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Demographics, Risk Factors, and Negative Historical Events of Inpatients with a History of Sexual Abuse

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A history of sexual abuse is associated with numerous social and emotional issues that undermine healthy development throughout the lifespan (Barnes, Noll, Putnam & Trickett, 2009; Cutajar, Cutajar, Mullen, Ogloff, Thomas, Wells, & Spataro, 2010). A history of sexual abuse also increases the likelihood 3.65 times that the individual will have contact with public mental health services in comparison to the general population (Cutajar, et al., 2010). Thus a history of sexual abuse predisposes individuals to be involved with mental health services, regardless of whether the individual is pursing services to support her/his prior victimization or other issues. Individuals with a history of sexual abuse were three times more likely to suffer mental health issues than the general population (Cutajar, et al., 2010). For example, a lifetime prevalence of psychotic disorders is only 1.5% in the general population (Powers, Fani, Cross, Ressler, & Bradley, 2016). However those with a psychotic disorder were 3.5 times more likely to have a history of sexual abuse (Powers, et al., 2016). Thus involvement in mental health systems is far more likely if one has a sexual abuse history.

The purpose of this research is to better understand how those who have been most involved in the public mental health system, i.e., those who have had an inpatient stay, are influenced by a history of sexual abuse. Though there has been research (Cutajar, et al., 2010; Shack, Averill, Kopecky, Krajewski, & Gummattira, 2004) on the relationship between a history of sexual abuse and a later inpatient stay, there is no known research using a large sample of hospitalized adult patients to better elucidate the impacts of a history of sexual abuse, in which childhood and adult sexual abuse is considered, on their current condition. It is hoped that this research can make a major contribution to improving trauma informed care with this population.

Though males are less likely to be studied in sexual abuse research (Trickett & McBride-Chang, 1995), Leary (2009) found that males who had been sexually abused as children were ten times more likely to have clinical diagnoses than their peers who did not experience abuse. Additionally, demographic variables such as gender (Amado, Arce & Herraiz, 2015; Barnes et al. 2009; Townsend & Rheingold, 2013), sexual orientation (McCauley, et al., 2014; Menning & Holtzman, 2014), race/ethnicity and national origin (Amado, et al., 2015; Finkelhor, Ormrod, R., Turner, H., & Hamby, S. L., 2005; Ullman, Townsend, Filipas, & Starzynski, 2007), and household income (Finkelhor et al., 2005) have been found to predispose sexual victimization with females, those with minority sexual orientation, individuals that identify as Hispanic,

and/or those with lower household incomes having higher rates of victimization than those who do not share these characteristics.

There are a plethora of mental health diagnoses and concerning behaviors that are empirically related to a history of sexual abuse. In particular, individuals who have been a victim of sexual abuse are more likely to experience: **Depression** (Amado, et al., 2015; Barnes et al. 2009; Comer, 2010; Friedman et al., 2011; Lahav & Elklit, 2016; Stinson, Quinn, & Levenson, 2016; Trickett &McBride-Chang, 1995; Walsh, Fortier, DiLillo, 2010), **Anxiety** (Amado, et al., 2015; Friedman et al., 2011), **Dysthymia** (Amado, et al., 2015), **Borderline personality disorder** (Cutajar, et al., 2010; Lahav & Elklit, 2016), **Somatization disorder** (Cutajar, et al., 2010; Lahav & Elklit, 2016; Trickett &McBride-Chang, 1995), **Psychosis** (Gibson, Alloy, & Ellman, 2016; Powers, et al., 2016), **Sleep disorders** (Friedman et al., 2011), **Substance abuse** (Barnes et al. 2009; Comer, 2010; Cutajar, et al., 2010; Lahav & Elklit, 2016; Laser & Nicotera, 2011; Stinson, et al., 2016; Trickett &McBride-Chang, 1995; Townsend & Rheingold, 2013; Walsh, et al., 2010), **Post-traumatic stress disorder** (Comer, 2010; Cutajar, et al., 2010; Friedman et al., 2011; Lahav & Elklit, 2016; Powers, et al., 2016; Ullman, et al. 2007; Walsh, et al., 2010), **Dissociative disorders** (Barnes et al. 2009; Friedman et al., 2011;Lahav & Elklit, 2016; Tickett &McBride-Chang, 1995; Walsh, ete al., 2010), **Eating disorders** (Cutajar, et al., 2010; Friedman et al., 2011), **Suicide attempts** (Comer, 2010; Cutajar, et al., 2010; Friedman et al., 2011; Stinson, et al., 2016), **Danger to self** (Cutajar, Mullen, Ogloff, Thomas, Wells, & Spataro, 2010; Laser & Nicotera, 2011), **Involved in sexual risk behaviors** (Barnes et al. 2009; Lahav & Elklit, 2016), **Perform poorly in school** (Comer, 2010), **Be arrested for sex crimes** (Comer, 2010; Cutajar, et al., 2010), **Commit criminal offenses** (Barnes et al. 2009; Comer, 2010; Laser & Nicotera, 2011), **Display anti-social behavior** (Barnes et al. 2009; Cutajar, et al., 2010; Trickett &McBride-Chang, 1995), **Have attachment disorders** (Lahav & Elklit, 2016), **Have incomplete memory** (Ullman et al. 2007), **Have trust issues** (Lahav & Elklit, 2016), **Have emotional regulation issues** (Lahav & Elklit, 2016), **Have poor adult relationships** (Barnes et al. 2009; Comer, 2010; Lahav & Elklit, 2016;Masten 2014; Stinson, et al., 2016; Trickett &McBride-Chang, 1995; Ullman, et al. 2007), **Parent poorly** (Trickett &McBride-Chang, 1995), **Victim of domestic violence** (Barnes et al. 2009), **Self-blame** (Comer, 2010; Trickett &McBride-Chang, 1995; Ullman et al 2007), **Have low self-esteem** (Barnes et al. 2009; Comer, 2010; Stinson, et al., 2016), and **Have a higher unemployment rate** (Comer, 2010; Topitzes, Pate, Berman, & Medina-Kirchner, 2016). Thus, there are a myriad of mental health diagnoses and behavioral issues that are related to a history of sexual abuse.

Sadly, those who have experienced sexual abuse are more likely to have multiple victimizations (Barnes et al. 2009; Finkelhor, Ormrod &Turner, 2009; Finkelhor, Ormrod &Turner, 2007; Finkelhor, et al., 2005; Lahav & Elklit, 2016). In particular, females with a sexual abuse history are 3-5 times more likely to have subsequent sexual victimization (Barnes et al. 2009). Thus not only does sexual abuse put individuals more at risk for many mental health issues and behavior problems, it also makes individuals more at risk for being revictimized, creating a cycle of abuse and increasing the likelihood, severity, and comorbidity of mental health issues.

METHODOLOGY

Sample

The records of all adult inpatients, aged 18 to 89 at admission, with admissions from 07/01/2007 to 06/30/2015 in a mountain region public mental health hospital were included in the sample (n= 2811). The sample was limited to this time period due to differences in the data collection methods prior to 07/01/2007. Any patient who had disclosed that they had a sexual abuse history on Colorado Clinical Assessment Record (CCAR) during any stay at the hospital were included (n=800). Research has found that asking sexual abuse history at multiple times increases accuracy of reports (Townsend & Rheingold, 2013). Patients with a diagnosis indicating a history of sexual abuse were also included (n=2). Thus most patients sexual abuse history was not a diagnosis and were seeking help for other mental health issues. A comparison group was created using patients that do not disclose sexual abuse history at either admittance or discharge on the clinical tool (n= 1932). The majority (70.9%) of the patients in the sample had one visit during the time period. The mean number of visits was 1.79 (*SD* = 1.44).

Sample demographics. The sample was 43.3% female and 56.7% males, as compared to the state, 49.8% female and 50.2% male (United States Census Bureau, state quick facts, 2016).

Table 1 Ethnicity/Race of Sample in Comparison to State

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Ethnicity/Race	In Hospital (*N* = 2811)	In State * (*N* =)
American Indian	1.0%	1.6%
Asian /Pacific Islander	2.2%	3.1%
African American/Black	13.6%	4.5%
Latino/Hispanic	15.3%	21.2%
Caucasian/White	66.8%	69.0%
Other	1.0%	.6%

*Source: United States Census Bureau, state quick facts, 2016.

The sample was 98.6% civil patients and 1.4% forensic patients. Only 1.4% of the sample claimed veteran status, though there is a veteran population in the state of 12%(U.S. Department of Veterans Affairs, 2016) most likely due to opting to use VA services instead.

Generally, the level of education within the hospital was low, with 65.7% of the patients having a 12th grade education or less as compared to the state where only 36.3 % had a 12th grade education or less (Census 2000 Profile, State Census Profile, 2002).

Interestingly, inpatient men with a sexual abuse history had on average 6 months less education than non-sexually abused inpatient men. This difference in education level was not present when comparing inpatient women with a sexual abuse history to those without a

sexual abuse history. Additionally, the income of the patient sample was low with 99.5% earning less than $25,000 per year as compared to 23.1% of the state population that earn less than $25,000 (Census 2000 Profile, State Census Profile, 2002). Most inpatients (67.3%) had never been married. The most common primary diagnoses were: Schizophrenia/Schizoaffective disorders (53.8%), Bipolar disorders (22.4%), and Depressive disorders (8.8%).

Measurement of risk factors and negative historical events

Risk factors and negative historical events were measured using a combination of responses to the Colorado Clinical Assessment Record (CCAR) and through records maintained on electronic databases by the mental health hospital. The CCAR is extensive; it includes demographics, education, employment status, payee information, living arrangements, disability statuses, historical issues, diagnoses, substance abuse history, and mental health outcomes. For the purpose of this study the last completed version of the CCAR for any patient was utilized as it was believed this would provide the most accurate information. Negative historical events were capture in the History of Issues section, which includes items such as trauma, set fires, and family mental illness. Risk factors were captured through the current issues section, which includes items such as sexual misconduct, suicide attempt, and injures others. The CCAR is completed by the patient's assigned social worker. In completing the survey the social worker consults the patient's admission paperwork, the patient's medical records from any past admissions, interviews the patient, and interviews family members or friends involved in the patient's care. Variables are primarily measured dichotomously. The results are entered into a secure database. The CCAR is required by the state in which the hospital is located. It was designed by the Colorado mental health program evaluators in 1976 and first implemented by the Colorado Division of Mental Health in 1978. It has been utilized in multiple states and Canada since its implementation. Other sources of data were secure databases maintained to provide quick access to commonly refer to information without needing to consult the paper charts. They contain information such as patient demographics, diagnoses, admission date, and discharge date.

Risk factors and negative historical events were considered to be present if they were recorded in any source. For example, a patient was considered to have the risk factor of having a TBI if they had diagnosis of TBI within the hospital databases or if the CCAR indicated they had a TBI. In addition, risk factors and negative historical events were considered present if a patient reported them at least once over one or more visits.

RESULTS

The results first presented are the risk factors and negative historical events experienced by the inpatient sample, then separated by gender and then compared to the general population. Results were separated by gender to explore potential differences due to that may be associated with higher rates of victimization in the sample and in previous studies (Amado, Arce & Herraiz, 2015; Friedman et al., 2011; Ullman Townsend, S. T., Filipas, H.H., &. Starzynski, L. L. 2007).

Table 2 Risk factors and Negative Historical Events by Gender

Event	**All Patients** (N=2811)	**Females** (n=1216)	**Males** (n=1595)	**General Population in U.S.**
History of Trauma				
Yes	47.6%	46.5%	43.2%	4.0% a
No	52.4%	53.5%	56.8%	96.0% a
Suicide Attempts				
Yes	44.2%	49.6%	40.0%	4.6% b
No	55.8%	50.4%	60.0%	95.4% b
History of Sexual Misconduct				
Yes	8.6%	5.5%	10.9%	.2% c
No	91.4%	94.5%	89.1%	99.8% c
Property Destruction				
Yes	13.7%	8.0%	18.1%	.1% d
No	86.3%	92.0%	81.9%	99.9% d
Fire Setting				
Yes	3.0%	1.3%	4.4%	.004% d
No	97.0%	98.7%	95.6%	99.006% d
Animal Cruelty				
Yes	1.9%	0.8%	2.6%	5.0% e
No	98.1%	99.2%	97.4%	95.0% e
Danger to Self				
Yes	51.8%	52.8%	51.1%	4.0% b, f
No	48.2%	47.2%	48.9%	96.0% b, f
Danger to Others				
Yes	20.4%	13.8%	25.5%	10.0% g
No	79.6%	86.2%	74.5%	90.0% g
Mental Illness in Family				
Yes	48.5%	49.0%	46.6%	20.0% h
No	51.5%	51.0%	53.4%	80.0% h
History of Neglect				
Yes	19.0%	18.2%	19.5%	7.1% i
No	81.0%	81.8%	80.5%	92.9% i
History of Physical Abuse				
Yes	39.5%	47.2%	33.7%	17% i
No	60.5%	52.8%	66.3%	83.0% i
Developmental Disability				
Yes	11.0%	9.7%	12.0%	15.0% k
No	89.0%	90.3%	88.0%	85.0% k
Traumatic Brain Injury				
Yes	9.6%	6.8%	11.7%	8.5% l
No	90.4%	93.2%	88.3%	91.5% l
Learning Disability				
Yes	13.7%	11.7%	15.2%	10.0% m
No	86.3%	88.3%	84.8%	90.0% m
History of Sexual Abuse				
Yes	29.3%	43.9%	18.2%	8.0% i
No	70.7%	56.1%	81.8%	92.0% i

Sources:
a (Briere, Dietrich, & Agee, 2015)
b (Kessler, Borges, Walters, 1999)
c (http://www.worldatlas.com/articles/state-by-state-numbers-of- registered-sex-offenders-in-the-us.html, 2016) Used number of registered sex offenders/ US population
d (FBI, 2011)
e (Melson, 2013)
f (Klonsky, Oltmanns, & Turkheimer, 2003)
g (Thienhaus & Piasecki, 1998)
h (NAMI, 2016)
i (Child Trends, 2016)
k (U.S. Department of Health and Human Services, 2014)
l (CDC, Developmental Disabilities, 2016)
m (CDC, TBI, 2016)

As indicated in Table 2, many historical experiences of the sample differ from the general population.

Differences between those with and without a sexual abuse history
Prevalence of negative historical experiences and risk factors were dependent upon sexual abuse history. The frequency of the following experience was higher among patients who were sexually abused than those who did not have a sexual abuse history.

Specifically, those with a sexual abuse history were significantly different from those who had not experienced sexual abuse with respect to trauma (1, N=2730) = 364.00, p

< .001, suicide attempts (1, N=27320 =149.78, p < .001), sexual misconduct (1, N=2732) = 31.70, p < .001, property destruction (1, N=2732) = 9.47, p = .003, danger to self (1, N=2732) = 60.39, p < .001, family mental illness (1, N=2732) = 114.68, p

< .001, neglect (1, N=2732) =163.77, p < .001, physical abuse (1, N=2732) = 360.33, p <.001, developmental disability (1, N=2732) =30.62, p <.001, traumatic brain injury (1, N=2732) = 7.84, p =.006 and learning disability (1, N=2732) = 46.65, p < .001.

Difference in time in hospital between those with and without a sexual abuse history
Interestingly, those with a sexual abuse history were significantly different from those who had not experienced sexual abuse with respect to total time in the hospital, t (1229.16) = -3.06, p =.002 and the number of admissions t (947.64) = -7.04, p < .001. The total time in the hospital was different for each gender; female patients with a history of sexual abuse stayed 72 days longer (M=148.28, SD=361.63) than female patients without a history of sexual abuse (M=76.28, SD=164.88), t (684.47) = -4.20, p < .001.

This difference was not evident among the male patients. Regardless of gender, the amount of time per stay was not significant t (2730) =.084, p =.933).

DISCUSSION

The present study investigated the prevalence of sexual abuse history among adult inpatients within an acute care facility. The percentage of patients who were sexually abused was significantly higher than the general population (29% vs 8%). Similar to other studies (Amado et al., 2015; Friedman et al., 2011; Ullman et al., 2007) prevalence rates for females with a history of sexual abuse were considerably higher (43.9%) than for males (18.2%). Yet inpatient males with a sexual abuse history were more than twice the rate of the general population and females were more than four times the rate of the general population, signifying this inpatient population had inordinately been victims of sexual abuse.

Similar to the Stinson et al. (2016) study of patients in forensic mental hospitals, the data show patients have experienced a greater prevalence of negative historical events (i.e., physical abuse, sexual abuse, and neglect) than the general population. In this primarily non-forensic inpatient sample (*n*=1.4% forensic), patients also differ substantially from the general population with respect to history of trauma, suicide attempts, history of sexual misconduct, property destruction, fire setting, danger to self, danger to others, and family mental illness. Gender also exerted an influence. As expected, females in the sample had higher rates of internalizing behaviors (i.e., suicide attempts and danger to self) and males had higher rates of externalizing behaviors (i.e., sexual misconduct, property destruction, fire setting, danger to others, and animal cruelty).

Consistent with the Stinson et al. (2016) findings, forensic inpatients who were sexually abused reported more suicide attempts and danger to self-behaviors. In comparison to patients without a history of sexual abuse, patients with a sexual abuse history were also more likely to experience trauma, physical abuse and neglect. Moreover, forensic patients who have been sexually abused reported significantly more risk factors such as sexual misconduct, property destruction, and family mental illness than those who had not experienced sexual abuse. Interestingly, developmental disability, traumatic brain injury, and learning disability among the inpatients did not differ significantly from the general population; although these experiences were significantly increased for those who had experienced sexual abuse in comparison to inpatients who had not experienced sexual abuse. Thus sexual abuse exerts a profound influence upon the lives of the individuals.

Most surprisingly, patterns of stay were actually different when sexual abuse was entered into the equation; sexually abused patients had more admissions and longer total time of stay. Perhaps the underlying issue that brought patients back to the hospital was the sexual abuse history, suggesting that mental hospitals need to create protocols for sexually abused patients. Protocols would need to include trauma focused treatment and perhaps longer or more focused stay for those with a history of sexual abuse to reduce total time in hospital and number of subsequent readmissions. Future studies should examine the relationship between sexual abuse history and readmission rates. The present study identified risk factors and historical events of sexually abused patients within an acute care facility; future studies should examine the predictive strength of each risk factor and their relationship to length of stay in treatment.

CONCLUSION

Developmental histories

Those who are receiving psychological or psychiatric care should be assessed on developmental histories including a history of sexual abuse to understand how a history of sexual abuse could contribute to or exacerbate the presenting psychopathology (Cutajar et al., 2010; Stinson et al., 2016). Though the client/patient may present a constellation of mental health diagnoses and concerning behaviors, the underlying issue may be not having healed from an earlier history of sexual abuse.

Therapies

Individuals with a sexual abuse history who are well-adjusted in adulthood have been found to employ effective coping strategies (Walsh, Fortier, & DiLillo, 2010). These coping strategies included both seeking support and finding meaning from the abuse (Walsh, Fortier, DiLillo, 2010). Trauma-informed interventions such as Cognitive Processing Therapy for Sexual Abuse (CPT-SA; Chard, Weaver & Resnick 1997) has been found to reduce abuse-related cognitive distortions and rumination of the sexual abuse (Walsh et al., 2010). Similarly, therapies that focus on interpersonal regulation and skills have been found to be effective with childhood victims of sexual abuse (Lahav & Elklit, 2016). Thus treatment needs to be holistic, strength based, and connect systems of support.

Education on disclosure

Lastly, in all communities, educating the public on listening to children's disclosure is important in reducing sexual abuse's effect on the population. Trickett and McBride-Chang (1995) have found that maternal support regarding disclosure has changed outcomes of sexual abuse. If the parent, especially the mother believed the child's report of sexual abuse better outcomes have been found (Trickett &McBride-Chang, 1995). Thus teaching mothers, and all childcare providers, to listen to their children especially in issues of sexual abuse is important. Conversely, it has been found that negative reactions to disclosure increases psychological distress, sometimes long term, of those who have been sexually abused (Ullman & Filipas, 2005; Ullman, et al. 2007). Thus supportive listening is crucial for reducing sexual abuse's deleterious effect.

Limitations

Retrospective designs have some inherent limitations, the most serious problem is that memory distortions can occur (Trickett &McBride-Chang, 1995). However, Barnes, Noll, Putnam & Trickett (2009) found that victims recalled with accuracy their sexual abuse reports. Additionally, relying on contact with public mental hospital services, underestimates the total number of cases that see private practitioners or in private facilities (Cutajar et al., 2010). Thus the actual numbers are probably greater than what is reported in a public hospital sample. Even with the above limitations, the present study contributes to the limited literature on the influence of sexual abuse history on hospital stay. This study also holds potential for informing research on development of psychopathologies, which may assist with early identification and guide intervention efforts.

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