**THE HEALTH IMPLICATION OF CHILD ABUSE IN MAITUMBI, BOSSO LOCAL GOVERNMENT AREA, NIGER STATE**

**CHAPTER ONE**

**1.0 INTRODUCTION**

This chapter will discuss the background of the study, statement of the problem, aim of the study, objectives of the study, research question and hypothesis, significance of the study, scope of the study as well as operational definition of terms

**1.1 BACKGROUND OF THE STUDY**

Survivors of childhood abuse often suffer from health problems long after the abuse has ended. Abuse survivors are sick more often and go to the doctor more (Felitti, 1991). They report more symptoms and are less likely to describe their health as good. They have surgery more often—in one study, almost twice as much (Kendall-Tackett, Marshall, & Ness, 2000). Adult survivors are at increased risk of having one or more chronic pain syndromes (Drossman *et al*., 1990; Kendall-Tackett, 2000; Schofferman, Anderson, Hinds, Smith, & White, 1992). And in the Adverse Childhood Experiences (ACE) study, Felitti and colleagues (Felitti *et al.,* 2001) found that subjects who experienced four or more types of adverse childhood events were at increased risk of a wide range of conditions including ischemic heart disease, cancer, stroke, chronic bronchitis, emphysema, diabetes, skeletal fractures, and hepatitis. The childhood events that they studied included psychological abuse, physical abuse, contact sexual abuse, exposure to substance abuse, parental mental illness, exposure to violent treatment of the mother or stepmother, and exposure to criminal behavior. Over the past decade, researchers have documented the higher frequency of these health problems among adult survivors. The next step for researchers is to understand why this happens. In this study, a model with four possible pathways by which victimization might influence health is described. By looking at the long-term effects of childhood abuse in a new way, clinicians and researchers can begin to understand the mechanisms by which health problems occur. The four types of pathways described are behavioral, social, cognitive and emotional. Adult survivors can be influenced by any or all of these and the four types influence each other. Indeed, they form a complex matrix of interrelationships, all of which influence health. A child is a person that has not attained the age of 18. For centuries, the Nigerian child has been seen as “an instrument or property with no absolute privilege of its own”. In the traditional African society the belief was that children should merely be seen and not heard. Children were not allowed to listen to adults’ discussions/conversation let alone make contributions. This situation was prevalent not only in the society but found its way into the educational system. Consequently, teachers only allowed children to make contributions when they deemed necessary. Recently, there has been serious concern about the child with the realization that children play important part in the family and the society. It is generally agreed that children are the future generation, the leaders of tomorrow and the potential flag bearers of any nation. To carry out these duties, the child therefore has certain rights that must be protected and not be trampled upon or denied. recognition of the socio-cultural and educational dimension of the child, the United Nations, European Union, African Union, UNICEF and ANPPCAN have all joined efforts in advocating for protection of the right and well-being of children. Among other provisions, UNICEF and the National Policy on Children grant children the following rights: Protection against indecent and in human treatment like abuse and neglect Provision of a conducive environment to promote early stimulation to learning for the child Entitlement of every child (male/female) to receive compulsory basic education and equal opportunity for higher education Promotion and encouragement of child-friendly principles in all relevant institutions. The above provisions recognize the importance of education for the optimum development of the child thus advocating for compulsory basic education and the provision of conducive learning environment. Education is therefore recognized as one avenue through which the child can develop properly. Many developing nations place a high premium on the education of their citizen because education is viewed as an instrument for cultural, social, political, economic and technological development and emancipation In Nigeria, for instance, education is viewed as a means of building a free democratic, just and equalitarian society; a united strong and self-reliant nation; a land of bright and full opportunities for all citizens (Federal Republic of Nigeria, 2004). Thus, Nigeria and his people need a change and growth in education so as to be in line with the developed nations. During the past 30 years, the focus on the extent and nature of child abuse and neglect has been coupled with an increasing interest in the impact on children’s development, health and mental wellbeing. Child maltreatment is both a human rights violation and a complex public health issue, likely caused by a myriad of factors that involve the individual, the family, and the community. Child abuse includes any type of maltreatment or harm inflicted upon children and young people in interactions between adults (or older adolescents). Such maltreatment is likely to cause enduring harm to the child. The different forms of abuse and neglect often occur together in one family and can affect one or more children. These include, in deceasing level of frequency: neglect; physical abuse and non-accidental injury; emotional abuse; and sexual abuse (Cawson *et al.*, 2000; 2002). Recently, bullying and domestic violence have been included as forms of abuse of children.

**1.2 STATEMENT OF PROBLEM**

Children are a responsibility of themselves, their parents, social and academic institutions, and the government. Parents and other caregivers take responsibility of caring for their children and explaining the most important living issues to them.

Following the close relationship that children have with their caregivers, they learn and trust them as guides in life. However, child abusers who may be parents, relatives, or strangers violate the trust that children have in them.

Each child should have the opportunity to have a safe upbringing. However, an unknown number of children continue experiencing serious traumas because of abuse and parental neglect (Centers for Disease Control and Prevention, 2014). Child maltreatment and neglect restrict a person’s life.

Child abuse has a number of effects on how people behave, develop their abilities, and/or comprehend their duties. It causes many behavioral problems.

Sousa *et al.,* (2011) reveal how child abuse and other cases of domestic violence considerably influence children and their further development. They become less attached to their caregivers, demonstrate antisocial behavior when they are adolescents, and/or become bad examples to their children or people around them. It is not easy to recover from child abuse and trauma. People need professional help and explanations regarding why child abuse may take place and the effects that may be observed.

It has been noted that children, who experience maltreatment if left alone or untreated, can be at a heightened probability of having future issues concerning their behaviors and emotions.

The problem of child abuse remains crucial for analysis, as people must understand its effects on human behavior and the urgency in preventing abuse.

**1.3 AIM OF THE STUDY**

The aim of this research work is to investigate the health implication of child abuse in Maitumbi, Bosso Local Government Area, Niger state.

**1.4 OBJECTIVES OF THE STUDY**

* To identify different forms of child abuse among children in Maitumbi.
* To evaluate the health implication of child abuse among children in Maitumbi.
* To examine ways of controlling child abuse among children in Maitumbi.

**1.5 RESEARCH QUESTIONS**

* What are the different forms of child abuse?
* What are the health implication of child abuse?
* What are the ways of controlling child abuse?

**1.6 SIGNIFICANCE OF THE STUDY**

The importance of this research work will be that it will provide more knowledge to the masses especially the parents or guardians on the implications of any form of child abuse and neglect on adolescents. It will also enlightened people on the different forms of child abuse and some suggested solutions to the problems of child abuse in our society.

The parents or guardians will be in the positions to understand the implications and consequences of child abuse in other to abstain from such act. The research will also update it knowledge in the cause of child abuse among children.

The end result of this study will serve as a reference material to future research in related study. The outcome of this study will also help the public health students to be aware of the health implications of child abuse and also serve as a guide when they embark on their own research.

Furthermore, the study will serve as tool of drawing the attention of the government and concerned agencies to take an everlasting measure to get rid of the health implications of child abuse by reinforcing health talk as an intervention to parents or guardians. The study also assist in increasing knowledge to the existing one especially in respect to those with little knowledge of the health implications of child abuse.

**1.7 SCOPE OF THE STUDY**

The research work focused on the health implication of child abuse among children in Maitumbi ward of Bosso Local Government Area of Niger State. And the target population is 100 members.

**1.8 OPERATIONAL DEFINITION OF TERMS**

* CHILD: A child is a person who is easily controlled due to his frail personality and dictated for by the adult members of the society.
* CHILD ABUSE: Child abuse is used in terms of child labor beyond the age of the child for example, long hours of labor, sending the child to do some paid jobs in other to assist the family income where the child is supposed to go to the school l, etc.
* CHILD NEGLECT: Child neglect means a situation where by ty child is not given proper care or attention as being the pride of the basic comfort of life.
* HEALTH: Is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

**CHAPTER TWO**

**2.0 REVIEW OF RELATED LITERATURE**

Parents now push over the responsibility of caring for their children to the school. Many young children who would have been at home at about two years have been pushed over to the school. The tasks thus become enormous for the teachers and the school management to carry leading to many children being neglected, despised and abused on a daily basis. This clearly undermines the provision for the right of the child on ‘protection against indecent and inhuman treatment like abuse and neglect’ earlier stated. Rather, the child has been subjected to all kinds of maltreatment, is not protected, valued nor defended. Most times, the treatment meted out to young children as corrective measures constitutes one form of abuse or the other. It is evident that child abuse is a serious global problem that is deeply rooted in cultural, economic and social practices and occurs in a variety of ways and places. According to the National Child Abuse and Neglect Data System (NCANDA, 2006) reported by Gelles (2009) in the United States for instance, more than 900,000 children suffer severe or life threatening injury and some (1,000 to 2,000) children die as a result of abuse and those who survive often suffer emotional trauma that may take long for the bruises to be healed. In the same vein, our Nigerian society is still plagued with incidences of child labor, child maltreatment, child marriage, child trafficking, neglect, and child prostitution. The effect of such abuses are many and varied including teenage pregnancies/mothers, youth restiveness and violence, cultism, youth decadence, joblessness, armed bandits, molestations, and school dropouts. These menaces have eaten into the life of most Nigerian children. These abuses take place not only at home and undertaken by persons known to and trusted by the child, but also in the school where the child spends a greater part of his/her early life. In most literature, child abuse is studied as it relates to the home and the society. Few authors have bordered to look into the issue of the child as it relates with the school system. The fact that the society has a strong belief in education system (school) in the task of helping children develop their abilities, attitudes, values and good judgment may make one not to think of child abuse as occurring in the school. Yet, incidence of abuse abound in schools and sometimes in subtle ways unknown to the school authorities but at the same time posing serious dangers to children at the same time having damaging and far more consequences on the life of the child. If the school, which is supposed to be a custodian of knowledge as well as functioning as an avenue for the optimum development of the child fosters and indulges in child abuse, then one wonders how children will benefit from the process of education.

**2.1 FORMS OF CHILD ABUSE**

Child abuse can be broadly categorized into five perspectives namely physical abuse, emotional abuse, sexual abuse, neglect and child exploitation (child labor).

**Physical Abuse:** Physical abuse may be seen as the inflicting of a non-accidental bodily injury on a child. The injury may not have been intended by the parent or caretaker and is not an accident but may be due to over-discipline or corporal punishment that may not be appropriate or is unjustifiable for the child at that age.

**Emotional Abuse:** Emotional abuse is also known as verbal abuse, mental abuse or psychological maltreatment. The National Clearinghouse on Child Abuse and Neglect Information (2006) defines emotional abuse as “acts or omissions by the parents or other caregivers that have caused, or could cause serious behavioral, cognitive, emotional or mental disorders”. Emotional abuse can thus be seen as any attitude, behavior or failure to act on the part of a caregiver which interferes with a child’s mental health, social development or sense of self-worth. It is probably the least understood, yet the most prevalent, cruelest and destructive type of abuse. It attacks the child self-concept making the child see his/herself as unworthy, worthless and incapable. When a child is constantly humiliated, shamed, terrorized or rejected the child suffers more than if he/she had been physically maltreated. The resulting effect is that most children often withdraw to themselves leading to depression and lack of concentration in school (Khartri, 2004).

**Sexual Abuse:** Sexual abuse is defined by CAPTA (Khartri, 2004) as the employment, use of persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct. It is the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other forms of sexual exploitation of children or incest with children. As a result of the secrecy that characterizes these cases, sexual abuse is the most often under-reported form of child maltreatment. Sexually abused children experience emotional problems from a feeling of guilt and shame (Corwin & Olafson, 1997).

**Neglect:** This is a failure to provide basic needed care for the child such as shelter, food, clothing, education, supervision, medical care and other basic necessities needed for the child physical, intellectual and emotional development. It is a situation where the guardians or parents fail to perform tasks that are necessary for the well-being of the child which invariably can lead to the child’s health and safety being endangered.

**Child Exploitation:** Child exploitation often referred to as child labor or child trafficking involves the use of a child in work or other activities for the benefit of others. Child exploitation is a systematic process of using children to work with little or no compensation and consideration for their health and safety (Newton, 2001). These children are used to do hard works in the farms that are above their ages and some are made to hawk wares for long hours without food. Such children rarely benefit from education and will eventually drop out of school. By the time these children reach adulthood, they are physically, emotionally, morally and intellectually damaged.

**2.2 EFFECTS OF MALTREATMENT ON CHILDREN’S HEALTH**

In many cases, child maltreatment has consequences for children, families, and society that last lifetimes (Kendall-Tackett, 2003). Infants and young children are particularly vulnerable to the physical effects of maltreatment. Physical abuse is associated with various types of injuries, particularly when exposure to such abuse occurs in the first three years of life (Vinchon *et al.,* 2005). Shaking an infant may result in bruising, bleeding, and swelling in the brain. The physical consequences of ‘shaken baby syndrome’ can range from vomiting or irritability to more severe effects, such as concussions, respiratory distress, seizures, and death (Conway, 1998). Two-thirds of subdural hemorrhages in children under two are caused by physical abuse (Vinchon *etal.,* 2005). It is estimated that 10 per cent of admissions to pediatric burns and plastic surgery units are related to child maltreatment (Chester *et al*, 2006). Infants who have been neglected and malnourished may also experience a condition known as ‘non-organic failure to thrive’. This refers to a situation in which the child's weight, height, and motor development fall significantly below age-appropriate ranges, without a medical or organic cause. In extreme cases, the death of the child is the end result. Even with treatment, the long-term consequences can include continued growth problems, retardation, and socioemotional deficits (Wallace, 1996). Domestic abuse poses a serious risk even to the unborn foetus, as violence may increase the risk of premature birth, low birth weight, chorioamnionitis, and foetal injury and in the worst case, death (Mezey and Bewley 1997, Connolly *et al.,* 1997, Bacchus *et al.,* 2002). It has been suggested that foetal morbidity resulting from violence is more prevalent than that from gestational diabetes or pre-eclampsia (Sidebotham and Golding, 2001). Foetal abuse can have effects on the developing infant’s brain, leading to childhood anxiety and hyperactivity (Hosking and Walsh, 2005). New technologies such as functional MRI (magnetic resonance imaging) and PET (positron emission tomography) have enabled scientists to identify the chemical and structural differences between the central nervous systems of abused and non-abused young people (Anderson *et al.*, 2002; Teicher *et al.*, 2004; Weniger *et al.*, 2008). Many health problems, including panic or post-traumatic stress disorder, chronic fatigue syndrome, fibromyalgia, depression, some auto-immune disorders, suicidal tendencies, abnormal fear responses, preterm labor, chronic pain syndromes, and ovarian dysfunction can be understood, in some cases, as manifestations of childhood maltreatment (Kendall-Tackett, 2000; De Bellis, 2005). Evidence shows that maltreatment may inhibit the appropriate development of certain regions of the brain (Glaser, 2000). A neglected infant or young child may not be exposed to stimuli that normally activate important regions of the brain and strengthen cognitive pathways. The connections among neurons in these inactivated regions can literally wither away, hampering the child’s functioning later in life. As a result, the brain may become ‘wired’ to experience the world as hostile and uncaring. This negative perspective may influence the child's later interactions, prompting the child to become anxious and overly aggressive or emotionally withdrawn. Neglect and other forms of abuse may also be associated with neuromotor handicaps, such as central nervous system damage, physical defects, growth and mental retardation, and speech problems (Chester, 2006). Recent studies have also found an association between childhood abuse and hormonal disruption, manifesting in a dysregulation of the HPA (hypothalamic pituitary adrenal) axis (Cicchetti and Rogosch, 2001). In addition, childhood abuse also has strong links to later health problems, including heart disease, liver disease, cancer and chronic lung disease (Felitti et al, 1998). Maltreatment may affect a child’s health indirectly. For instance, physical and sexual abuse is a major factor in the homelessness of young people, which may result in risk-taking behaviors including substance abuse, self-harming, prostitution, and increased vulnerability to further assault. Child victims of sexual abuse, for example, may be more prone to sexually transmitted infections, including syphilis and HIV (human immunodeficiency virus). Importantly, abnormal ano–genital signs are uncommon in children examined for suspected child sexual abuse (Heger *et al*., 2002; RCPCH, 2007). Adolescents who have experienced sexual abuse are more likely to experience ongoing health problems such as chronic pelvic pain and other gynecologic problems, gastrointestinal problems, headaches, and increased obesity (Springer *et al*., 2007). Both physical and sexual abuse are associated with a doubling of the risk of attempted suicide for young people by the time they reach their late twenties (Gilbert *et al*., 2008). The link between maltreatment and many of these adverse consequences may be stress and depression, which can influence the immune system and may lead to higher risk-taking behaviors such as smoking, abuse of alcohol, illegal drugs, and overeating (Widom and Maxfield, 2001). The broad range of direct and indirect health effects of child maltreatment is likely to have a substantial impact on a victim’s life expectancy and long-term health-related quality of life (HRQL).

**2.3 EFFECTS ON CHILDREN’S MENTAL HEALTH AND WELLBEING**

All types of maltreatment can affect a child's emotional, psychological and mental wellbeing, and these consequences may appear immediately or years later. The immediate and longer-term impact of abuse can include mental health problems such as anxiety, depression, substance misuse, eating disorders, self-injurious behavior, anger and aggression, sexual symptoms and age-inappropriate sexual behavior (Lanktree *et al*., 2008). Numerous studies have documented associations between a child’s exposure to maltreatment with negative mental health outcomes: low self-esteem and depression (Briere, 1996; Heim and Nemeroff, 2001); severe anxiety (Kendler *et al.,* 1998); addictions, drug and alcohol abuse (Bremner *et al*., 2000); post-traumatic stress disorder (McCauley *et al.*, 1997); self-harming and suicidality (Oates, 2003); and being bullied (Duncan, 1999). Other psychological and emotional conditions include panic disorder, dissociative disorders, attention deficit/hyperactivity disorder, and reactive attachment disorder (Teicher, 2000; De Bellis and Thomas, 2003; Springer *et al.*, 2007). In one long-term study by Silverman *et al*., (1996), as many as 80 per cent of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder by the time they reached age 21. These young adults exhibited many problems, including depression, anxiety, eating disorders, and suicide attempts. Children who experience rejection or neglect are more likely to develop antisocial traits as they grow up and are more associated with borderline personality disorders and violent behavior (Schore, 2003). Abused and neglected adolescents are estimated to be at least 25 per cent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems (Kelley *et al.,* 1997). Other studies suggest that abused young people are likely to engage in sexual risk-taking as they reach adolescence, thereby increasing their chances of contracting sexually transmitted infections (Johnson *et al.*, 2006). Evidence shows that around 50 per cent of people receiving mental health services report abuse as children: one review found that “on careful questioning, 50 to 60 per cent of psychiatric inpatients and 40 to 60 per cent of outpatients report childhood histories of physical or sexual abuse or both.” (Read, 1998). Others have concluded that “child abuse may have a causative role in the most severe psychiatric conditions.” (Fergusson *et al.,* 1996; Mullen *et al.*, 1993). While the negative effects on health and development can often, though not always be reversed, this requires timely identification of the maltreatment and appropriate intervention. The harmful effects vary depending on a number of factors, including the circumstances, personal characteristics of the child, and the child’s environment (Gelles, 1998), and may endure long after the abuse or neglect occurs. Researchers have identified links between child maltreatment with difficulties during infancy, such as depression and withdrawal symptoms, common among children as young as three who have experienced emotional or physical abuse, or neglect (Dubowitz *et al.*, 2002). Heim and Nemeroff (2001) suggest that early childhood abuse and trauma can cause a persistent biological state, which is likely to function as a risk factor for the occurrence of mental disorders in later life. It follows that abuse in childhood should be recognised as an important risk factor for mental disorders (Agid *et al.*, 2000). Persistent neglect can lead to serious impairment of health and development; children may also experience low self-esteem or feelings of being unloved and isolated.

**2.4 DOMESTIC ABUSE AND ITS EFFECTS ON CHILDREN**

Research has consistently shown that a high proportion of children living with domestic violence are themselves being abused, either physically or sexually, by the same perpetrator. Walby and Allen (2004) report a co-occurrence of domestic violence and child abuse in 40 per cent of cases, while Mullender *et al.,* (2003, 2005) estimate that in 90 per cent of incidents, children are witnesses to the violence. Prolonged and/or regular exposure to domestic abuse can, despite the best efforts of the parents to protect the child, seriously affect the child’s development, health and emotional wellbeing in a number of ways. It poses a threat to unborn children (Bacchus *et al.,* 2002), because assaults on pregnant women frequently involve punches or kicks directed at the abdomen, risking injury to both mother and foetus (Jasinski, 2004). Domestic abuse during pregnancy and the first six months of child rearing is significantly related to various types of child maltreatment (child physical abuse, neglect, and emotional abuse) up to the child’s fifth year, with children under one year at the highest risk of injury or death (Goodall and Lumley 2007). Older children may also suffer blows during episodes of violence, and children who live in homes where domestic violence occurs are 15 times more likely to be physically abused or seriously neglected compared to the general child population (Carlson, 2000). Children may also be greatly distressed by witnessing the physical and emotional suffering of a parent (Mullender, 2005; Hester *et al*., 1998; McGee 2000; Mullender *et al*., 2003), which can in itself be psychologically and emotionally harming. Studies by Silvern *et al.,* (1995) and Singer *et al.,* (1998) indicate that child witnesses to domestic violence are, on average, more aggressive and fearful and more often suffer from severe anxiety, depression and other trauma-related symptoms. They live with constant anxiety and may be at a higher risk of alcohol or drug abuse, experience cognitive problems or stress-related ailments (headaches, rashes), and have difficulties in school

**2.5 MEDICAL AND PHYSIOLOGICAL CONSEQUENCES OF CHILD ABUSE**

Physical abuse in infants and young children can lead to brain dysfunction (Dykes, 1986) and sometimes death. Most fatality victims of abuse and neglect are under age 5. In 1991, an estimated 1,383 children died from abuse or neglect; 64 percent of these deaths were attributed to abuse and 36 percent to neglect (McCurdy and Daro, 1992). However, the number of child deaths caused by abuse and neglect may actually be much higher, since cause of death is often misclassified in child fatality reports (McClain *et al*., 1993; Robinson and Stevens, 1992).

A child does not need to be struck on the head to sustain brain injuries. Dykes (1986) has indicated that infants who are shaken vigorously by the extremities or shoulders may sustain intracranial and intraocular bleeding with no sign of external head trauma. Thus early neglectful and physically abusive practices have devastating consequences for their small victims.

Neglect cases may occur at any point of a child's development but are often associated with early childhood, when they are more likely to be discovered by health professionals, educators, and child welfare workers. One form of child neglect is associated with *nonorganic failure to thrive*infants. The absence of physical growth in these infants can be measured by objective scales of weight and height (Drotar, 1992). Neglect is usually suspected when such infants demonstrate significant weight gain following hospital admission or child removal from the family. Derivational dwarfism, a medical term applied to children of small stature whose physical growth is impaired by the absence of nutritional requirements, is another type of child neglect associated with some young children. Even after diagnosis and treatment, the psychological consequences of emotional neglect persist. Polansky *et al*., (1981) found that young adolescents who in their infancy were diagnosed as failure to thrive were defiant and hostile. Drotar (1992) notes that factors that trigger nonorganic failure to thrive and child neglect should be separated from factors that maintain these behaviors. In early periods of neglectful behavior, the child may exhibit stressful behaviors in the forms of feeding problems, irritability, or deficits in social responsiveness that place increased demands on the parent's caretaking duties (Powell and Low, 1983; Powell *et al*., 1987). In some cases, nutritional deprivation, combined with increased maternal detachment, sets into motion a "vicious cycle of cumulative psychological risk" (Drotar, 1992:121). Eventually, the parent may begin to perceive the child as quiet, sickly, or not very competent, perceptions that may not be shared by others who observe the child (Ayoub and Miler, 1985; Kotelchuck, 1982). In the absence of growth indicators of nonorganic failure to thrive or deprivational dwarfism, clinical diagnosis of child neglect is quite difficult. Oates (1984a,b; 1992) has described some nonspecific behavioral characteristics of nonorganic failure to thrive infants, which include lack of smiling, an expressionless face, gaze aversion, self-stimulating behavior, intolerance of changes in routine, low activity level, and flexed hips.

Abuse and neglect may result in serious health problems that can adversely affect children's development and result in irremediable lasting consequences. Early studies of physically abused children documented significant neuromotor handicaps, including central nervous system damage, physical defects, growth and mental retardation, and serious speech problems (Elmer and Gregg, 1967; Green *et al*., 1974; Martin et al., 1974; Morse *et al*., 1970). Physically abused children have been found to have more mild neurologic signs, serious physical injuries, and skin markings and scars than their nonabused peers (Kolko *et al*., 1990). Children who have been sexually abused, and some children who have been physically neglected, have shown heightened sexuality and signs of genital manipulation. A particularly serious biological consequence of child and adolescent sexual abuse is the risk of sexually transmitted diseases, including human immunodeficiency virus, gonorrhea, and syphilis

 **2.6 COGNITIVE AND INTELLECTUAL CONSEQUENCES**

Cognitive and language deficits in abused children have been noted clinically (Augoustinos, 1987; Azar *et al*., 1988; Fantuzzo, 1990; Kolko, 1992). Abused and neglected children with no evidence of neurological impairment have also shown delayed intellectual development, particularly in the area of verbal intelligence (Augoustinos, 1987). Some studies have found lowered intellectual functioning and reduced cognitive functioning in abused children (Hoffman-Plotkin and Twentyman, 1984; Perry *et al*., 1983). However, others have not found differences in intellectual and cognitive functioning, language skills, or verbal ability (Alessandri, 1991; Allen and Oliver, 1982; Elmer, 1977; Lynch and Roberts, 1982).

Problematic school performance (e.g., low grades, poor standardized test scores, and frequent retention in grade) is a fairly consistent finding in studies of physically abused and neglected children (Eckenrode *et al*., 1991; Salzinger *et al*., 1984; Wolfe and Mosk, 1983), with neglected children appearing the most adversely affected. The findings for sexually abused children are inconsistent.

Dodge and colleagues (1990) found that physically harmed 4-year-old children showed deviant patterns of processing social information, related to aggressive behavior, at age 5. Physically harmed children (relative to nonphysically harmed children) were significantly less attentive to social cues, more inclined to attribute hostile intent, and less able to manage personal problems. They explain possible cognitive deficits in abused and neglected children by suggesting that physical abuse affects the development of social-information-processing patterns, which in turn lead to chronic aggressive behavior. The experience of severe physical harm is associated with the "acquisition of a set of biased and deficient patterns of processing social provocation information" (p. 1679).

Differences in findings on the cognitive and intellectual consequences of childhood maltreatment may be related to the failure to control for important variables, such as socioeconomic status, and the lack of statistical power of small sample sizes.Other possible explanations for the inconsistencies in this literature are the tendency of earlier studies to aggregate different types of maltreatment (which may mask different consequences associated with specific forms of child maltreatment) or the inclusion of children who had neurological dysfunction to begin with (which can dramatically influence cognitive and intellectual performance). More recent studies have excluded children with obvious neurological impairments. Yet maltreatment, especially early maltreatment, can cause injury to the central nervous system that results in future cognitive impairments (Lewis and Shanok, 1977).

 **2.7 PSYCHOSOCIAL CONSEQUENCES OF CHILD ABUSE**

 Some studies suggest that certain signs of severe neglect (such as when a child experiences dehydration, diarrhea, or malnutrition without receiving appropriate care) may lead to developmental delays, attention deficits, poorer social skills, and less emotional stability. Consequences of physical child abuse have included deficiencies in the development of stable attachments to an adult caretaker in infants and very young children (Cicchetti, 1989; Cicchetti and Barnett, 1991; Crittenden and Ainsworth, 1989). Poorly attached children are at risk for diminished self-esteem and thus view themselves more negatively than no maltreated children. In several studies, school-age victims of physical abuse showed lower self-esteem on self-report (Allen and Tarnowski, 1989; Kinard, 1982; Oates *et al*., 1985) and parent-report measures (Kaufman and Cicchetti, 1989), but other studies found no differences (e.g., Stovall and Craig, 1990).

The consequences of neglectful behavior can be especially severe and powerful in early stages of child development. Drotar (1992) notes that maternal detachment and lack of availability may harm the development of bonding and attachment between a child and parent, affecting the neglected child's expectations of adult availability, affect, problem solving, social relationships, and the ability to cope with new or stressful situations (Aber and Allen, 1987; Main *et al*., 1985). One study by Rohner (1986) has presented impressive cross-cultural evidence of the negative consequences of parental neglect and rejection on children's self-esteem and emotional stability.

In a prospective study of the qualitative range of caregiving in a high-risk sample, Egeland and Sroufe (1981) identified a group of mothers who were psychologically unavailable to their infants. These mothers were detached and unresponsive to their children's bids for care and attention. Children from this group were compared with physically abused, neglected, verbally rejected, and control groups from the same high-risk sample. Using multiple measures across different situations and outcome measures designed to assess the salient developmental issues of each age, the results indicated that children in all maltreatment groups functioned poorly (Erickson *et al*., 1989). Over time their functioning deteriorated. There were many similarities in terms of the pattern of development between the maltreatment groups, but there were also a number of interesting differences.

Nearly all the children in this study whose mothers were psychologically unavailable were anxiously attached at 18 months of age, with the majority of these classified as anxious avoidant (86 percent). These children were observed with their mothers in a problem-solving situation at 24 months and a teaching task at 42 months and were found to be angry, non-complacent, lacking in persistence, and displaying little positive affect. One of the most dramatic findings for these children was the nearly 40 point decline in performance on the Bayley Scales of Infant Development between 9 and 24 months. In the preschool classroom, these children presented varied and serious behavior problems.

Studies have reported evidence of other psychosocial problems in young children. Higher incidence of suicide attempts and self-mutilation have been reported in clinical samples (Green, 1978). Comparison studies with nonphysically abused children indicate heightened levels of depression, hopelessness, and lower self-esteem in physically abused children (Allen and Tarnowski, 1989; Kazdin *et al.,* 1985). Greater emotional difficulties in older physically abused children have also been identified (Kinard, 1980, 1982). In a more recent investigation involving prepubescent (ages 7 to 12) maltreated children, Kaufman (1991) found a disproportionate number of the maltreated children who met the diagnostic criteria for one of the major affective disorders.

Linkages between parental behaviors that have emotionally or psychologically destructive consequences on children have not been clearly established. While verbally or symbolically abusive acts designed to terrorize or intimidate a child (such as constant belittling or the destruction of a favorite object or pet) are associated with severe long-term consequences (Vissing *et al.,* 1991), the processes by which children interpret aggressive or neglectful actions are poorly understood. The failure to provide age-appropriate care (such as parental availability and nurturance), cognitive stimulation, or achievement expectations also can have profound psychological impact, especially when such omissions occur during critical child and adolescent developmental periods.

Although causal linkages between parental behaviors and the consequences on the child's development have been assumed, pathways that govern or mediate such linkages have not been well documented (Knudsen, 1992).

Inappropriate sexual behavior, such as frequent and overt self-stimulation, inappropriate sexual overtures toward other children and adults, and play and fantasy with sexual content, are commonly cited as symptoms of sexual abuse in studies that compare sexually abused with nonabused or nonclinical children (Kendall-Tackett *et al.,* 1993). Across six studies of sexually abused preschoolers (those most likely to manifest such symptoms), approximately 35 percent of the abused children showed such behaviors. Sexual abuse has also sometimes been associated with the onset of sexual activity in middle childhood. Reported rates vary widely because of differences in samples, measurement instruments, and definitions of the outcome behavior. The lowest estimates (of 7 percent) were based on a large study that included many well-functioning and older children.

While sexualization seems relatively specific to sexual abuse, inappropriate sexual behavior has been noted in nonsexual abused children. Deblinger *et al*., (1989) compared the reports of inappropriate sexual behaviors across sexually abused, physically abused, and non-abused psychiatrically hospitalized children matched for age, sex, and socioeconomic status. They found that approximately the same percentage of sexually inappropriate behavior in physically abused (17 percent) as in sexually abused children (18 percent). However, early sexual abuse may occur and not be documented until much later in life (Stein and Lewis, 1992).

In a recent review of studies reporting quantitative findings about the impact of sexual abuse of minors, Kendall-Tackett *et al*., (1993) found that sexually abused children were often more symptomatic than their nonabused counterparts in terms of fear, nightmares, general post-traumatic stress disorder, withdrawn behavior, neurotic mental illness, cruelty, delinquency, sexually inappropriate behavior, regressive behavior, running away, general problem behaviors, and self-injurious behavior. Estimates of sexually abused children diagnosed as meeting the DSM-III-R criteria for post-traumatic stress disorder range from 21 percent (Deblinger *et al.,* 1989) to 48 percent (McLeer *et al.,* 1988).

Sexually abused children, particularly those abused by a family member, may show high levels of dissociation, a process that produces a disturbance in the normally integrative functions of memory and identity (Trickett and Putnam, in press). Many abused children are able to self-hypnotize themselves, space out, and dissociate themselves from abusive experiences (Kluft, 1985). In some clinical studies, severely abused children appear to be impervious to pain, less empathetic than their nonabused peers, and less able than other children to put their own suffering into words (Barahal *et al*., 1981, Straker and Jacobson, 1981).

 **2.8 BEHAVIORAL CONSEQUENCES OF CHILD ABUSE**

Physical aggression and antisocial behavior are among the most consistently documented childhood outcomes of physical child abuse. Most studies document physical aggression and antisocial behavior using parent or staff ratings (Aber *et al*., 1990; Hoffman-Plotkin and Twentyman, 1984; Perry *et al*., 1983; Salzinger *et al*., 1984); other measures, such as child stories (Dean *et al*., 1986); or observational measures across a wide variety of situations, including summer camps and day care settings (Alessandri, 1991; Bousha and Twentyman, 1984; Howes and Eldredge, 1985; Howes and Espinosa, 1985; Kaufman and Cicchetti, 1989; Main and George, 1985; Trickett and Kuczynski, 1986; Walker *et al*., 1989). Some studies indicate that physically abused children show higher levels of aggression than other maltreated children (Hoffman-Plotkin and Twentyman, 1984; Kaufman and Cicchetti, 1989) although other studies indicate that neglected children may be more dysfunctional (Rohrbeck and Twentyman, 1986).

A prospective study comparing preschool children who were classified as physically harmed with those who were unharmed (Dodge *et al*., 1990) found that children with a history of physical harm were rated six months later as more aggressive by teachers and peers. These differences were not accounted for by the child's demographic or family background. Evidence from other longitudinal studies indicates continued problems of aggression and anger (Egeland and Sroufe, 1981b) and the development of conduct disorder (Rogeness *et al*., 1986). Children who experienced severe violence were reported (by their parents) in the National Family Violence Survey to have higher rates of conduct problems and rule violating behaviors than those who did not experience severe violence (Straus and Gelles, 1990; Hotaling *et al*., 1990).

Maltreated children may also be less competent in their social interactions with peers (Straus and Gelles, 1990; Howes and Espinosa, 1985). For some physically abused children, this may manifest in withdrawal or avoidance (Kaufman and Cicchetti, 1989), or fear, anger, and aggression (Main and George, 1985).

**CHAPTER THREE**

**3.0 RESEARCH METHODOLOGY**

This chapter deals with the method used in collecting data required in carrying out this research work under the following procedures;

- Research Design

- Population of the study

- Sampling and Sampling Techniques

- Instrument for Data Collection

- Validity of the Instrument

- Reliability of the Instrument

- Method of Data Collection

- Method of Data Analysis

**3.1 RESEARCH DESIGN**

For this research descriptive method was used to deal with meaningful documents concerning child abuse record of Maitumbi ward. This method was chosen because it will help to describe, record, analyze and interpret the condition that exist in the study.

**3.2 POPULATION OF THE STUDY**

There are many settlement which made up Maitumbi ward of Bosso Local Government Area. However, not all the settlement were used, but all the settlements are expected to be population of the study. It should be noted that the population was reduced to the barely minimum, to have an accurate and reliable result. The settlements used was Sabon Anguwa and Gudugudu. The population used also covered the following group of people: parents, teachers, other civil servants and guardians. All these people were contacted at offices, market square and other residing places in the settlement covered.

**3.3 SAMPLING AND SAMPLING TECHNIQUES**

The sampling technique utilized to obtain the fact presented in this research was the random sampling. The total number of 100 members were sample for the research

**3.4 INSTRUMENT FOR DATA COLLECTION**

Questionnaire was the master Instrument used for data collection. It was divided into two sections; A and B. Section A contained the demographic data of the respondents, while section B consist of questions relevant to the subject matter. The questionnaire was designed to obtain sufficient and relevant information from the respondents.

**3.5 VALIDITY OF THE INSTRUMENT**

The questionnaire was presented to the research supervisor for corrections and suggestions in order to make the Instrument more accurate and reliable.

**3.6 RELIABILITY OF THE INSTRUMENT**

The reliability of the Instrument was done by selecting 10 of the respondents and administered the Instrument twice (2) in seven (7) days and the correlation of coefficient is calculated to ensure the clarity and effectiveness of the Instrument.

**3.7 METHOD OF DATA COLLECTION**

Data for the study was collected using self-structured questionnaires in which a total number of one hundred (100) questionnaires was distributed to respondents.

**3.8 METHOD OF DATA ANALYSIS**

The data was analyzed by the use of table of frequency and percentage. This is appropriate because it aimed at enhancing better and clear understanding of work.

x/y × 100/1

x= No of respondents

y= Total number of respondents

100= Percentage of average

This will enable the researcher to represent the respondents in a simple term.

**CHAPTER FOUR**

**4.1 RESULTS AND DISCUSSION**

This chapter presents the findings on the data which researcher obtained from the people sample in the area of study and the discussion of the result. The analysis of data collected is in percentage (%). It should be noted that the analysis was based on 74 retrieved questionnaires.

**4.2 PRESENTATION OF DATA**

 **SECTION (A) DEMOGRAPHIC DATA**

**TABLE 1**: Sex of the respondents?

|  |  |  |
| --- | --- | --- |
| Sex | FREQUENCY | PERCENTAGE |
| Male  | 31 | 42% |
| Female | 43 | 58% |
| TOTAL | 74 | 100% |

The above table shows that majority of the respondents were female with 58% and the remaining were 42% male.

**TABLE 2**: Age of the respondents?

|  |  |  |
| --- | --- | --- |
| VARIABLE | FREQUENCY | PERCENTAGE |
| 20 – 25 | 11 | 15% |
| 26 – 30 | 24 | 32% |
| 31 – 35 | 20 | 27% |
| 36 – 40 | 14 | 19% |
| 41 and above | 5 | 7% |
| TOTAL | 74 | 100% |

The above table shows that 32% of the respondents were between the age range of 26-30, followed by 27% of those with the age of 31-35, then 19% age range between 36-40, while 15% range between 20-25 and 7% range between 41 and above.

**TABLE 3**: Religion of the respondents?

|  |  |  |
| --- | --- | --- |
| RELIGION | FREQUENCY | PERCENTAGE |
| Muslims | 51 | 69% |
| Christians | 23 | 31% |
| Others | 0 | 0% |
| TOTAL | 74 | 100% |

The above table shows that the majority of the respondents were Muslims (69%), followed by Christian's (31%).

**TABLE 4**: Marital status of the respondents?

|  |  |  |
| --- | --- | --- |
| MARITAL STATUS | FREQUENCY | PERCENTAGE |
| Married | 37 | 50% |
| Single | 34 | 46% |
| Divorced | 3 | 4% |
| Widow | 0 | 0% |
| TOTAL | 74 | 100% |

The above table shows that (50%) of the respondents were married, followed by (46%) single, then the remaining (4%) were divorced.

**TABLE 5**: Tribe of the respondents?

|  |  |  |
| --- | --- | --- |
| TRIBE | FREQUENCY | PERCENTAGE |
| Gbagyi | 31 | 42% |
| Nupe | 19 | 26% |
| Hausa | 15 | 20% |
| Others | 9 | 12% |
| TOTAL | 74 | 100% |

The above table shows that the majority of the respondents were Gbagyi (42%), followed by Nupe (26%), then Hausa (20%) and (12%) Yoruba, Igbo and Fulani.

**TABLE 6**: Educational level of the respondents?

|  |  |  |
| --- | --- | --- |
| EDUCATIONAL LEVEL | FREQUENCY | PERCENTAGE |
| SSCE/OND | 24 | 32% |
| HND/BSC | 20 | 27% |
| PGD/MSC | 11 | 15% |
| PHD | 14 | 19% |
| Others | 5 | 7% |
| TOTAL | 74 | 100% |

The above table shows the educational level of the respondents, SSCE/OND with (32%), then HND/BSC with (27%), then PHD with (19%), followed by (15%) PGD/MSC, and (7%) other qualifications.

**SECTION (B) RESEARCH QUESTIONS**

**TABLE7**: What are the most common form of maltreatment in your locality**?**

|  |  |  |
| --- | --- | --- |
| RESPONSES | FREQUENCY | PERCENTAGE |
| Physicalabuse | 19  | 26% |
| Emotionalabuse | 31 | 42% |
| Educationalneglect | 9 | 12% |
| Medicalneglect | 15 | 20% |
| Others | 0 | 0% |
| TOTAL | 74 | 100% |

The above table shows that (42%) respondents believed that emotional abuse is the most common type of maltreatment, followed by physical abuse with (26%), then medical neglect with (20%) and Educational neglect with (12%) respondents respectively.

**TABLE 8**:What are the common health implications of child abuse in your community?

|  |  |  |
| --- | --- | --- |
| RESPONSES | FREQUENCY | PERCENTAGE |
| Post-traumatic stress | 4 | 5% |
| Developmental delay | 39 | 53% |
| Eating disorder | 20 | 27% |
| Physical ailments and injuries | 5 | 7% |
| Learning disorder | 6 | 8% |
| TOTAL | 74 | 100% |

The above table shows that 39 of the respondents with (53%) believed that developmental delay is one of the common health implication of child abuse, followed by eating disorder with 20 (27%) while 6 (8%) of the respondents said learning disorder, followed by physical injuries and ailments with 5(7%) and those that said post-traumatic stress with4(5%)respectively.

**TABLE 9**: What suggestions can you make on how child abuse can be eliminated/controlled in our society?

|  |  |  |
| --- | --- | --- |
| RESPONSES | FREQUENCY | PERCENTAGE |
| Keep your children healthy, do not deny children food, sleep or healthcare | 18 | 28% |
| Get control of yourself before disciplining a child | 6 | 8% |
| Join a support prevention program for new parents | 7 | 10% |
| Make your home a violence free home | 4 | 4% |
| Government should support families and provide parents with the skills and resources they need | 10 | 11% |
| All of the above  | 29 | 39% |
| TOTAL | 74 | 100% |

The above table shows that 29 respondents with 39% believed that all the measures can be used to eliminate child abuse in our society, then 18 respondents with 28% believed that keeping your children healthy, do not deny them food, sleep or healthcare is the measure to be taken to eliminate child abuse, while 11% believed that government should support families and provide parents with the skills and resources they need is the measure to be taken and other 7 respondents with 10% believed that joining a support prevention program for new parents is the measure to be taken, then 6 respondents with 8% believed that getting control of yourself before disciplining a child is the measure to be taken and finally the remaining 4 respondents with 4% believed that making your home a violence free home is the best measure to be used.

**CHAPTER FIVE**

 **CONCLUSION AND RECOMMENDATION**

**5.1 CONCLUSION**

This research work have been able to bring out some of the problems and possible challenges faced by abused children. Starting from the diseases that affect the abused children, dangers involved in life and personality challenges. The paper is not to curse those that were affected and my research conclude that those affected are not nonentity, they still have function to discharge.

Coping with all this challenges requires that couples should be committed to remaining in the relationship through it's inevitable up and downs. They will be need to be tolerant of each other's imperfections and keep their perspective and sense of humor. Commitment is a promise of a shared future, a promise to be together come what may. Committed partners put effort and energy into the relationship no matter how they feel, they take time to attend to their partner, give compliments, deal with conflict when necessary and take good care of their children.

**5.2 RECOMMENDATION**

* Parent should be encouraged to give an appropriate education to their children.
* There should be public enlightenment programs to combat mass ignorance and public awareness on the right to freedom from all forms of child abuse.
* Government, health agencies and medical personnel’s should encourage parent on family planning in other to reduce child abuse by giving children good/quality education, adequate food supply and medication.
* Government and those that are financially buoyant should create job opportunities to reduce child abuse and neglect.
* Government should create awareness to those who have cultural believe on children, most of which are only fetish and contribute negatively to the upbringing of children.

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**DELIGHT COLLEGE OF HEALTH SCIENCES AND TECHNOLOGY**

 **MINNA, NIGER STATE.**

**DEPARTMENT OF COMMUNITY HEALTH EXTENTION WORKERS (CHEW)**

**QUESTIONNAIRE ON THE HEALTH IMPLICATION OF CHILD ABUSE IN MAITUMBI WARD OF BOSSO LOCAL GOVERNMENT AREA MINNA, NIGER STATE.**

Dear Respondents,

I am a final year student of the above named institution, conducting research project to find out the **"HEALTH IMPLICATION OF CHILD ABUSE IN MAITUMBI WARD OF BOSSO LOCAL GOVERNMENT AREA OF NIGER STATE"** as part of the requirements of Community Health Extension workers Registration Council of Nigeria for the award of National Diploma (ND) certificate.

Your truthful information/opinion will be held as confidential issue.

 Thank you for your participation and cooperation.

 **Zakari Ubaidat.**

**QUESTIONNAIRE**

**INSTRUCTIONS**

Please tick {✔️} appropriate below

**SECTION (A) DEMOGRAPHIC DATA**

(1) Sex of respondent?

 (a) Male { }

 (b) Female { }

(2) Age distribution of respondents?

 (a) 20 -25 { }

 (b) 26-30 { }

 (c) 31-35 { }

* 36-40 { }
* 41 and above { }

(3) Religion of respondents

 (a) Muslim { }

 (a) Christian { }

 (c) Others specify...............................................

(4) Marital status of respondents?

 (a) Married [ ]

 (b) Single [ ]

 (c) Divorce [ ]

 (d) Widow [ ]

(5) Tribe of respondents?

 (a) Gbagyi { }

 (b) Nupe { }

 (c) Hausa { }

 (d) Others specify....................................................

(6) Educational qualification of respondents

 (a) SSCE/OND { }

 (b) HND/BSC { }

(c) PGD/MSC { }

 (d) PHD { }

 (e) Others specify……………………………….

**SECTION (B)**

(7) What are the most common types of maltreatment in your locality?

 (a) Physical abuse { }

 (b) Emotional abuse { }

 (c) Educational neglect { }

 (d) Medical neglect { }

 (e) Others specify........................................................

(8) What are the common health implications of child abuse in your community?

(a) post-traumatic stress

(b) Developmental delay

(c) Eating disorder

(d) Physical ailments and injuries

(e) Learning disorder

(9) What suggestion can you make on how child abuse can be eliminated/controlled in our society?

 (a) Keep your children healthy, do not deny children food, sleep or healthcare { }

 (b) Get control of yourself before disciplining a child { }

 (c) Join a support prevention program for new parents { }

 (d) Make your home a violence free home { }

 (e) Government should support families and provide parents with the skills and resources they need { }

 (f) All of the above { }