Sexual Abuse in Childhood and Youth as Psychopathologically Relevant Life Occurrence: Cross-sectional Survey

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Aim. To assess the perpetrators of sexual abuse in childhood, forms of simultaneous abuse, and characteristics of the families of origin, and the possible effects of abuse on health in adult life.

Methods. A cross sectional study conducted between 1998 and 2002 included a random group of 936 inpatients (723 women) aged (mean±standard deviation) 41.0±2.5 years at the psychosomatic clinic in Simbach, Germany. The following questionnaires, previously validated in German, were used to assess the patients: Questionnaire for Life Story and Partnership, Scale for Survey of Quality of Life, Existential Orientation Scale, Leipzig Incidence and Psychological Stress Questionnaire, Questionnaire for Assessment of One’s Own Body, Survey of Life Satisfaction, Frankfurt Physical Concept Scale, Giessen Complaint Survey, and the Survey for Collection of Health Behavior Data. We compared the inpatients who had been sexually abused in their childhood (n=250) with other psychiatric inpatients in the control group (n=486).

Results. Out of 250 sexually abused patients, 25.7% were victimized by fathers/stepfathers, 4% by mothers/stepmothers, 12.4% by aunts or uncles, 10% by brothers or sisters, 7.6% by grandparents/grandfathers, 30.1% by family acquaintances, and 29.3% by strangers. Unlike the parents of patients in the control group, the parents of sexually abused patients had more conflicts, especially over alcohol consumption (p<0.001) and extramarital affairs (p<0.001), they divorced more frequently during the first seven years of the patient’s life (p<0.001), and had more underlying emotional (p<0.001) and physical illnesses (p=0.006). Significantly more sexually abused patients reported having poor concentration (odds ratio [OR]=5.03; 95% confidence interval [CI]=1.98-9.70; p<0.001) and sexual handicaps (OR=5.16; 95% CI=1.81-13.9; p<0.001), tended to hide their body (OR=3.65; 95% CI=1.69-7.30; p<0.001), abused illicit drugs (OR=2.38; 95% CI=1.08-6.01; p<0.001), had borderline personality disorder (OR=4.21; 95% CI=2.44-8.40; p<0.001), and suicidal ideation (OR=2.87; 95% CI=1.71-5.96; p<0.001).

Conclusion. The patients who were sexually abused in childhood had significantly less satisfactory lives and more frequent psychiatric illnesses, suicidal ideation, disturbed social functioning and perception of the body, and psychosomatic diseases.

Key words: borderline personality disorder; child abuse, sexual; eating disorders; stress disorders, traumatic

There is a significant association between childhood sexual abuse and the development of psychological disorders in later life (1,2). Surveys revealed that sexual abuse in childhood had a statistically significant negative impact on the development of mature sexuality (3,4), and highly correlated with hysterical neurosis, borderline personality disorders, eating disorders, alcohol dependency or other substance addictions, depression, and adiposity (4). Among patients with multiple drug dependencies, 70% of the women and 56% of the men report sexual abuse (5). Also, 26% of the psychosomatic patients, 58% of the patients in outpatient psychoanalytical therapy, and 75-86% of the psychotherapeutic inpatients report being sexually abused in childhood (5). Childhood sexual abuse and a pathological family situation lead to impaired development of the child’s self-worth and its coping resources, and increase the probability of psychological problems and suicide attempts in later life (6). The central damage originates from the child’s self-image (7).

Estimates are that 15-38% of women in the USA were sexually abused in childhood, whereas the prevalence of sexual abuse in Europe is assumed to range from 6% to 36% for girls under 16 and from 1% to 5% for boys of a similar age (8).

Our aim was to assess the frequency of sexual abuse experience, and the ensuing consequences, of patients in need of psychosomatic and psychothera-
Participants and Methods

Participants

Participants for this cross-sectional trial were selected from inpatients at the Inntalklinik, Germany, a clinic for psychosomatic medicine and psychotherapy. The clinic treats patients with a wide spectrum of psychiatric and psychosomatic diagnoses, such as affective disorders, obsessive-compulsive disorders, eating disorders, borderline personality disorders, somatoform disorders, and pain disorders. The final diagnosis is reached by use of the Structured Clinical Interview (SCID) I and II, according to DSM-IV (9).

The calculation of the random sample size was made for the difference of the mean values. We used the following formula:

\[ n = \left( \frac{z_1 + z_2}{2} \right)^2 \times \left( \frac{\sigma_1^2}{m_1} + \frac{\sigma_2^2}{m_2} \right) \]

where \( z_1 = 2.576 \) for a Type I error of 1%, \( z_2 = 1.282 \) for a power of 90%, \( \sigma_1, \sigma_2 \) – standard deviation of deviation in group 1, \( m_1, m_2 \) – mean value in group 1, \( m_1 - m_2 \) – mean value in group 2. The corresponding mean values (test SEL, \( m_1 = 260.5, m_2 = 251.0 \)) and standard deviation (SD) (\( \sigma_1 = 25.5, \sigma_2 = 29.5 \)) were obtained from a small, previously conducted study of 23 sexually abused patients we found among the first 100 patients admitted to the clinic between 1998 and 2002, although all patients admitted in that period were considered for inclusion. The exclusion criteria were age under 16 years, acute psychosis, insufficient command of German language, and illiteracy. The patients for the study were randomly selected by the use of Excel-generated random number table. The patients were recruited every week, during their admission to the clinic. For example, out of 20 patients admitted over a week, 8 were selected and asked by the professional staff to participate in the study. Out of 1,100 patients, 947 subjects fulfilled the inclusion criteria and initially agreed to participate (Fig. 1). To ensure that the study participants were blinded, the aim of the study was revealed to them only after the test was completed and the patients had had prior contact with previously surveyed subjects. After informed consent was obtained, the patients’ data were collected. Eleven patients withdrew from the study after learning about the aim of investigating.

Among 936 patients who agreed to participate in the study (response rate, 85.1%), 41.4% had depressive disorders, 26.0% had phobic anxiety disorders. 3.0% had obsessive-compulsive disorders. 14.5% had eating disorders, 10.7% had specific personality disorders, and 4.4% suffered from other disorders (Table 1). These diagnoses were made during medical examination after the study recruitment and testing. The data on the patients who met exclusion criteria (n = 122) or refused to participate in the survey (n = 42) were not evaluated any further.

Methods

We prepared a battery of questionnaires to assess the prevalence of sexual abuse in the patient’s childhood and to collect the information on the perpetrator, forms of simultaneous abuse, characteristics of the patient’s family of origin, and life situation, life satisfaction, health, sexuality, and medical and psychotherapeutic treatment received by the patient as an adult. There were 111 variables assessed all together, including sex, age, height, weight, and data collected by the following tests, which were all previously validated in German: the state of health test scale (Befindlichkeits-Skala (BfS), ref. 16), quality of life test scale (Skalen zur Erfassung der Lebensqualität (SELS), ref. 11), health behavior assessment scale (fragebogen zur Erfassung des Gesundheitsverhaltens (FEG), ref. 12), Giessen Complaint Survey (Gießener Fragebogen [GBB], ref. 13), Frankfurt Physical Concept Scale (Frankfurter Körperskalen [FKKS], ref. 14), Survey of Life Satisfaction (fragebogen zur Lebenszufriedenheit [FZL], ref. 15), Leipzig Incidence and Psychological Stress Questionnaire (Leipziger Erkrankungs- und Belastungsinventar [LEBI], ref. 16), Questionnaire for Assessment of One’s Own Body (fragebogen zur Beurteilung des eigenen Körpers [FbeK], ref. 17), Questionnaire for Life Story and Partnership (fragebogen zur Lebensgeschichte und Partnerschaft [FLP], ref. 18), as well as additional data on family history and sexual, physical, and psychological trauma.

The questionnaire was independently and anonymously filled out by the patients immediately after the recruitment. The professional staff checked the data for completeness. The data were logged into a computer twice by independent operators and automatically checked for deviations; 3.2% of the entries were erroneous and adjusted accordingly.

Statistical Analysis

We used STATISTICA (Version 6; StatSoft, Inc., Tulsa, OK, USA) for all statistical analyses. Since data were not normally dis-

Table 1. Flow chart of participants throughout the study.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>No. (%) of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean±SD, years)</td>
<td>sexually abused (n=250)</td>
</tr>
<tr>
<td>No. (%) of women</td>
<td>40.9±10.7</td>
</tr>
<tr>
<td>Living with a partner</td>
<td>220 (88)</td>
</tr>
<tr>
<td>Blue-collar worker</td>
<td>90 (36)</td>
</tr>
<tr>
<td>White-collar worker</td>
<td>67 (26.8)</td>
</tr>
<tr>
<td>Home-maker</td>
<td>93 (37.2)</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>45 (18.0)</td>
</tr>
<tr>
<td>Anxiety and phobia</td>
<td>154 (61.6)</td>
</tr>
<tr>
<td>Depressive disorders</td>
<td>13 (5.2)</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>56 (22.4)</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>20 (8.0)</td>
</tr>
</tbody>
</table>

*Odds ratio (95% confidence interval).
Results

The patients who reported having sexual abuse experiences (n = 250) on the LEBI test were compared with the control group consisting of 686 non-abused psychosomatic patients (Table 1). A mean period of 31.5 ± 2.1 years had passed since the abuse.

Perpetrators

According to LEBI test results of patients who were sexually abused in childhood, their perpetrators were mostly family acquaintances (30.1%), strangers (29.3%), and fathers/stepfathers (25.7%), followed by aunts or uncles (12.4%), brothers or sisters (10%), grandmothers/grandfathers (7.6%), and mothers/stepmothers (4%). In 21.4% of the cases, more than one perpetrator was simultaneously or sequentially involved.

Simultaneous Abuse

According to the LEBI test results and data on family history and trauma, the association between physical and emotional abuse was highly significant. Patients who were sexually abused as children reported being more frequently beaten than the patients in the control group (118 or 47.2% abused vs 150 or 21.9% controls; p < 0.001). Canes, whips, and other instruments were significantly more frequently used in physical abuse of sexually abused patients than in controls (61 or 24.4% abused vs 21 or 3.1% controls; p < 0.001). The sexually abused patients were more frequently exposed to subjective negative feelings in childhood (Table 2).

Table 2. Negative feelings according to Leipzig Incidence and Psychological Stress Questionnaire test results.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>No. (%) of patients*</th>
<th>OR (95% CI)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belittled</td>
<td>162 (64.8)</td>
<td>6.93 (5.13-9.36)</td>
</tr>
<tr>
<td>Withdrawal of love</td>
<td>151 (60.4)</td>
<td>3.87 (2.86-5.19)</td>
</tr>
<tr>
<td>Shamed</td>
<td>134 (53.6)</td>
<td>2.32 (1.73-3.11)</td>
</tr>
<tr>
<td>Scorned</td>
<td>110 (44.0)</td>
<td>2.38 (1.76-3.21)</td>
</tr>
<tr>
<td>Often lonely</td>
<td>152 (60.8)</td>
<td>3.49 (2.60-4.68)</td>
</tr>
<tr>
<td>Anxious</td>
<td>151 (60.4)</td>
<td>3.79 (2.82-5.09)</td>
</tr>
<tr>
<td>Depressed</td>
<td>116 (46.4)</td>
<td>2.16 (1.61-2.90)</td>
</tr>
</tbody>
</table>

*All differences between the two groups were significant at p < 0.001.
†Odds ratio (95% confidence interval).

Families of Origin

According to the FLP test results and family data, there were significantly more illegitimately born persons among sexually abused patients (58, or 23.2%) than among controls (53, or 7.7%; p < 0.001). Also, significantly more sexually abused patients had 3 or more siblings (112 or 44.8% abused vs 184 or 26.8% controls; p < 0.001), and had been separated from their parents for longer than 6 weeks during the first 4 years of their life (58 or 23.2% abused vs 89 or 13.0% controls; p < 0.002). Also, their parents divorced more frequently during the first seven years of the patient’s life (34 or 13.6% abused vs 32 or 4.7% controls; p < 0.001). The parents of sexually abused patients more frequently suffered from emotional problems (70 or 28.0% abused vs 116 or 16.9% controls; p < 0.001) and chronic physical illnesses (60 or 24.0% abused vs 57 or 8.3% controls; p < 0.001) during the first seven years of the patient’s life, and more frequently had alcohol addiction (96 or 38.4% abused vs 116 or 16.8% controls; p < 0.001).

Regarding their parents’ financial situation, there was no difference between the abused patients and controls (103 or 41.2% abused vs 214 or 31.2% controls; p = 0.42). The study participants saw their parents as having more conflicts, especially over alcohol consumption (88 or 35.2% abused vs 85 or 12.4% controls; p < 0.001) and extramarital affairs (68 or 27.2% abused vs 84 or 12.2% controls; p < 0.001). Sexually abused patients were more frequently threatened with violence in childhood, usually by the father (111 or 44.4% abused vs 88 or 12.8% controls; p < 0.001), more often used as scapegoats (61 or 24.4% abused vs 53 or 7.7% controls; p < 0.001), and more often suffered from anxieties (171 or 68.4% abused vs 178 or 25.9% controls; p < 0.001). Matter-of-fact discussions with their parents were impossible (198 or 79.2% abused vs 307 or 44.7% controls; p < 0.001). As children, the sexually abused patients experienced affection from the mother (121 or 48.4% abused vs 222 or 32.4% controls; p < 0.001) and father (116 or 46.4% abused vs 205 or 29.9% controls; p < 0.001) as dependent on performance.

Patients who were sexually abused as children and youth described the emotional climate of their families of origin as marked by loneliness (167 or 66.8% abused vs 201 or 29.3% controls; p < 0.001), depression (152 or 60.8% abused vs 198 or 28.9% controls; p < 0.001), anxiety (198 or 79.2% abused vs 231 or 33.7% controls; p < 0.001), and insecurity (182 or 72.8% abused vs 189 or 27.5% controls; p < 0.001).

Life Situation and Life Satisfaction

According to the SEL, FLZ, CIPS, LEBI, and FLP tests, sexually abused persons perceived themselves as having difficulties concentrating and cooperating with colleagues, they felt more burnt out and avoided dealing with the public (Table 3). They viewed themselves as handicapped in areas such as recreation, social activities, career, family, and sexuality, perceived themselves as a burden to their fellow human beings, and experienced their lives as less satisfactory or disappointing. Changes of residence on account of conflicts with siblings and parents occurred more frequently. In comparison with controls, no differences were found in the accomplished education level (Table 1).

Health and Sexuality

The SEL, FEG, LEBI, GBB, and FLP tests revealed that, during the 12 months preceding the survey, the sexually abused patients had suffered from multiple pains in the abdomen, rectum, arms, and legs. They did not like to be touched, were dissatisfied with their...
and anorexia were found in the sexually abused group, a significantly higher portion of patients diagnosed with borderline personality disorder, as opposed to 4.9% patients in the control group (OR=2.87, 95% CI=1.71-5.96; p<0.001).  

Medical and Psychotherapeutic Treatment  
According to the FEG and FLP test results, sexually abused persons more frequently remained in psychotherapy for longer than 3 years (128 or 51.2% abused vs 35 or 5.1% controls; p<0.001), and changed their psychotherapists more often than 5 times (33 or 13.2% abused vs 35 or 5.1% controls; p=0.003).

Discussion  
Our results showed that sexual abuse of children frequently co-occurred with parental low job security and upbringing by non-biological parents. However, it was not connected with low social or financial status in the family of patient’s origin (3). Further predictors were parent’s abuse of alcohol, chronic physical illness, and psychological problems. Due to the study design, however, we were not able to determine whether other family factors, such as attention-deficit hyperactivity disorder (ADHD), antisocial personality disorder, paraphilia, schizophrenia, organic psychiatric disorders, or mental retardation, might have played a role in patients with sexual abuse history (19).

Our study highlights the significance of sexual abuse in childhood as an important factor contributing to the development of psychosomatic complaints and psychiatric illnesses in adulthood. Sexual harassment can also trigger functional complaints and psychosomatic illnesses (20-24).

Sexually abused patients enrolled in our study suffered significantly more frequently from pain in different body parts; they did not like to be touched, were dissatisfied with their appearances and sexual features, and tended to hide their body. With the distorted development of self-worth and failure to learn self-efficacy, the probability of a psychosomatic syndrome manifesting itself in adulthood increases. Sexual abuse threatens the psychological and intellectual integrity of the victim and interferes with the development of a positive physical self-image (25,26).

Abused patients in our study also had borderline personality disorders and problems with addiction and substance abuse more frequently than other patients (1). Other studies also revealed a correlation between traumatic childhood experiences and the development of a borderline personality disorder (27,28). Among abused patients in psychiatric and psychotherapeutic treatment, up to 70% are diagnosed with a borderline disorder. Previous studies established a close relationship between the severity of the abuse, neglect in childhood, a severe borderline disorder, and disturbances of interpersonal relationships (29,30).

Patients with anorexia nervosa and bulimia nervosa, but not obese patients (in contrast to ref. 1), reported that the sexual abuse they suffered led them to continuously reduce and control their eating. In other studies, sexually abused patients also had highly developed eating disorders and impulsive self-injury behavior even 10-15-years aged girls (31-33). Sexual

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No. (%) of patients</th>
<th>OR</th>
<th>(95% CI)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased concentration</td>
<td>169 (67.6)</td>
<td>201 (29.3)</td>
<td>5.03 (1.98-9.7)</td>
</tr>
<tr>
<td>Burnt out feeling</td>
<td>179 (71.6)</td>
<td>248 (36.1)</td>
<td>4.45 (1.72-8.28)</td>
</tr>
<tr>
<td>Difficulties cooperating</td>
<td>92 (36.8)</td>
<td>126 (18.4)</td>
<td>2.59 (1.59-6.52)</td>
</tr>
<tr>
<td>Difficulties dealing with the public</td>
<td>107 (42.8)</td>
<td>131 (19.1)</td>
<td>3.17 (1.81-7.78)</td>
</tr>
<tr>
<td>Handicapped in recreation</td>
<td>183 (73.2)</td>
<td>241 (35.1)</td>
<td>5.04 (1.81-7.39)</td>
</tr>
<tr>
<td>Handicapped in social activities</td>
<td>175 (70.0)</td>
<td>217 (31.6)</td>
<td>5.04 (1.91-8.56)</td>
</tr>
<tr>
<td>Handicapped in career</td>
<td>180 (72.0)</td>
<td>242 (35.3)</td>
<td>4.72 (1.77-8.35)</td>
</tr>
<tr>
<td>Handicapped in family</td>
<td>164 (65.6)</td>
<td>216 (31.5)</td>
<td>4.15 (1.79-9.42)</td>
</tr>
<tr>
<td>Handicapped in sexuality</td>
<td>185 (74.0)</td>
<td>244 (35.6)</td>
<td>5.16 (1.81-11.39)</td>
</tr>
<tr>
<td>Perceived themselves as a burden</td>
<td>107 (42.0)</td>
<td>133 (19.4)</td>
<td>3.11 (1.78-7.74)</td>
</tr>
<tr>
<td>Less satisfactory life</td>
<td>82 (32.8)</td>
<td>105 (15.3)</td>
<td>2.7 (1.66-5.75)</td>
</tr>
<tr>
<td>Change of residence</td>
<td>116 (46.4)</td>
<td>129 (19.4)</td>
<td>3.74 (2.00-6.04)</td>
</tr>
</tbody>
</table>

*Tests: Scale for Survey of Quality of Life, Survey of Life Satisfaction, Existential Orientation Scale, Leipzig Incidence and Psychological Stress Questionnaire, and Questionnaire for Life Story and Partnership (all differences p<0.001).

†Odds ratio (95% confidence interval).

Psychiatric Diagnoses and Suicidal Ideation  
In the sexually abused group, 18.0% of patients met the criteria for borderline personality disorder, as opposed to 4.9% patients in the control group (OR=4.21; 95% CI=2.44-8.4; p<0.001; Table 1). Likewise, a significantly higher portion of patients diagnosed with anxiety and phobia, depression, bulimia, and anorexia were found in the sexually abused group of patients, who also had significantly more suicide attempts (36 or 14.4% abused vs 38 or 5.5% controls; OR=2.87, 95% CI=1.71-5.96; p<0.001).

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No. (%) of patients</th>
<th>OR</th>
<th>(95% CI)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain in abdomen</td>
<td>164 (65.6)</td>
<td>221 (35.2)</td>
<td>4.01 (1.75-9.38)</td>
</tr>
<tr>
<td>Pain in rectum</td>
<td>59 (23.6)</td>
<td>60 (8.7)</td>
<td>3.22 (1.96-7.73)</td>
</tr>
<tr>
<td>Pain in arms and legs</td>
<td>136 (54.4)</td>
<td>202 (29.4)</td>
<td>2.86 (1.56-5.2)</td>
</tr>
<tr>
<td>Don’t like to be touched</td>
<td>178 (71.2)</td>
<td>250 (36.4)</td>
<td>4.31 (1.77-8.24)</td>
</tr>
<tr>
<td>Dissatisfied with their appearances</td>
<td>161 (64.4)</td>
<td>210 (30.6)</td>
<td>4.10 (1.84-6.45)</td>
</tr>
<tr>
<td>Dissatisfied with sexual characteristics</td>
<td>130 (52.0)</td>
<td>160 (23.3)</td>
<td>3.56 (1.85-7.69)</td>
</tr>
<tr>
<td>Tended to conceal their body</td>
<td>159 (63.6)</td>
<td>222 (32.4)</td>
<td>3.65 (1.69-7.30)</td>
</tr>
<tr>
<td>Corporeality impeded contact with others</td>
<td>116 (46.4)</td>
<td>157 (22.9)</td>
<td>2.92 (1.66-5.48)</td>
</tr>
<tr>
<td>Menstrual complains</td>
<td>152 (60.8)</td>
<td>109 (15.9)</td>
<td>8.21 (3.15-22.65)</td>
</tr>
<tr>
<td>Feeling of losing control</td>
<td>173 (69.2)</td>
<td>137 (20.0)</td>
<td>9.00 (2.92-12.12)</td>
</tr>
<tr>
<td>Abuse of appetite</td>
<td>13 (5.2)</td>
<td>4 (0.6)</td>
<td>4.19 (1.29-7.17)</td>
</tr>
<tr>
<td>Abuse of laxatives</td>
<td>20 (8.0)</td>
<td>15 (2.2)</td>
<td>2.26 (1.06-5.56)</td>
</tr>
<tr>
<td>Abuse of illicit drugs</td>
<td>28 (11.2)</td>
<td>13 (1.9)</td>
<td>2.38 (1.08-6.01)</td>
</tr>
<tr>
<td>Abuse of psychopharmaceuticals</td>
<td>37 (14.8)</td>
<td>41 (6.0)</td>
<td>2.73 (1.64-6.74)</td>
</tr>
</tbody>
</table>

*Tests: Scale for Survey of Quality of Life, Survey of Collection of Health Behaviour Data, Leipzig Incidence and Psychological Stress Questionnaire, Giessen Complaint Survey, and Questionnaire for Life Story and Partnership (all differences p<0.001).  

†Odds ratio (95% confidence interval).
abuse is only one of the several factors contributing to the development of eating disorder, along with physical abuse, which is equally significant as a predictor (34). For the development of certain eating disorders, such as binge eating, emotional abuse, physical abuse, and depression have been shown as significantly more relevant than sexual abuse (35,36). The high rate of suicide attempts among the abused patients in our survey was in accordance with previous findings (6).

ADHD, posttraumatic stress disorder (PTSD), and oppositional defiant disorder (ODD) are commonly diagnosed disorders in sexually abused children (37,38). There is a high degree of symptom overlap and comorbidity between these disorders, making a differential diagnosis confusing at times (37). We were not in the position to determine whether these disorders could be diagnosed in our adult patients.

The female patients in our study unequivocally affirmed that sexual abuse experiences in childhood and youth complicated the development of a mature sexuality. This finding corresponded with other studies in which a minimal real interest in sexual activities and communication of sexual desires, promiscuity, and sexual function disorders were found among abused patients (3,39-42).

Whether the dysfunctions, pains, drug consumption, and dissatisfaction with life reported by the abused patients can be originally attributed to the sexual abuse, or were an expression of the patients’ current psychosomatic illnesses, cannot be clearly determined. In a few studies, only a small percentage of psychosomatically ill patients attributed their psychological and physical problems to a prior sexual abuse experience (3,24,25). In our survey, the severity of the clinical picture and clearly unfavorable standards of living distinguished the abused patients from the control group.

Our finding that more than a quarter of the hospitalized psychosomatic patients had experienced sexual abuse lies in the focus of international epidemiological studies (43). On the other hand, we found that 29.3% of all acts of abuse of our patients were committed by strangers, which contradicts the results of other studies (8). This finding can probably be explained through the lack of an operational definition of the term abuse.

The individual’s sexuality evolves in concert with, and as a result of, interaction with the family and ethnic, social, and cultural influences (43). Certain forms of abuse, such as sexual molestation and verbal harassment, are more often committed by strangers, because the perpetrators view them as petty offences. Unfortunately, the German versions of the gold standard for the assessment of sexual abuse, the Structured Trauma Interview, and the very useful screening instrument, the Sexual and Physical Abuse Questionnaire, have not yet been validated (44).

The limitations of the study were an ambiguous definition of sexual abuse used in patient selection. To give the patients sufficient leeway in their subjective assessments of what constitutes abuse, we refrained from using a detailed operationalization of sexual abuse. The present results must therefore be cautiously interpreted because of the loose definition of abuse and the subjective character of patient statements. Furthermore, we analyzed only inpatients. A study including outpatients would be more representative. Also, the randomization procedure, which is in itself worthy of discussion, and the blinding procedure, which can only be partially realized, lead to possible distortion in psychotherapeutic studies. Clear instructions for group comparison are given in the research methodology (56,57).

Our study results provide a good basis for improving the “therapeutic intake”. Already on the first contact, abused patients would feel understood if their physically represented suffering encountered an empathetic listener, so that mutual trust and a stable therapeutic relationship could be built quickly (45). The sensitive perception of body language in the further course of psychodynamic psychotherapy is of major significance until the patient can sufficiently verbalize his or her roles in conflict situations (27,46, 47). Deliberate cultivation of symbolic expression in contact with oneself and with the other person should help enable the patient to transcend the border to the preverbal. The patients then begin to overcome the repression, to speak about the abuse experiences and their behavioral consequences, and to become open for intensive interpersonal relationships (45,48-55).

Our finding that sexual abuse frequently co-occurred with low job security in the family of origin and that almost one-third of all acts of abuse were committed by strangers seems interesting from an epidemiological standpoint. Neither of these results corresponds to previous findings. Also, clearly more pronounced social impediments, as well as psychiatric and psychosomatic illnesses, suffered by those who had been abused suggests heavy financial burden on the health care system. A prophylactic approach, therefore, can be justified on more than just moral arguments.

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