

Psychological Profiles of Rehabilitation Patients Reporting Childhood Sexual Abuse

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INTRODUCTION

The incidence of sexual abuse in America has been estimated to one in three females and one in five males (Finkelhorn, 1986). Several studies have found that a number of medical syndromes are associated with reports of sexual assault. Adults who report childhood sexual assault (CSA) have been found to be less likely to benefit from lumbar surgery and report higher levels of pelvic pain than non-CSA patients (Schofferman, et al, 1992). These effects

in previous studies have led many medical and rehabilitation professionals to assume that survivors of CSA have a much worse prognosis for recovery from injuries than those patients who have not experienced sexual trauma. The following study evaluated the differences between CSA and non-CSA patients in census-matched community and physically injured patient samples.

METHOD

SUBJECTS

Patient and community samples were gathered from a total of 2,262 subjects in 36 U.S. States at over 90 sites during the BHI validation studies. The final patient sample was comprised of 527 patients who were currently in treatment for a physical injury. The community sample was comprised of 725 community subjects. The demographics of both groups approximated the U.S. Census for race, education, age, and gender. All of the subjects were adults ranging in age from 18 to 65.

PROCEDURE

The subjects of the patient group were recruited by their health care providers, and were reimbursed for participation. A total sample of 777 patients was obtained. From this sample, the 527 subjects were selected at random as the BHI patient normative sample.

A similar procedure was used with the sub-

jects of the community sample, who were recruited through advertisements, and who were also reimbursed for their time. The community sample was comprised of 725 community subjects, who were selected at random from a pool of 1485 community subjects.

Subjects were administered the BHI-R, and additional data was also gathered. The BHI-R was administered anonymously. Subjects were classified as having undergone childhood sexual assault (CSA) if they positively endorsed an item regarding being sexually molested as a child.

INSTRUMENTATION

The Battery for Health Improvement (BHI) is a 202-item inventory designed for the psychological assessment of medical patients. It is included within a larger 600-item research version (BHI-R), which was administered to the subjects in this study.

TABLE 2

Analysis of Variance for BHI Scores for Assaulted and Non-Assaulted Patients

Scale	df	Mean Score CSA Group	Mean Score Non-CSA Group	F
Depression	1	54.7	48.5	38.60****
Anxiety	1	55.0	48.4	45.60****
Hostility	1	53.6	49.0	20.01****
Borderline	1	54.6	48.5	38.01****
Symptom Dependency	1	52.8	49.1	13.40***
Chronic Maladjustment	1	54.4	48.6	34.30****
Substance Abuse	1	53.4	49.0	18.70****
Perseverance	1	46.3	51.2	23.70****
Family Dysfunction	1	56.6	48.2	74.30****
Job Dissatisfaction	1	50.9	49.8	1.27
Doctor Dissatisfaction	1	51.7	49.6	4.24*
Somatic Complaints	1	55.1	48.5	44.20****
Pain Complaints	1	53.1	48.7	18.80****
Muscular Bracing	1	54.0	48.7	27.60****

* p < .05 ** p < .01 *** p < .001 **** p < .0001
 n = 527

TABLE 4

Percentage of Patients Reporting Childhood Sexual Assault in Four Insurance Systems

Insurance System	Non CSA		CSA		Total	
	Count	Row %	Count	Row %	Count	Row %
Auto/Personal Injury	39	66.1	20	33.9	59	100
Medicare/Medicaid	22	71.0	9	29.0	31	100
Private Health Insurance	156	86.2	25	13.8	181	100
Worker's Compensation	127	75.1	42	24.9	169	100
Total	344	90.7	96	9.2	440	100

df = 3 $\chi^2 = 13.86$ p = .0033

TABLE 2

Frequency of Reported Child Sexual Assault in Patient and Community Samples

Subject Group	CSA		Non-CSA		Total	
	Count	Row %	Count	Row %	Count	Row %
Census	110	15.2	615	84.8	725	100
Patient	124	23.5	403	76.5	527	100
Total	234	18.7	1018	81.3	1252	

df = 1 $\chi^2 = 14.03$ p = .0002

DISCUSSION

The results of this study supported some of the previous research regarding the effects of CSA on medical conditions. Patients did report CSA on the BHI significantly more often than community members. However, it was expected that patients reporting CSA would be more prone to delayed recovery and would thus comprise a higher proportion of patients in work hardening and chronic pain programs. The data did not support this hypothesis.

The lack of difference in rate of patients reporting CSA in various treatment settings could have several explanations. It is possible that physicians are simply unaware of the presence of such trauma. Another possibility is that childhood trauma often requires adaptive skills to be learned at an early age, and these skills may offset the effects of the trauma. This could normalize aspects of their symptomatic presentation, and not make them any more likely to be referred on to secondary or tertiary care treatment programs.

The BHI scores of patients reporting CSA reflect a significantly higher degree of psychological distress and somatic complaints than non-CSA patients. They also were likely to be unsatisfied with their physician, and to report suicidal ideation on the BHI. The findings also revealed that patients suffering from CSA had elevated scores on the BHI Family Dysfunction scale, but not on Job Dissatisfaction.

It had been anticipated that the highest levels of CSA would occur in the patients in the worker's compensation system. There is considerable research supporting variety of psychosocial precursors to filing a work injury report. While the rate of reported CSA was significantly higher in worker's compensation than in private health insurance, the overall highest rate was observed in the personal

injury/auto insurance system. The cause of this effect was not clear, but the following hypotheses are offered.

It is possible that individuals reporting CSA are for some reason more prone to be involved in an accident. Sufferers of CSA may be more distractible or greater risk takers. It is also possible that individuals reporting CSA may have heightened senses of vulnerability following an accident, feel more traumatized, are more somatically preoccupied, or are more likely to seek treatment. Lastly, it is also possible that persons reporting CSA respond differently to some treatments. An example of this is that sufferers of CSA may feel less comfortable with hands-on examination or treatment.

The results suggest that CSA is common in rehabilitation patients and plays an important role in the process of recovery. Although inquiring about CSA is a sensitive matter, these findings suggest that developing a positive patient/provider relationship and rapport is essential so that helpful exploration into the effects of emotional and physical reactions can be addressed and treated properly during rehabilitation. Self regulation techniques (Biofeedback, etc.) can be implemented to assist patients who have suffered from CSA in reducing negative learned patterns of hyper-arousal that impede recovery (Wurtle, Kaplan, & Keairnes, 1990).

The findings in this study as well as studies elsewhere regarding the effects of CSA and rehabilitation should not be used to revictimize the patient by denying medical procedures and treatment. Providing injured patients who have suffered from CSA with short-term solution-focused treatment regimens that reduce interfering cognitive emotional and physical reactions from injury may significantly improve the patient's recovery from injury.