Psychiatric Morbidity in Adult Inpatients With Childhood Histories of Sexual and Physical Abuse

George R. Brown, M.D., and Bradley Anderson, M.D.

**Objective:** To extend the knowledge on long-term effects of childhood abuse in psychiatric patients to a large sample, the authors explored childhood sexual and physical abuse in adult inpatients over 1,040 consecutive admissions. **Method:** The 947 patients were admitted to a tertiary-care military medical center. Each patient was interviewed, and abuse history, DSM-III-R diagnosis, and other characteristics were recorded. **Results:** The prevalence of reported childhood abuse was 18% overall: 9% for sexual abuse (with or without physical abuse), 10% for physical abuse (with or without sexual abuse), and 3% for combined abuse. More female than male patients reported abuse. Alcohol use disorders were more common in victims of physical or combined abuse than in sexually abused or nonabused patients. Axis II diagnoses, particularly borderline personality disorder, were more frequent in abuse victims than in nonabused patients. Histories of drug and alcohol abuse were more common in patients reporting physical or combined abuse than in nonabused patients. Suicidal was also more frequent in abused than nonabused inpatients and was noted in 79% of the patients with histories of combined abuse. Combined abuse in women and physical abuse in men were associated with a family history of psychiatric illness, most commonly alcoholism in male relatives. **Conclusions:** These findings emphasize the need for greater attention to family dynamics, aggressive diagnosis and treatment of alcoholism within the family, and, especially, determination of patients’ abuse histories, even if repeated questioning is necessary.


Mental health professionals are becoming more aware of the possibility of sexual and physical abuse in the histories of patients requesting treatment in a variety of clinical settings (1–3). This awareness is based on a burgeoning, largely descriptive literature on child abuse and its potential sequelae and on increased media attention to incest, rape, battering, and domestic violence. However, in the last decade, few studies have examined the childhood abuse histories of general adult psychiatric inpatients. Jacobson and Richardson (4) conducted one of the few studies with a contemporaneous interview design. Of their 100 psychiatric inpatients, 57% reported that they had been victims of either sexual or physical abuse before admission. Carmen et al. (5, 6) investigated the abuse experiences of 188 psychiatric inpatients using retrospective chart review techniques, and they found that 43% reported histories of abuse. With the exception of these studies, most examinations of adult psychiatric inpatients have focused on the childhood abuse of female patients only (7–10), a limitation that is unfortunate given the growing recognition that males are sexually abused far more frequently than was once believed (11).

Several studies have examined specialized psychiatric inpatient samples, e.g., male alcoholic patients in a Veterans Administration hospital (12, 13) and opiate addicts in the inner city (14). Studies of the long-term effects of childhood sexual abuse on adult outpatients have been reviewed elsewhere (1, 15).

In spite of the plethora of descriptive papers regarding the putative long-term effects of childhood sexual and physical abuse on adult psychological functioning, the study of such sequelae is in its infancy. Few studies have involved large samples, and many did not use valid comparison groups, making their results impos-
sible to interpret. To our knowledge, no studies have compared DSM-III-R psychiatric diagnoses in a large sample of abused and nonabused general adult psychiatric inpatients.

Methodological problems notwithstanding, clinicians recognize that abused individuals seeking treatment may display characteristic symptoms that need to be addressed in any successful psychotherapeutic intervention. For example, many exhibit chronic self-destructive behavior, poor self-esteem, anxiety, feelings of isolation, sexual maladjustment, and interpersonal dysfunction (15, 16). Other investigators (4, 5, 8) have called for routine inquiry into patients’ histories of physical and sexual abuse to address how widespread these clinical findings are and to fill the large gaps in empirical knowledge.

Our study answers the call for routine inquiry. We report on what we believe to be the largest group of consecutively admitted, adult psychiatric inpatients to be routinely interviewed for childhood histories of physical and sexual abuse (1,019 admissions). DSM-III-R psychiatric diagnoses, drug and alcohol use patterns, suicidality, family history data, length of stay, and demographic characteristics of adult inpatients with self-reported histories of abuse were compared to corresponding data for nonabused inpatients from the same treatment unit. Associations between specific diagnoses and a history of abuse have been suggested in previous studies of small groups of inpatients (3, 17, 18). We addressed these associations but used a much larger patient sample.

METHOD

Sample

Wilford Hall Medical Center is the U.S. Air Force’s largest tertiary-care medical center. Active-duty and retired military members from all branches of the armed services and their dependents are entitled to care. Patients consecutively admitted to one of two identical 30-bed psychiatric wards were each routinely queried during one or more interviews regarding history of physical and sexual abuse, and these data were entered into a prospectively maintained data base along with demographic variables, admission and discharge diagnoses, past and family psychiatric histories, medications, treatment outcome, and disposition (19). This study used no retrospective chart review data. We logged 1,040 consecutive admissions between Sept. 1, 1987, and Oct. 1, 1989; 21 records (2%) were incomplete and were excluded from analyses, yielding 1,019 records on 947 different patients. A low rate of readmission is characteristic of this medical center: 63 patients were admitted twice during this 25-month period, eight patients were admitted three times, and one patient was admitted four times. The mean length of stay in this unit was 13 days, and no patient stayed longer than 95 days.

Because patients frequently responded differently to abuse questions at different admissions, multiple admissions were treated as separate patients; unless otherwise specified, all numbers and percentages involving patients refer to admissions (1,019).

In our sample, 66% of the admitted patients were on active duty at the time of evaluation (N=673), and 34% were civilians (N=346); 18% (N=188) were admitted during basic military training at Lackland Air Force Base. Because the latter group represents a highly specific subpopulation, even in the military setting, duplicate analyses were performed. All branches of the armed services were represented.

Over half of the subjects were men (59%, N=601). Seventy-two percent were white (N=734), 14% were black (N=141), 8% were Hispanic (N=85), and 6% were Asian (N=59). The average age of the sample was 30 years (median=25 years, range=7–90). The proportions of married and single patients were equal (45%, N=459); 7% were divorced (N=71), and 3% were widowed (N=31).

The majority of the patients were employed, attending college, and/or receiving retirement benefits. A minority were considered to have low socioeconomic standing, and less than 1% were classified as homeless and mentally ill.

Procedure

Each patient was evaluated by at least one of two Board-certified psychiatrists on the faculty of the Wilford Hall Medical Center psychiatry residency training program. The interrater diagnostic differences for primary axis I diagnoses were found to be negligible (less than 5%) for 40 paired, blind assessments of the same inpatients. Each patient was also interviewed by one or more psychiatric residents. All information revealed to interviewers at any time during the hospital stay was used for analysis.

The definition of sexual abuse used in this study was as follows: any self-reported sexual contact—ranging from fondling to sexual intercourse—experienced by a patient on or before age 18 and initiated by someone 5 or more years senior or by a family member at least 2 years senior. This definition includes exploitative sexual contact with minor children between 16 and 18 years of age and incestuous contact between siblings of different developmental ages (16, 20). Furthermore, it encompasses the U.S. National Center on Child Abuse and Neglect’s definition of child sexual abuse (any act perpetrated on a child by a significantly older person with the intent to stimulate the child sexually and to satisfy the aggressor’s sexual impulses) (21).

Physical abuse was defined as any self-reported assault on or before age 18 that was perpetrated by an assailant 5 or more years senior or an assault by a family member at least 2 years senior that was not interpreted by the patient as an intrafamilial fight, e.g.,
sibling rivalry. Fights between peers were excluded, as was verbal or psychological abuse in the absence of physical contact. A suspected history of abuse not admitted by the patient was not recorded as an abuse case.

Histories of sexual and physical abuse were elicited by means of sensitive, broad questions, such as, “Before you were 18 years old, did anyone touch you or engage you in a sexual way without your permission?” An affirmative or ambivalent response was followed by a more detailed series of questions to obtain specific recollections of events and the perpetrators, if known. For example, “I realize this may be difficult for you to talk about, but could you tell me who it was? What exactly happened to you? How old were you at the time? Were any other adults involved, or did they know about the incident?” Physical abuse histories were elicited with the question “While you were growing up, before age 18, were you disciplined by anyone in a way that you considered excessive?” Histories of physical abuse without the pretense of discipline were also sought. All abuse experiences that occurred after the age of 18 were excluded. Because of the need for confidentiality and our concern for the safety of the patients, no corroborating evidence was sought for any self-reported case of abuse.

Chi-square analyses with Yates’ correction, 2×2 or 2×3, were performed to compare patients in each abuse category (physical, sexual, or combined) with the remainder of the inpatient group, who served as a comparison group. To limit type I error, a significance level of p<0.01 was uniformly applied.

RESULTS

Of the 947 patients interviewed, 166 (18%) reported histories of abuse. Sexual abuse (with or without physical abuse) was reported by 86 patients (9%), physical abuse (with or without sexual abuse) was reported by 94 patients (10%), and combined abuse was reported by 28 patients (3%). Physical abuse alone was reported by 70 patients (7%), 41 (59%) of whom were male. Sexual abuse alone was reported by 68 patients (7%), 20 (29%) of whom were male.

More women than men reported sexual abuse (71 versus 25; χ²=48.8, df=1, p<0.0001) and physical abuse (52 versus 46; χ²=6.9, df=1, p=0.008). Of the 28 patients who reported combined abuse, 23 (82%) were women and five were men (χ²=38.3, df=1, p<0.0001). Physical abuse was significantly more common among the 71 sexually abused women than among other female inpatients (32% versus 8%; χ²=30.7, df=1, p<0.0001). In contrast, physical abuse was not significantly more common among the 25 sexually abused men than among other male inpatients (24% versus 7%) (χ²=4.0, df=1, p=0.05).

DSM-III-R psychiatric diagnoses for patients in each abuse category are listed in table 1. In addition to current diagnoses of alcohol use disorders, the patients with physical abuse histories also had a higher prevalence of past alcohol use disorders (N=49) than patients who had not been physically abused (50% versus 32%; χ²=13.0, df=1, p=0.0003). They also had a higher prevalence of illicit drug use during their lifetimes (38% versus 24%; χ²=9.5, df=1, p=0.002). This relationship was not observed for patients who had been sexually abused. The difference in past history of alcohol use disorders between the combined abuse group and the nonabused group approached significance (54% versus 38%; χ²=6.6, df=2, p=0.04).

The prevalence of lifetime illicit drug use increased with increasing levels of reported abuse: 23% of the nonabused group (N=200), 30% of those reporting either type of abuse (N=41), and 46% of those who reported combined abuse (N=13) (χ²=9.6, df=2, p=0.008). When the female abuse victims were considered separately, the prevalence of illicit drug use was nearly twice as high in those who reported combined abuse (44%, N=10) than in those with either a physical or sexual abuse history alone (23%, N=18) (χ²=11.9, df=2, p=0.003).

Personality disorders were diagnosed significantly more frequently in all abuse groups than in nonabused patients (table 1). A significant stepwise increase in the proportion of patients with borderline personality disorder was noted with increasing levels of reported abuse: 3% of nonabused patients, 13% of patients with either type of abuse alone, and 29% of those with both types of abuse (χ²=57.3, df=2, p<0.0001). Borderline personality disorder accounted for 48% of all axis II diagnoses in the abused patients.

Suicidality (ideation, recent gesture, or attempt) at admission was examined in all groups. The proportion of patients who were suicidal on admission was significantly higher in the patients with histories of either physical or sexual abuse (75%, N=103) than in the nonabused patients (57%, N=490) (χ²=18.7, df=2, p<0.0001). Suicidality was noted in 79% (N=22) of the patients with combined abuse. Male inpatients with sexual abuse histories were more likely to be suicidal on admission (88%, N=22) than men who did not report sexual abuse (57%, N=329) (χ²=8.4, df=1, p=0.004). There was no significant association between homicidality (ideation, intent, or attempt) and any abuse category.

Family history of major psychiatric illness was significantly more prevalent among abused women than among nonabused women. Fifty-one percent of the nonabused women (N=159) reported positive family histories, whereas 65% of the women who had been either sexually or physically abused (N=50) and 78% of the women with combined abuse (N=18) related such histories (χ²=10.5, df=2, p=0.005). A family history of major psychiatric illness was reported by 48% of the nonabused men (N=261) but was significantly more common in the men with histories of physical abuse only (89%, N=41; χ²=27.4, df=1, p<0.0001) or combined abuse (80%, N=4; χ²=26.3, df=2, p<0.0001).

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A complete reanalysis of the data after exclusion of basic trainees (N=188) yielded only minor differences from the data already reported. Seven percent of the trainees (N=14) reported physical abuse, 7% reported sexual abuse (N=14), and 1% reported combined abuse (N=1). All differences in results between the samples including and excluding the basic trainees were at statistical levels greater than p=0.05.

Table 2 lists the relationships of the reported perpetrators of abuse to their victims. Twenty-seven percent of all perpetrators of physical abuse were women (N=32), and only 7% of the sexual abusers were women (N=8). Between 95% (N=114) and 97% (N=116) of the physical abusers were family members (by birth or by law), and 56% (N=69) to 67% (N=83) of the sexual abusers were related to the victim (the maximum figure assumes all "unspecified" perpetrators were family members).

**DISCUSSION**

To our knowledge, the results reported here are derived from the largest sample of consecutively admitted adult inpatients to be examined systematically for the presence of childhood abuse histories. The prevalence of abuse reported herein (18%) was lower than that in other studies of inpatients (4, 5, 8). The other studies used highly selected samples and exclusion criteria, which may have inflated the prevalence of abuse by preferentially reducing the denominators. For example, Jacobson and Richardson (4) eliminated 58% of the admissions during their 2-month study and Bryer et al. (8) eliminated all male patients and included only 38% of the female patients admitted during their study. Because we excluded only 2% of all consecutive admissions over the 25-month study period, it is conceivable that our rate may be a more accurate reflection of abuse in adult inpatients. If the 189 patients with symptoms of psychosis on admission were eliminated from our study, the prevalence of reported abuse would rise to 19%.

The low rate of abuse in our sample may also be a function of our methods. For example, even though we attempted to collect abuse histories from patients with psychotic disorders only after they were stabilized, the number of affirmative responses may be spuriously low. Other researchers have shown that a high percentage of abused patients in state hospitals who are observed over many months have chronic psychotic.

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**TABLE 1. Diagnoses Given for 1,019 Consecutive Admissions of Psychiatric Inpatients With or Without Childhood Histories of Physical and/or Sexual Abuse**

<table>
<thead>
<tr>
<th>DSM-III-R Diagnosis</th>
<th>Physical (N=98)</th>
<th>N</th>
<th>%</th>
<th>Sexual (N=96)</th>
<th>N</th>
<th>%</th>
<th>Combined (N=28)</th>
<th>N</th>
<th>%</th>
<th>None (N=853)</th>
<th>N</th>
<th>%</th>
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<td>2</td>
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<td>Bipolar disorder</td>
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</table>

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aSome patients were admitted more than once; the numbers in the table refer to numbers of diagnoses. For patients with multiple admissions, repetitions of the same diagnosis were excluded. The physical and sexual abuse categories overlap, i.e., they contain patients who reported both types of abuse. The statistical comparisons refer to differences between the abuse groups and the group with no reported history of abuse.

b$\chi^2=12.9$, df=1, p=0.0003.
c$\chi^2=8.7$, df=2, p=0.01.
dSignificantly fewer patients in each abuse category were diagnosed as having any psychotic disorder (schizophrenia, schizoaffective disorder, paranoid disorder, psychotic disorder not otherwise specified, brief reactive psychosis) ($\chi^2=17.8$, df=2, $p<0.0001$).
e$\chi^2=13.6$, df=1, p=0.0002.
f$\chi^2=16.8$, df=1, p<0.0001.
g$\chi^2=31.9$, df=2, p<0.0001.
hSignificantly more frequent in all abuse categories than in the group with no abuse ($\chi^2=57.3$, df=2, p<0.0001).
i$\chi^2=9.0$, df=2, p=0.01.
disorders (7, 9). Therefore, we may not have an accurate estimate of abuse histories in these patients.

Men may be less likely to reveal their childhood sexual assault experiences to their therapists than are women (4). The higher proportion of men in this study compared to most nonfederal general inpatient settings may lead to higher rates of underreporting if one assumes that males in our culture are less likely to report abuse (22).

Most victims of combined abuse are women. Unlike the situation for males, experiencing one type of abuse appears to be a risk factor for the other in females. Data on family psychiatric history may explain this. In our study, many abused patients came from families with psychiatric illnesses, of which alcoholism appeared to be the most common. Women with histories of combined abuse had the highest percentage of families with psychiatric disorders (78%). Male family members were the most frequent perpetrators of both physical and sexual abuse and were more often identified as problem drinkers and alcoholics by the female inpatients than by the male abuse victims. Alcohol use disorders are frequently reported to exist in perpetrators of child abuse (4, 12, 23) and may be linked to the high rates of combined abuse in girls and physical abuse in boys, both of which were committed most often by fathers or stepfathers. Relative to the incidence of father-daughter incest, father-son incest is rare.

Alcohol use disorders are also common in victims of abuse (5, 14). In our study, this was most striking for the subjects who reported physical abuse alone, who had significantly higher rates of both past and current alcohol use disorders than the nonabused inpatients. This high prevalence may be attributable in part to greater family history of alcoholism, but alcohol abuse itself may in some cases be a nonspecific, but suggestive, adult symptom of childhood physical abuse.

A history of physical abuse is also strongly linked to use of illicit drugs during one’s lifetime; the percentage of patients who reported lifetime use of illicit drugs was twice as high for the patients who had experienced combined abuse as for nonabused inpatients. Much of this drug use was reported to have occurred during adolescence, either during the period in which the abuse occurred or shortly thereafter. Although some patients retreat from abusive environments through dissociation (24, 25), multiple personality disorder (26), or somatization (27), it appears that many abused people rely on chemical escape routes, even more frequently than nonabused patients who suffer from other psychiatric illnesses.

Suicidality was not only the most common symptom on admission for abused patients, but it was also much more common in them than it was in nonabused psychiatric inpatients, a population known for having a higher rate of suicidality than the general population. Compared to the nonabused patients, significantly more of the patients with histories of either sexual or physical abuse were suicidal on admission. Combined abuse did not result in an identifiable additive or synergistic effect. Despair, guilt, and self-reproach regarding past abuse were rarely implicated by patients as “reasons” for suicidality. Many of the suicidal abused patients had no accompanying axis I psychiatric disorders and could not identify why they were suicidal, but they noted that this was a chronic, intermittent symptom beginning sometime after they had been abused. Our study extends previous findings (8) of a strong association between childhood sexual abuse and suicidality on admission for female patients to male patients as well.

This study offers dramatic confirmation of the high prevalence of borderline personality disorder in adults who report childhood histories of abuse, which was suggested by others (3, 8, 25). Bryer et al. (8) noted that the only significant finding which spanned all abuse categories in female inpatients who completed the Millon Clinical Multiaxial Inventory was a stepwise increase in the score for borderline personality; nonabused patients scored lowest, sexually abused women scored intermediate, and victims of both physical and sexual abuse scored the highest. On the basis of the frequent difficulties such patients have with trust, it can be hypothesized that many of the patients with borderline personality disorder in the “nonabused group” had actually been abused but they had either dissociated these experiences or chosen not to discuss them with their therapists. Patients in our study did not always report histories of abuse on their first admission. Certainly this line of inquiry should be followed carefully and repeatedly on each admission with patients who meet the criteria for borderline personality disorder. Zanarini et al. (25) have suggested that childhood physical and/or sexual abuse is etiologically important in the development of borderline personal-

### TABLE 2. Perpetrators of Childhood Physical and/or Sexual Abuse Reported by Psychiatric Inpatients

<table>
<thead>
<tr>
<th>Perpetrator’s Relationship to Victim</th>
<th>Physical (N=94)</th>
<th>Sexual (N=86)</th>
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<td>%</td>
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<td>0</td>
</tr>
<tr>
<td>Stepparent</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cousin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unrelated adult</td>
<td>4</td>
<td>3b</td>
</tr>
<tr>
<td>Unspecified</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Multiple abusers</td>
<td>24</td>
<td>25</td>
</tr>
</tbody>
</table>

*The total number of perpetrators was 120 for physical abuse and 123 for sexual abuse. Unless otherwise specified, the numbers in the table refer to numbers of patients.

*Percentage of total number of specified perpetrators.

*Teacher, stranger, babysitter, or family friend.

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CHILDHOOD ABUSE

In most patients from disadvantaged backgrounds. Our investigation tentatively extends the probable etiological role of childhood abuse to a sample of largely middle-class inpatients.

The majority of perpetrators of sexual abuse are natural fathers or stepfathers of the victims (10). We found that uncles were more often named as sexual abusers than all other relatives except fathers. In addition to the mothers who were identified as direct perpetrators of sexual abuse, many other mothers apparently knew about their children's abuse, but passive involvement was not recorded as active abuse in this study. The destructive impact of their mothers' passive permission for the abuse was a recurrent theme in the therapy of patients who believed or knew that their mothers did little or nothing to intervene on their behalf. Mothers have rarely been identified as sexual abusers in other studies.

In this study, both physical and sexual abuse were predominantly intrafamilial. Among the reported perpetrators of the childhood abuse, the ratio of fathers to mothers was 6:1 for sexual abuse but 2:1 for physical abuse. Physical abuse by unrelated individuals was rarely reported by the inpatients in our group, whereas at least one-third of the sexual abusers were unrelated to their victims. However, these unrelated abusers were nearly always known to the abused patients and/or their families. Almost three-fourths of all abused patients suffered childhood abuse at the hands of a single adult. Greater attention to family dynamics and direct questioning about current and past abuse are warranted. Alcoholism within the family should be aggressively diagnosed and treated. The importance of eliciting abuse histories from both inpatients and outpatients, even if repeated questioning is necessary, cannot be overemphasized.

Our examination of adult psychopathology in inpatients with abuse histories does not yield a unique symptom complex. However, the following patient profile was found to be commonly associated with a past history of abuse: drug and/or alcohol abuse, suicidality on admission (often chronic), and character pathology (especially symptoms of borderline and self-defeating personality disorders) against a backdrop of family dysfunction and psychiatric illness (often alcoholism in the father or stepfather) and unsuccessful outpatient treatment before admission. This profile is consistent with the "disguised presentation" described by Gelinas (24) and underscores the need to identify abuse as a critical factor in a patient's history if psychotherapy is to be effective.

The limitations of this study are worthy of attention. Military samples, whether consisting of active duty or retired service personnel or civilian dependents, may be unique, thereby preventing generalization to other inpatient psychiatric settings. Although one-third of our patients were not serving on active duty, the life experiences of these patients may have varied dramatically from those of hospital inpatients generally, in spite of the fact that significant numbers of patients in civilian hospitals also have been affiliated with the armed services at some time in their lives. Other limitations include the higher proportion of men and smaller proportion of elderly patients (less than 10%) in our sample than in patients in many nonfederal institutions.

Although we achieved high interrater reliability by limiting the number of diagnosticians to two, the cost may have been systematic bias in our application of diagnostic criteria. Use of the Structured Clinical Interview for DSM-III-R (28) or a similar structured interview would have limited this potential source of bias.

Future research is needed to address the effects of combined abuse as a variable separate from physical or sexual abuse alone. In other studies, these effects are rarely appreciated and are lost in pooled data analyses. The abuse experiences of males are poorly understood, as are the possible psychiatric sequelae in men. This, too, is an area worthy of closer attention.

REFERENCES