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Behavioural psychopathology of child sexual abuse in schoolgirls referred to a tertiary centre: A North London study

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Abstract The sexually abused girls in this study were a sub-sample of a group of girls referred to a Regional Centre for Psychotherapy for the whole of London, North Thames. An inclusion criterion was that they were psychologically symptomatic and so it is likely that they were more problematic cases causing concern in their locality. The control clinical group consisted of referrals to local Child and Family consultation services, were an opt-in matched sample and not a total clinic referral sample. In addition, the reasons for referral covered both child disorder and family problems. It is, therefore, important to bear in mind the differences between these two groups. Certain clear cut findings have emerged from this study. No disorders specific to child sexual abuse in girls were identified but the extent and severity of the disturbance in the sexually abused sample was most striking. In these girls an event (CSA), together with referral because of emotional symptoms, was associated with enhanced severity of

disorder and comorbidity particularly with reference to a cluster of disorders comprising post-traumatic stress disorder, depressive disorder, anxiety disorders (general and separation), social phobias and reactive attachment disorder. In the community clinic sample the identified disorders were mainly those of separation anxiety disorders and adjustment. Wide comorbidity was common in the sexual abuse sample and also severity of impairment was notable when compared to the clinic sample. However, because of the selected nature of the abuse group the findings are not generalisable beyond the population from which they emerged. The view is advanced that there are strong grounds for exploring the utility of psychodynamic psychotherapy in similar samples of sexually abused girls. These findings are discussed in the light of the current literature.

Key words Psychopathology – child sexual abuse – clinical referrals – school girls

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Introduction

A major and unique study of the efficacy of psychotherapy for sexually abused girls was organised between the Tavistock Clinic, the Royal Free Hospital, Camberwell Child Guidance Clinic and Guy's Hospital and the Maudsley Hospital. As part of this study the crucial

question arose – whether anything about the behaviour of sexually abused children, in terms of either individual symptoms or patterns of symptoms, is specific to them. Not enough is known about the natural history of abused children in comparison with that of non-abused children. Behavioural symptoms are known to be widespread in sexually abused children and reviews of

studies conclude that it has harmful effects (3). While many studies have reported that sexually abused children have more psychopathological symptoms than matched groups of non-clinically referred non-abused children (8, 9, 17), this is not a consistent finding, as other studies report no differences or fewer symptoms amongst the sexually abused children than amongst clinical comparison groups. Often in subjects where there is a suspicion of abuse, physical evidence is not sufficient to support the diagnosis. Hence, social and legal services often wish to be guided by evidence from behavioural assessments. It is also important to know whether the specific trauma of child sexual abuse (CSA) results in chronicity or intractability over and above that which occurs with other adverse life experiences. Given the prevalence of child sexual abuse, this information is crucial for service development and planning. It was suspected that the abused group of girls referred to a regional centre would present with more worrying mental health problems and would be more likely to live in unstable families than would non-abused girls referred to a district child mental health clinic.

One way such questions can be addressed is by comparing two groups of girls, the first comprising those who, indubitably, have been sexually abused, are symptomatic and have been referred to a regional centre for treatment; and the second group comprising girls who, as far as can be gauged, are only clinically disturbed and who have been referred to a local psychiatric clinic. To this end, a group of non-abused girls referred to psychiatric clinics has been matched for age and ethnicity with a group of sexually abused girls from a larger study (27). All the girls in the larger study were sexually abused and were symptomatic. To clarify, the sexually abused subjects were not accepted if they were asymptomatic. By definition the clinic cases were all symptomatic. For neither group was a definable disorder a selection criterion. In both groups it was necessary to establish the nature of the psychopathology.

The aim has been to examine, in depth, the differences between symptomatic abused girls and clinically referred non-abused girls and their respective families in terms of: family constellation, quality of mother-child relationships, presenting symptoms, psychiatric morbidity, chronicity and in due course prognosis. This paper presents findings about psychopathology for the control sample from a North London Teaching Hospital and a North London Community Child and Family Service on the one hand – and on the other, from a matched subsample from the North London Child Sexual Abuse Psychotherapy Research Cohort attending the Tavistock Clinic (27). Some descriptive background data are included.

The relevance of behavioural psychopathology in child sexual abuse

Childhood sexual abuse is not a diagnostic category – it is an event in the life of the child. Nevertheless, the rates of associated behavioural psychopathology reported in the literature are high; hence one can easily reach the false conclusion that such symptoms are specific to CSA. However, epidemiological approaches reveal the invalidity of such conclusions: for instance, bedwetting is common in pre-school children who have been abused, but it is also common in the general population – between 13 and 14% (point prevalence rate) of boys and girls still wet the bed at the age of 5. However, only a minority of such bedwetters will prove to have been abused. Thus, if bedwetting is to be used as a screen for sexual abuse, the sensitivity and specificity of the measure must be checked. Similar principles would apply if clinicians wanted to use behavioural psychopathology as a screen. An allied question is whether the patterns of psychopathology that emerge in girls attending psychiatric clinics are specific to CSA and would not be found in girls presenting with clinical disorders without sexual abuse (meaning contact sexual abuse).

Aims and hypotheses of the study

The intention of this paper is to focus on defined disorders with associated impairment, rather than on syndromes and symptoms. Hypotheses were established based on themes emerging from literature reviews and also clinical practice. The following four hypotheses are addressed:

1. Sexually abused girls will show both an excess and a diversity of psychiatric disorders;
2. Some of the psychiatric disorders will prove to be specific to sexual abuse;
3. Extensive comorbidity will be a characteristic feature of child sexual abuse;
4. Overall severity of psychiatric disorder will be a particular feature of child sexual abuse.

Design and method

Sample

A group of 21 sexually abused girls attending the Tavistock Clinic, North London, who were entering a psychotherapy trial, were compared with a clinical group of 21 girls who had not been sexually abused. These two groups were matched for age and ethnicity. Their ages ranged between 8 and 14 years with a mean age of 11.5 years for the CSA group and 11.4 years for

the clinical comparison group. The majority of the girls (65%) were Caucasian, 10% were Afro-Caribbean, 10% Asian/Chinese and a further 15% were of mixed race. All the subjects referred to the sexually abused girls project were known to have been abused. Only 3 subjects refused to participate at the baseline assessment.

The clinical control group was drawn mainly from new referrals to Enfield Child Guidance Service, with the rest from the Royal Free Hospital and these girls were all symptomatic. The recruitment at these clinics was a carefully thoughtout three stage process. First, the clinic staff were aware that the focus of the study was to provide a comparable sample of clinic referrals without a sexually abusive experience. Second, any suggestions of sexual abuse, either in the initial referral letter or from contact with the referrer, would have excluded that case. Third, the research assessments were undertaken after the initial clinical consultation. That meant that clinic staff members who undertook that initial interview had an opportunity to assess the risk of abuse and some cases were excluded at this interview. Thus, as far as possible sexual abuse of the control group subjects was excluded. During the first consultation, these girls and their families were approached and the project was explained to them. They were assured that a single interview was involved and that this would not interfere with their clinical treatment. They were given a letter explaining the project and a stamped addressed card to return saying whether they would like to participate in the project. Most children and their families considered suitable agreed to participate. The assessments were conducted by members of the research team who had previously achieved satisfactory agreements between assessors using the research instruments. Information was obtained as follows: (1) direct interview with the child, with an average duration of 1-2 hours; (2) parental interview and completion of self-rating questionnaires; (3) parental permission was obtained to contact the schools in order that two teacher questionnaires concerning each girl could be completed.

Measures

A number of semi-structured and structured instruments were employed to ensure systematic collection of information. For the purpose of this paper the following were collected:

- (1) Demographic data were obtained from the girls and their carers.
- (2) Behavioural psychopathology: diagnostic interview and global impairment (Kiddie-SADS).
- (3) Post-traumatic stress disorder (PTSD) questionnaire (21).

Interview with the child

A shortened version of the standardised semi-structured Kiddie-SADS (7) diagnostic interview was used. This validated schedule, which has been widely employed with children aged 6-17 years, is a reliable instrument for measuring symptoms of depression, anxiety, emotional disorder and conduct disorder. It is an interview questionnaire and consists of definitions of the item, followed by set probes and scales that have to be rated on the basis of the information provided. On the basis of the available Kiddie-SADS data, best estimate diagnoses were achieved using DSM-IV criteria. The raters were not blind to the groups but consensus checks as to diagnoses were undertaken with an independent senior colleague (IK). The DSM system also allows for codings of severity of disorder; thus, disorders could be classified as showing difficulty, moderate difficulty or severe difficulty. The information available allowed two parallel sets of diagnoses - current disorder and episodes of disorder manifesting over the previous year. For the purposes of this paper, only the latter were explored. An extension of the Kiddie-SADS is a post-traumatic stress disorder questionnaire developed by Orvaschel (21). This has been included to allow diagnosis of PTSD when appropriate.

Global impairment, concerning social, psychological or school functioning, was assessed, utilising the Kiddie-SADS variation (7) which is derived from the children's Global Assessment Scale (GAS) (25), which, itself, is a variation of the GAS drawn up by Endicott et al. (12).

Although the DSM-IV criteria were not available at the time of the preliminary data collection, the method and system for achieving diagnosis was modified subsequently to allow for this and the diagnoses redetermined by DSM-IV criteria.

Operational decisions about comorbidity:
Basis of the classification approaches
employed in the study

In preliminary presentations of the research, helpful comments about the extent and comorbidity of the psychopathology in sexually abused girls led to a review of the diagnostic concepts and systems that were employed.

An important issue is discreteness of diagnostic category (4). An older view was that classification must provide an adequate differentiation between disorders, together with adequate coverage to ensure that important disorders are not omitted (24). However, these earlier notions of what comprises discreteness do not, in child psychiatry, coincide with current concepts or with empirical findings of modern research on comorbidity (6).

A second issue is whether diagnoses should be based on current evidence of psychopathology alone (28). Cantwell and Rutter (5) argue for the importance of validation by means of epidemiological data, family data, longitudinal studies and laboratory studies. However, in the current study such desirable validating factors were not available; furthermore, the samples were too small to allow the results of searches for such data to be analysed with any sense of confidence.

Reliability in diagnoses

The interviewers had been trained to conduct systematic semi-structured open-ended interviews and to use the resulting data to make best estimate diagnostic distinctions in a standard way. This was supplemented by consensus checks whereby all the psychopathology data were reviewed jointly by a research fellow and by an independent supervisor (IK). At the same time the diagnoses, where necessary, were revised to ensure that they complied with DSM-IV criteria. The approach adopted partly meets the criteria suggested by Cantwell (4).

Comorbidity – bases of operational solutions

A review of the empirical data collected in this study revealed wide comorbidity, which suggested either over-diagnosis of disorders or an insufficient distinction between syndromes and disorders. This called for a revision of the classification and diagnostic stance and allied operational solutions. An important question was whether the diagnostic system used (DSM-IV) had compounded the comorbidity. Cantwell and Rutter (5), point out that comorbidity is likely to occur more commonly with DSM-IV than ICD-10. The distinction is that, in ICD-10, the assessor is expected to select the diagnosis that most closely approximates psychopathological features elicited from the patient; together with the need to ensure that independent disorders validly exist in order to achieve double or multiple diagnoses. However, with the DSM-IV a broad set of rules is pertinent to each disorder and the clinician has only to ensure that these rules have been met. This issue can be conceptualised quite simply as to whether any emergent multiple syndromes represented separate disorders. A guiding principle is provided in DSM-IV where a mental disorder is defined as a 'clinically significant behaviour or psychological syndrome ... that occurs in a person that is associated with present distress ... or disability (impairment) of one or more important areas of functioning'. Thus, the concept of handicap or impairment provides one of the bases for making a distinction between the syndromes and disorders. In

addition, there is the issue of severity. Cantwell and Rutter (5) point out that most disorders will vary in their severity, but caution against a disorder being defined solely in terms of severity.

Specific operational solutions

On the basis of the above, the following operational decisions were made: First, that classifications and diagnosis follow closely to the DSM-IV principles. Second, it was agreed that diagnoses of comorbid disorders should not be underpinned by the presence of symptomatology which overlapped widely the different disorders. This proved less difficult to ensure than had been anticipated. The extent of comorbidity was also reduced further by the decision to exclude dysthymia as one of the potential comorbid conditions and, further, to reduce the number of comorbid anxiety conditions by combining overanxious disorder and general anxiety disorder. Third, it was agreed that all diagnoses should be underpinned by evidence of distress and/or impairment of functioning. However, this criterion proved less than helpful because it was often not evident in what way the distress and impairment of functioning could be considered to be specific to a particular disorder. Finally, there was the issue of severity, which for purposes of the current study followed the DSM specifications of mild, moderate and severe. Thus, a final criterion for the purpose of distinguishing between syndromes and disorders was that those conditions labelled severe were always accepted as representing disorders. In practice, this proved a useful criterion.

Interview with the parents

The parents were given brief self-rating questionnaires covering such demographic information as family size, current circumstances, life events, and family structure, etc.

Results

General demographic data

Two-thirds of the girls came from Caucasian families. Of the controls, about 90% were living with either their natural parents or biological mother alone; this was only 43% for the CSA group. Only 5% of controls were either in care or living with relatives, compared with 47% for the CSA group. Some 47% of the control mothers were working full-time or part-time, whereas only 29% of CSA mothers were doing so. There were

also no differences in the families relating to concerns about finances or to secondary school education of the parents. There were also no differences in ordinal position of the children; in pre-school separation from parents; in whether they were in primary or secondary school; in the type of school.

Psychopathology

The findings (Table 1) are presented in relation to the hypotheses. Hypotheses 1 and 2 (See section on 'Aims and Hypotheses of the Study'): The data are presented according to the rates of a particular disorder by comparison groups. As the sample sizes were small, relatively large differences between groups did not necessarily give rise to statistical significance (as statistical significance does not only depend on the magnitude of differences but is also tied to the size of the samples). Odds ratios were calculated, as they are not dependent on the small size of samples and give a better profile of the magnitude of differences between the groups. Finally, the disorders were ranked according to the size of the odds ratios (only an odds ratio of 1.4 and above are listed).

It is notable that the highest odds ratios are for PTSD, Major Depressive Disorders, Adjustment Disorders and Reactive Attachment Disorders – with PTSD having the highest rates. PTSD and Reactive Attachment Disorders constitute diagnoses that are not based on psychopathology alone but require a link with environmental events; hence, neither can be used as a screening measure for a single traumatic event or a series of such events. Notably, there are no instances of such disorders in the control group. Major Depressive Disorder is also a powerful discriminant – but so, too, are Adjustment Disorders (see below).

The next group includes Attention Deficit Disorder, followed by General Anxiety Disorder, Separation Anxiety Disorders and Social Phobias; and finally, by the Avoidant Disorder of Childhood or Adolescence (DSM-IV), where social avoidance is defined as sufficiently severe to interfere with social functioning in peer relationships. At lower odds ratio levels are Specific Phobias and Conduct Disorder.

It is important to ascertain if any psychopathology is specific for CSA (other than PTSD and Reactive Attachment Disorders, as these are compromised diagnoses). For such a circumstance the rates would need to be high in the CSA group and low or absent in the other clinical group (e.g. over 60% and under 20%, respectively). Only Major Depression and General Anxiety Disorder approach this criterion, and thus none of the disorders proved to be specific to CSA. A number of other disorders proved relatively common (i.e. more than 20% in the CSA group), but the differences between the groups proved not to be significant.

Finally, are there any patterns that appear to be representative of the clinical psychiatric group compared with the sexually abused group? A trio of features occur relatively commonly in the clinical group: first, Separation Anxiety Disorders followed by Adjustment Disorder and, at a lower level, Depression; however, only Adjustment Disorder appears to be specific to the clinical group. However, such apparent specificity is likely to be related to the diagnostic criteria used. In theory adjustment disorders should be present in girls exposed to the traumatic stress of sexual abuse. However, commonly these subjects met the criteria for another specific axis I disorder which was predominant; furthermore, it was often difficult to determine the time criteria and so the adjustment diagnosis could not be applied in a systematic way. In contrast, in the controls, there were no problems in applying the adjustment disorder diagnosis.

Table 1 DSM-III-R diagnoses: comparison: rates of disorder

DSM-III-R diagnosis	Clinic group		CSA group		Chi-squared ¹ p	odds ratio
	n = 21	(%)	n = 21	(%)		
Post traumatic stress disorder	0	(0)	15	(71)	<0.001 a	50.0
Major depressive disorder	4	(19)	14	(67)	<0.01 a	8.5
Adjustment disorder	7	(33)	0	(0)	<0.01 a	-10.0
Reactive attachment disorder	0	(0)	6	(29)	<0.05 b	8.0
Attention disorder deficit	0	(0)	5	(24)	<0.05 b	6.25
General anxiety disorder	3	(14)	8	(38)	NS	3.7
Separation anxiety disorder	8	(38)	13	(62)	NS	2.6
Social phobia	2	(9)	7	(33)	NS	4.75
Avoidant disorder	1	(5)	4	(19)	NS	4.7
Conduct disorder	1	(5)	4	(19)	NS	4.7
Specific phobias	2	(9)	5	(24)	NS	3.0

Odds Ratio: where a zero is listed it is substituted with 1.
(a) Adjustment has been made for continuity; (b) Fisher's Exact Text

Table 2 Comorbidity

Number of disorders	Clinic group	CSA group
1 or 2	17 (80%)	5 (24%)
3 or more	4 (19%)	16 (76%)
Mean number of disorders	1.6	3.9

Chi-square = 13.7; df = 1; p < 0.001; Odds ratio = 13.6

Hypothesis 3 (see Table 2): Only four subjects from the clinical control group (19%) proved to have three or more coexisting disorders, whereas 16 (76%) of the CSA group presented with this pattern. Indeed, four in ten of the CSA group were found to have five or more coexisting disorders. The extent of the comorbidity is demonstrated by the mean number of disorders, which was 1.6 in the clinical group as compared with 3.9 in the sexually abused group.

Hypothesis 4 (See Table 3): Subclassification of the global assessment of functioning data based on the Kiddie SADS format into three categories (mild impairment, moderate impairment and severe impairment) showed that the children in the CSA group have greater degrees of global severity of impairment of functioning as compared with those in the clinical control group.

Discussion

Generalisability of the findings

The CSA group was not a random group of sexually abused girls: it was rather a selected group of girls who had been sexually abused, who were symptomatic and who were considered to merit psychotherapy. In other words, they may not be representative of all sexually abused girls but were representative of clinical cases of girls who had been sexually abused.

Comorbidity

The most dramatic feature was the evidence of extensive comorbidity with a complex picture of diverse and often coexisting disorders. Originally, DSM-III-R diagnostic

Table 3 KIDDIE-GAS (K-GAS). Severity of impairment over previous year: Social, psychological and school functioning

	Clinic group	CSA group
No more than mild impairment (7 or greater)	11 (52%)	1 (5%)
Moderate impairment (6)	3 (14%)	6 (29%)
Serious impairment (5 or less)	7 (33%)	14 (66%)

Chi-squared = 11.71; 2df, p < 0.001; Odds ratio (serious impairment versus rest) = 4.0

criteria were used and subsequently DSM-IV criteria were applied. This diagnostic system is much more facilitative of multiple diagnosis than the ICD-10 system (23). However, not all the emergent disorders represent separate and distinct conditions in the same subject: they may be part and parcel of a broader disorder from higher in the hierarchy resulting from the same underlying cause(s); some such disorders should be considered as representing single rather than multiple diagnostic condition. Thus, a study of Table 1 might suggest that the eleven apparently distinct diagnoses could be reduced to seven or eight main categories. The findings suggest that some of the diverse identified disorders share the same set of risk factors of family dysfunction and trauma. The pattern consisted of PTSD, Reactive Attachment Disorders, Social Phobias, Avoidance Disorders, Depression, General Anxiety Disorders, Phobic Disorders and, finally, Attention Deficit Disorders. One other issue is whether Social Phobia (Social Anxiety Disorders) and the Avoidant Disorder categories, should be combined as indicated by DSM-IV. But if combined, it has only a small effect on the extent of comorbidity.

Another possibility is that the diagnostic procedure may be flawed, but this has been checked and rechecked, together with a review of critical defining criteria for each disorder; thus, the possibility of a flaw in the procedure has been ruled out.

Why do these sexually abused girls have such widespread comorbidity? Caron and Rutter (6) indicate that it is usual for a child with one diagnosed disorder 'to have at least one other diagnosis as well'. To be included in the CSA group, a child had to be symptomatic; but the subsequent assessment revealed the presence of at least one current disorder. However, it would seem that, in sexually abused girls, having one clinically diagnosed disorder carries the risk, in three-quarters of the subjects, of not one but at least three or more diagnosed disorders. Such extensive psychopathology must have implications with regard to both prognosis, response to psychotherapy and for service development and planning. It was not surprising that the offer of a psychotherapy service often came as a relief to Social Service Departments, given the immensity of the task of managing these cases.

Primary and secondary risk factors

Child sexual abuse and associated family and social adversities must be viewed as risk factors in relation to the emergence of the widespread co-occurring psychiatric disorders, but especially in relation to post-traumatic stress disorder, depression and reactive attachment disorder. A major issue is the nature of further risk factors. Family adversities are reported as

constituting risk factors for depression without sexual abuse (1, 13).

Commonly, depression in young people co-occurs with other types of psychopathology (18), especially anxiety disorders which some consider to be antecedents of depressive disorders (19, 22). Perhaps this would explain the extent of depression in the clinical sample who were referred primarily for anxiety disorders (both anxiety and separation anxiety). Thus, one can speculate that anxiety and depression may be risk factors for the more widespread other types of psychopathology. It can be argued, therefore, that family and social adversity can be viewed as primary risk factors for psychiatric disorder and so, too, can sexual abuse. Nevertheless, the psychopathology initially emerging may constitute secondary risk factors for the emergence of further psychopathological conditions.

When seeking common comorbid patterns, an obvious one consists of at least three of four disorders in about 40% or more of the subjects (the disorders being Post-Traumatic Stress Disorder, Major Depression, General Anxiety and Separation Anxiety). It is also important that comorbid depressive disorders have a reputation for extreme severity and grave prognosis (14). Finally, it has been reported that Depressive Disorders usually co-occur at a significant level with conduct disorder. With the nature of the trauma associated with CSA, it could be hypothesized that such co-occurrence would prove to be particularly high in these cases, but this did not prove to be so in the current sample.

Psychopathology in sexually abused girls

The issues

That sexual abuse carries with it a higher risk for psychiatric disorder is well known. Kendall-Tackett et al. (16) reviewed 45 empirical studies focusing on the impact of sexual abuse on children and reported that they had more symptoms than the clinically referred non-abused children. Abuse apparently accounted for 15% of the variance for the symptom of anxiety, 32% of the variance for externalising behaviours and 35–38% for internalising symptoms on the Child Behaviour Check List (CBCL). However, there is little in the way of substantial evidence of what is unique about the psychiatric disorders reported in the sexually abused population (20).

A distinction must be made between those girls who have been sexually abused and who present with psychopathology at a clinical level and those who have been clinically referred but not sexually abused. Thus, the current study does not attempt to provide a picture of psychiatric disorder in a representative sample of sexually abused girls, but rather examines the prevalence

of such disorder in a clinical sample of symptomatic sexually abused girls referred for consideration for psychotherapy. Thus, two of the main inclusion criteria were, first, that there was evidence of sexual abuse using the technical criterion of "on a balance of probabilities" and, second, that there was sufficient concern about psychiatric symptoms to merit consideration for psychotherapy. To reiterate, subjects were not included on the basis of abuse alone.

One further associated issue is that the distinction highlighted above has to be examined and put into some perspective in the light of the literature about children who have been abused but who do not present with a psychiatric disorder. For instance, Sirles et al. (26) have assessed the psychiatric status of over 200 child victims of intra-familial abuse and concluded that, in most of these cases, the criteria for psychiatric disorder were not met. The problem with such studies is twofold, in that, first, the older studies tended not to look for post-traumatic stress disorder; and second, they often did not use standardised instruments for determining the diagnosis (20). When there is a specific focus on PTSD, then usually the conclusion is that this is a common diagnosis in the majority of CSA studies.

Comparable studies in the literature

The literature was surveyed in an attempt to identify comparable studies up to the end of 1996 but these proved few and only three justify discussion. First, Cosentino et al. (10) contrasted 20 sexually abused girls aged between 6 and 12 years with 20 from a child psychiatry outpatient department, together with 20 from a general paediatric clinic. However, it was not possible to use Cosentino's data for comparison with other studies because the subjects were not assessed using direct clinical assessments but were rated on the Child Behaviour Check List, with the data presented as means and standard deviations, rather than in a percentage and categorical format. In addition, both the sexually abused and psychiatric controls had been in treatment for between 7 and 9 months, on average; hence, according to the authors these children are not representative of the pool of children that may initially present for treatment. Further, although the study is useful in demonstrating differences between the two clinical groups and the paediatric controls, it is less useful for exploring differences between the sexually abused group and the child psychiatry outpatient group. The authors report that there may have been an attrition bias in the outpatient clinical sample as, for example, 'less symptomatic children may have dropped out of treatment after initial intake'.

Second, the recent study by McLeer et al. (20) examined the prevalence of psychiatric disorders in a clinical sample of 26 sexually abused children referred

for outpatient evaluation and compared with 23 non-abused children. The hypotheses and method were broadly consistent with that of the current study – that the sexually abused group would have more PTSD than the non-sexually abused group. The similarity was that both studies were assessed by trained interviewers and interviewed using the Kiddie-SADS E version which included a PTSD section (21). However, there were three major differences between the studies. The most important was that in the study by McLeer et al. (20) the children were of both sexes whilst in the current study the population was all female. The second difference was that, in the McLeer study the age range extended up to the age of 16 years, whereas in the current study it was only 14 years. The third major difference between the studies was that in the McLeer et al. (20) study was no stipulation that there should be evidence of clinical symptomatology as one of the referral criteria, and hence it is not surprising that they report five (19%) of the sexually abused children had no psychiatric diagnosis. They also reported only one significant difference between the groups (see below) and, in both groups, Attention Deficit Hyperactivity Disorder was the most frequent diagnosis. However, the rate of Post Traumatic Stress Disorder among sexually abused children (42%) was significantly greater than in the non-sexually abused group (8.7%). The conclusion was that sexually abused children were at a heightened risk for the development of Post Traumatic Stress Disorder.

Despite the lack of significant differences between groups regarding other psychopathological conditions in the study by McLeer et al. (20), it is worth comparing the rates of such conditions in the sexually abused and the control children. Thus, in the former there were higher rates of Attention Deficit Hyperactivity Disorder (ADHD) (46% vs. 30%) and Conduct Disorder (27% vs. 4%). It is important to stress that comparisons are not really possible between the studies nor were the findings of either the McLeer or other studies generalisable to the entire population of sexually abused children (20).

There are three clear differences between the study by McLeer et al. (20) and the study reported here. In the current study the subjects went up to the age of 14 rather than 16 years; second, they were all girls rather than a mixed-sex group; third, normally children attending a child psychiatry clinic in the United Kingdom are not sent there because of an 'at risk' experience but rather because not only have they been exposed to an adverse experience but also they are showing signs of a psychopathology as well. Additionally, the inclusion of abused boys in the McLeer study (20) are likely to have increased the incidence of ADHD and conduct disorder. Hence, the differences in referral criteria between these studies may explain the different findings. It is, therefore, necessary to attempt to identify other studies with a similar referral pattern which would facilitate a more

valid comparison of the nature and severity of the psychopathological conditions.

The study by Deblinger et al. (11) was designed to treat PTSD and other emotional difficulties in 100 sexually abused children who had attended forensic medical examinations at the Centre for Children's Support. Representatives from both the Division of Youth and Family services and the prosecutor's office were invited to refer non-offending parents and sexually abused children who met screening inclusion criteria for participation in the treatment study. These inclusion criteria were experience of contact CSA in children aged 7–13; and children who showed at least three post-traumatic stress symptoms. Relevant exclusions were (i) ongoing unsupervised contact with the alleged perpetrators (ii) dangerously aggressive behaviour, (iii) suicidal tendencies, and (iv) a female caretaker who was not willing to participate. About 90 of the 100 completed the pretreatment assessments of which 83% were girls and 17% were boys. Evidence of psychopathology including anxiety and depression were gathered using the Kiddie-SADS E (epidemiological version) and the data were subject to DSM-III-R diagnosis. In addition, the PTSD picture was examined using the measure described by Orvaschel et al. (21). The frequency of DSM-III-R disorders was as follows: PTSD, 71%; major depression, 29%; oppositional, 34%; attention deficit, 20%; separation anxiety, 11%; overanxious, 10%; conduct, 6%; specific phobias, 5%; and obsessive compulsive, 1%.

With regard to differences in rates of axis I disorder, although the rates obtained for PTSD in the current study are broadly comparable to those reported by Deblinger et al. (11), there are some major differences. In the current study there are higher rates over a range of conditions that loosely can be described as 'internalising' and as attachment disorders, and these merit explanation. The Tavistock, North London is a regional psychotherapy clinical service and hence referring local services will tend to retain subjects with lesser problems and refer those with more serious problems. This emphasises the importance of a referral bias. The Deblinger study (11) had the inclusion criterion of PTSD symptoms, which biased the sample to PTSD disorders (but the rates of PTSD are similar to those in the London study). Further, the exclusion of children with suicidal tendencies and the inclusion of boys would bias the sample away from internalising disorders including depression and anxiety. In contrast, the Tavistock Clinic is a well-known psychotherapy clinic and it may well be that the specification of the inclusion criterion of evidence of psychiatric symptomatology has biased the sample to internalising disorders.

A number of other factors could account for the differences in the pattern of disorders: for example, in the UK there is a 'cultural diagnosis fashion', with the

researchers more likely to emphasise attachment disorders and separation anxiety disorders. In addition, the Tavistock interviewers were all senior child psychiatrists with particular expertise in diagnosing clinical psychopathology, whereas in the study by Deblinger et al. (11) they were psychotherapists.

Implications for psychotherapy

A final point concerns the extensive presence of PTSD in the various studies of psychic trauma. In adult subjects with exposure to psychological trauma – such as war trauma (2) in veterans who sought psychiatric treatment 4–6 years afterwards – extensive PTSD comorbidity was diagnosed. Both lifetime (100%) and current (87%) PTSD was diagnosed with major depressive disorder being the most prevalent comorbid diagnosis (95% lifetime, 50% current).

This pattern does not differ greatly from that reported in child sexual abuse where PTSD is a common disorder. PTSD is known to show continuity across time, has an impact on behaviour and social development and is also commonly resistant to treatment. Thus, children who develop PTSD may be at considerable risk for prolonged dysfunction (20). Some argue that PTSD precedes post-trauma depression, with depression a secondary consequence of PTSD (15). Hence, there are strong grounds for exploring the utility of psychotherapy for children and adolescents who have been both sexually abused and are clinically psychiatrically disordered.

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