effects. The popular categories of abuse are physical abuse, sexual abuse, economic abuse (concerned with working children), and physical and emotional neglect.

[5] Executive Director, OXEVIN, U.K.

David Gil (1968) has defined *physical abuse* as "any non-accidental physical attack or physical injury, inflicted upon the child by the child's caretakers". Attacker or abuser may be anyone who is at least a temporary caretaker of the victim such as; parent, teacher, employer, relative or elder sibling.

Unlike other maltreatments, *sexual exploitation or abuse* of minors is one of the most horrendous crimes. Kempe' and Kempe' (1978) has defined it is "the involvement of dependent and immature children in sexual activities they do not fully comprehend, to which they are unable to give informed consent". Sexual abuse is physical, verbal or emotional sex treatment to the child. It occurs when an older or more knowledgeable child or adult uses child for sexual pleasure. Abusers make the child comply in different ways such as deception, bribery, verbal intimidation and physical force (Gomez-Schwartz, Horowitz, & Cardarelli, 1990). In such cases, the sexual interaction of victim with the perpetrator may lead to an act either by commission or by omission. Act of sexual abuse may include sexual touching or fondling, confrontation with sexual media (showing the child printed or audio-visual sexual stuff), having sexual chat with them, having them pose, undress or other sexual performance, peeping or spying over them and rape or attempting rape.

A peculiar form of child sexual abuse is child's exposure to pornography. According to Zillmann (1989) prolonged exposure to pornography may result in many behavioural abnormalities including elevated level of violence, altered perception of sexuality, insensitivity toward victims of sexual abuse and being capable of committing rape etc. The problem is further aggravated when children themselves are lured or forced to become subjects of such activity. On the face of it, it looks to be relatively easy business and therefore many runaway children try to adopt it to survive in large cities (Encyclopaedia of crime and Justice, 1983). Impacts of the pornographic experiences often produce feelings of betrayal, guilt, worthlessness and rage (Pierce, 1984).

With the reach of media particularly the Internet expanding and enlarging uncontrollably, the child's vulnerability to confrontation with sexual stuff has grown to a great extent (Carlsson, 1999). Accessing Internet pornography by children becomes more dangerous as it provides access for child abusers, blackmailers and paedophiles (Aftab, 1999). Paedophiles form their association and forum on Internet developing their own vocabulary and code words to operate and communicate with each other in order to engage children in inappropriate sexual communication and to entangle them in a sexual trap (Quayle and Taylor, 2001).

Economic exploitation of a poor working child is also an abuse of the child. It is not a category of abuse which is popular in common parlance but, with children forming a sizeable workforce of many countries including India, its importance cannot be lost sight of. Children of very low socio-economic strata do petty remunerative jobs under various non-organised / cottage undertakings such as, glassware, brassware, lock factories and small roadside hotels (*dhabas*). These child workers are generally not protected by any legal / labour agency and usually work under the mercy of their employers. In order to exact more work while paying less, employers usually harass them and do not pay them properly. This economic exploitation comes under the category of economic abuse. Economic abuse may include:

- Not paying them for their work. (non-payment)
- Paying less for their work. (under-payment)
- Keeping their payments pending.
- Forcing them to work more than their due remuneration.
- Demanding loans/snatching money from them.

Physical and emotional neglect is another form of abuse. Failure to recognize hazardous

circumstances or responding improperly to child's nutritional, health and developmental needs, or leaving a child unattended either wilfully or inadvertently, leading young children to serious accidents, deaths from falls or burns and poisoning etc. also come under the purview of abuse (Lupton, C.; Khan, P.; & Lacey, D. 1997). Kratcoski and Kratcoski (1979) have defined physical neglect as "the failure to provide the essentials for normal life, such as food, clothing, shelter, care and supervision, and protection from assault. He further explained emotional neglect as the lack of expressed love and affection and the deliberate withholding of contact and approval. Under the category of emotional maltreatment children are usually blamed, belittled, rejected, unequally treated with reference to siblings and are targets of lack of concern from parents/caretakers.

Apart from the four major types of child abuse described above, some other issues like child marriage and child labour also come under the category of abuse.

Indicators of child abuse:

Bear, Schenk, Buckner (1993) have identified some physical and behavioural indicators of the forms of child abuse. These indicators have been tabulated below:

	Physical Indicators	Behavioural Indicators	
Physical Abuse	▪ Unexplained bruises (in various stages of healing) welts, human bite marks, bald spots ▪ Unexplained burns, especially cigarette burns or immersion burns ▪ Unexplained fractures, lacerations or abrasions	▪ Self destructive ▪ Withdrawn and aggressive – behavioural extremes ▪ Uncomfortable with physical contact ▪ Arrives at school early or stays late, as if afraid.	▪ Chronic runaway (adolescent) ▪ Complains of soreness or moves uncomfortably ▪ Wears clothing inappropriate to weather, to cover body
Physical Neglect	▪ Abandonment ▪ Unattended medical needs ▪ Consistent lack of supervision ▪ Consistent hunger, inappropriate dress, poor hygiene. ▪ Lice, distended stomach, emaciation.	▪ Regularly displays fatigue or listlessness, falls asleep in class. ▪ Steals food, begs room classmates. ▪ Reports that no caretaker is at home.	▪ Frequently absent or tardy ▪ Self-destructive ▪ School dropouts (adolescents)
Sexual Abuse	▪ Torn, stained or bloodied underclothing ▪ Pain or itching in genital area ▪ Difficulty walking or sitting ▪ Bruises or bleeding in external genitalia ▪ Venereal disease ▪ Frequent urinary or yeast infections	▪ Withdrawn, chronic depression ▪ Excessive seductiveness ▪ Role reversal, overly concerned for siblings ▪ Poor self-esteem, self devaluation, lack of confidence ▪ Peer problems, lack of involvement ▪ Massive weight change	▪ Suicide attempts (especially adolescents) ▪ Hysteria, lack of emotional control ▪ Sudden school difficulties ▪ Inappropriate sex play or premature understanding of sex ▪ Threatened by physical contact, closeness ▪ Promiscuity.

Indicators of emotional neglect according to Denver (1961) are:

- Habit disorders such as biting, thumb sucking.
- Conduct disorders such as destructiveness, cruelty and stealing
- Neurotic traits such as sleep disorders and inhibition of play.
- Psycho-neurotic reactions such as hysteria, phobias and obsession.
- Behaviour extremes such as appearing overly complainant, extremely passive or aggressive, very demanding or undemanding.
- Lag in emotional and intellectual development and
- Attempted suicide.

Indicators of economic abuse may overlap with the characteristics of other types of abuses. It is difficult to observe and state the signs of economic abuse as clearly as can be done in the case of sexual and emotional abuse.

SOME OTHER PHYSIOLOGICAL MANIFESTATIONS OF CHILD ABUSE:

Munchausen Syndrome by Proxy (MSBP):

A syndrome, which mystifies physicians, was first described in 1977 (Von Burg and Hibbard 1995a). Especially in western countries where law towards the childcare is more forceful, parent/s sometimes try to induce fictitious symptoms of illness in their child to escape from accountability in case of neglect or abuse on their own account (Blumenthal, 1994; Mehl, Coble and Johnson, 1990; Yorker and Kahan, 1990; Kravitz and Wilmott, 1990). This fabricated illness in the child is also known as medical child abuse (Boros et. al. 1995; Evans, D. 1995 and Marcus et. al., 1995)

Kwashiorkor Disease:

If for a long period of time quantitative or qualitative under-supply of nutrition is given to the child, he/she may lose weight and may get stagnation and/or stunted growth. This state is known as Kwashiorkor disease (Bonet et. al. 2001). This is measured with the comparison of expected growth (considering height, weight etc.) with actual body size of the child (Wehner, et. al. 1999).

Legal strictures and international action:

The problem of child abuse has been defined in legal terms and necessary laws have been made to check this social evil. Government of India has also recognised the seriousness of the problem and passed the Immoral Trafficking (Prevention) Act in 1986.

> *Article 24, clause (f) of this act casts a duty on states to declare that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation against moral material abandonment.*

Together with this, the Indian Penal Code, Section 361 has considered kidnapping or maiming a child for begging or for prostitution as an offence. Major international bodies associated with United Nations viz. UNDP, UNICEF and UNESCO are working for the betterment of poor children, abolition of their maltreatments and management of the detrimental effects of the maltreatment.

United Nations in this connection, made several declarations of the rights of the child. One such convention on the rights of the child was adopted by the general assembly of the United Nations on 20th November 1989. The Government of India acceded to this convention on 11th December 1992. This convention was the extended version of earlier conventions i.e. the Geneva Declaration of the Rights of the child (1924) and the Declaration of the Rights of the Child adopted by the General Assembly on 20th November 1959. The declaration has made various provisions not only the controlling and management of maltreatment of children but the rehabilitation provisions have also been made. In this reference Article 19 (1)

of this declaration says that, "States shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or natural violence, injury or abuse, while in the case of parent(s), legal guardian(s) or any other persons who has the care of the child."

Article 34 is dedicated particularly to the sexual exploitation of children. This article declares that, "States undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, states shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement of coercion of a child to engage in any unlawful sexual activity.
(b) The exploitative use of children in prostitution or other unlawful sexual practice.
(c) The exploitative use of children in pornographic performances and materials.

This convention has manifested its concern towards the rehabilitation of child victims and management of their problems. In this connection Article 39 declared that, "States shall take all appropriate measures to promote physical and psychological recovery and social re-integration of a child victim of any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and re-integration shall take place in an environment, which fosters the health, self-respect and dignity of the child.

Consequences of child abuse:

Consequences of child abuse are detrimental and far-reaching. It is suggested by work in this area that child abuse results in severe consequences to the victim, physiologically; socially and psychologically. After the discovery of *battered child syndrome* in 1962 by Henry Kempe', so many health-related researches have been conducted in this direction, surfacing the *physiological consequences* of child abuse. The physical symptoms of child abuse are bruises/welts, cuts/scratches, dislocation of joints, burns, scalds and bone fractures (de Paul, J.; Milner, J.S.; Mugica, P. 1995, Block, S.S. 1996). In chronic cases, haemosiderin deposits in lungs and liver (Dorandeu, A. et. al. 1999), internal injuries such as intracranial haemorrhage and abdominal visceral injuries leading to the severe morbidity and mortality (Cheah, I.G. et. al. 1994) etc. *Skeletal manifestations* include general fractures (Patterson M.M. 1998; Cramer, K.E. 1996 and Block, S.S. 1996) fracture of ribs (Strouse, P.J. and Owings, C.L. 1996) and fractures of chostochondral junctions (Ng, C.S. and Hall, C.M. 1998).

Physiological responsiveness such as heart rate, pulse rate, skin temperature and conductance, electromyography and motor reactivity of abused children to different stimuli of the environment may be delayed as compared to the non-abused children (Carrey, N.J. et. al. 1995). This explains that *slow reactivity or responsiveness to the environment* may be one of the impacts of child abuse.

Child abuse most often result in *Orofacial injuries*. Von Burg and Hibbard (1995) maintained that more than 50% of physical abuse occurs to the head and facial area and more than 70% fatalities happen due to such implementations. Orofacial injuries, according to Jessee (1995) include fracture of teeth or maxilla, mandible and other facial bone, facial burns, lacerations of lips and lingual fraenum and bite marks on face and neck. Besides the orofacial injuries, *Ocular Injuries* are also important to come under the purview of child abuse. These include intraocular haemorrhage, periorbital edema, ecchymosis and retinal detachment (Harley, 1980).

Child sexual abuse may result in sexually transmitted diseases. (Petrak, Byrne and Baker 2000; Laszlo, et. al. 1991; Koss and Harvey 1991). Researchers have found connection

between CSA and HIV (Zierler, et. al 1991; Wingood and DiClemente 1997; Bartholow, et.al, 1994; Brown et. al. 1997; Kissinger, Clark and Abdalian, 1997).

Psychological Impacts of child abuse are far reaching (Gilles, 1999) and it is a significant risk for mental health problems in childhood (Beitchman et al.. 1991; Kendall-Tackett, Williams, & Finkelhor,1993) such as self-esteem, depression, anxiety, and feelings of anger and hostility (Gomes-Schwartz et. al., 1985; Mannarino, Cohen & Gregor 1989). Detrimental effects of abuse could be seen among the victims in short-term as also in the long-term.

General behaviour changes that may occur for *short term* in abused children include *fear or dislike of certain people, sleep disturbances, headaches, school problems, withdrawal from family, friends, or usual activities, excessive bathing or poor hygiene, return to younger and more babyish behaviour, depression, anxiety, discipline problems, running away, eating disorders, passive or overly pleasing behaviour, delinquent acts, low self-esteem, self destructive behavior, hostility or aggression, drug or alcohol problems, sexual activity or pregnancy at an early stage and suicide attempts* (Irving, 1983).

According to Milling (1999) abused children show lower grades in academic subjects, more days absent, more placements in special education programs, more retention in grade, and more school problems than non-abused children. Sexual victimization may profoundly interfere with and alter the development of attitudes toward self, sexuality, and trustworthy relationships during the critical early years of development (Tsai & Wagner, 1984). Early age sexual experiences also result in emotional immaturity and distorted views of sex (Dillon, 1999). Children who have higher rates of physical abuse, sexual abuse, severe neglect and family breakdown and parental criminality develop themselves as borderline personality (Guzder, et. al. 1999). It has also been noted that abused children can have a preoccupation for situations or behavior similar to the initial traumatizing circumstance (Eth & Pynoos, 1985), victims with a post-traumatic stress disorder selectively process threatening material while undergoing the expectations test. (Bryant & Harvey, 1995; Foa, Feske, Murdock, Kozak, & McCarthy, 1991).

According to Stevenson (1999) abused children are at risk of *long-term* adverse psychological sequelae related to the abuse per se. Finkelhor (1984) notes that, victims of sexual abuse may sexualise all their relationships in an attempt to gain affection; in adolescence this can lead to a self-destructive pattern of promiscuity with a succession of abusive relationships.

Prominent theories on the effects of child abuse have focused on abuse variables in predicting mental health outcomes. Childhood victimization of abuse and neglect is associated with increased risk for lifetime Post-traumatic Stress Disorder. Very less part of the population of abused children meet DSM-III-R criteria of lifetime PTSD. Disordered eating attitudes in adult life with depression, anxiety and dissociation is also a result of childhood abuse (Kent et.al., 1999).

Severe levels of dysfunction in adulthood, including psychosis high frequency of auditory hallucinations, particularly command hallucinations to kill oneself, paranoid ideation and delusions have high correlation with the history of child sexual abuse (Read and Argyle, 1999). The pernicious experiences of childhood abuse may hamper the proper personality developments like cognitive processes specially perception of moral concepts (Faruquie & Ahmad, 2002), attitude formation (Kousar et. al., 1993) and constriction in the self and healthy character development (Famularo, Kinscherff and Fenton, 1990).

If perceptions and ideations can be affected by the experience of abuse, children undergoing these experiences may manifest features different from what children usually express in others appraisal and judgment of morally loaded issues. Realizing such

seriousness of the problem, it is indeed of high importance to understand the evidence which puts forward the claim of negative consequences of child abuse.

Evidence on child outcomes:

There is a huge body of cross-cultural and sub-cultural evidence which confirms negative outcomes of child abuse. It is however impossible to sum and represent the entire volume, the most relevant studies are being described here.

It is warranted that evidence from India is quoted first where child abuse is rampant and widespread but least attended. Segal and Ashtekar (1994) attempted to assess whether the abuse of children by caregivers/parents is a phenomenon that is prevalent in Indian society. In this connection, 515 children were interviewed in Bombay. Approximately 50% of the respondents reported of physical violence from parents or caregivers and over two-thirds reported the use of abusive violence. In addition, over 60% of the children who had run away from their homes, cited violence by parents as the primary reason for their leaving. Authors proposed that this might be one of the variables adding to the numbers of street children in India.

Continuing their previous trend, Segal (1995) conducted another study to determine if the abuse of children was prevalent among middle-class professionals in India. Face-to-face interviews were conducted with a stratified random sample of 319 subjects, in three cities in India, to assess their attitudes toward child rearing and their expectations about child development. 56.9% of the subjects reported having used "acceptable" violence, while 41.9% revealed that they had engaged in "abusive" violence. Interestingly, 2.9% admitted to having employed "extreme" violence toward their children. It was suggested that violence against children in India may well be the result of social sanction. Children of low socio-economic strata are more vulnerable to an abusive treatment. Mcloyed (1998) found that children, who are socio-economically disadvantaged, receive harsh and inconsistent parenting. The most important and wide ranged epidemiological work was carried out by the Ministry of Women and Child Development (2007) which covers 13 states in India with a sample size of 12,447 and looked at the extent and characteristics of child abuse and girl neglect in India. Findings show that children on the street, children at work and children in institutional care reported the highest incidence of sexual assault, while the majority of abuse cases take place within the family environment. The study reveals that two out of three children were physically abused, 53% children reported to have faced one or more forms of sexual abuse among which 22% faced severe forms of sexual abuse. In 50% cases of sexual abuse, abusers were known to the child or in a position of trust and responsibility. Every second of the contacted child reported facing emotional abuse in which 83% of the cases parents were the abusers.

At international level, the problem of child abuse has got rather serious attention of researchers. Therefore, the problem has not only been studied for its prevalence and epidemiology but its theoretical connections and socio-behavioural pathways have also been established (Thompson and Wyatt, 1999). According to them children's emotional or behavioural problems, learning disabilities or other difficulties often reflect broader problems that are associated with abuse or neglect.

Brezina (1997), established theoretical relationship between maltreatment of children and its social consequences, using three behavioural dimensions viz. social control, social learning and strain. According to the author, social control theory contends that, maltreatment disrupts important delinquency–inhibiting ties; social learning view says that the deviant values and patterns of behaviour are learned from the abuser, either implicitly or explicitly, whereas general strain theory says that criminogenic emotions such as anger and resentment are likely to arise amongst the victims. This theoretical explanation opens the possibility that abuse may have its impact on child's cognitive-developmental process and

behavioural pathology.

The notion that post-traumatic stress disorder (PTSD) may be found in children who have experienced abuse (sexual in particular) has become an important issue in research and clinical practice (Morrissette, 1999). Children who have been exposed to violence are at risk for developing PTSD (VanFleet, Lilly and Kaduson, 1999). Ratna and Mukergee (1998) in a quest to establish relationship of child sexual abuse with PTSD estimated that approximately 20% of victims go on to have serious long-term pathology. It was concluded that there is high incidence of PTSD following sexual trauma. Furthermore, evidences of neuro-endocrine disturbances similar to those seen in war veterans with PTSD were also found amongst the victims. Saunders et. al. (1999) interviewed adult women with a history of childhood rape and found that childhood rape dramatically increases risk for development of psychological problems such as, PTSD, major depression and substance use. Likewise, Dubner and Motta (1999) studied and compared three groups of children comprising of 50 sexually abused, 50 physically abused and 50 non-abused children. Subjects completed Child Post-Traumatic Stress Reaction Index. Results indicated that sexually and physically abused children demonstrated a high incidence of PTSD. Authors further noted that preadolescents demonstrated more severe PTSD than early adolescent subjects. Widom (1999) observed that 37.5% victims of childhood sexual abuse, 32.7% of childhood physical abuse and 30.6% of childhood neglect met DSM-III R criteria for lifetime PTSD.

Impact of physical and sexual abuse during childhood may become permanent resulting in long-term sequalae related to the abuse per se (Stevenson, 1999). Abnormalities caused by the childhood experiences may surface up during adulthood. Sheldon and Bannister (1998) studied problems of adult female survivors of childhood sexual abuse. Authors noted major long-term consequences of child sexual abuse and divided them in three categories. First, psychological problems with a psychiatric presentation such as depression, anxiety, sleeping difficulties, eating disorders, self-harm and alcohol and drug dependence. Second, severe interpersonal difficulties characterised by feelings of isolation, alienation, distrust, fear of men, repeated victimization in an adult relationship and difficulty in their relationships with their own children. Third category includes sexual problems such as avoidance of sex, sexual anxiety, and guilt, promiscuity and prostitution.

Child abuse has its detrimental effects on behavioural pathology leading to the psychotic or neurotic problems in victims. Read and Argyle (1999) studied three positive symptoms of schizophrenia namely hallucinations, delusions and thought disorders amongst physically and sexually abused children. It was seen that there is a relationship between specific type of abuse and specific symptom. Hallucination was found highly associated with sexual abuse whereas delusion and thought disorder were associated with physical abuse. The study findings confirmed previous findings of a high frequency of auditory hallucinations; particularly command hallucinations to kill oneself, and paranoid ideation among inpatients with a history of abuse. Straus and Kantor (1994) studied the impact of corporal punishment on mental health and social relationships amongst teenagers of low socio-economic strata. Authors found that children who experienced corporal punishment in adolescence had an increased risk later in life of depressive symptoms, suicidal thoughts, alcohol abuse, physical abuse of children and wife beating. Zlot and others (2000) compared women having major depression with women suffering from pain due to psychological factors. Results of the study showed that negative childhood experiences ("brutality between parents", "brutality towards child" and "sexual abuse) are prominent and similar in both groups.

It has commonly been found that abused children are at risk for later becoming abusive parents. Narang and Contreras (2000) examined the relationship between history of child abuse and abusiveness as an adult. Researchers adopted a cross-sectional design to examine

three constructs viz. physical abuse history, dissociation and physical abuse potential in 190 respondents. Results showed that all three constructs were correlated with each other significantly.

Anxiety and depression seem to be a basic behavioural digression caused by trauma or abuse. Cohen and Mannarino (1988) in their study found that parents of sexually abused girls (aged 6-12 yrs) rated them having significantly more behavioural problems such as depression, anxiety or low self-esteem as compared to parental ratings of non-abused sample. Raskin et al (1989) examined the early childhood experiences of socio-economically disadvantaged patients having anxiety disorders. More than 50% of the subjects were found to be abused during their childhood. Hudson (1990) found severe separation anxiety, fear of starting school, avoidance of their own bed, refusal to sleep alone, and fear of the dark amongst children who were sexually molested by adult strangers, were threatened with murder if they revealed the abuse, and being photographed during the abuse. Devor (1994) found fear, anxiety and depression amongst subjects who encountered at least one severe level of sexual, physical or emotional child abuse. Using Beck Depression Inventory on adult survivors of child abuse, Holmes (1995) found that in comparison to patients having no history of abuse, those with a history of abuse showed no improvement in anxiety scores after therapy.

Cahill, Kaminer and Johnson (1999) in order to discuss developmental, cognitive, and behavioural sequelae of child abuse, explored the literature on the short and long term sequelae of physically and sexually abused and neglected children, and concluded that abuse and neglect effects on child's neurologic, behavioural, and cognitive system.

Earlier on Carrey et.al. (1995) compared physiological responses of abused children to different stimuli with responses of children in a reference group and to correlate the physiological responses with intellectual and personality functioning. In the first session of this study children were shown slides with emotional or cognitive content while heart rate, pulse rate, skin conductance, electromyography, and skin temperature were measured. In the other session, intellectual and personality functioning was measured using the WISC-R, Quick Neurological Screening Test, and the Junior Eysenck personality inventory. Abused children had higher introversion and lower Verbal and Full Scale IQ scores. Verbal and Full Scale IQ scores were inversely related to the severity of abuse that had been experienced. When these variables were used in a discriminant function analysis, children were assigned to the correct group 86% of the time. Authors conclude that these findings support a model that describes the effects of abuse as delaying cognitive development and inhibiting physiological responsiveness to the environment.

DeFronzo and Pawlak (1993) Found that childhood trauma (i.e., having been beaten as a child) promoted both smoking and alcohol abuse whereas religious belief and belief in the importance of conformity with shared moral principles have significant negative effects on smoking, alcohol use, and alcohol abuse. Authors' resultant findings support the notion that abused children are more prone to commit substance abuse.

The strength of global evidence and the wide prevalence of the problem in India alarms us that the country faces huge burden of child abuse. The presented evidence in this connection may be helpful for the stakeholders and policymakers for identifying the most effective, efficacious and cost-effective interventions for the prevention from child abuse and treatment of the aftereffects with the victims. The evidence would also be helpful to evolve practice guidelines for the implementation agencies and NGOs.

References

Aftab, P. (1999). *Sexual abuse of children, child pornography and paedophilia on the internet: An international challenge.* UNESCO, Paris.

Bartholow, B.N.; Doll, L.S. and Joy, D. et. al. (1994). Emotional, behavioural and HIV risk associated with sexual abuse among adult homosexual and bisexual men. *Child Abuse and Neglect, 18*, 747-761.

Bear, T.; Schenk, S. and Buckner, L. (1993). "Supporting victims of child abuse." *Educational Leadership,* 50 (4), 44.

Beitchman, J.H.; Zucker, K.J.; Hood, J.E.; Da Casta, G.A.; and Ackman, D. (1991). A review of the short-term effects of child sexual abuse. *Child Abuse and Neglect, 15,* 537-556.

Brown, L.K.; Danovsky, M.B. and Lourie, K.J. et. al. (1997). Adolescents with psychiatric disorders and the risk of HIV. *Journal of American Academy of Child and Adolescent Psychiatry, 36*, 1609-1617.

Bryant, R.A. & Harvey, A.G. (1995). Processing threatening information in posttraumatic stress disorder. *Journal of Abnormal Psychology, 104*, 537-541.

Cahill L.T., Kaminer R.K. & Johnson P.G. (1999) Developmental, cognitive, and behavioral sequelae of child abuse. *Child and Adolescent Psychiatry Clinic of North America, 8* (4), 827-843.

Carlsson, U. (1999), "Child pornography on the internet: Research and information", News on Children and Violence on the Screen, Vol.3, No.1, pp.4–5.

Carrey N.J.; Butter H.J.; Persinger M.A. & Bialik R.J. (1995) Physiological and cognitive correlates of child abuse. *Journal of American Academy of Child & Adolescent Psychiatry, 34* (8), 1067-1075.

Cohen, J.A. & Mannarino, A.P. (1988).Psychological symptoms in sexually abused girls. *Child Abuse & Neglect, 12*(4), 571-577.

Corby, B. (1993), *Child Abuse – Towards A Knowledge Base*, Open University Press.

DeFronzo, J.; Pawlak, R. (1993). Effects of social bonds and childhood experiences on alcohol abuse and smoking. *Journal of Social Psychology, 133*(5) 635-642 .

Denver, M. (1961). Protective services and emotional neglect. *The American Human Association,* pp. 6-7.

Devor, H. (1994). Transsexualism, dissociation, and child abuse: An initial discussion based on non-clinical data. *Journal of Psychology & Human Sexuality, 6*(3) 49-72.

Dubner, A.E. and Motta, R.W. (1999). Sexually and physically abused foster care children and posttraumatic stress disorder. *Journal of Consulting & Clinical Psychology, 67* (3), 367-373.

Encyclopaedia of Crime and Justice (1983). Volume-3, New York: Free Press, 1080-1081.

Faruquie, D.S. & Ahmad, H. (2002). Moral judgement and moral practice amongst abused working children. Paper presented at *89th Indian Science Congress Association,* Lucknow, India.

Finkelhor, D. & Dziuba-Leatherman, J. (1994). Victimisation of children. *American Psychologist, 49*, 173-183.

Foa, E.B.; Feske, U.; Murdock, T.B.; Kozak, M.J. & McCarthy, P.R. (1991). Processing of threat related information in rape victims. *Journal of Abnormal Psychology, 100*, 156-162.

Gil, D. (1968). Incidences of child abuse and demographic characteristics of persons involved. In Helfer & Kempe (eds.) *The Battered Child*, Chicago: Univ. of Chicago, pp. 20.

Gilles, E.E. (1999). Integrating a neurobiological system approach into child neglect and abuse theory and practice. *Children's Health Care, 28*(2), 167-187.

Gomez-Schwartz, B., Horowitz, J.M. & Cardarelli, A.P. (1990). *Child sexual abuse: Initial effects.* Newbury Park, California: Sage.

Gomez-Schwartz, B., Horowitz, J.M. & Sauzier, M. (1985). Severity of emotional distress among sexually abuse preschool, school-age and adolescent children. *Hospital and Community Psychiatry, 36*, 503-508.

Harley, R.D. (1980). Ocular manifestations of child abuse. *Journal of Pediatrics Opthalmology Strabismus*, 17 (5).

Holmes, T.R.(1995).History of child abuse: A key variable in client response to short-term treatment. *Families in Society, 76*(6) 349-359.

Hudson, P.S.(1990).Ritual child abuse: A survey of symptoms and allegations. *Journal of Child & Youth Care,* Special Issue, 27-53.

Jessee S.A.(1995).Orofacial manifestations of child abuse and neglect. *American Family Physician, 52* (6), 1829-1834.

Jill, K. (1981). *Child abuse and neglect: Cross-cultural perspectives,* Berkeley, University of California Press.

Kempe', C.H.; Silverman, F.H.; Steele, B.F. et.al. (1962). The battered child syndrome. *Journal of American medical association, 181* p. 105.

Kempe', R.S. and Kempe', C.H. (1978). *Child abuse*. London, Fontana.

Kendall-Tackett, K.A.; Williams, L.M. and Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*,164-180.

Kissinger, P.; Clark, R.A. and Abdalian, S.E. (1997). Psychosocial characteristics of HIV-infected adolescents in New Orleans. *Journal of Adolescent Health, 20,* 258.

Koss, M. and Harvey, M. (1991). *The rape victim: Clinical and community interventions.* Newbury Park, California: Sage Publications.

Kratcoski, P.C. and Kratcoski, L.D. (1979). *Juvenile delinquency*, New Jersey, Prentice-Hall.

Laszlo, A.; Burgess, A. and Grant, C. (1991). HIV counselling issues and victims of sexual assault. In: A. Burgess (Ed.) *Rape and Sexual Assault III.* New York: Garland Publishing.

Lupton, C.; Khan, P. and Lacey, D. (1997). *Concerted action on the prevention of child abuse in Europe: Workpage 3.* Social Services Research and Information Unit, University of Portsmouth, U.K.

Morissette, P.J. (1999) Post-traumatic stress disorder in childhood sexual abuse: A synthesis and analysis of theoretical models. *Child & Adolescent Social Work Journal, 16*(2), 77-99.

Narang, D.S. and Contreras, J.M.(2000). Dissociation as a mediator between child abuse history and adult abuse potential. *Journal of Child Abuse and Neglect, 24* (5), 653-665.

Parke, R.D. and Collmer, C.W. (1975). *Child Abuse: An interdisciplinary analysis.* Chicago, University of Chicago Press.

Petrak, J.; Byrne, A. and Baker, M. (2000). The association between abuse in childhood and STD/HIV risk behaviours in female genitourinary (GU) clinic attendees. *Sexually Transmitted Infections, 76*, 457-461.

Pierce, R.L. (1984). Child pornography: A hidden dimension of child abuse. *Child Abuse and Neglect, 8*(4), 483-493.

Quayle, E. and Taylor, M. (2001) Child seduction and self-representation on the internet. *Cyber Psychology and Behaviour*, *4*(5) 597-608.

Raskin, M.; Nurnberg, H. G.; Prince, R.; Fine, J.; et al (1989). Abuse of the child and anxiety in the adult. *New York State Journal of Medicine, 89*(3), 138-140.

Ratna, L. and Mukergee, S. (1998). The long-term effects of childhood sexual abuse: Rationale for and experience of pharmacotherapy with nafazodone. *International Journal of Psychiatry in Clinical Practice, 22* (2), 83-95.

Read, J. and Argyle, N. (1999). Hallucinations, delusions, and thought disorder among adult psychiatric inpatients with a history of child abuse. *Psychiatric Services, 50* (11), 1467-1472.

Saunders, B.E; Kilpatrick, D.G.; Hanson, R.F.; Resnick, H.S. et.al. (1999). Prevalence, case characteristics, and long-term psychological correlates of child rape among women: A national survey. *Child Maltreatment: Journal of American Professional Society on the*

abuse of Children, 4 (3), 187-200.

Segal U.A. & Ashtekar A. (1994). Detection of intrafamilial child abuse: children at intake at a children's observation home in India. *Child Abuse & Neglect, 18* (11) 957-967.

Segal U.A. (1995) Child abuse by the middle class? A study of professionals in India. *Child Abuse and Neglect 19* (2), 217-31.

Sheldon, H. and Bannister, A. (1998). Working with adult female survivors of childhood sexual abuse. A. Bannister (Ed.), In: *From hearing to healing: Working with the aftermath of child sexual abuse (2nd ed.).* New York: John Wiley and Sons, 96-117.

Stevenson, J. (1999). The treatment of the long-term sequelae of child abuse. *Journal of Child Psychology and Psychiatry, 40* (1) 89-111.

Straus, M.A. and Kantor, G.K. (1994) Corporal punishment of adolescents by parents: a risk factor in the epidemiology of depression, suicide, alcohol abuse, child abuse, and wife beating. *Adolescence, 29* (115), 543-561.

VanFleet, R.; Lilly, J.P. and Kaduson, H. (1999) Play therapy for children exposed to violence: Individual, family and community interventions. *International Journal of Play Therapy, 8*(1), 27-42.

Von Burg M.M.; Hibbard R.A.(1995).Child abuse education: do not overlook dental professionals. *ASDC Journal of Dentistry for Children, 62*(1), 57-63.

Von Burg M.M.and Hibbard R.A.(1995a).Munchausen syndrome by proxy: a different kind of child abuse. *Indiana Medicine, 88* (5) p378-82.

Widom, C.S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Psychiatry, 156* (8), 1223-1229.

Wingood, G.M. and DiClemente, R.J. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African American women. *American Journal of Public Health, 87*, 1016-1018.

Zierler, S.; Feingold, L. and Laufer, D. et. al. (1991). Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. *American Journal of Public Health, 81*, 747-761.

Zillmann, D. (1989). Effects of prolonged consumption of pornography. In Zillmann, D. and Bryant, J. (Eds.), *Pornography: Research advances and policy considerations.* New Jersy: Hillside, 127-157.

Zlot SI, Herrmann M, Hofer-Mayer T, Adler M, Adler RH (2000). Childhood experiences and adult behaviour in a group of women with pain accounted for by psychological factors and a group recovered from major depression. *International Journal of Psychiatry and Medicine; 30* (3): 261-75.

****