

INCIDENCE AND IMPACT OF SEXUAL ABUSE IN A CHILD OUTPATIENT SAMPLE: THE ROLE OF DIRECT INQUIRY

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Abstract—From the child psychiatry outpatient department of a university medical center, 64 charts were reviewed in two phases: 29 were randomly selected from outpatient files, and 35 were examined after clinicians were asked to directly query sexual abuse. Although the reported sexual abuse rate for randomly selected charts was quite low (6.9%), reference to sexual abuse history in charts of children who were asked about molestation was 4.5 times more frequent (31.4%; 11.5% of all boys, 50% of all girls). Children with an identified sexual abuse history reported more psychological symptoms, had made more suicide attempts in the past, and were more likely than nonabused children to receive a diagnosis of major depression.

Key Words—Sexual abuse, Incidence, Psychological effects, Chart review.

INTRODUCTION

A RECENT STUDY (Briere & Zaidi, 1989) revealed that randomly selected adult patient charts in an urban psychiatric emergency room documented childhood histories of sexual abuse quite infrequently. The same study indicated, however, that when emergency room personnel were requested to specifically ask about childhood sexual victimization, chart references increased eleven-fold to a 70% sexual abuse rate. This finding was congruent with recent studies of adult psychiatric inpatients, which often report high frequencies of childhood sexual abuse (e.g., Bryer, Nelson, Miller, & Krol, 1987).

The chart review approach to studying the prevalence of child abuse histories in a given clinical sample is, however, problematic under certain circumstances. Abuse may be underes-

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timated if (1) the clinician does not routinely ask about maltreatment history; (2) the patient does not spontaneously report it, or if asked, for some reason chooses to withhold such information; or (3) the clinician does not note an abuse history in the chart despite the patient's reporting one. Alternatively, however, the chart review methodology can be quite informative if clinicians uniformly ask about abuse during patient evaluations, and chart the results of their direct inquiry.

The notion of sexual abuse information not being known unless the clinician directly queries it is particularly critical to the treatment of child psychiatric patients. Immediate child abuse reporting and interventions can end ongoing sexual abuse, the safety and protection of the child can be facilitated, and developing symptomatology can be addressed before behavioral patterns become established.

Despite the likelihood that many children presenting in child clinics and inpatient settings have been sexually abused, only a few studies have examined this possibility. Those studies that have, however, tend to report relatively high abuse rates. Kolko, Moser, and Weldy (1988), for example, found that 28% of child psychiatric inpatients in their study had been sexually abused, whereas Cavaiola and Schiff (1988) reported that 30% of adolescents treated at a residential chemical dependency treatment center were identified as physical and/or sexual abuse victims. Such rates tend to be lower than those found in adult clinical populations, since adult samples typically examine sexual exploitation that occurred on or before age 15 or 16—several years beyond the age of most subjects in child studies. In addition, adult studies frequently include only female subjects, whereas child studies typically use both genders, a procedure that tends to decrease incidence figures, given the consistent finding of greater sexual abuse reports in female than male samples (Conte & Berliner, 1981; Gale, Thompson, Moran, & Sack, 1988; Jaffe, Dynneson, & Bensel, 1975).

A number of recent studies suggest that childhood sexual abuse may be associated with subsequent psychological symptomatology, including anxiety and fear, guilt, depression, sexualized behavior, and withdrawal (see reviews by Browne & Finkelhor, 1986; Conte & Schurman, 1987; Mrazek & Mrazek, 1981). Kolko et al. (1988), for example, specifically found greater hypersexuality, fear, and anxiety among sexually abused than nonabused child psychiatric inpatients, while such differences were not found to differentiate physically abused from nonabused children. A few studies, however, fail to demonstrate reliable short-term impacts of sexual abuse, at least by child self-report (e.g., Cohen & Mannarino, 1988).

The present study was designed to examine the impact of direct inquiry about sexual abuse in a sample of child psychiatric outpatients. We hypothesized that in child mental health clinics, too, many abuse victims go unrecognized unless the intake clinician specifically queries victimization history. Rates of sexual abuse reports were calculated for both queried and unqueried charts, and the presence or absence of various clinical problems and diagnoses in these charts was noted. Finally, physical abuse and client gender were also analyzed in relation to symptomatology, since these variables were thought to potentially covary with sexual victimization.

METHOD

The current study involved a detailed review of 64 randomly sampled charts from the child psychiatric outpatient clinic of a major urban university medical center. These clinical records were not selected on the basis of any client variable (e.g., presenting problem, clinical status, child abuse history), and thus are likely to reflect the normal range of generic pediatric mental health cases seen at this clinic.

In order to replicate the general methodology of the Briere and Zaidi (1989) study, charts

were studied in two phases. In Phase I, 29 charts were randomly selected from current outpatient files, and coded in terms of gender, age at intake, race, reference to physical abuse, and reference to sexual abuse (both intrafamilial and extrafamilial). In Phase II, 35 charts were randomly selected from all those written by clinicians who had been specifically asked to query child abuse history. In contrast to the Briere and Zaidi study, however, where clinicians were merely requested to “ask about” history of child maltreatment, Phase II of the current study involved evaluation of charts completed by clinicians who had received specific training in child sexual abuse evaluation and treatment (at minimum, attendance at a weekly child sexual abuse seminar), and who were specifically asked to explore potential abuse histories in detail. No standardized abuse interview protocol was used, however, since these charts were written in the course of therapists’ normal clinical activities.

Variables examined in Phase II included: gender, age at intake, race, reference to physical abuse, reference to sexual abuse (both intrafamilial and extrafamilial), age molestation began, duration of molestation, number of perpetrators, whether oral/anal/vaginal penetration occurred, number of suicide attempts, number of family stressors cited, DSM-III-R diagnoses, and total number of psychological symptoms reported.

Number of family stressors was assessed via an 18-item list (available from the first author). Items included events such as parental divorce or separation, suicide of a family member, gang involvement of family member, financial stress, and parental physical illness. Items from this checklist were summed to form a single score.

DSM-III-R diagnoses were those routinely assigned by evaluating clinicians. As such, they represent naturalistic data arising from standard clinical practice. In the absence of formal diagnostic schedules or protocols, however, the reliability and validity of such diagnoses are unknown.

Total number of psychological symptoms was assessed with a 46-item “problem checklist” (available from the first author), consisting of all symptoms cited by any one of the total sample of charts. Given (1) the many items of this checklist, (2) the known unreliability of single-item symptom variables (Anastasi, 1982), and (3) the modest sample size of the current study (limiting the total number of variables that could be studied), the total number of symptoms per chart were summed to produce a single score, rather than each checklist item being tested individually. Typical checklist items were reference to sleep disturbance, somatic concerns, headaches, low self-esteem, phobias, attention problems, and anxiety attacks.

Physical abuse was defined in the present study as physical injury intentionally inflicted by a parent or caretaker and/or reference to being thrown downstairs or into furniture, punched, kicked, or burned. Sexual abuse was defined as direct physical contact (ranging from fondling to intercourse) on or before age 16 by someone 5 years or more older. Due to the modest *N* of this study, only DSM-III-R diagnoses that occurred in at least 10% of all cases (Phases I and II combined) were analyzed.

RESULTS

Comparison of Phase I and Phase II Charts

Analysis of background variables revealed no differences between Phase I and II charts in terms of patient age, $t(62) = 0.69$, n.s.; sex, $\chi^2(1) = 0.28$, n.s.; race, $\chi^2(3) = 3.13$, n.s.; or family stressors, $t = 0.54$, n.s.; suggesting equivalence between phases. Summary data for these variables appear in Table 1. There was a substantial difference, however, in the proportion of sexual abuse victims reported in Phase I versus Phase II charts. In Phase I, where no instructions were given to query abuse, 6.9% (2 of 29) of all clinic charts indicated a sexual

Table 1. Background Variables for All Subjects

Variable	Value
Age	$\bar{x} = 12.1, SD = 3.87$
Sex	
Female	48.4%
Male	51.6%
Race	
Caucasian	6.3%
Black	9.4%
Hispanic	81.3%
Other	3.1%
Family Stressors	$\bar{x} = 1.4, SD = 1.5$

abuse history. In Phase II, however, where abuse was directly queried, 31% (11 of 35) of clinic charts reported sexual abuse. This four-fold increase in reported abuse was statistically significant, $\chi^2(1) = 5.9, p < .015$.

Analysis of Phase II Charts

Characteristics of Phase II abuse victims. According to the Phase II charts of sexual abuse victims, molestation began, on average, at age 7.3 years (range = 3 to 14), was intrafamilial in 82% of the cases, involved an average of 1.6 perpetrators (range = 1 to 3), had a mean duration of 2.1 years (range = one incident to 5 years), and involved vaginal, anal, or oral penetration in 54.5% of victims.

Comparison of abused and nonabused children. As shown in Table 2, there were a number of variables that discriminated sexually abused from nonabused children in Phase II charts. Victims were over 4 times more likely to be female (resulting in a 50% abuse incidence rate for girls, versus a 11.5% rate for boys), were more likely to have made at least one suicide attempt

Table 2. Comparison of Sexually Abused and Nonabused Charts (Phase II)

Variable	Nonabused (<i>n</i> = 24)	Abused (<i>n</i> = 11)	Statistic
Age (\bar{x})	11.9 (<i>SD</i> = 3.8)	13.3 (<i>SD</i> = 3.6)	<i>t</i> (33) = -1.36, <i>ns</i>
Sex			
Female (%)	37.5	81.8	$\chi^2(1) = 5.93, p < .015$
Male (%)	62.5	18.2	
Race			$\chi^2(3) = 2.60, ns$
Caucasian (%)	4.2	18.2	
Black (%)	12.5	18.2	
Hispanic (%)	79.2	63.6	
Other (%)	4.2	0.0	
Physical Abuse (%)	29.2	36.4	$\chi^2(1) = 0.18, ns$
Family Stressors (\bar{x})	1.5 (<i>SD</i> = 1.5)	1.5 (<i>SD</i> = 1.8)	<i>t</i> (33) = 0.57, <i>ns</i>
Suicide Attempts (%)	8.3	36.4	$\chi^2(1) = 4.17, p < .041$
Number of Attempts (\bar{x})	0.1 (<i>SD</i> = .5)	0.7 (<i>SD</i> = 1.3)	<i>t</i> (33) = 2.08, <i>p</i> < .021
Total Symptoms (\bar{x})	6.5 (<i>SD</i> = 2.9)	8.8 (<i>SD</i> = 3.0)	<i>t</i> (33) = 2.15, <i>p</i> < .018
<i>Diagnoses:</i>			
Conduct Disorder (%)	16.7	27.3	$\chi^2(1) = 0.53, ns$
Oppositional Disorder (%)	16.7	18.2	$\chi^2(1) = 0.12, ns$
Adjustment Reaction (%)	45.8	54.5	$\chi^2(1) = 0.23, ns$
Major Depression (%)	8.3	36.4	$\chi^2(1) = 4.17, p < .041$
Dysthymia (%)	29.2	27.3	$\chi^2(1) = 0.01, ns$

and to have attempted suicide more frequently, had a greater number of symptoms on the problem checklist, and were more likely to receive a diagnosis of major depression than were nonabused subjects.

Possible relation to physical abuse and gender. Although sexual abuse was significantly associated with symptomatology, it was possible that other client variables would also correlate with psychological problems and thus potentially confound the sexual abuse effect. Most relevant to this analysis was the possibility that Phase II physical abuse and/or client gender might also correlate with symptomatology. In order to examine this possibility, stepwise multiple regression analysis was performed, regressing client gender, physical abuse, and sexual abuse on total number of symptoms (the most generic dependent variable available), with a minimal F -to enter and F -to remove of 4.0 and 3.9 respectively. This procedure resulted in the entry of sexual abuse alone ($R = .35$, $F(1, 33) = 4.61$, $p < .037$), with the remaining variables failing to meet the minimal F criterion. Because of potential limitations of multiple regression analysis at the Phase II sample size ($n = 35$) however, simple r s were also calculated. Although sexual abuse was a significant predictor, as noted above, both physical abuse and gender status in Phase II were unrelated to total number of symptoms ($r = .15$, ns, and $r = -.25$, ns, respectively).

DISCUSSION

The current results parallel, within a child outpatient psychiatric sample, recent findings regarding direct inquiry in adults. Sexual abuse reports increased four-fold, from 7% to 31%, when clients were directly asked by clinicians whether they had been molested. Such data suggest that a substantial proportion of abuse victims in child clinical samples may go unrecognized unless specifically queried regarding victimization. In this regard, it should not be assumed that children and their families will spontaneously disclose information that they view as potentially embarrassing and traumatic and as likely to severely disrupt the family system. Given that the majority of sexual abuse disclosures in this study (82%) involved intrafamilial contact, it is especially understandable that such children, typically presenting with their parents and for other reasons (e.g., behavioral problems, depression, withdrawal), did not spontaneously offer abuse-related information prior to the clinician introducing the topic.

An alternate hypothesis for the current findings, of course, is that some children may choose to fabricate incidents of molestation when directly asked, due in part to potential "demand characteristics" of abuse specific questions. It is now generally accepted, however, that in most cases children do not misrepresent sexual abuse (Finkelhor & Browne, 1985; Green, 1986; Jones & McGraw, 1987). The turmoil that frequently ensues following disclosures of molestation, often anticipated by children and their families, especially argues against the notion of false reporting as an explanation for the dramatic increase in Phase II abuse disclosures. In the absence of definitive data in this area, of course, the impacts of direct inquiry on the validity of child abuse allegations remains unknown. Similarly, it cannot be ascertained in the present study whether some children who denied abuse in Phase II were, in fact, sexual abuse victims who did not feel secure enough to disclose victimization experiences during assessment or treatment. If so, the incidence data reported for Phase II may be, in fact, an underestimate.

The rate of sexual abuse found in this sample under the direct inquiry condition is consistent with rates reported by Kolko et al. (1988) and Cavaiola and Schiff (1988). Further, when the data are examined according to gender, the abuse rate for females (50%) is surprisingly

consistent with adult clinical studies focusing on female subjects (e.g., Briere & Runtz, 1987; Briere & Zaidi, 1989), although the rate for males is more similar to what is reported in nonclinical research (Badgley, et al., 1984; Finkelhor, 1979). Due to the paucity of data on children in clinical settings, however, and the modest size of the current sample, these sexual abuse rates should be further replicated before they are assumed to reflect the typical proportion of victims in child clinical populations.

As in most previous research (e.g., Friedrich, Urquiza, & Beilke, 1986; Kolko et al., 1988), sexual abuse was found to be associated with psychological problems that frequently bring children into psychiatric treatment settings. Children who reported sexual abuse were more likely to have attempted suicide, made more suicide attempts, presented with a greater number of psychological symptoms, and had a greater likelihood of being assigned a diagnosis of major depression than did children not reporting a molestation history. As with Kolko et al.'s study, such relationships did not emerge for physical abuse, despite the fact that extreme behaviors (e.g., physical injury, being thrown downstairs, etc.) were used to define physical maltreatment.

Because the same clinicians assessed both abuse status and psychological functioning in this study, it is possible that chart references to depression and psychological problems among molestation victims in Phase II were influenced by evaluator assumptions regarding the effects of childhood sexual abuse. Although this possibility cannot be ruled out entirely, the additional association between sexual abuse and self reports of suicide attempts (presumably less likely to reflect clinician bias), as well as the fact that depression was assessed with objective diagnostic criteria (DSM-III-R), provide some reassurance that these findings represent actual abuse effects.

The increased depression and suicidality found among sexual abuse victims suggest that sexual abuse may be associated with significant morbidity in at least some child psychiatric outpatients. Such data reinforce the findings of Briere and Runtz (1986), who reported that of 14 women whose first suicide attempt was before age 13, most (93%) were sexual abuse victims. These data further suggest the importance of assessing suicidality when working with sexually abused children.

Given the relationship of sexual abuse to significant and, in some cases, life-threatening psychological problems in the present study, it is clear that in not soliciting information regarding victimization, clinicians run the risk of both exposing children to further maltreatment and dismissing an important opportunity to immediately intervene in those aspects of sexual abuse which may either stimulate self-destructiveness or lead to long-term psychological problems when left untreated (Briere, 1989). Although some clinicians may not feel comfortable addressing sexual abuse issues and may anticipate immediate difficulties with clients and their families upon confronting this problem (e.g., reporting abuse to authorities and dealing with the intense negative affect that often follows), this study demonstrates the need to routinely query abuse history in child as well as adult clinical settings.

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Résumé—Soixante-quatre dossiers d'un service externe de pédopsychiatrie situé dans un centre hospitalier universitaire ont fait l'objet d'une étude en deux phases: 29 dossiers ont été choisis de façon aléatoire parmi tous les cas dans le service; et 35 dossiers où on avait dû vérifier s'il y avait eu abus sexuels ont été retenus. Dans l'échantillon aléatoire, seulement 6.9% des cas avaient été abusés sexuellement; par contre, les dossiers dans le deuxième groupe contiennent 4.5 fois plus de mentions d'abus sexuels (31.4%; 11.5% pour les garçons et 50% pour les filles). Les enfants qui avaient connu des expériences d'abus sexuels révélaient plus de symptômes d'ordre psychologique, avaient tenté de se suicider plus souvent dans le passé et étaient plus aptes à se retrouver devant un diagnostic de dépression majeure que les enfants non abusés.

Resumen—Se revisaron en dos etapas, sesenta y cuatro historiales clínicos del departamento ambulatorio de psiquiatría infantil del centro médico de una universidad: 29 fueron elegidos al azar de los archivos de pacientes externos, y 35 fueron examinados después que se les solicitó a los clínicos que investigaran directamente si había abuso sexual. A pesar de que la proporción de abuso sexual reportado en los casos seleccionados al azar, fue bastante baja (6.9%), las referencias a historias de abuso sexual en los estudios de casos de niños que se les preguntó sobre caricias sexuales inadecuadas (moslestation) fue 4.5 veces más frecuente (31.4%; 11.5% de todos los varones, 50% de todas las hembras). Los niños(as) con una historia identificada de abuso sexual reportaron más síntomas psicológicos, hicieron más intentos suicidas en el pasado, y tenían más probabilidad, que los niños no abusados, de recibir un diagnóstico de Depresión Mayor.