ASSOCIATION BETWEEN CHILD SEXUAL ABUSE AND ADULT PSYCHOPATHOLOGY

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ABSTRACT

Objective: To test the feasibility of conducting a research on child sexual abuse, as a culturally sensitive issue, among ethnic minority groups living in the West United Kingdom.

Method: One hundred and two males out of one hundred and twenty eight males between the ages of 18-43 years in an ethnic minority group living in the UK responded to two questionnaires: a general health questionnaire and a self administered questionnaire which included questions on sexual molestation as well as other forms of abuse.

Results: Preliminary results showed that 8.8% (95% CI 3.3%-14.3%) of the whole sample experienced sexual molestation before they reached age 18 with an adult or a person who is at least five years older than them. The results also indicated that having a sexual molestation before the age of 18 results in significant and profound mental health consequences (t= 4.83, P-value < 0.001).

Conclusion: Difficulties, alternative research options suitable for non-Western societies, future recommendations and implications for service provision are also discussed in the paper. Moreover, the study proposed the need for family education about child sexual abuse in those communities and stressed on the need for new model of services which are culturally appropriate, responsive and able to liaise with other agencies.

Key words: Sexual molestation, Ethnic groups, Culture

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Introduction

In recent years, there has been a welcome improvement in awareness and understanding of child sexual abuse (CSA) and its associated phenomena. Accordingly, a large number of studies conducted in different cultural settings; predominantly Western, indicated that CSA is a major public health problem. Unfortunately, despite the rapidly growing child population and the major social changes, the issue has rarely been studied in the developing countries as well as amongst immigrants' communities in the European countries. The uncertainty about the true prevalence rates in the developing societies made it difficult to decide what the best research strategy is, or what treatment and health policy that may improve the quality of life for victims of sexual abuse.

There is a considerable variation in the prevalence rate for CSA in the studies conducted largely in the West. Reported rate of both the contact and the non-contact forms of CSA ranges from 6%-62% for females and from 3%-16% for males.[1] Variations in the prevalence rates may reflect differences in the definitions of CSA used in various studies, a true difference in the prevalence among populations, or variation in methodological approaches used. Feldman[2] concluded that the increase in reporting

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child abuse is due to improved legislation and social climate rather than a true increase in prevalence. Moreover, it was suggested that greater consistency, particularly in definition would assist the comparative conclusions to be made with less ambiguity and greater validity.[3]

There is growing evidence that the prevalence of sexual abuse is not higher among Afro-Americans than the white US population.[4] Also CSA before the age of 18 years appeared to be of equal concern for both ethnic groups (white and black Americans).[5] A study in a Far-Eastern culture found that only 4% of victims report abuse to authorities in Hong Kong. Moreover, those who would not report abuse were less likely to classify the abuse situation as abusive and more likely to believe that seeking advice and help would be either unhelpful or troublesome.[6]

Men and women of Asian ancestry reported higher levels of physical abuse, emotional abuse and neglect than did their Euro-ancestry counterparts. Euro-ancestry women also reported a higher incidence of sexual abuse than did Asian–ancestry women. Across ethnicity, men reported higher levels of physical abuse and neglect but lower levels of sexual abuse than women.[7] Girls were more likely to be victims of sexual abuse than boys. No significant age differences were observed for physical or emotional abuse and no racial differences were detected for any type of abuse.[8]

The overall rating in India in the categories of sexual abuse, fostering, delinquency, and educational neglect is relatively equal to those in the USA and there is no difference in perceptions of severity of different forms of abuse.[9] Studies from at least 19 countries in addition to USA and Canada found comparable rates ranging from 7%-36% for women and 2%-29% for men. Direct comparisons between countries were difficult because of different methodologies used to assess prevalence. However, theses studies suggest that sexual abuse is an international problem, although notably there is lack of studies in the developing countries.[10] In China traditional families have shameful secrets within their circles more than Western families. Moreover, the topic remains a taboo locally and denial is a common reaction even in identified cases.[11]

The primary aim of this piece of research is to explore whether it is feasible to conduct a research on CSA among a Non-Western community. In addition, the influence of religion, exposure to new culture and educational status on the prevalence level will be evaluated. Added to that, the study will propose alternative research options on CSA in a sensitive area in Middle East Countries.

Methods

Given the sensitivity of the research topic, a convenient sample of 128 adult males aged 18-43 years was selected from an ethnic minority group living in the UK who either were born in the UK or moved with their parents when they were very young. One hundred and two successfully responded to a one stage retrospective survey questionnaire; resulting in a response rate of 80%. The questionnaire also included general health section (GHQ30).[12] The initial questionnaire was developed for the purpose of the study and prior ethical approval was secured and university authorized tutors were assigned to supervise this piece of research at that time. The questionnaire was found to have face validity as agreed with a group of mental health providers and representatives from the area where the research was supposed to be conducted. Cultural, religious, social and ethical factors were taken into consideration as discussed with same group. For this purpose a pilot study of 15 people from the supposed area was conducted to insure acceptability, understanding of wording and content of the questionnaire.

Direct questions about sexual abuse that were considered unethical were removed from the questionnaire. In addition, all community leaders recommended that females should be excluded in order to avoid any possible ethical or social conflicts due to the sensitivity of the topic. Accordingly it was agreed that the questionnaire should include all forms of abuse and the word “sexual molestation” was moved under the heading "others". It was also agreed that the definition of sexual molestation will be given verbally to the subjects at the time of the meeting and will be restricted to the contact form of sexual abuse (fondling of breasts and genitals, intercourse and oral or anal sex), *i.e.* “has an adult or a person at least five years older than yourself ever taken advantage of you or hurt you in the following ways before you reached the age of 18: “touched your sexual organs, forced you to touch his sexual organs, attempted to do sex with you or completed sex with you”. The phrase hurt you/took advantage of you in the questionnaire was used rather than abuse to encourage response. Ambiguity in the definition of sexual experiences is less likely to be reduced if the definition of CSA is restricted to the

contact form only. Non-contact experiences (encounters with exhibitionists, solicitation to engage in sexual activities where no physical contact occurred and verbal propositions) were excluded as the answers might be high. Moreover, it was agreed that the community representatives will submit the questionnaire during a meeting with the respondents rather than the researcher himself. This would make them feel more comfortable compared with a situation where a stranger is coming to them with a questionnaire. The representatives were totally aware of the research goals as well as the topic of CSA. The area from which the sample was collected as well as the names of the representatives will not be mentioned to ensure confidentiality as it was agreed. The research was conducted purely on apparently healthy community sample. No patients whatsoever were included in the research process.

The questionnaire was focused on one major question:

"*Has an adult or a person at least five years older than yourself ever taken the advantage of you or hurt you in any of the following ways before you reached the age of 18 yrs?"*

1. Physical	Yes / No
2. Emotional	Yes / No
3. Rejection, e.g. by parents, carer, close friend	Yes / No
4. Racial abuse	Yes / No
5. Others, e.g. sexual molestation	Yes / No

Background information such as the victims' age was collected at this stage of the survey. To insure further confidentiality there were no names, or personal details or any other indication of the residential area from which the sample was taken on the questionnaire. Interviews after completing the questionnaire were not carried out in order to encourage response and avoid any possible ethical or social complications. A study on comparing the efficacy of both self administered questionnaire and face to face interview, concluded that interviews do not have clear advantage over the self-administered formats in assessing the disclosure of CSA, and disclosure may be encouraged further if the subjects know that they cannot be identified or re-contacted.[13]

To ensure randomization and representation, the questionnaire was submitted on three different occasions. On each occasion there were people from the proposed areas who met regularly.

At the first meeting, 45 questionnaires were submitted following a lecture on the topic of CSA, its long term consequences and the aim of the research which was given during the meeting by a representative who was orientated to medical research. Respondents were informed that results will be confidential and that there will be no names, interviews, or further contact for those who complete the questionnaire. As mentioned earlier, the definition of CSA was given verbally at the time of meeting. Enough distance between respondents was maintained to ensure privacy. Before leaving, each respondent was asked to put the completed questionnaire in a sealed box. The relationship with the abuser was not identified. This was done to avoid social and ethical problems.

Thirty-six out of forty-five questionnaires were returned and placed in the sealed box. At the second meeting, the same instructions as above were given and 40 out of 53 questionnaires were received. Later, 30 questionnaires were given to three different representatives; instructions were given through them and 26 out of 30 questionnaires were returned or mailed. All respondents were males with an age range between 18-43 years. The total sample size was 102 out of 128 with a drop off rate of approximately 20%. The respondent consent was taken verbally following a discussion of the research topic and its implication for service development.

At the end of the questionnaire a statement thanking the subjects for their participation was placed along with an advice to those who feel that they need help to see their family doctor or a mental health specialist.

Statistical analysis was done using the Statistical Package for the Social Sciences (SSPS). The odd ratio (OR) was calculated by cross tabulation of the sexual abuse variables (yes or no) and the psychopathology variables (positive scored more than 5 on the GHQ or negative scored less than 5).

Results

The results showed that 8.8% (95% CI 3.3%-14.3%) of the whole sample experienced sexual molestation before they reached the age of 18 yrs with an adult or a person at least 5 years older. To examine the difference between a child sexual abuse group and a non CSA group on mental health status (GHQ30), t-test was used and showed that the CSA of the group rated GHQ (x =15.44, SD 8.88) significantly higher than the non CSA (x =4.42, SD 6.29) group (t =4.83, $P < 0.001$). The results

indicated that the sexually abused subjects have more mental health problems. The relation between mental health GHQ30 and sexual abuse was examined by using the Fisher's exact test and the results showed strong correlation between child sexual abuse and mental health status ($P< 0.001$). To measure the association between sexual abuse variables (yes or no) and psychopathology variables (screened positive or negative) the OR was found to be 7.72. Thus subjects who experienced sexual molestation were on average 7.72 times more likely to have problems compared to those who did not experience sexual abuse before they reached the age of 18. The relationship between the GHQ30 scores and age was examined and it was found that those who scored more than five had a younger mean age.

The average age for those who scored below five was 31 years, and the average age for those who scored above five was 22 years. The mean age of abuse disclosure was examined and the t- test results showed that there was no significant difference in the mean age between those who disclose sexual molestation and those who did not disclose abuse.

Discussion

In spite of the above mentioned difficulties (social, religious, cultural and ethical) in conducting this piece of research, results showed that the prevalence of CSA in this community sample was within the range of international figures.[10]

At this stage it is worth discussing the results by raising the following questions:

1. Can we generalize the results?
2. What is the influence of culture and religion on the disclosure and reporting of abuse?
3. Does the change in the financial and educational status of the ethnic minorities influence the disclosure and reporting of CSA?
4. What is the impact of CSA on the adult mental health?
5. What other alternatives and options are available to assess the prevalence of CSA in such communities?

Although all the necessary precautions were taken (ethical approval, piloting), it is still difficult to generalize the results because it is only based on a sample from one of the communities living in the UK. In spite of this, the results obtained are within the international ranges which mean that the problem needs to be addressed.

It is believed that the ethnic minorities living in the West are still carrying the same cultural, religious beliefs as well as the same attitudes toward sex they used to have in their countries of origin. Added to that, there are fears within such communities to be surveyed, as many believe that local people want to expose them and influence their life.

In spite of the changes in the economic and educational status of ethnic minority groups living in the West, they are still living in closed communities and carrying the same customs of their countries of origin.

There is now considerable evidence that sexual abuse has a harmful effect on children as well as on the adult mental health. Factors considered as determinants of outcome[14] are: the type of the abuse, its chronicity, and the age of the child and the overall relationship of the victim with the abuser.

It was reported[15] that who experienced CSA are more likely to receive life time diagnoses of major depression, conduct disorder, panic disorder, alcoholism and more likely to report suicidal ideation and have histories of suicidal attempts .

Also it was concluded that post traumatic stress disorder is a frequent diagnosis among the victims of CSA.[16]

The relationship of childhood abuse to impulsivity and suicidal behavior in adults with major depression necessitated the understanding and awareness among health professionals to such an association when treating a patient with such a presentation.[17]

There is no doubt the CSA acts as a significant stressor and substantially raises the risk of childhood and later adult psychological difficulties. Also it is important to address the point that not all victims of abuse will develop problems later in life. The results depend on many factors, for example, family support and awareness amongst mental health professionals, response of understanding services and the proper treatment and management.

What are the alternative research options? We believe it is still difficult to conduct a quantitative research in such communities. The primary research results from the developing societies centered on the difficulties in conducting research. Researchers from the developing countries[5,10] admitted that the topic is surrounded with guilt, shame and secrecy. Also we believe that most of the research on CSA in the developing societies depends largely on questionnaires and variables validated for Western society. This partly explains the under-reporting and lack of accurate date from the developing societies. The other option is to resort to qualitative research

which will help make sense of or interpret phenomena in terms of the meanings people bring to them. It also helps develop concepts which help us understand social phenomena in natural rather than experimental settings, giving due emphasis on the meaning.

Study Limitations

1. Although the study involved a convenience sample from three different occasions, individuals who would go to such a community event would not be representative of the full population. This is an initial study in a sensitive area so it may be a challenge to have true population estimates.
2. The sample included only male respondents to avoid possible ethical and social problems.
3. The relationship of victims with the abuser was not identified.
4. The responses to the questionnaire were yes / no. This will influence the sensitivity and increase the possibility of missing some cases.
5. The sexual abuse (molestation) was only one item in the questionnaire; this may have reduced the validity to elicit the sexual abuse. To tackle this problem of validation, the definition of CSA was given verbally to the respondent prior to the commencement of the questionnaire.
6. In interpreting the results, a statistically significant difference on the GHQ and the odd ratio (OR) result between those who report and those who did not report CSA is just a correlation and /or association. The proper interpretation at this stage is that subjects reported higher rate of problems, which could be due to number of factors that are not included in the study.
7. Moreover, subjects' difficulties encountered in recalling the past events of sexual abuse were not included in our study.

Conclusion

We would like to mention that the hypothesis under scrutiny in this research was influenced to a great extent by cultural, religious and political issues. Accordingly, this study recommended the establishment of new models of services and further training of mental health professionals working with people in such societies. Also the service models should be culturally appropriate, responsive and able to liaise with voluntary agencies dealing with ethnic minorities living in the West. Family education about sexual abuse, its long term consequences and systems to support victims are vital issues among this group.

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