Depression, developmental level and disclosure in sexually abused children

A L Pillay, M B W van der Veen

Objective. To investigate the relationship between sexual abuse disclosure, developmental level and psychopathology in children.

Design. A retrospective analysis of case records, using chi-square and *t*-tests for statistical significance.

Setting. Child and Adolescent Unit, Midlands Hospital, Pietermaritzburg.

Subjects. One hundred children consecutively admitted for all types of mental health problems.

Outcome measures. Diagnostic evaluations were made using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition, revised).

Results. Forty of the 100 children had been sexually abused, but 14 (35%) of the abused children did not disclose their abuse until after admission. The post-admission disclosure group had a significantly higher mean age (13.71 years) than the pre-admission disclosure group (10.96 years). Also, significantly more post-admission disclosure children received a diagnosis of major depressive disorder than their pre-admission disclosure counterparts.

Conclusion. The study highlights the issue of sexual abuse disclosure and its relationship to depression and developmental level. Internal psychological and developmental mechanisms appear to influence the disclosure/non-disclosure of sexual abuse.

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The epidemiology of childhood sexual abuse in South Africa and elsewhere in the world is not really known, given the gross under-reporting of these crimes. However, police department statistics in South Africa show that during 1995, just over 16 000 cases of sexual crimes against children were reported to their Child Protection Units nationwide.[1] Over 10 000 of these were cases of rape, while the remaining 6 000 or so were classified as indecent assault, sexual offences, sodomy and incest.

A history of sexual abuse is a common finding among children and adolescents receiving treatment for psychological and psychiatric disturbances.[2] A review of all

Sub-department of Medically Applied Psychology, University of Natal and Midlands Hospital, Pietermaritzburg

A L Pillay, MA (Clin Psych), MSc (Maternal & Child Health), PhD

M B W van der Veen, M Soc Sc (Clin Psych)

published empirical studies on the psychosocial impact of sexual abuse found that in 45 studies, sexually abused children had more psychological symptoms than non-clinically referred, non-abused children, with the abuse accounting for 15 - 45% of the variance.[3]

According to McLeer *et al.*[4] up to two-thirds of sexually abused children have significant and severe symptoms in the affective, cognitive, physical and behavioural domains. The result is that, to date, no specific set of psychiatric symptoms has been documented as unique to this childhood population. The most significant areas of psychological impairment that have been reported in sexually abused children are anxiety disorders, depression, increased aggression and disturbance in sexual behaviour and gender roles.[5] An American study found significantly higher rates of depression, and externalising and internalising of problems in sexually abused children than in a non-abused, non-clinical community sample.[6] That study also noted that sexual abuse has a negative effect on the psychological functioning of children, which cannot be accounted for by their specific living situation or socio-economic environment.

Research by Kiser *et al.*[2] found that 55% of children who have experienced physical or sexual abuse develop symptoms characteristic of post-traumatic stress disorder (PTSD). A more recent investigation confirmed earlier findings that sexually abused children are at increased risk for the development of PTSD. The study also demonstrated that the prevalence of PTSD distinguished clinically referred sexually abused children from a group of non-sexually abused children referred for psychiatric evaluation. It has been further suggested that PTSD and its symptoms may represent core manifestations of the sexual abuse trauma.[7] Goodwin,[8] who was the first clinician to describe post-traumatic symptoms in children sexually abused by family members, noted heightened fear, startle reactions, re-enactment of the trauma, flashbacks, sleep disturbance and depressive symptoms. In addition, she found that sexually abused children displayed more severe and long-lasting symptoms than adult rape victims, which was attributed to the children's experience of more frequent assaults over a more prolonged period. A subsequent study by McLeer *et al.*[9] found that 75% of children abused by their biological fathers and 25% of those abused by other trusted adults exhibited symptoms of PTSD while none of the children abused by an older child showed such symptoms. Considering the stability of PTSD over time, its effects on social and emotional adjustment, and its resistance to traditional treatments, those sexually abused children who develop PTSD are likely to be at considerable risk of prolonged dysfunction.[4]

Researchers have also noted high rates of depressive disorders in sexually abused children. One investigation reported a 71% incidence of major depression in sexually abused adolescents who had been admitted to a psychiatric hospital.[10] Another researcher noted depression, guilt and low self-esteem, along with a sensation of permanent damage or 'damaged-goods' syndrome as pivotal issues in sexually abused children.[11] A greater severity of depressive symptoms and high frequency of self-destructive behaviours have been found in sexually abused adolescent inpatients relative to non-abused inpatients.[12] Similarly, a study using the Children's Depression Inventory (CDI) found that sexually abused children were significantly more depressed than non-clinical controls, with a mean CDI score almost twice as high as that of controls.[6] The type of abuse has also been correlated with depressive pathology and a recent investigation has shown that girls were almost 8 times more likely to suffer depression when the abuse involved penetration than when other types of abuse occurred.[13]

The issue of disclosure of sexual abuse has also increasingly come under the spotlight, particularly in view of the exceedingly high rate of under-reporting of this crime. Although not much research has been done in this area, reports have tended to suggest that developmental levels may account for the variance in children's abilities to disclose sexual abuse. For example, Reinhart[14] found no school-age boys disclosing their abuse in his study. He believed that the psychological development during the latency years influenced the boys' failure to disclose the information. Other researchers also found older children to be less likely to disclose sexual abuse than younger children.[15] They noted that the older children were more aware of the social consequences of disclosure and, therefore, chose not to report the incidents. It has also been suggested that as a result of the greater awareness of the stigma associated with sexual victimisation, older children feel more shame and guilt and are therefore at greater risk for depression.[5]

Subjects and method

The study was conducted at the Child and Adolescent Unit, Midlands Hospital, Pietermaritzburg. This is the only specialised inpatient child mental health facility in the province of KwaZulu-Natal and, as such, serves a tertiary care function mainly for treatment-resistant cases referred from various clinics and hospitals.

The design involved a retrospective analysis of the case records of 100 consecutive admissions for all types of mental health problems. Biographical and clinical data were recorded. Primary diagnoses, according to the *DSM-III-R*, which was used at the time, were also noted. In the case of sexually abused children the time of first disclosure was recorded. Information was obtained to determine whether the child's disclosure of the abuse was made before or after admission to the unit. For the purpose of this study Finkelhor's[16] 'contact' definition of child sexual abuse was used.

Results

Of the 100 children whose records were examined, 40% had been treated for sexual abuse. The mean age of the abused children was 11.9 years with girls comprising 80% of this group. However, not all cases of sexual abuse had been identified as such by the referral agents. Only 26 of these children had disclosed their abusive experiences prior to admission. This means that over one-third (35%) of the sexually abused children did not disclose their experiences until after they began therapy for manifested psychological problems. In other words 14% of the children hospitalised for mental health problems had, in fact, been sexually abused but had not previously reported it.

A further finding was that the children in the post-admission disclosure group had a mean age of 13.7 years while those in the pre-admission disclosure group had a mean age of 10.9 years. This difference was found to be statistically significant ($t = 2.64$; df = 38). In this investigation statistical significance was assumed when $P < 0.05$.

Table I shows the distribution of primary diagnoses for the 40 sexually abused children, according to their pre- or post-admission disclosure status. Significantly more children in the post-admission disclosure group received a primary diagnosis of major depressive disorder than those in the pre-admission disclosure group (chi-square = 6.26, df = 1). This level of significance was obtained with the Yates correction technique for smaller cell frequencies.

Table I. Diagnostic distribution for the sexually abused group

	Pre-admission disclosure	Post-admission disclosure	Total
Major depressive disorder	5	9	14
PTSD	11	2	13
Adjustment disorder	2	-	2
Conduct disorder	1	1	2
Attention-deficit hyperactivity disorder	2	-	2
Mental retardation	2	-	2
Family relational problem (V-Code)	2	-	2
Oppositional defiant disorder	-	1	1
Other	1	1	2
Total	26	14	40

Although a higher number of children with pre-admission disclosures received a primary diagnosis of PTSD than their counterparts with post-admission disclosure, this difference was not found to be statistically significant ($\chi^2 = 2.10$, df = 1).

Discussion

The finding that 40% of the children being treated for mental health problems had suffered sexual abuse is rather alarming. Also, given the increasing number of cases reported each year[1] it is evident that this problem is going to put increasing pressure on the already over-extended child mental health resources in this country.

Of concern is the rate of sexual abuse disclosure prior to admission to the Child and Adolescent Unit. Over one-third of the abused children did not disclose their trauma until after engaging in therapy. This means that they were referred purely on the basis of their behavioural or emotional presentations. Considering the large numbers of children being sexually abused in this country, and the varying degrees of manifested psychopathology known to result, it is clear that many abused children are unlikely to be referred for mental health care or even identified as sexually abused. This means that only those sexually abused children who have developed marked psychological reactions and those who have disclosed the trauma will receive mental health care. While no statistics are immediately available, it is evident that a sizeable number of abused children will neither come to mental health attention nor receive the necessary care.

The disclosure during the course of psychological therapy by 14 (35%) of the sexually abused children is an indication of their need for a safe, protective environment in order to relate their experiences. It is widely known that such revelations within the home situation are often met with hostility and disbelief, even by the non-offending family members.[5] Abused children are frequently threatened in order to discourage disclosure and also made to believe they are 'bad' because of their involvement in the abusive acts. The therapeutic milieu of the Child and Adolescent Unit, together with the individual psychotherapy process, has obviously provided the child with the opportunity to feel supported and accepted, which of course, allows the development of trust and, therefore disclosure.

The other finding was that the abused children who had not previously disclosed their experiences were adolescents and significantly older than those who had disclosed their abuse earlier. This is an extremely valuable finding, given the lack of research, nationally and internationally, on the influence of developmental variables on disclosure of sexual abuse. It could be hypothesised that the higher levels of socialisation and sexual knowledge in adolescents tend to increase their perception of their experiences as taboo. In addition, they have a greater sense of awareness about the possible consequences of disclosure, for example, involvement of the police, imprisonment of the perpetrator and, perhaps most significantly, the destruction and disorganisation of the family system. As a result of their development these older children have also acquired the intellectual abilities to withhold the information from others intentionally. Furthermore, psychological defence mechanisms serve to provide a shield against painful emotions by removing the abuse from conscious awareness.[17] For these reasons, older children are more able than younger ones to inhibit the disclosure of the trauma. On a cautious note, it must be borne in mind that the age-finding in this investigation could also be influenced by the admission criteria to this specialised unit.

The significantly higher rate of major depressive disorder among those children who had not disclosed their trauma prior to admission (compared with those who did) could be viewed in two possible ways. Firstly, by attempting to withhold or contain this painfully traumatic information these older children suffer a great deal more internal strain, believing they cannot or should not reveal this to anyone. This, of course, results in their feeling that they cannot obtain help and that they are essentially on their own. The sense of psychic loneliness and internal crisis which follows appears to be responsible for the development of depressive conditions. Depressive disorders are, in fact, known to be disorders of internalisation, often representing internalised feelings of distress. Secondly, the post-admission disclosure group is also the group of significantly older children. Since depressive reactions are more frequently diagnosed in abused older children and adolescents, the depressive symptoms may, in all likelihood, be related to the shame and guilt that the child has to endure. Older children also feel a greater need to maintain secrecy of the event(s) in an attempt to hide what they perceive as their own responsibility for the abuse.[17] As a

function of their relative maturity older children, especially those entering their adolescent years, tend to feel considerably more stigmatised by the sexual abuse of their bodies. The feeling of guilt, low self-esteem and the 'damaged-goods' syndrome that have been documented in sexually abused adolescents are key ingredients in the development of depressive illness in this group.[11] Of course, since major depressive disorders are more commonly diagnosed in older children (whether or not they have been abused) the possible influence of age must be considered a confounding variable in this investigation. Larger multivariate studies would need to address this methodological issue.

The lack of significant difference in the PTSD incidence between the pre- and post-admission disclosure groups may well be related to the small sample size. This study certainly shows a tendency towards higher numbers of PTSD cases in the pre-admission disclosure group, i.e. the group showing significantly less depression. Although not statistically significant this finding lends support to that of Kiser *et al.*[2] that abused children who do not develop the symptoms of PTSD tend to show more depressive symptomatology. Perhaps larger local studies may be able to verify this.

The findings of the present study, particularly with regard to sexual abuse disclosure, developmental level and depression are suggestive of associations between those variables. They can, therefore, be of assistance in alerting health workers to the largely underreported problem of childhood sexual abuse by aiding early identification.

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Reprint requests to: Dr A L Pillay, Midlands Hospital, PO Box 370, Pietermaritzburg, 3200 SA.