

Section



Early life trauma: impact on health and disease



Childhood trauma: epidemiology and historical themes

The history of early life trauma and abuse from the 1850s to the current time: how the past influences the present

Martin J Dorahy, Onno van der Hart and Warwick Middleton

...there are few topics in modern life that are more repugnant to consider than the abuse of a child by the very persons entrusted with his care

K. B. Oettinger (1968, p. v) [1]

While the etiological significance of early trauma and abuse for mental health difficulties has long been on the periphery of psychological thought, it has rarely taken center stage. On those occasions where it has drawn interest (e.g., the 1890s), the importance of early trauma and abuse has been resisted, rebuked and recanted, leaving its prominence to dwindle. Understanding the history of early trauma and abuse requires an appreciation of the social and political processes that govern society [2]. To limit early trauma and abuse of children to enactments by adults seeking satisfaction for perverse desires de-emphasizes societal attitudes and decrees responsible for much of the harsh and brutal treatment of children [3]. Dispute and disbelief often follow suggestions that violence within society perpetrated by those ordained to protect has a lasting impact.

Noting the resistance that acceptance of child maltreatment and its enduring effects have, this chapter outlines the history of child abuse and neglect in the medical and mental health fields. It is noteworthy that Tardieu's initial concern with physical abuse in the mid 1800s [4,5] gave way to a greater focus on child sexual abuse in late 1800s, and that Caffey's and Kempe's work on physical maltreatment in the mid 1900s [6–10] led to much greater attention on sexual abuse in the 1980s and early 1990s. The focus on sexual abuse has been supplanted by an enhanced appreciation of multiple forms of abuse and neglect and their potentially deleterious effects on physical and mental health. Despite

progress in social awareness and scientific understanding, acknowledgement of the existence and impact of child maltreatment is continually threatened by a propensity to deny and disavow [11,12], an historical theme that recurs repeatedly in the literature reviewed in this chapter.

From the 1850s to publications about sexual abuse

In reviewing the history of childhood, DeMause [13] outlined six modes of childrearing that he believes have characterized the association between parenting and abuse. He argued that these have evolved from the “infanticidal” mode to the “socialization” mode. The “infanticidal” mode is characterized by extreme inhumane treatment, where children were socially sanctioned as sexual and sacrificial objects. The “socialization” mode, the mode currently most dominant, sees children still exposed to considerable levels of violence, but within the home there is a greater level of socialization rather than brutality in their education. DeMause suggested that future generations will evolve to the final mode of ‘helping’, where the parents support the children to reach their own rather than the parents’ goals. The fledgling nature of more humane parental practices in the 1800s may have led clinicians in their private practices to become aware of the pathological outcomes of trauma, even if some shied away from causal explanations.

In 1860, Ambroise Tardieu published the first paper directly related to the abuse of children, entitled “Étude Médico-Légale sur les Sévices et Mauvais Traitements Exercés sur des Enfants” (Medico-legal studies on

cruelty and ill-treatment upon infants) [4]. He noted (p. 361; quoted by Masson in 1984, p. 18 [14]):

[a]mong the numerous and very diverse facts which make up the medico-legal history of blows and wounds, there is one that forms a group completely separate from the rest. These facts, which until now have remained in total obscurity, deserve, for more than one reason, to be brought to the light of day. I am speaking of the facts of cruelty and brutal treatment of which children are particularly the victims and which derive from their parents, their teachers, from those, in a word, who exercise more or less direct authority over them.

He outlined in this work 32 cases, the majority of which were children under 10 and had the parent as the primary perpetrator. This paper identified forms of what would now be described as childhood physical abuse, as well as outlining childhood physical neglect, including starvation and other types of deprivation. Tardieu graphically presented cases of brutality and torture including severe and persistent beatings with various implements (e.g., whips, batons) and burns resulting from red-hot irons and corrosive substances. Abuses chronicled by Tardieu had led to death in over half the cases presented. Tardieu indicated that abusive parents often attempt to explain away their child's injuries as the results of an accident sustained during play or in some other innocuous way. Knight [15] has argued that Tardieu's paper contains most of the features accepted as part of the spectrum of child abuse present today.

While Tardieu focused heavily on the physical abuse of children in this 1860 paper [4], he was not ignorant of the existence, frequency and brutality of child sexual abuse, as indicated in other works. As Masson [14] outlined in some detail, Tardieu's book *Étude Médico-légale sur les Attentats aux Moeurs (A Medico-legal Study of Assaults on Decency)*, published in its seventh and final edition in 1878 [5], details the sexual abuse of children, primarily by their fathers. Many of the cases referred to very young girls from the first few years of life to middle childhood. In early editions of the book (e.g., 4th edition, 1862), he outlined several hundred cases of child sexual abuse. Cunningham [2] pointed out that Tardieu "was the first to investigate and publish his findings on intrafamilial sexual abuse of children" (p. 346). Masson [14] suggested that, while the topic of sexual abuse was unpopular and evoked theories regarding "simulation" and children pretending to be abused for secondary gain, some French physicians from the second half of the nineteenth century accepted

the child's testament of what had been inflicted upon them, as well as the supportive physical evidence that was often present.

Around the time of Tardieu's early work on abuse, Paul Briquet [16] challenged a belief that had persisted for two and a half millennia: hysteria affected only women and resulted from the uterus, or toxins from the uterus, periodically travelling to the brain [17]. Unlike the medico-legal perspective that was the focus for Tardieu and his predecessors and that charted the physical injuries of those abused, Briquet was more interested in psychopathology.¹ The description of the disorder which subsequently bore his name is filled with anecdotal references to domestic violence and child abuse, hinting at their etiological significance for mental ill-health [16]. Of the 87 cases of hysteria in children under the age of 12, Briquet stated that one-third had been "habitually maltreated or held constantly in fear, or had been directed harshly by their parents" [16]. In another 10%, the children's symptoms were attributed to traumatic experiences other than parental abuse. Briquet came to the conclusion that hysteria was caused by "the effect of violent emotions, protracted sorrows, family conflicts, and frustrated love, upon predisposed and hypersensitive persons" (Ellenberger, 1970, p. 142 [18]). In 501 hysterical patients, he found traumatic childhood experiences, often sexual abuse, in just over 75% [19].

Jean Martin Charcot (1825–1893) accepted Briquet's findings that hysteria did not have its origins in the unfulfilled sexual needs of women but fell short of attributing early trauma as etiologically important in hysteria [20]. As Masson [14] discovered, Charcot accepted the existence of childhood sexual abuse and co-authored a little known paper [21] that focused on the psychopathology of perpetrators. While Charcot largely avoided exploring the impact of childhood trauma on victims, he recognized that traumatizing events, including child abuse in women and work-related accidents in men, were evident in many of his hysteria patients. For example, he noted childhood sexual abuse in his patient Augustine, who re-enacted experiences of rape during hysterical "attacks," but he

¹ Cunningham [2] made clear that while Tardieu was interested in the physical consequences of abuse he also realized that abuse could occur without identifiable physical repercussion and abuse broadly could have a significant impact on psychological functioning, with the residue including feels of shame and terror.

gave it no etiological significance [20–23]. He maintained that the primary reason for their condition was constitutional weakness. He considered work-related traumatization an “agent provocateur for constitutional vulnerabilities” in males suffering from so-called traumatic hysteria [22].

Pierre Janet (1859–1946) also included constitutional factors in his view on the development of hysteria, but he regarded traumatic experiences – and, therefore, the existence of traumatic memories – as a major etiological factor. In 1925, he wrote: “Directly or indirectly, [the traumatic memory] was the cause of some of the symptoms of the disease” (p. 590), in both hysteria and psychasthenia (the other broad class of mental disorders that Janet distinguished). Of the 591 cases described in Janet’s first four major clinical works, 257 involved some degree of traumatization [19]. The traumas experienced by Janet’s patients included traumatic loss, witnessing violent death, incest, rape, physical abuse in childhood and traffic accidents. His publications do not show a specific interest in child abuse and neglect, and he may actually have overlooked this background in some of his patients. However, he regarded inadequate childrearing practices, either in combination with traumatic experiences or in their own right, as factors that may contribute to the development of mental disorders [24].

Such was the power of Freud’s conviction in the role of incestuous childhood trauma (a view shared by Binet and other French luminaries) that in an 1896 paper [25] which represented a synopsis of the ideas expanded shortly after in “The aetiology of hysteria,” he noted the nature and timing of sexual childhood trauma required for later psychological difficulties, namely hysteria. He stated, “...sexual traumas must have occurred in early childhood (before puberty), and their content must consist of an actual irritation of the genitals (of processes resembling copulation)” (p. 163, italics in original). In “The aetiology of hysteria” Freud [26], further specified that sexual trauma between the ages of 1 and 8 years is required for hysterical symptoms to develop (i.e., sexual experiences “date ... back, into the third or fourth, or even second year of life ... a person who has not had sexual experiences ... [before 8] can no longer become disposed to hysteria...” p. 212). In the 18 cases (6 men, 12 women) that form the data for the childhood sexual experience theory of hysteria, Freud outlined the origin and characteristics of three different trauma types associated with eventual symptom development. The first is an isolated

sexual assault committed by a relative stranger. The second grouping is sexual experiences at the hands of carers, including “close relatives”² (p. 208), and which were generally more chronic in nature. Finally, he noted sexual relationships between two children, often brother and sister, and often being the direct result of the brother re-enacting his own sexual abuse experiences on his sister [26].

Two years after “The aetiology of hysteria,” Freud hinted at doubts about the early sexual etiology of hysteria in a letter to Fliess in August 1897 [28], and further articulated them in a follow-up letter a little over a month later [27]. However, Freud never fully recanted his belief that real child sexual abuse by the father was not etiological related to later psychological difficulties.³ For example, in a footnote added in 1924 to his 1896 paper [31], “Further remarks on the neuro-psychosis of defence,” Freud notes:

This section is dominated by an error which I have since repeatedly acknowledged and corrected. At that time [1896] I was not yet able to distinguish between my patients’ phantasies about their childhood years and their real recollections. As a result, I attributed to the aetiological factor of seduction a significance and universality which it does not possess ... Nevertheless, we need not reject everything written in the text above. *Seduction retains a certain aetiological importance, and even today I think some of these psychological comments are to the point* (p. 168, italics added).

Freud’s dwindling faith from 1897 in the role of sexual trauma in psychopathology development, along with his growing theoretical formulations concerning oedipal fantasy, shifted focus away from the impact of child abuse. It provided one framework for professionals and society at large to distance themselves from the reality and shame of adults’ exploitative actions towards children. Interestingly, while around the turn of the century Freud’s belief in the impact of childhood sexual abuse had greatly diminished, interest in other forms of child maltreatment remained.

² Freud did not explicitly state the father here, though seemingly had this in mind, as evidenced in his quoted correspondence with Fliess in 1897 [27].

³ Kris [29] was later to term as the “seduction theory” Freud’s belief in the etiological significance of child sexual abuse for hysteria. The use of the term “seduction,” which Freud himself used, seems to curiously understate child sexual abuse by an adult when associated with terms such as “win over” or “attract” but more fully captures the power differential and cruel maltreatment when associated with terms such as “betrayal” “corrupt” and “dishonour” [30].

In 1899, the Vienna newspapers focused increasingly on cases of parents who had murdered or tortured their children [32]. Socially, child physical abuse was in the foreground, but this largely failed to ignite professional interest in the psychological sequelae of such maltreatment:

- initial focus on harsh childrearing practices and physical maltreatment preceded significant psychological interest in child sexual abuse
- the traumatic etiology of hysteria was largely replaced by fantasy.

From 1900 to publications about physical abuse

Psychoanalysis' emphasis on fantasy did not go completely unchallenged by analysts. Perhaps most famously, Ferenczi in 1949 [33] espoused the frequency and reality of child sexual abuse as a central etiological factor in the development of neurosis. His paper "Confusion of tongues between adults and the child" was originally presented at the 1932 International Psycho-Analytic Congress, and Ferenczi implored those present to be open not only to the reality of sexual abuse narratives in their patients but also to ways in which they (the analysts) inadvertently suppressed such narratives. Yet the cultural tension within the analytic movement created by such suggestions meant that Ferenczi's paper was initially withheld from publication by Freud's intellectual guardian, Ernest Jones [34].

With psychoanalysis dominating clinical psychological thought for much of the first half of the twentieth century, the etiological significance of early trauma was largely confined to a footnote. In some areas of psychiatry, the effects of childhood trauma, such as those pertaining to what was then called multiple personality, were not entirely forgotten. Janet was very mindful of the effects of early trauma in many of his dissociative patients [35,36]. Moreover, Barresi [37] proposed that Prince's case work shows that childhood traumas other than sexual and physical abuse could have profound effects on psychological functioning. He explored in depth Prince's second case of multiple personality (BCA) and indicated the traumatic experience that laid the foundations for later psychological problems. He also noted that others have suggested that the etiological foundations for severe problems in Prince's first case of multiple personality (Miss Beauchamp [38]) was the loss of a brother in childhood. Modern theory might speculate on the nature of disrupted attachment

associated with such loss. These historical accounts highlight the importance of not limiting the potential damaging effects of childhood trauma to sexual and physical victimization at the hands of caregivers.

After Freud's shift away from seduction and prior to the mid 1900s, the little interest that psychological trauma generated as an etiological variable was dominated by the horrors of war, given the human cost of World Wars I and II [39,40]. Yet, even these massive traumas failed to capture the collective minds of psychological scientists and the general population. This may have been partially because of the dominance of Freud's intrapsychic fantasy model, Babinski's "simulation" model (which promoted suggestibility rather than trauma as a cause of hysterical disturbance) and the German emphasis on secondary gain (e.g., compensation) in the creation and maintenance of combat-related difficulties [12].

It took pediatric interest in the medically unexplainable physical injuries of children to revive awareness of child maltreatment. Growing medical attention to the phenomenon and cause of pediatric subdural hematomas (e.g., Ingraham & Heyl [41] and Sherwood [42]) lead Caffey [67] to profile the histories and physical injuries in such cases. In the six case reports he presented, all had multiple fractures to large bones in the arms and legs. Perhaps understandably reticent at that point to go beyond the data he had, Caffey suggested that all fractures seemed to be the result of physical trauma, but that the origin and "causal mechanism remain obscure" (p. 173). He suspected child physical abuse in all cases, noting that new fractures appeared shortly after the child was discharged from hospital and returned home. However, in only one case did he more explicitly state parental "intentional ill-treatment" (p. 172). Caffey's work continued to focus on trauma as an origin for these grave physical injuries [7]. However, his attention was not on sadistic, brutal and wilful parenting practices, such as direct, aggressive and powerful physical blows to the infant's body. Rather, he was concerned with what he saw as the very common practice of shaking infants and engaging in other physical practices, deemed by parents and physicians at that time as relatively innocuous, but which were responsible for death, physical injury and severe abnormal neurological development in many cases [8]. The 1960s brought with it a greater focus on direct and intentional child maltreatment, courtesy of changes at a social level:

- while psychoanalytic thinking was largely focused on sexual fantasy, several key figures studying multiple personality continued to see the etiological relevance of child trauma
- interest in the physical impact of brutal parenting was re-awakened by pediatric investigators.

From 1960 to publications about child abuse and neglect

The 1960s saw an increase in social awareness of child maltreatment conforming with the plea of Fontana *et al.* [43] that “[s]ociety must acknowledge that the problem of child abuse and neglect does exist” (p. 1393). The breaking through into social consciousness of the reality of childhood trauma was largely linked to social changes arising from more professionals working with children and families, and to the liberation of women from the domestic realm, with their movement into occupations providing insights and perspectives that had been largely missing from social influence [44]. These social changes, according to Finkelhor [44], brought with them moral changes that impacted on child maltreatment and included the idea that love, not strict and harsh discipline, was more effective for socialization and emotional development.

While the occurrence of child maltreatment had been evident in the medical literature prior to the mid 1900s, Parton [45] argued that it was not until this time that it was considered a social problem. This view originally arose in the USA and then expanded to other parts of the world. Parton believed that the discovery of child abuse as a social problem was dependent on the development of diagnostic radiology in pediatric medicine. Knight [15] has provided a case published by West in 1888 [46] of several children from one family showing injuries that were consistent with severe physical abuse, but for which the medical professionals developed other theories, including rickets and syphilis. Knight suggested that child abuse would have been brought into the diagnostic frame if radiological equipment had of been available at that time. From the publications of Caffey’s [6,8] onwards, the structural damage resulting from physical assaults by caregivers could be clearly seen, as noted by Kempe *et al.* [10]: “To the informed physician, the bones tell a story the child is too young or too frightened to tell” (p. 18).

Kempe and colleagues [10] put child physical abuse on the medical radar by proposing the term battered child syndrome. They defined it as “... a clinical

condition in young children [usually younger than 3] who have received serious physical abuse, generally from a parent or foster parent” (p. 17). The term captured the extant literature on physical abuse at that time and indicated the primary dominance of physical abuse as a focus for child maltreatment investigation. Finkelhor [44] noted, “What the Kempe work signalled ... was that influential medical professionals had joined the ranks of those advocating for child protection and were prepared to lead a new social movement to greatly expand governmental activity in this area” (p. xii). To define a more inclusive range of maltreatment and neglect types, the term battered child⁴ or battered baby, as it became known in the UK [45], was eventually changed to “child abuse and neglect.” This term stressed the pervasive and perhaps permanent adverse effects on emotional well-being and psychological and physical development [47].

The emphasis on child sexual abuse so prominent in the late 1800s was largely absent from discussion by the pioneers of child physical abuse during the mid 1900s. Various forms of physical abuse and neglect were described, and emotional neglect was even in the frame. Yet, sexual abuse tended to be excluded from the list of events described under child maltreatment. Fontana *et al.* [43] perhaps best captured this omission when they note, “[t]he neglect and abuse of children denotes a situation ranging from the deprivation of food, clothing, shelter and parental love to incidents in which children are physically abused and mistreated by an adult, resulting in obvious physical trauma to the child, and, unfortunately, often leading to death” (p. 1389). While professionals and society may have been more readily open to believing that parents could physically and emotionally maltreat their children, greater change was required before the existence and effects of sexual abuse could be revisited. Even key psychiatric texts in the mid 1970s grossly underestimated the prevalence of incest and trivialized its malignant impact on the victims (e.g., Freeman *et al.* [48]).

Following the impetus created in the 1960s, a string of influential publications in the 1970s and early 1980s ensured that child abuse and neglect became serious topics of professional and academic endeavor, and

⁴ Various terms were proposed around this time to describe physical injury in children from caregivers, including not only the battered child syndrome [10], but maltreatment syndrome in children [43] and parent–infant stress syndrome [8]. The use of the term syndrome indicated the medicalization of the experience of child physical abuse and neglect.

further raised social awareness of their presence and impact [9,49–54]. Amongst these were scholarly papers on child sexual abuse, some of which became prominent in the literature thanks partly to the influence of the women’s liberation movement on social attitudes and awareness of the victimization of women [11]. The 1980s to early 1990s saw both increased reporting and increased interest in child sexual abuse (e.g., Berliner & Elliott [55]).

The renewed interest in a professional sexual abuse literature has so far survived attempts to undermine it. These include challenges put forward by such organizations as the False Memory Syndrome Foundation. As society in the 1980s began to grapple with the real extent of child abuse, and child sexual abuse in particular, it was perhaps inevitable that society’s resistance became more organized. In the early to mid 1990s, societal counter-transference responses to childhood trauma began to encompass two extremes: those who denied it, minimized it, or who as perpetrators had vested interests in discrediting its investigation; and those who so strongly identified with abuse victims that they progressively lost objectivity. Polarized views on the existence and effect of child abuse have now shifted to a more middle ground.

Interestingly, the relatively selective focus on child sexual abuse in the 1980s and 1990s has not yet given way to disinterest and paradigm shift as it did in the late 1880s, nor has it further increased polarized perspective taking. Rather, it has created a greater appreciation and investigation of other forms of abuse and neglect. For example, the study of emotional abuse, emotional neglect and exposure to domestic violence as particular forms of trauma warranting investigation in their own rights has become more prominent [56,57].

With the tide of interest still high, contemporary studies of the incidence and prevalence of various forms of childhood abuse have become more sophisticated in an attempt to determine the scale of the problem with greater accuracy [58–60]. For example, in coalescing 16 studies of non-clinical participants, primarily on child sexual abuse in adults, Gorey and Leslie [61] found a prevalence of 14.5% in women and 7.2% in men. These figures were derived after excluding the amplifying effects of low response rate and a broad definition of abuse (e.g., non-contact, exhibitionism). Using a very large nationally representative sample, with tightly defined definitions of abuse, Cappelleri *et al.* [62] found an incidence rate over a 3 month period in 1986 of 2.11 per 1000 for child sexual abuse and 4.95 per 1000 for

child physical abuse. Numerous studies dating from the early 1980s have demonstrated that from 40% to over 70% of psychiatric inpatients will give a history of childhood sexual and/or physical abuse when enquiry is made [63–66]. Similar trends have been reported with psychiatric outpatients.

In addition to effects to achieve more accurate determination of the epidemiology of child abuse, research is documenting the psychological and physical effects of early trauma. DeMause [67] provided a relatively comprehensive list of difficulties found to be associated with early abuse, including: “Severe somatic reactions, depersonalisation, self-hatred, hysterical seizures, depression, borderline personality formation, promiscuity, sexual dysfunction, suicide, self-mutilation, night terrors and flashbacks, multiple personalities [i.e., dissociative identities], post-traumatic stress disorders, delinquency, bulimia, and the overall stunting of feelings and capacities” (p.140). More recently, explanatory frameworks have been offered for the etiological role of early trauma in a range of psychological difficulties [68–70]. Research has also expanded beyond mental health, implicating child maltreatment and early trauma as etiologically significant in a range of physical health problems, including liver and heart disease (Ch. 8).

Just as developments in technology from the 1940s assisted the identification of physical abuse, various technological advances in observing and analyzing the brain have allowed the structural and functional effects of child abuse to be examined. Various chapters in this volume have reviewed this work (e.g., Chs. 11 and 12):

- physical abuse dominated clinical interest in the mid 1900s
- sexual abuse dominated clinical interest in the late 1990s
- a broad interest in various forms of child maltreatment is now evident.

The enuous existence of child maltreatment

As Herman [11] observed, the recognition and interest in trauma broadly and child abuse specifically have always fought powerful social and psychological forces aimed at suppressing them: “The knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long. Denial, repression and dissociation operate on a social as well as an individual

level” (p. 2). DeMause [71] has chronicled the professional resistance and personal attacks aimed at him by colleagues in various academic disciplines for developing a theoretical framework and accruing supporting evidence suggesting that the history of childhood is less than rosy, with trauma and abuse the norm rather than exception. Kempe and colleagues [10] noted the reluctance of professionals to acknowledge physical abuse as a cause of injury, despite radiological evidence.

As a result, the proliferation of research on child maltreatment since the 1960s should not be interpreted as the end of professional skepticism regarding the significant effects of child relational trauma. The drive to ignore or attack the importance of current and past child maltreatment remains evident in many areas of mental health practice. For example, while biological factors undoubtedly play a significant role in many cases of psychosis, there is an abundance of evidence supporting the impact of early trauma on the development of psychosis (see Read *et al.* [72]), yet biological accounts in isolation still dominate treatment and teaching on the etiology of psychosis [73]. Early abuse and trauma, if implicated at all, are seen as secondary to biological factors, rather than as primary enablers for psychotic disturbance. Just as the research findings do not support childhood abuse and neglect as the only pathway to psychosis, there is no compelling evidence to suggest that biological models satisfactorily account for all psychosis (e.g., Ross [73]). Acceptance and acknowledgement of explanations more consistent with empirical findings needs to overcome what societal attention to child abuse and neglect has always had to overcome: society’s desire for minimization and denial.

- the existence and effect of child maltreatment is perpetually fighting for acceptance against powerful psychological and social processes set to deny, ignore or undermining it

Summary and conclusion

References to childhood trauma from Tardieu’s early work focused on physical abuse in the mid 1800s. Later that century, and with a shift from the physical to psychological consequences of early trauma, the literature was dominated by a central etiological focus on sexual abuse. A similar pattern occurred in the mid 1900s. The literature, which refocused attention on the importance of childhood trauma and set the trajectory for a greater appreciation and acceptance of childhood

adversity in health and mental health problems, was dominated by accounts of physical abuse [74]. The role of sexual childhood trauma began to dominate thinking again from the late 1970s and characterized the bulk of interest throughout the 1980s and early 1990s [64,74]. Not only did changing social pressures (e.g., the women’s liberation movement) and the weight of evidence force an acceptance of the reality of child sexual abuse, but also the long held belief that incest was a universal cultural taboo was persuasively debunked [67]. The focus on early sexual abuse gave way to a greater and broader investment in the role of various forms of childhood trauma, abuse and neglect in having adverse effects on psychological and physical development, as well as on health and mental health functioning. The renewed interest in child abuse has yet to follow in the footsteps of its last dominant foray into consciousness by being turned away from and ignored. This may be in part because child abuse and neglect now fit with the “psychosocial conception of reality,” which was not the case in the mid-late 1800s (Cunningham, p. 350 [2]).

Yet, as Radbill [3] noted, “[a]buse of children has excited periodic waves of sympathy, each rising to a high pitch, and then curiously subsiding until the next period of excitation” (p. 15). Rather than accept the traumatic consequence that one human’s malevolent and maltreating actions can have on another, it is seemingly easier to deny that it happened at all, to deny the extent of its impact, to blame its victims, or to relabel its manifestations as caused by things other than ourselves [11,75]. If history has a lesson, it may be that the current significance given to childhood abuse and trauma for health and mental health outcomes rests on unsolid foundations. These foundations appear dependent on society’s ability to tolerate and take responsibility for adults’ maltreatment of children. The ability to accept such a proposition rests in part on accepting that one of the single most pathogenic factors in the causation of mental illness, and some physical health problems, is humans themselves.

References

1. Oettinger, K. B. (1968). Foreword. In R. E. Helfer and C. H. Kempe (eds.), *The battered child* (p. v). Chicago, IL: University of Chicago Press.
2. Cunningham, J. L. (1988). Contributions to the history of psychology: French historical views on the acceptability of evidence regarding child sexual abuse. *Psychological Reports*, 63, 343–353.

3. Radbill, S. X. (1968). A history of child abuse and infanticide. In R. E. Helfer and C. H. Kempe (eds.), *The battered child* (pp. 3–17). Chicago, IL: University of Chicago Press.
4. Tardieu, A. (1860). Étude médico-légale sur les sévices et mauvais traitements exercés sur des enfants. *Annales de Hygiène Publique et Médecine Légale*, **13**, 361–398.
5. Tardieu, A. (1878). *Étude médico-légale sur les attentats aux moeurs*, 7th edn. Paris: Baillière.
6. Caffey, J. (1946). Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *American Journal of Roentgenology*, **56**, 163–173.
7. Caffey, J. (1965). Significance of the history in the diagnosis of traumatic injury to children. *Journal of Pediatrics*, **67**, 1000–1014.
8. Caffey, J. (1972). On the theory and practice of shaking infants: Its potential residual effects of permanent brain damage and mental retardation. *American Journal of Diseases of Children*, **124**, 161–169.
9. Kempe, C. H. (1978). Sexual abuse: Another hidden pediatric problem. *Pediatrics*, **62**, 382–389.
10. Kempe, C. H., Silverman, F. N., Steele, B. F., Droegemueller, W. and Silver, H. K. (1962). The battered-child syndrome. *Journal of the American Medical Association*, **181**, 17–24.
11. Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence: From domestic abuse to political terror*. New York: Basic Books.
12. van der Kolk, B. A., Weisaeth, L. and van der Hart, O. (1996). The history of trauma in psychiatry. In B. A. van der Kolk, A. C. McFarlane and L. Weisaeth (eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 47–74). New York: Guilford.
13. DeMause, L. (1998). The history of child abuse. *Journal of Psychohistory*, **25**, 216–236.
14. Masson, J. M. (1984). *The assault on truth: Freud's suppression of the seduction theory*. London: Faber & Faber.
15. Knight, B. (1986). The history of child abuse. *Forensic Science International*, **30**, 135–141.
16. Briquet, P. (1859). *Traité clinique et thérapeutique de l'hystérie*. Paris: Baillière.
17. Stone, M. H. (1998). *Healing the mind: A history of psychiatry from antiquity to the present*. London: Norton.
18. Ellenberger, H. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic Books.
19. Crocq, L. and De Verbizier, J. (1989). Le traumatisme psychologique dans l'oeuvre de Pierre Janet. *Annales Médico-Psychologiques*, **147**, 983–987.
20. De Marneffe, D. (1991). Looking and listening: The construction of clinical knowledge in Charcot and Freud. *Signs: Journal of Women in Culture and Society*, **17**, 71–111.
21. Charcot, J. M. and Magnan, V. (1882). Inversion du sens génital et autres perversions sexuelles. *Archives de Neurologie*, **7**, 296–322.
22. Micale, M. S. (2001). Jean-Martin Charcot and les névroses traumatiques: From medicine to culture in French trauma theory of the late nineteenth century. In M. S. Micale and P. Lerner (eds.), *Traumatic pasts* (pp. 115–139). Cambridge, UK: Cambridge University Press.
23. Van der Hart, O. (2008). Charcot, Jean-Martin (1825–1893). In G. Reyes, J. D. Elhai and J. Ford (eds.), *The encyclopedia of trauma* (pp. 111–112). New York: Wiley.
24. Janet, P. (1919). *Les médications psychologiques*. Paris: Félix Alcan. [English edition: *Psychological healing*. New York: Macmillan, 1925.]
25. Freud, S. (1896). Further remarks on the neuro-psychosis of defence. In J. Strachey (ed.), *The standard edition of the complete psychological works of Sigmund Freud*, Vol. 3. London: Vintage, 2001.
26. Freud, S. (1896). The aetiology of hysteria. In J. Strachey (ed.), *The standard edition of the complete psychological works of Sigmund Freud*, Vol. 3. London: Vintage, 2001.
27. Freud, S. (1897). Letter to Fliess (letter 69). In J. Strachey (ed.), *The standard edition of the complete psychological works of Sigmund Freud*, Vol. 1. London: Vintage, 2001.
28. Freud, S. (1897). Letter to Fliess (letter 67). In J. Strachey (ed.), *The standard edition of the complete psychological works of Sigmund Freud*, Vol. 1. London: Vintage, 2001.
29. Kris, E. (1954). *The origins of psychoanalysis*. New York: Basic Books.
30. *Collins dictionary and thesaurus* (1991). Glasgow: HarperCollins.
31. Freud, S. (2001). Early psycho-analytic publications. In J. Strachey (ed.), *The standard edition of the complete psychological works of Sigmund Freud*, Vol. 3. London: Vintage.
32. Wolff, L. (1988). *Postcards from the end of the world: Child abuse in Freud's Vienna*. New York: Atheneum.
33. Ferenczi, S. (1949). Confusion of tongues between adults and the child. *International Journal of Psychoanalysis*, **30**, 225–231. [Original presented to the International Psycho-Analytic Congress in 1932.]
34. Hoffer, A. (2003). Images in psychiatry: Sandor Ferenczi, MD, 1873–1933. *American Journal of Psychiatry*, **160**, 1937.
35. Dorahy, M. J. and van der Hart, O. (2007). Relationship between trauma and dissociation. In E. Vermetten, M. J. Dorahy and D. Spiegel (eds.), *Traumatic dissociation: Neurobiology and treatment* (pp. 3–30). Arlington, VA: American Psychiatric Press.
36. van der Hart, O. and Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage. *Dissociation*, **2**, 3–16.

37. Barresi, J. (1994). Morton Prince and B.C.A.: A historical footnote on the confrontation between dissociation theory and Freudian psychology in a case of multiple personality. In R. M. Klein and B. K. Doane (eds.), *Psychological concept and dissociative disorders* (pp. 85–129). Hillsdale, NJ: Lawrence Erlbaum.
38. Prince M. (1905). *The Dissociation of a Personality*. New York: Longmans, Green & Co.
39. Kardiner, A. (1941). *The traumatic neuroses of war*. New York: Hoeber.
40. Myers, C. S. (1915). A contribution to the study of shell shock. *Lancet*, *i*, 316–320.
41. Ingraham, F. D. and Heyl, H. L. (1939). Subdural hematoma in infancy and childhood. *Journal of the American Medical Association*, *112*, 198–204.
42. Sherwood, D. (1930). Chronic subdural hematoma in infants. *American Journal of Diseases of Children*, *39*, 980–1021.
43. Fontana, V. J., Donovan, D. and Wong, R. J. (1963). The “maltreatment syndrome” in children. *New England Journal of Medicine*, *269*, 1389–1394.
44. Finkelhor, D. (2002). Introduction. In J. E. B. Myers, L. Berliner, J. Briere et al. (eds.), *The APSAC handbook on child maltreatment, 2nd edn* (pp. xi–xvi). London: Sage.
45. Parton, N. (2004). The natural history of child abuse: A study in social problem definition. *British Journal of Social Work*, *9*, 431–451.
46. West, S. (1888). Acute periosteal swellings in several young infants of the same family, probably rickets in nature. *British Medical Journal*, *i*, 856.
47. Helfer, R. E. and Kempe, C. H. (1976). *Child abuse and neglect: The family and the community*. Cambridge, MA: Ballinger.
48. Freeman, A. M., Kaplan, H. I. and Sadock, B. J. (1976). *Modern synopsis of comprehensive psychiatry*. Baltimore, MD: Williams & Wilkins.
49. Garbarino, J. (1978). The elusive ‘crime’ of emotional abuse. *Child Abuse & Neglect*, *2*, 89–99.
50. Gil, D. A. (1975). Unraveling child abuse. *American Journal of Orthopsychiatry*, *45*, 346–356.
51. Herman, J. L. (1981). *Father–daughter incest*. Cambridge, MA: Harvard University Press.
52. Meadow, R. (1977). Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet*, *ii*, 343–345.
53. Pelton, L. H. (1978). Child abuse and neglect: The myth of classlessness. *American Journal of Orthopsychiatry*, *48*, 608–617.
54. Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, *7*, 177–193.
55. Berliner, L. and Elliott, D. M. (2002). Sexual abuse of children. In J. E. B. Myers et al. (eds.), *The APSAC handbook on child maltreatment, 2nd edn* (pp. 55–78). London: Sage.
56. Erickson, M. F. and Egeland, B. (2002). Child neglect. In J. E. B. Myers, L. Berliner, J. Briere, et al. (eds.), *The APSAC handbook on child maltreatment, 2nd edn* (pp. 3–20). London: Sage.
57. Iwaniec, D., Larkin, E. and Higgins, S. (2006). Research review: Risk and resilience in cases of emotional abuse. *Child and Family Social Work*, *11*, 73–82.
58. Finkelhor, D., Hotaling, G., Lewis, I. A. and Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. *Child Abuse & Neglect*, *14*, 19–28.
59. National Center on Child Abuse and Neglect (1988). *Study findings: Study of the National incidence and prevalence of child abuse and neglect*. Washington, DC: US Department of Health and Human Services.
60. Pilkington, B. and Kremer, J. (1995). A review of the epidemiological research on child sexual abuse: Community and college student samples. *Child Abuse Review*, *4*, 84–98.
61. Gorey, K. M. and Leslie, D. R. (1997). The prevalence of child sexual abuse: Integrative review adjustment for potential response and measurement biases. *Child Abuse and Neglect*, *21*, 391–398.
62. Cappelleri, J. C., Eckenrode, J. and Powers, J. L. (1993). The epidemiology of child abuse: Findings from the Second National Incidence and Prevalence Study of Child Abuse and Neglect. *American Journal of Public Health*, *83*, 1622–1624.
63. Bryer, J. B., Nelson, B. A., Miller, J. B. et al. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry*, *144*, 1426–1430.
64. Craine, L. S., Hensen, C. E., Colliver, J. A. and MacLean, D. C. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Hospital and Community Psychiatry*, *39*, 300–304.
65. Enslie, G. D. and Rosenfeld, A. (1983). Incest reported by children and adolescents hospitalised for severe psychiatric problems. *American Journal of Psychiatry*, *140*, 708–711.
66. Jacobson, A. and Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry. *American Journal of Psychiatry*, *144*, 908–913.
67. DeMause, L. (1991). The universality of incest. *Journal of Psychohistory*, *19*, 123–164.
68. Bremner, J. D. (2002). *Does stress damage the brain: Understanding trauma-related disorders from a mind–body perspective*. New York: Norton.
69. Ross, C. A. (2000). *The trauma model: A solution to the problem of comorbidity in psychiatry*. Richardson, TX: Manitou Communications.

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70. van der Hart, O., Nijenhuis, E. R. S. and Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York: Norton.
71. DeMause, L. (1988). On writing childhood history. *Journal of Psychohistory*, 16, 135–171.
72. Read, J., Fink, P. J., Rudegeair, T., Felitti, V. and Whitfield, C. L. (2008). Child maltreatment and psychosis: A return to a genuinely integrated bio-psycho-social model. *Clinical Schizophrenia and Related Psychosis*, October, 235–254.
73. Ross, C. A. (2004). *Schizophrenia: Innovations in diagnosis and treatment*. New York: Haworth.
74. Oates, R. K. and Donnelly, A. C. (1997). Influential papers in child abuse. *Child Abuse & Neglect*, 21, 319–326.
75. Middleton, W. (2004). Dissociative disorders: A personal “work in progress.” *Australasian Psychiatry*, 12, 245–252.