

# Childhood Sexual Abuse among Outpatients Attending Adult Psychiatric Outpatient Clinics: A Case-Control Study

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## ABSTRACT

*Only a few studies have focussed on the importance of routine investigation of childhood sexual abuse in outpatients attending adult psychiatric outpatient clinics. The aim of this study is to explore the association between having a history of childhood sexual abuse (CSA) and attending adult Psychiatric Outpatient Clinics in Trinidad.*

**Methods:** *This was a case-control study conducted in twelve psychiatric outpatient clinics located throughout Trinidad. A questionnaire covering demographic, social, and sexual abuse components was administered by semi-structured interview to 566 participants, of whom 242 were cases, 239 were controls and 85 had incomplete questionnaires. The cases were 242 patients attending psychiatric outpatient clinics in Trinidad and the controls were 239 non-physician staff members at the clinics. Results were analyzed using the Statistical Package for the Social Sciences (SPSS) version 10.*

**Results:** *Chi-square analyses revealed several significant differences between the cases and control group. Sixty-three (26%) cases and 29 (12.1%) controls experienced CSA ( $p < 0.000$ ). Twenty-five (39.7%) of the CSA cases had their experiences between the ages of 4 to 8 years and 13 (44.8%) of the CSA controls had their experiences between the ages of 9 to 12 ( $p < 0.01$ ). Twenty-six (41.3%) of the cases and 3 (10.3%) of the controls had been abused at least 5 times ( $p < 0.000$ ). Seventeen (58.6%) abused CSA controls reported having been sexually abused as a child only once. CSA with both force and manipulation was reported by 30 (47.6%) CSA cases while 6 (20.7%) CSA controls experienced CSA with force and manipulation ( $p < 0.025$ ). The abused CSA cases reported having a smaller social network of 2 persons compared to the abused CSA controls who had a social network of more than 4 persons ( $p < 0.05$ ). Of the 92 abused participants, 73.9% were women, and only 52.2% had told someone about the CSA. For the majority of CSA cases and CSA controls, the abuse involved one abuser.*

**Conclusion:** *A positive correlation was established between earlier onset of CSA, repeated abuse (occurring more than 5 times), a limited social network in patients who had CSA and attending adult psychiatric outpatient clinics. Identifying CSA in psychiatric outpatients may lead to early intervention and aid patient management.*

# Abuso Sexual Infantil Entre los Pacientes Externos que Asisten a las Clínicas Psiquiátricas Ambulatorias para Adultos: un Estudio de Caso-Control

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## RESUMEN

*Pocos estudios han centrado su atención en la importancia de la investigación de rutina en relación con el abuso sexual infantil en pacientes externos que asisten a las clínicas psiquiátricas ambulatorias para adultos. El objetivo del presente estudio es explorar la relación que existe entre poseer una historia de abuso sexual infantil (ASI) y asistir a las clínicas psiquiátricas ambulatorias para adultos en Trinidad.*

**Métodos:** *Se trató de un estudio de caso-control realizado en doce clínicas psiquiátricas para pacientes externos, diseminadas por toda Trinidad. Se administró un cuestionario que abarcaba componentes demográficos, sociales y sexuales, mediante entrevistas semi-estructuradas, a 566 participantes, de los cuales 242 fueron casos, 239 fueron controles, y 85 dejaron sus cuestionarios incompletos. Los casos*

fueron 242 pacientes que asistían a las clínicas externas de psiquiatría, y los controles fueron 239 miembros no médicos del personal en las clínicas. Los resultados fueron analizados usando la versión 10 del Paquete Estadístico para las Ciencias Sociales (SPSS).

**Resultados:** Los análisis de chi-cuadrado revelaron varias diferencias significativas entre los casos y el grupo de control. Sesenta y tres (26%) casos y 29 (12.1%) controles habían experimentado ASI ( $p < 0.000$ ). Veinticinco (39.7%) de los casos de ASI tuvieron sus experiencias entre las edades de 4 a 18 años y 13 (44.8%) de los controles de ASI tuvieron sus experiencias entre las edades de 9–12 ( $p < 0.01$ ). Veintiséis (41.3%) de los casos y 3 (10.3%) de los controles habían sido víctimas de abuso por lo menos 5 veces ( $p < 0.000$ ). Diecisiete (58.6%) de los controles víctimas de ASI, reportaron haber sido abusados sexualmente cuando niños, una sola vez. ASI con fuerza y manipulación, fue reportado por 30 (47.6%) casos de ASI mientras que 6 (20.7%) controles de ASI, experimentaron ASI con fuerza y manipulación ( $p < 0.025$ ). Los casos de abuso de ASI, reportaron haber tenido una red social más pequeña de 2 personas, en comparación con los controles de abuso de ASI, que tenían una red social de más de 4 personas ( $p < 0.05$ ). De los 92 participantes víctimas de abuso, 73.9% eran mujeres, y sólo 52.2% le habían contado a alguien sobre el ASI. Para la mayor parte de los casos de ASI y controles de ASI, en el abuso hubo un solo abusador implicado.

**Conclusión:** Se estableció una correlación positiva entre el comienzo más temprano del ASI, la repetición del abuso (que ocurría más de cinco veces), y una limitada red social en pacientes que fueron víctimas de ASI y asistían a las clínicas psiquiátricas ambulatorias. La identificación de ASI en pacientes psiquiátricos externos, puede conducir a una temprana intervención y tratamiento de ayuda al paciente.

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## INTRODUCTION

Child sexual abuse (CSA) has been known in the privacy of affected families but acknowledging abuse has long been a social taboo. Those who have been affected by CSA are often reluctant to disclose their experience to human service professionals or law enforcement personnel (1). Until recently, this pattern was also evident in Trinidad.

Many studies (2–13) have been published on the psychopathological impact of and psychiatric symptoms related to CSA. However, only a few studies (14, 15) have focussed on the importance of routine investigation of childhood sexual abuse among psychiatric outpatients.

The aim of this study was to explore the association between a history of CSA and attending Psychiatric Outpatient Clinics in Trinidad. The study also examined whether earlier onset of CSA, higher frequency of CSA, a lack of social support, and nature of the episodes of CSA (force or manipulation) predisposed one to attend a psychiatric outpatient clinic in Trinidad. Few studies have been done in Trinidad and Tobago in this area.

## SUBJECTS AND METHODS

A case-control study was used to explore the association between CSA and the attendance of adults at psychiatric outpatient clinics in Trinidad. This study was given ethical approval by the Ethics Committee of the Faculty of Medical Sciences, the University of the West Indies (St Augustine campus).

Questionnaires were distributed among the cases and the controls at each of the specified clinics under each regional health authority in Trinidad (6 clinics in the North West Regional Health Authority and Eastern Regional Health

Authority: St Ann's, Petit Valley, Sangre Grande, Arima, Rio Claro and Tacarigua; 6 clinics in the South West Regional Health Authority: San Fernando, Point a Pierre, Cedros, Siparia, Princes Town and Couva).

Data were collected from 566 participants. There were 242 cases, 239 controls and 85 participants who had incomplete questionnaires. Of the 85 incomplete questionnaires, 52 (61.1%) were from the 'cases' group and 33 (38.9%) were from the control group. Data were collected by one-to-one interviews. The sample size was calculated based on assumptions from a previous study, which estimated 23% of controls would have experienced childhood sexual abuse, and 37% of cases would have been sexually abused as children (16). By convention, the  $\alpha$  (type I error) and  $\beta$  (type II error) were set at 0.05 and 0.1 respectively.

The cases were all registered outpatients at psychiatric clinics throughout Trinidad. Each patient was initially screened to establish that he or she was a Trinidadian above the age of 16 years. The controls were staff members employed at medical and psychiatric clinics of the North West Regional Health Authority but excluded doctors. These staff members included janitors, clerical staff, drivers, nurse's aides, porters, cooks and messengers, and other staff employed at the respective clinics. The interviewers were not known to the controls. Written informed consent was obtained from each participant. In a semi-structured interview, the cases and controls were administered a questionnaire which had been pre-tested on non-clinical staff and on students at the University of the West Indies.

The questionnaire used to collect data comprised three components: a demographic section, a social background section and a childhood sexual abuse component. The demo-

graphic component included age, gender, residence, religion, ethnicity, marital status, education, income, and household size. The social background component explored participants' comfort with interpersonal relationships and available social support systems and consisted of an 11-item list. Childhood sexual abuse was assessed using 23 items. For the purposes of this study, CSA was defined as sexual events: a) using force, violence, subtlety, or coercion/ manipulation; b) involving fondling, exhibitionism, unwanted sexual advances, penetration, and/or portrayal of and participation in pornography; c) experienced by children under the age of 16 years; d) involving a family member, family friend, or stranger at least 3 years older than the child (17, 18). The demographic component was assessed with 12 items and a frequency for each item was calculated. Social support items were averaged to form a single score for each participant. Frequencies and proportions were obtained regarding various aspects of the CSA experiences reported by the participants.

Statistical analyses were carried out using the Statistical Package for the Social Sciences (SPSS) version 10. Bivariate statistics (chi-square with Yates's correction for 2 x 4 and 2 x 3 contingency tables and 2 x 2 tables) were used to compare: 1) respondents who reported a history of childhood sexual abuse with those who did not experience childhood sexual abuse and 2) the frequency of childhood sexual abuse and familial and social variables between sexually abused respondents with and without subsequent attendance at psychiatric outpatient facilities in Trinidad.

## RESULTS

Table 1 shows the demographics of the cases and controls. As seen in the Table, the majority of respondents in both subsamples were female, of East Indian and African origin, Christian, single and from a two-parent household. The mean age of cases was 40.9 years (SD 13.8), range, 17–72 years, and for the controls the mean age was 36.2 (SD 14.6), range 17–62 years. Among the entire sample, ninety-two (16.3%) participants experienced childhood sexual abuse (CSA). Of these participants, 63 (68.5%) were cases and 29 (31.5%) were controls.

Adult psychiatric outpatient cases (63/242 = 26.0%) were significantly more likely than the controls (29/239 = 12.1%) to have experienced CSA ( $\chi^2 = 15.01$ ,  $df = 1$ ,  $p < 0.000$ ). A positive association between CSA and attendance at psychiatric outpatient clinics was confirmed.

Table 2 describes the characteristics of the CSA for the cases and controls. For the majority of cases and controls, the abuse involved one abuser and this abuser was usually a person other than parents, siblings, aunt, uncle or family friend.

Table 3 describes the identity of the abuser. Among the cases 16 /63 (25.4%) reported that a family friend was the abuser and among the controls 8/29 (27.6%) reported that a family friend was the abuser. Some respondents indicated

Table 1: Demographics of participants

Demographics	Cases (n = 242)		Controls (n = 239)	
	n	%	n	%
<b>Age</b>				
10–19*	6	2.5	1	0.4
20–29	36	14.9	92	38.5
30–39	46	19.0	48	20.1
40–49	69	28.5	48	20.1
50–59	52	21.5	41	17.2
60–69	26	10.7	5	2.1
70–79	4	1.7	0	0.0
Not given	3	1.2	4	1.7
<b>Gender</b>				
Male	109	45.0	46	19.2
Female	132	54.5	190	79.5
Not given	1	0.4	3	1.3
<b>Ethnicity</b>				
African	69	38.7	100	41.8
East Indian	100	39.8	107	44.8
Chinese	2	0.4	0	0.0
Other	70	20.1	28	11.7
Not given	1	1.1	4	1.7
<b>Religion</b>				
Christian	161	66.5	151	63.2
Islam	18	7.4	19	7.9
Hindu	46	19.0	58	24.3
Other	15	6.2	11	4.6
Not given	2	0.8	0	0.0
<b>Marital Status</b>				
Married	50	20.7	92	38.5
Single	131	54.1	114	47.7
Divorced	9	3.7	10	4.2
Separated	16	6.6	5	2.1
Widowed	25	10.3	6	2.5
Common law	10	4.1	7	2.9
Not given	1	0.4	5	2.1
<b>Household</b>				
Single parent	64	26.4	53	22
Two parent	165	68.2	178	74.5
No parents	10	4.1	3	1.3
Not given	3	1.2	5	2.1
<b>Income/month (TT\$)</b>				
<500	110	45.3	4	1.7
500–999	45	18.6	2	0.8
1000–1999	28	11.6	21	8.8
2000–2999	26	10.7	55	23.0
>3000	24	9.9	141	59.0
Not given	9	3.7	16	6.7
<b>Education</b>				
Primary	115	47.5	18	7.5
Secondary	88	36.4	121	50.6
Tertiary	17	7.0	55	23.0
University	13	5.4	43	18.0
Blind school	4	1.7	0.0	0.0
Not given	5	2.1	2.0	0.8

\*No participant was under 16 years  
Cases n = 242, Controls n = 239

Table 2: Characteristics of childhood sexual abuse for abused cases (n = 63) and abused controls (n = 29)

Characteristics of CSA	Cases (n = 63)		Control (n = 29)	
	n	%	n	%
<b>Nature of Abuse</b>				
Force	23	36.5	14	48.3
Manipulation	10	15.9	9	31.0
Both	30	47.6	6	20.7
<b>Age of Onset</b>				
0-3	1	1.6	2	6.9
4-8	25	39.7	4	13.8
9-12	14	22.2	13	44.8
13-16	22	34.9	4	13.8
Not known/missing	1	1.6	6	20.7
<b>Age of Termination</b>				
0-3	1	1.6	1	3.4
4-8	9	14.3	2	6.9
9-12	12	19.0	9	31.0
13-16	22	34.9	7	24.1
more than 16	14	22.2	3	10.3
never stopped	0	0.0	4	13.8
not known/missing	5	7.9	3	10.4
<b>Number of Abusers</b>				
One	38	60.3	14	48.3
Two	7	11.1	5	17.2
Three or more	17	27.0	3	10.3
Not known/missing	1	1.6	7	24.1

CSA in cases 63/242, CSA in controls 29/239

Table 3: Identity of abuser for abused cases (n = 63) and abused controls (n = 29)

Identified abuser	Cases (n = 63)	Controls (n = 29)
Mother	2	0
Father	4	0
Family friend	16	8
Sibling	8	0
Uncle	7	1
Aunt	1	1
Other	38	19

Note: Some respondents indicated that they were abused by more than one person. Therefore, percentages are not reported, since they would total greater than 100%.

that they were abused by more than one person therefore it was not possible to work out the statistical significance of this finding.

Regarding the role of force, 30 (47.6%) CSA cases reported that their abuse involved both force and manipulation while 6 (20.7%) CSA controls reported that their abuse involved both force and manipulation. The cases and controls also differed in the nature of the means used to accomplish the abuse. Cases were significantly more likely

than controls to report that a combination of force and manipulation was used ( $\chi^2 = 6.046$ ,  $df = 1$ ,  $p < 0.025$ ).

In the majority of CSA cases (n = 25, 39.7%), the age of onset of CSA was between 4 and 8 years as compared to the majority of CSA controls (n = 13, 44.8%) where the age of onset of CSA occurred between 9 and 12 years.

Figure shows the frequency of CSA in abused cases and abused controls. Twenty-six CSA cases (41.3%) ex-

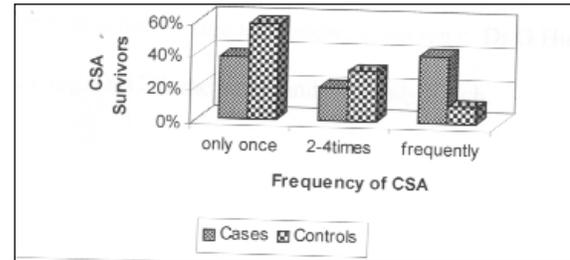


Figure: Frequency of childhood sexual abuse

perienced CSA at least five times while the same was true for 3 (10.3%) CSA controls. This finding achieved statistical significance ( $\chi^2 = 22.65$ ,  $df = 4$ ,  $p < 0.000$ ). It was not possible to calculate the mean, mode and standard deviation of the number of times that the CSA cases and controls were abused; some respondents were abused so frequently that they could not give an accurate count of the number of times they had been abused.

Twenty-four CSA cases (39.1%) had vaginal intercourse against their will and 3 CSA controls (10.3%) had a similar experience ( $\chi^2 = 6.10$ ,  $d.f. = 1$ ,  $Yates p < 0.01$ ). In the 2 x 2 case of the chi-square test of independence, expected frequencies less than 5 are usually considered acceptable if Yates' correction is employed.

Nine CSA cases (14.3%) were subjected to anal intercourse against their will but none (0.0%) of the CSA controls had a similar experience. The data in this case did not meet the statistical requirement for chi-square testing; however, inspection of the data suggests a strong association.

Thirty-three CSA cases (52.4%) had abuse that involved either vaginal or anal penetration while 3 CSA controls (10.3%) had vaginal penetration.

More controls than cases reported having a social network of four or more persons ( $\chi^2 = 8.64$ ,  $df = 3$ ,  $p < 0.05$ ).

## DISCUSSION

This study yielded a positive association between childhood sexual abuse and attendance at psychiatric outpatient clinics in Trinidad. Victims of CSA were 2.2 times more likely to be seen in psychiatric consultations than controls (OR 2.2%, 95% CI 1.5, 4.25,  $p = 0.001$ ). In both the cases and controls, females accounted for a higher percentage (73.9%) of those abused compared to the males (26.1%). This finding is in keeping with other studies in different cultures (19-23).

When comparing the abused cases with the abused control, it was found that, generally, the CSA cases had an

earlier onset of abuse than the CSA controls. This may imply that the earlier the experience of abuse, the weaker the coping mechanism for dealing with it, thus increasing the likelihood of developing a mental illness later on in life. There were not many instances of abuse reported under the age of four years, which was expected, because it is likely that most people are unable to recall information from that early in their childhood (24).

This study also showed a positive association between a high frequency (occurring more than 5 times) of abuse and attendance at psychiatric outpatient clinics. This was clearly indicated by the results in which the majority of CSA cases reported having experienced CSA on multiple occasions while the majority of CSA controls reported having experienced CSA on only one occasion. Though a high percentage of abused participants reported their sexual abuse involved force, abuse that involved both force and manipulation may have been a contributing factor to the development of mental illnesses.

Prior investigations suggest that severe abuse involving attempted or completed penetration were associated with the development of greater adjustment difficulties (25–31). The findings, in this present study that a history of vaginal and anal intercourse were associated with attending psychiatric clinics, confirmed this. The clinical implication of this finding is that certain forms of CSA are particularly detrimental. An important finding was that the abused controls had a larger social network than the abused cases. Prior investigations have also shown that supportive family environments can reduce the risk of negative outcomes in individuals who are victims of CSA (27–29). In the present study, one variable that appeared to confer some protection against the development of psychiatric disorders in individuals who had been abused was having four or more individuals to whom they could report the abuse and received support from. Lack of social support systems (32, 33) has been shown to increase the risk of post traumatic stress disorder and other psychiatric disorders in trauma exposed individuals.

Except in a few studies where a family friend, acquaintance, stranger or neighbour were the main perpetrators (34–37) of CSA, the finding in the index study that the majority of perpetrators were not parents or other family members is contrary to international research (38–43).

The limitations of this study were as follows: firstly, the control group comprised various levels of staff members at medical and psychiatric clinics excluding doctors. It is possible that some of the controls would be somewhat more sensitized to the possible effects of sexual abuse than the sexually abused patient by virtue of the fact that they worked in the medical and psychiatric clinics. Additionally, the controls tended to be younger, and mainly females who were married and better educated. This could possibly help to explain why the control group coped better with the trauma of sexual abuse than the cases.

Secondly, the information gathered was based on the patients' ability to recall childhood events (24), was retrospective and for many participants it required recall of events that may have occurred two decades prior. Memory decay, elaboration of events and 'working through' of the CSA experience may have, in different ways, affected the reliability of reporting of CSA-related events (44). The validity of information obtained from the study population may therefore be questionable since childhood memories may have been forgotten, repressed or denied in both cases and control groups. Additionally, psychiatric patients may be more likely to report false memories (45). Thirdly, the reliability of the data obtained from the study population raises another issue. Although the researchers were trained on how to conduct a semi-structured interview, communication barriers were inevitable. If the research team did not establish good rapport with the participants, they would be reluctant to disclose information of such a sensitive nature. Finally, the details of CSA reported by the study population were subjective. The information was one sided since the perpetrators were not questioned hence it was difficult to determine the veracity of the responses. There was no objective proof showing that the 'CSA survivors' were in fact abused.

From the results, it was found that 26% of cases were abused and that 12.1% of the controls were abused. Though these percentages were lower than expected, these values were referenced from a study done abroad which estimated that 37% of the cases and 23% of the controls would be abused (17).

This difference in values may be due to the stigma and embarrassment attached to sexual abuse, resulting in under-reporting. In the case of the controls, the difference might also reflect that they were somewhat higher functioning, better educated individuals than the general population.

This study emphasizes the associations specifically between CSA and adverse mental health outcomes. The findings of the study support an urgent need for psychiatrists to take a comprehensive history which includes mandatory inquiry on CSA. There is also a need to further raise society's awareness of CSA, educating them about the signs, symptoms and treatment for CSA. Open discussion concerning CSA should also be encouraged in schools as well as in medical institutions throughout the country.

## CONCLUSION

A positive correlation was established between CSA occurring at an early age, multiple experiences of abuse, abuse involving force and manipulation, a history of vaginal and anal intercourse and a limited social network in patients who had CSA and attending adult psychiatric outpatient clinics. Many patients seeking psychiatric services as adults are CSA survivors and this issue should be explored routinely as part of every psychiatric assessment.

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