Exploring psychological abuse in childhood: II. Association with other abuse and adult clinical depression

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A new retrospective interview assessment of childhood psychological abuse, an extension to the Childhood Experience of Care and Abuse (CECA) instrument, is described in a companion article (Moran, Bifulco, Ball, Jacobs, & Benaim, 2002). The purpose of the present article is to examine the relationship of childhood psychological abuse to other adverse childhood experiences and to major depression and suicidal behavior in adult life. Childhood experience and lifetime disorder were assessed retrospectively in a high-risk, community series of London women (n = 204). Psychological abuse from parents was examined in relation to seven other parental behaviors (neglect, antipathy, role reversal, discipline, supervision, physical abuse, and sexual abuse). Psychological abuse was significantly related to all seven behaviors. The highest associations found were to antipathy (gamma = .76), neglect (.73), and sexual abuse (.72). Factor analysis showed the existence of two factors reflecting care and control, with psychological abuse associated with both factors. Childhood psychological abuse was highly related to chronic or recurrent adult depression, with a “dose-response”
evident for severity of abuse. The rates ranged from 83% for “marked” to 55% for “mild” abuse and 37% for “little/no” psychological abuse (p < .002). Psychological abuse was also related to lifetime suicidal behavior but here any level of abuse from marked to mild had similar rates (36% overall vs. 18% with no psychological abuse, p < .04). There was no evidence of specificity of childhood experience to adult depression; nearly all types of childhood adversity examined were significantly related. An analysis using an index of multiple abuse, including psychological abuse, showed a clear dose-response relationship to disorder. Somewhat fewer forms of maltreatment were related to suicidal behavior, but again multiples showed a clear dose-response effect. (Bulletin of the Menninger Clinic, 66[3], 241-258)

It is now well established that neglect and abuse in childhood increases risk for psychiatric disorder in adulthood (e.g., Bifulco, Brown, & Harris, 1994; Briere & Runtz, 1990; Mullen, Romans-Clarkson, Walton & Herbison, 1988; Parker et al., 1997). It is, however, only relatively recently that studies have examined more than one type of abuse simultaneously. These studies have tended to find relatively little specificity between types of abuse and disorder outcomes, but they have found multiple abusive experience to be consistently associated with higher rates of disorder (Bifulco & Moran 1998; Clausen & Crittenden, 1991; Mullen, Martin, Anderson, Romans, & Herbison, 1996). Where specificity is demonstrated, it tends to be in terms of intervening variables, particularly different emotional-cognitive effects such as aggression versus low self-esteem (e.g., Briere & Runtz, 1990). The search for specificity of type of abuse to type of disorder is often confounded by the high association of different types of childhood abuse. To continue the search, and to gain more precision in examining threshold effects of multiple abuse, it is necessary to ensure broad coverage of abusive experience. It is only recently that psychological abuse has been added to the list of types of childhood maltreatment, such as neglect, physical abuse, and sexual abuse. Debate about the correct definition and operationalization of psychological abuse has delayed its systematic investigation compared to other types of maltreatment, which have achieved greater consensus in definition. Thus the long-term effects of psychological abuse on adult psychopathology are yet to be fully investigated.

Although speculation based on case studies and clinical observation has led several authors to hypothesize that psychological maltreatment may lead to depression, low self-esteem, conduct disorders, with-
drawal, and enuresis in children (e.g., Garbarino, Guttman, & Seeley, 1986; Hart & Brassard, 1991; Navarre, 1987; Stone, 1993) without long-term follow-up of samples, it is unclear whether the negative impact of such maltreatment endures into adulthood. Of the few studies that have examined the association between childhood psychological abuse and adult outcomes, Briere and Runtz (1988) demonstrated that such abuse is associated with a range of disorders, such as somatizing, anxiety, depression, interpersonal sensitivity, obsessive-compulsive disorder, dissociation, and suicidal ideation. Similarly, Rorty, Yager, and Rossotto (1994) reported that a history of psychological abuse and multiple abuse increased the likelihood of lifetime comorbid Axis I disorders and personality disorders among bulimic patients compared to a control group of women without eating disorder. A link with borderline personality disorder has also been shown by Park and colleagues, who found that 100% of their borderline personality patients had experienced psychological abuse in childhood compared with 32% of other patients (Park, Imboden, Park, Hulse, & Unger, 1992).

A number of studies have focused specifically on the association between psychological abuse in childhood and depression and suicidal tendencies in adult life. For example, higher Beck Depression Inventory scores (BDI; Beck, 1967) were reported by students with a history of both psychological abuse and physical abuse in childhood compared to those who reported only one or the other type of abuse (Gross & Keller, 1992). Childhood psychological abuse in the form of “emotional deprivation” was shown to relate to depressive illness and suicidal behaviors in adulthood in a sample of community-based women (Mullen et al., 1996). An association between abuse and suicidal behaviors was also reported by Bryant and Range (1995), but this proved to be largely because women who reported sexual abuse in combination with other forms of maltreatment, including psychological abuse, were significantly more suicidal than those who were not maltreated or those who reported other types of maltreatment. Thus it would appear that psychological abuse in combination with other abuses has the most damaging long-term effect on suicidal behavior.

Although most of the literature reports a positive association between childhood psychological abuse and adult disorder, several methodological weaknesses limit the conclusions that can be drawn from such studies. The first concerns definition and measurement. The studies reviewed have typically used a variety of means of assessing psychological abuse, and the extent to which these measures are successfully tapping the construct they purport to measure, rather than related aspects of childhood maltreatment, are questionable. For example, Mullen and colleagues (1996) used scores falling one standard devia-
tion above the mean on both subscales of the Parental Bonding Instrument (PBI, Parker, Tupling & Brown, 1979) to indicate childhood psychological abuse, despite these being previously categorized as “affectionless control” indicating lack of care and overprotection. This method of defining psychological abuse is relatively nonspecific, and its overlap conceptually with other aspects of poor child care (such as neglect or discipline) is likely to make it overinclusive. Park and colleagues (1992) similarly used a scale of psychological abuse that included neglectful behaviors and relatively mild levels of adverse parental behaviors such as “non-recognition of the child’s special access to intuitive insights” (p. 20), which is also likely to be overinclusive. Thus reported associations between personality disorder and scores on this measure may be partly reflecting a relationship between disorder and neglect or maltreatment in general rather than psychological abuse per se.

In addition to lack of consensus regarding which perpetrator behaviors should be included in a measure of psychological abuse, there are also problems regarding the self-report nature of most scales. This can lead to biases in reporting due to effects of disorder itself on recall or to ignorance of the psychological abuse concept. With self-report questionnaires, the meaning of items and response scale points are open to differential and idiosyncratic interpretation by respondents. This problem can be minimized if investigator-based interview assessments are used, such as the Childhood Experience of Care and Abuse (CECA; Bifulco et al., 1994). Responses to extensive questioning on objective, behavioral details are here taken as evidence for maltreatment. The instrument has the facility for being used together with reports from other family members, so evidence for maltreatment does not always rely solely on the respondent’s account (Bifulco, Brown, Lillie, & Jarvis, 1997). The same thresholds for inclusion and severity of maltreatment are applied by the investigator systematically across the whole sample. Investigator ratings are made on the basis of training in precedent examples and panel (consensus) discussion of ratings. An added advantage of the investigator-based approach for the present retrospective study is that any bias in reporting of childhood history that might arise due to the effects of depressed mood is reduced (Brewin, Andrews, & Gotlib, 1993).

Another criticism of studies assessing psychological abuse in relation to depressive disorders is that outcome measures do not always assess depression at severe enough levels to be clinically significant (e.g., Gross & Keller, 1992). Studies are often based on student populations using self-report symptom scales, may merely reflect levels of dysphoria or distress. Where studies have used diagnostic clinical interviews, sample
sizes have tended to be small and the findings less generalizable to a larger sample or community-based sample (e.g., Stone, 1993).

The proposed study set out to investigate the association of childhood psychological abuse with depression and suicidal behaviors across the adult life course in a selected high-risk sample of community-based women. Investigator-based interview measures were used of childhood experience, with parallel clinical interviews for adult disorder from age 17 to interview. The CECA childhood interview included a new scale to assess psychological abuse, details of which are given in the companion article (Moran, Bifulco, Ball, Jacobs, & Benaim, 2002) alongside other forms of childhood maltreatment, including poor care (neglect, role-reversal, antipathy, lax supervision), control (discipline, physical abuse), and sexual abuse.

Specifically it was hypothesized that:

1. Psychological abuse would be highly related to other forms of adverse childhood experience.
2. More severe childhood psychological abuse would be associated with greater risk for adult depression and suicidality. Psychological abuse would add to prediction over and above antipathy from parents.
3. Multiple abuse in childhood, including psychological abuse, would relate to higher rates of disorder in adulthood.

METHOD

Sample
Two hundred and four community-based women were selected by questionnaire from registered general practitioner physician lists in Islington, North London, UK. The women selected were interviewed in depth about their childhood experience and adult disorder. The sample formed part of a program of research investigating vulnerability to lifetime clinical depression in different high-risk community groups. The vulnerability factors investigated had previously been identified in a large prospective, representative study of London women (Brown, Bifulco, & Andrews, 1990). The first group ($n = 105$) was selected by questionnaire screening (Vulnerability to Depression Questionnaire [VDQ]; Moran, Bifulco, Ball, & Campbell, 2001) for adult vulnerability in terms of either low self-esteem, negative interaction with partner or child, or lack of a close confidant at first contact (Bifulco, Brown, Moran, Ball, & Campbell, 1998). (See Figure 1 for full details of compliance rates.) The second group ($n = 98$) was selected for childhood vulnerability in terms of neglect or antipathy from mother before age
17, or positive response to an open question about maltreatment (CECA.Q; Bifulco, Bernazzani, Moran, & Jacobs, 2002; Bifulco et al., 1997). The third group \((n = 40)\) formed a comparison series of consecutive questionnaire responders unselected for either type of vulnerability. Although a sister of each of the women in the second and third groups \((n = 98)\) was interviewed for purposes of collaboration of childhood accounts (Bifulco et al., 1997), these were excluded from this analysis to avoid confounding any extraneous familial or genetic factors with those assessed in the study.

To summarize compliance: 45% responded to initial screening questionnaires after reminders, a figure consistent with prior surveys that rises to 70% when those misregistered with health practices in the locality are excluded (Brown, Craig, & Harris, 1985). Once demographic and risk characteristics were identified on returned questionnaires, 64% \((204/321)\) of suitable women approached agreed to complete the full interview, 21% \((68/321)\) refused, and 15% \((49/321)\) proved unobtainable when approached. In terms of demographic characteristics of the final 204 women, the average age was 35 (range 19-53). Over half \((60\%)\) were middle class at interview, and 67% were working part or full time at interview. Over half \((61\%)\) were married/cohabiting and most \((77\%)\) had children. Overall, a fifth were bringing up their children without a live-in partner.

**Measures**

All women were questioned about their childhood and adult experiences in detail. A full childhood interview examined a range of experiences, including psychological abuse before age 17. Adult experiences were questioned about in terms of life phases and adult adversity (Bifulco, Bernazzani, Moran, & Ball, 2000) together with an adult lifetime assessment of clinical depression and suicidal behavior. Information about the former helped to probe more fully for instances of depressive disorder and determine sequence and timing of these, but is not reported on here.

**Present State Examination (PSE; Wing, Cooper & Sartorius, 1974) and Schedule for Clinical Assessment in Neuropsychiatry (SCAN; Wing et al., 1990).** Clinical depression was assessed in terms of the PSE to cover a 12-month recent period and then extended using questions from the SCAN version to cover lifetime experience of depression from age 17. DSM-III-R criteria for major depression were used (American Psychiatric Association, 1987). A third of all episodes were deemed chronic in terms of 12 months continuous duration. To reflect depression over the life span, an index was compiled of the presence of either chronic de-
expression (12 months or more) or recurrent depression (two or more episodes) after the age of 17 up until interview.

Suicidal plans and acts were included in the assessment of lifetime depression. To be included, these had to involve actual suicide attempts or concrete plans for committing suicide, not just fleeting thoughts of suicide or death.

*Childhood Experience of Care and Abuse (CECA, Bifulco et al., 1994).* A semistructured childhood interview assessed key experiences of neglect and abuse before age 17. Investigator-based judgments were made of the presence and severity of neglect/abuse, with definitions given in the companion article (Moran, Bifulco, Ball, Jacobs, & Benaim, 2002).

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**Figure 1.** Sample selection: Women selected through family practitioner patient lists by screening questionnaire. *Sister groups excluded from this analysis.*
The scales were rated separately for mother and father (or surrogate parent) relationship with the child. Neglect was based on parental indifference to the child’s material care, health, schoolwork, friendships, and career. This was rated for biological parents and parent substitutes. Antipathy consisted of hostile, critical, or cold parental behavior. Role reversal was when child was obliged to take over parental responsibilities in terms of household duties or acting as support to the parent. Discipline consisted of enforcing rules of behavior with regard to socializing, clothing, smoking and drinking, and schoolwork. Supervision concerned the extent to which parents monitored the child’s behavior to maintain safety with regard to being left home alone or returning at a reasonable hour in the evening. Physical abuse consisted of attacks on the child by household members, mainly parent figures but also including older siblings and other live-in adults. This included repeated attacks with implements, serious beatings, or repeated punching or kicking. Sexual abuse was defined in terms of sexual contact with adults, whether in the household or not. Repeated instances of touching of breasts or genitals were included, plus any instance of sexual intercourse with an adult, including single incidents of rape. All experiences were rated on a 4-point scale of marked, moderate, mild or little/no severity. Psychological abuse definitions are given in the companion article (Moran et al., 2002). Instances of coercive control by parental figures or others were included as psychological abuse if they involved humiliation, terrorizing, cognitive disorientation, deprivation of basic needs, deprivation of valued objects, extreme rejections, corruption, or blackmail. Ratings on each of the subcategories was made, as well as an overall severity rating on a 4-point scale.

For the correlational and factor analysis, ratings of such experiences by each parent or surrogate parents are included, thus totaling two or more scores per subject. For the analysis examining adult disorder, peak experiences of each type of experience are included, thereby each respondent is reflected only once in the analysis. For this latter analysis only, this included some instances of abuse (sexual, physical, or psychological) by noncaregivers.

Reliability of the CECA measure is satisfactory and is reported elsewhere (Bifulco et al., 1994). Validity in terms of sisters reporting on their own and each other’s experiences also reached a high level of agreement when tested on the same series (Bifulco et al., 1997).

Parental Bonding Instrument (PBI; Parker et al., 1979). The PBI questionnaire was distributed to the 99 women in the Child Risk and Comparison series at the end of the interview, with 87% (86/99) returning the questionnaire by mail. This was completed separately for mother
figure and father figure (n = 171) and covered typical care and control in childhood. Affectionless control was determined by scoring below the average on Care items and above the average score on Control items.

**Data Analysis**

SPSS 9 was used for statistical analyses. Gamma and Pearson r correlations were used to examine the association of psychological abuse to other childhood experiences. Factor analysis, using principal components and varimax rotation, was used to examine the interrelationship of childhood scales. Chi-square tests, with Yates correction, were conducted to examine significance of relationships of psychological abuse and adult disorder. Binary logistic regression was used to examine the contribution of different childhood experiences to disorder outcomes.

**Results**

**Relationship of psychological abuse to other forms of maltreatment**

The relationship of psychological abuse to other CECA scales and to the PBI Care and Control scales is shown in Table 1. For this analysis, experiences from mother/surrogate mother and father/surrogate father were separately assessed and all included. The total numbers therefore came to 418 separate ratings for the 198 women. However, the PBI was only available for 171. The full 4-point CECA scales were used. It can be seen that the highest association of psychological abuse (using gamma) was with antipathy (.76), neglect (.73), and sexual abuse (.72).

<table>
<thead>
<tr>
<th>Childhood Experience</th>
<th>Gamma</th>
<th>p &lt;</th>
<th>Pearson’s r</th>
<th>p &lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipathy from parent</td>
<td>.76</td>
<td>.000</td>
<td>.32</td>
<td>.000</td>
</tr>
<tr>
<td>Parental neglect</td>
<td>.73</td>
<td>.000</td>
<td>.27</td>
<td>.000</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>.72</td>
<td>.05</td>
<td>.15</td>
<td>.002</td>
</tr>
<tr>
<td>Discipline</td>
<td>.68</td>
<td>.000</td>
<td>.21</td>
<td>.000</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>.68</td>
<td>.000</td>
<td>.24</td>
<td>.000</td>
</tr>
<tr>
<td>Role reversal</td>
<td>.38</td>
<td>.02</td>
<td>.16</td>
<td>.008</td>
</tr>
<tr>
<td>Supervision</td>
<td>-.27</td>
<td>NS</td>
<td>-.05</td>
<td>NS</td>
</tr>
<tr>
<td>PBI Care#</td>
<td>.36</td>
<td>.06</td>
<td>.16</td>
<td>.03</td>
</tr>
<tr>
<td>PBI Control#</td>
<td>-.22</td>
<td>NS</td>
<td>-.07</td>
<td>NS</td>
</tr>
<tr>
<td>PBI affectionless control#</td>
<td>.22</td>
<td>NS</td>
<td>.02</td>
<td>NS</td>
</tr>
</tbody>
</table>

*Note. n = 418 including each parental figure. Abuse from nonparental figures excluded. PBI = Parental Bonding Instrument; NS = not significant. #N = 171.*
This was closely followed by discipline and physical abuse (.68). Lower associations were shown with role reversal and supervision. There was a modest association with PBI Care (.36) but no significant association with PBI Control or with affectionless control.

A factor analysis was run twice, once on the full series and again for the two thirds of the series who had the PBI assessed. Results were essentially the same, so the figures for the latter are given to include PBI scores. Factor analysis showed the presence of two factors reflecting care and control (see Table 2). The first factor mainly loaded on neglect (.80) and PBI Care (0.71), followed by lax supervision (-.65), antipathy (.63), and role reversal (.58). The second factor had highest loading for discipline (.74) and PBI Control (.75), followed by supervision (.51). In terms of abuse, sexual abuse loaded on the care factor (.31), with physical abuse on control (.51), but the latter also loaded on the care factor (.47). Psychological abuse similarly loaded on both factors (.36 and .22, respectively).

The overlap of psychological abuse and other highly loaded care items (neglect and antipathy) was examined and showed that psychological abuse almost totally overlapped with the other two. In fact, there was only one instance of psychological abuse at the marked/moderate level that did not co-occur with neglect or antipathy at the same levels. Therefore psychological abuse is almost never unaccompanied by other types of maltreatment in this series.
Psychological abuse and adult disorder

Severity of psychological abuse was examined in relation to an adult history of chronic or recurrent depression, and lifetime suicidal behavior (see Table 3). A “dose-response” effect was clearly evident in the association with chronic or recurrent major depression, with rates from 83% at marked to 55% at mild levels. Psychological abuse also related to suicidal behavior, but here any level of abuse seemed to relate equally (36% with marked to mild psychological abuse had suicidal behavior vs. 18% with little/none, $p < .04$).

To test for bias from current symptomatology, the relationship of psychological abuse to prior recurrent depression was repeated, excluding those 18 women with major depression at interview. The same results held, with 80% (8/10) marked, 70% (7/10) moderate, 54% (6/11) mild, and 31% (48/158) little/no psychological abuse having chronic/recurrent major depression ($p < .001$). In order to control for possible bias in recall of lifetime depressive disorder, the association was reexamined in terms of psychological abuse and depression in the year before interview. The relationship was again confirmed, with 59% (13/22) of those with marked or moderate psychological abuse being depressed in the year prior to interview versus 30% (54/181) of the remaining women ($p < .005$).

Psychological abuse, other neglect/abuse and disorder

Nearly all the childhood forms of maltreatment examined were significantly related to lifetime chronic/recurrent major depression, apart from discipline (OR = .63, ns) and supervision (OR = .57, ns). When dichotomized at marked/moderate versus mild/little-none levels, odds ratios reached 3.61 for role-reversal ($p < .001$), 2.88 for neglect ($p < .001$), 2.76 for physical abuse ($p < .001$) and 2.00 for sexual abuse ($p < .02$). An index of any one of these reached an odds ratio of 3.58 ($p < .0001$). Antipathy from either parent reached an odds ratio

<table>
<thead>
<tr>
<th>Peak severity of psychological abuse</th>
<th>Lifetime chronic or recurrent depression % (n)**</th>
<th>Lifetime suicidal behavior % (n)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marked</td>
<td>83 (10/12)</td>
<td>42 (5/12)</td>
</tr>
<tr>
<td>Moderate</td>
<td>70 (7/10)</td>
<td>20 (2/10)</td>
</tr>
<tr>
<td>Mild</td>
<td>55 (6/11)</td>
<td>46 (5/11)</td>
</tr>
<tr>
<td>Little/none</td>
<td>37 (62/170)</td>
<td>18 (30/170)</td>
</tr>
</tbody>
</table>

Note. N = 201 subjects; Three missing values. *$p < .04$, **$p < .002$. 

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of 2.61 ($p < .001$), with psychological abuse reaching the highest odds ratio at 5.66 ($p < .0001$).

To test whether psychological abuse added to prediction over and above the other related adverse experiences, an index was created of marked or moderate neglect, role reversal, physical abuse, or sexual abuse. This was entered in a logistic regression together with antipathy from either parent and psychological abuse (see Table 4A). Psychological abuse added to prediction of lifetime recurrent major depression in addition to the index, but antipathy did not add to the model.

When suicidal behavior was examined, those childhood factors unrelated were discipline (OR = 1.48, ns), supervision (OR = 1.08, ns), neglect (OR = 1.54, ns) and role-reversal (OR = 1.56, ns). Of those with a significant relationship, sexual abuse had the highest odds ratio of 3.35 ($p < .001$), with physical abuse at 2.62 ($p < .007$). An index of either physical or sexual abuse reached an odds ratio of 3.41 ($p < .0001$). Antipathy from either parent had an odds ratio of 2.92 ($p < .003$); psychological abuse was 2.71 ($p < .01$). Logistic regression showed that neither psychological abuse nor antipathy added to the index of physical or sexual abuse in adding to prediction (see Table 4B).

**Number of types of maltreatment and disorder**

To examine multiple types of abuse on adult disorder, an index was created summing the six different experiences individually relating to chronic/recurrent depression. These were neglect, role reversal, physical abuse, sexual abuse, psychological abuse, and antipathy. A score of

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds-ratio</th>
<th>Wald</th>
<th>$p &lt;$</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Logistic regression: Chronic/recurrent adult depression outcome $^a$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>0.59</td>
<td>5.44</td>
<td>.01</td>
</tr>
<tr>
<td>Antipathy from either parent</td>
<td>1.21</td>
<td>1.58</td>
<td>NS</td>
</tr>
<tr>
<td>Neglect, role reversal, physical or sexual abuse index</td>
<td>2.51</td>
<td>6.55</td>
<td>.01</td>
</tr>
<tr>
<td>B. Logistic regression: Suicidal behavior outcome $^b$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>1.04</td>
<td>0.01</td>
<td>NS</td>
</tr>
<tr>
<td>Antipathy either parent</td>
<td>1.68</td>
<td>1.50</td>
<td>NS</td>
</tr>
<tr>
<td>Physical or sexual abuse</td>
<td>2.18</td>
<td>7.51</td>
<td>0.006</td>
</tr>
</tbody>
</table>

$^a$In terms of goodness of fit, 65% of subjects correctly classified. $^b$In terms of goodness of fit, 79.3% of subjects were correctly classified. NS = not significant.
1 was made for each experience present at marked or moderate levels, thus entailing a range of 0-6. Table 5a shows a clear dose-response effect for multiples of maltreatment and adult disorder ranging from 76% for the maximum 5-6 types of maltreatment to 40% for 1-2 types and 21% for no maltreatment ($p < .0001$).

A similar index was created in relation to suicidal behavior for those experiences individually relating to disorder. This included physical abuse, sexual abuse, psychological abuse, and antipathy. Again, a score of 1 was given for any experience present at marked or moderate levels, with a range of 0-4 possible. A clear dose-response effect occurred ranging from 58% with all four experiences to 14% with one alone, compared to 9% for no form of maltreatment ($p < .0001$) (see Table 5b).

**DISCUSSION**

Psychological abuse in childhood and adolescence proved to be highly correlated with other forms of maltreatment as assessed in this selected high-risk series of UK community women. It was particularly highly correlated with neglect and antipathy from parents, with which it had elements in common, but also with sexual abuse, with which it often co-occurred. It seldom occurred alone in this series. When factor-analyzed, psychological abuse was shown to load on both Care and Control factors. The high degree of overlap of psychological abuse with other types of maltreatment has implications for analyzing its relationship to adult disorder. Given that it rarely occurs in isolation, its presence is also a marker for combinations of maltreatment. Psychological abuse proved to be highly related to chronic/recurrent lifetime adult de-
pression, together with most of the other forms of maltreatment assessed. However, logistic regression showed that psychological abuse added to prediction of disorder over and above other neglect and abuse. This did not hold for antipathy from parents. Psychological abuse also showed a modest but significant relationship to lifetime suicidal behavior, but this failed to add to the model of disorder in logistic regression once physical or sexual abuse were examined simultaneously. Antipathy similarly failed to add to prediction over and above physical or sexual abuse.

Examining multiples of abusive experience did yield fairly clear results. An index of six types of abusive experience in childhood, which all individually related to depression (neglect, role reversal, physical abuse, sexual abuse, antipathy, and psychological abuse), showed a dose-response relationship to chronic/recurrent depression. This suggests that multiples of abusive experience are more predictive of outcomes such as depression than any one specific type of maltreatment, including psychological abuse. A similar result held for suicidal behavior, where summing physical abuse, sexual abuse, psychological abuse, and antipathy showed a dose-response relationship to disorder.

The study reported here has a number of limitations. First, the sample is highly selective; not only does it select for psychosocial risk factors, but it also includes only women and those in midlife. The results therefore need replication in representative series. Second, given the association between psychological abuse in childhood and adult personality disorder identified in the research literature, the measure ideally needs to be studied with a wider range of disorder outcome variables and in series selected for disorders such as personality disorder in order to test its wider applicability and for specificity of disorder effects. Third, the concurrent use of additional alternative measures of psychological abuse would help to mark out where the CECA scale fits in relation to self-report assessments. The use of the Parental Bonding Instrument for two thirds of this series showed little association with the psychological abuse scale. However, it was highly related to both care and control factors generated by the CECA interview. Finally, the assessment of both childhood maltreatment and disorder were both conducted retrospectively, which may have led to bias in reporting, despite careful procedures to minimize such bias.

However, because the measurement and study of psychological abuse is still relatively unestablished, there are certain merits to undertaking retrospective study, and that in selected series. First, there are fewer ethical issues in studying abuse that has been terminated at time of study, having occurred a number of years previously rather than that
ongoing with younger children. Thus the individual is more at liberty to be open without fearing negative consequences or reprisals. Second, with careful measurement to minimize bias in reporting, the long-term consequences can be assessed at the same time as the childhood experience, allowing for a simultaneous analysis, which would otherwise take many years to collect. This can then be used to inform ongoing longitudinal work. Third, cohort effects may mean that retrospective assessment is the only way of investigating the childhood experience of individuals who are adults now and whose abusive experiences happened some decades earlier, when rates of official intervention were low. No one yet knows the full effects of modern legislation and intervention policies on the consequences of abuse, or how it affects its form, duration, or prevalence. It is hoped that this will result in lower prevalence and more speedy termination of abuse. But unforeseen negative consequences might also arise. Anecdotal evidence from the present series suggests that abusers at times reverted to psychological abuse as an undercover abuse when physical or sexual abuse was no longer an option because of detection.

The search for specificity of effects of psychological abuse, and other forms of maltreatment, may be better sought in future investigations in two ways: first, in differentiating factors intervening between the childhood experience and adult disorder, and second, in comparing different types of adult disorder and comorbid conditions. In terms of intervening factors with depressive outcomes, both cognitive and social-environmental factors have been differentiated in life span models of depression (Harris, Brown, & Bifulco, 1990). In terms of cognitive factors, helplessness, low self-esteem, and avoidant attachment styles have been identified as central cognitive mechanisms in mediating childhood effects of abuse and adult depression (op cit; Bifulco, Moran, Ball, & Bernazzani, 2002; Bifulco, Moran, Ball, & Lillie, 2002). The second strand of the model involves those events that determine future adverse pathways such as teenage pregnancy, pregnancy loss, divorce/separation, employment routes, and long-term adult adversity as environmental mediators (Bernazzani & Bifulco, in press; Bifulco et al, 2000; Harris et al, 1990). Further investigation is required to formulate life span models differentiating elements of childhood experience such as psychological abuse in terms of branching environmental pathways as well as different cognitive styles in adulthood. Specific adult vulnerabilities could thus be examined in relation to different childhood experiences or their combinations and different disorder outcomes.

This exploration of the effects of psychological abuse in relation to depressive disorder outcomes has important intervention implications.
In terms of the five stages identified in prevention/intervention research cycle, this report contributes to the first two stages (defining problem and reviewing risk data) (Black et al., 2001). It has tested an operational definition of psychological abuse, as contrasted with other forms of maltreatment, in relation to adult depression and suicidality. This can serve to aid social workers, clinicians, and other practitioners with its definition and recognition. Its common co-occurrence with other types of abusive experience should alert practitioners to the need for questioning about its presence, even when other criteria for abuse are fulfilled, in order to correctly determine multiples of abuse.

References


physical maltreatment among university women. Child Abuse and Neglect, 12, 331-341.


