Psychological sequelae of sexual abuse in childhood

P D HOOPER

SUMMARY. A questionnaire survey was carried out in one practice to determine the relationship between sexual abuse in childhood and subsequent psychological morbidity. Out of 418 women who replied (62% response rate), 60 (14%) admitted experiencing some form of sexual abuse as a child. Twenty of these (33%) were found to have a record of some form of psychological problem in adult life, compared with 14% of a sample of the non-abused respondents and 20% of the non-respondents. In particular, 54% of 13 women who had experienced oral, genital or anal penetration or attempted penetration had psychological morbidity recorded. There was no relationship, however, between sexual abuse and psychosexual or marital problems in later life.

Introduction

CHILD sexual abuse is now a matter of intense public concern. Most published articles deal with the diagnosis, prevalence or management of this problem.[1-7] Brown and Finkelhor[8] have reviewed the literature relating to the sequelae of child sexual abuse but the studies they considered were largely taken from a narrow age band such as college students[9] or from highly selected samples such as people attending psychiatric clinics. All the studies reported in their review were carried out in North America. Markowe[10] surveyed British publications in this field and criticized the available information because of a lack of a uniform definition of child sexual abuse.

Although the psychological sequelae to child sexual abuse have been reported for individuals there have been no reported studies in the United Kingdom which have systematically investigated the psychological sequelae in adult life of sexual abuse experienced in childhood. The aim of the study was to remedy this gap in our knowledge.

Method

The study took place in a six partner practice which serves 13 000 patients in a mixed urban and rural part of the Isle of Wight. The social class distribution of the practice is similar to the national average. The author's personal list of patients is approximately 2500 and from the practice computer age–sex register, a printout of all women on the author's list between the ages of 20 and 60 years was prepared. Although boys are sexually abused this problem is more common among girls and for this reason the study was restricted to women. Approval for the study was sought and granted by the local ethical committee.

All the women identified were sent a questionnaire about sexual abuse in childhood. The questionnaire (Figure 1) was identical to that devised by Finkel[5] except that the identity of the 'abuser' was not requested. It was felt that including this question might reduce the number of respondents. A covering letter was sent with the questionnaire explaining the reason for the study and emphasizing the confidentiality of the replies. Confidentiality was ensured by the questionnaire being identified only by a number and the author being the only person with access to the register linking names with numbers.

The completed questionnaires were divided into two groups: abuse (categories 1–4) and non-abuse (category 0) The general practice records of all the abused group and a sample of the non-abused group (chosen by random sampling) were examined together with all the notes available for non-responders and women who had experienced one or more psychological problem were identified. Psychological problems were defined as follows: (1) neurotic personality, for example multiple consultations over many years for non-organic complaints, referrals to psychiatric day unit for assessment and treatment: (2) consultation for psychosexual problems; (3) two or more episodes of depression requiring drug treatment; (4) one episode of depression requiring hospital admission; (5) consultation for marital problems and/or divorce.

Results

There were 418 respondents, a response rate of 65%. Of these, 60 (14%) admitted experiencing some form of sexual abuse as a child; for 13 (3%) this was the most serious form (Table 1). Six women (10% of those abused) had experienced constant abuse but for 27 (45%) it had happened on two or fewer occasions. Because of the sensitive nature of the information being sought, no further follow up of non-respondents was made.

The analysis was made from the replies and records of 60 abused and 129 non-abused women and 197 non-respondents. Table 2 shows the analysis of sexually abused responders by decade of birth. The highest percentage of childhood sexual abuse was reported in women born in the decade 1928–37 (11.5%), but declined thereafter.

Figure 2 shows the ages at which the first episode of childhood sexual abuse took place; six respondents did not provide information on this. The majority of the 54 respondents (80%) had been first abused between the ages of seven and 13 years inclusive,

Did you experience:

0 No experience of molestation in any form?
1 Exposure–voyeurism–harassment?
2 Casual 'accidental' contact, rubbing, feeling?
3 Sex play without penetration of any oriface? (including oral kissing)
4 Oral, genital, anal penetration or attempted penetration.

Frequency:

Once/Twice/Three or more times/Constantly

Age of first incident:

Was the experience:

1	2	3	4	5
Painful	Unpleasant	Tolerable	Agreeable	Enjoyable

Did you tell anyone?

Within seven days/Later/Still have not

Figure 1. *Questionnaire about childhood sexual abuse.*

PD Hooper, FRCGP, general practitioner, Newport, Isle of Wight.
Submitted: 16 January 1989; accepted: 9 June 1989.

© *British Journal of General Practice,* 1990, **40**, 29-31.

Table 1. Respondents' experience of sexual abuse.

Type of abuse	Number (%) of respondents ($n=418$)
Exposure, voyerism, harassment	14 (*3*)
Casual 'accidental' contact, rubbing, feeling	24 (*6*)
Sex play without penetration of any orifice	9 (*2*)
Oral, genital, anal penetration or attempted penetration	13 (*3*)
Total	60 (*14*)

n = total number of respondents.

Table 2. Decade of birth of women who were sexually abused.

Decade of birth	Total number of women in practice born in decade	Number (%) who were sexually abused
1928–37	148	17 (*12*)
1938–47	178	18 (*10*)
1948–57	151	14 (*9*)
1958–67	162	11 (*7*)

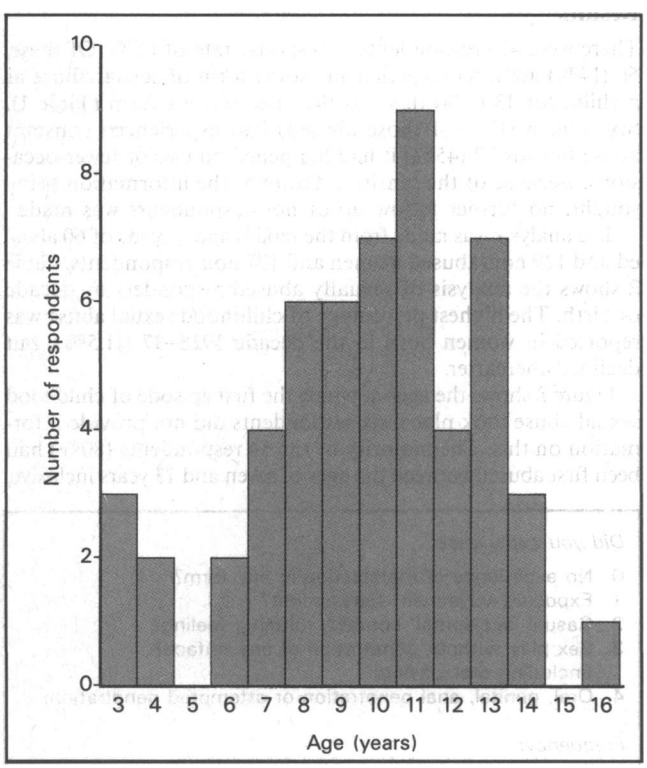

Figure 2. *Age of first episode of childhood sexual abuse for 54 abused women.*

but seven women had been abused at six years and below and three women reported abuse at the age of three years.

The psychological morbidity for the three groups are shown in Table 3. One-third of sexually abused women (33%) had some form of psychological morbidity recorded in the records compared with 14% of the non-abused and 20% of the non-respondents. Though the numbers are small, the rate of psychological morbidity for women experiencing the worst form of abuse was even higher at 54%. Fifteen of the abused women

Table 3. Psychological morbidity of abused and non-abused women.

Psychological morbidity	Number (%) of women: Sexually abused: All categories ($n=60$)	Sexually abused: Penetration or attempted penetration ($n=13$)	Sample of non-abused respondents ($n=129$)	Non-respondents ($n=197$)
No	40 (*67*)	6 (*46*)	111 (*86*)	158 (*80*)
Yes	20 (*33*)	7 (*54*)	18 (*14*)	39 (*20*)

(25%) had depression (categories 3 and 4) and eight (13%) had neurosis (category 1); some women had more than one type of problem. There was no increased incidence of psychosexual problems or marital problems among victims of sexual abuse in childhood. Six out of 14 women reporting the apparently mildest form of abuse also showed continuing psychological problems and five (36%) were recorded as having had episodes of depressive illness. In comparison, only 16 women (12%) in the non-abused sample were recorded as having suffered from depression.

The numbers responding were too small to be able to relate age at first abuse with subsequent psychological morbidity. Nor was it possible to relate frequency or duration of abuse to subsequent psychological problems.

Fifteen of the abused women (25%) had disclosed the abuse to another person within seven days of the episode but 28 (47%) of the respondents have still not disclosed the experience of abuse to anyone. The author's offer of counselling to anyone who wished to avail themselves of it was taken up by only one person. There was no evidence that failure to disclose abuse resulted in greater subsequent psychological morbidity.

Discussion

The response rate to the postal questionnaire was good in view of the very personal information which was being sought. This is demonstrated by the fact that almost half the respondents reporting abuse had not previously disclosed this fact to anyone. The percentage of respondents admitting childhood sexual abuse is lower than in other reports. Previous studies reported prevalence figures of 43% and 56% but they were taken from professional audiences at workshops on sexual abuse or from a sample of female doctors.[5,6] The other UK studies are less comparable with the present study because of a lack of unanimous definition of childhood sexual abuse.[10] However, Markowe quotes a MORI survey of a 'nationally representative' sample which reported that 12% of women had been sexually abused.[10]

This study has shown that there is an association between sexual abuse in childhood and psychological problems, in particular depressive illness and neuroses, in adult life. This indicates the importance of pursuing further research in this area. It has been shown to be feasible to use a postal questionnaire from a general practitioner as the basis for gaining information in this field and a collaborative research project involving several practices could generate high enough numbers to explore in more detail the relationship between childhood sexual abuse and subsequent psychological problems.

References

1. Oates K. Sexual abuse of children. *Aust Fam Phys* 1986; **15:** 786.
2. Fine H. Practical problems of child sexual abuse. *Update* 1988; **36:** 1853.
3. Cohen L. Sexual abuse of children — a review. *S Afr Med J* 1985; **67:** 730.
4. Russell D. The incidence and prevalence of intra-familial and extra-familial sexual abuse of female children. *Child Abuse and Neglect* 1983; **7:** 147.
5. Finkel KC. Sexual abuse of children in Canada. *Can Med Assoc J* 1984; **130:** 345.
6. Wilson MS. Sexual abuse of children. *J R Coll Gen Pract* 1987; **37:** 416.
7. Bentovim A, Boston P, van Elburg A. Child sexual abuse — children and families referred to a treatment project and the effects of intervention. *Br Med J* 1987; **295:** 1453.
8. Browne A, Finkelhor D. Impact of child sexual abuse: a review of the research. *Psychol Bull* 1986; **99:** 66.
9. Fromuth ME. The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of College women. *Child Abuse and Neglect* 1986; **10:** 5.
10. Markowe HLJ. The frequency of childhood sexual abuse in the UK. *Health Trends* 1988; **20:** 2.

Acknowledgement

My thanks are due to Ryan Lewis; to the Wessex faculty of the RCGP for financial help; to Beverly Nicholson; to the office staff in my practice and to Mrs M Bridgeman.

Address for correspondence

Dr PD Hooper, The Dower House, 27 Pyle Street, Newport, Isle of Wight PO30 1JR.

SURGERY FINANCE

Secured and Unsecured loans available for:

- Purchase of new practice premises (up to 100% if required).
- Establishment or increase of working capital.
- Purchase of retiring partners' share.
- Re-arrangement and re-structuring of existing loan arrangements.

All schemes tailored to individual requirements offering:

- Choice of fixed or variable interest rates.
- Repayment terms up to 25 years.
- Stage advances for surgery construction.
- Choice of repayment methods.

For details of our extensive service contact:

MEDICAL INSURANCE CONSULTANTS
Court Ash House
Court Ash
Yeovil, Somerset
BA20 1HG
Telephone: (0935) 77471

RCGP
Courses and Conferences

COMMUNITY HEALTH INITIATIVES AND GENERAL PRACTICE

21 March 1990, London

This one day Seminar for general practitioners, primary care team members and those involved in community health initiatives aims to explain what a 'Community Health Initiative' is, in order to help GPs and their practice teams work more effectively with the community they serve.

Most of the day will be spent in Workshop groups, exploring the types of project that can be undertaken, with an opportunity to share experiences with other health care professionals and project workers around the country, with a view to expanding or developing projects within practices.

It is hoped to include some, if not all of the following in the Workshop sessions:

- Self-help groups
- Neighbourhood health projects
- Interpreting and advocacy projects
- Well-woman centres
- A project in your practice?

Fees for this Seminar are £45 (GPs) and £35 (non-GPs). Section 63 zero-rated approval is being sought. For further details of this Workshop, organized by the Patients Liaison Group of the RCGP, please contact either Janet Hawkins or Simon Hope, Projects Office, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU (01-823 9703 RCGP courses line).

ATTENTION — ALL FORMER PRINCIPALS IN GENERAL PRACTICE

All doctors who were principals in general practice and whose names were included in the Medical List before 15 February 1981 are reminded that they are currently exempt from the requirement to hold a Certificate of Prescribed/Equivalent Experience from the Joint Committee on Postgraduate Training for General Practice, should they wish to enter general practice in the National Health Service.

This option to re-enter general practice as a principal without a Certificate expires on 15 February 1990, and a practitioner who wishes to re-enter general practice in the NHS after this date will be required to apply for a Certificate from the Joint Committee. Any application made before or after 15 February 1990 may result in a recommendation for further training before a Certificate can be issued.

This notice has been issued by: The Joint Committee on Postgraduate Training for General Practice, 14 Princes Gate, London SW7 1PU.