Childhood sexual abuse. Women's Mental and Social Health Before and After Group Therapy

Lundqvist, Gunilla

2005

Taylor&Francis
healthsciences

Childhood sexual abuse. Women's health when starting in group therapy

GUNILLA LUNDQVIST, CARL GÖRAN SVEDIN, KJELL HANSSON

Lundqvist G, Svedin CG, Hansson K. Childhood sexual abuse. Women's health when starting in group therapy. Nord J Psychiatry 2004;58:25–32. Oslo. ISSN 0803-9488.

Childhood sexual abuse has been shown to be common among adult women, 15–30% in prevalence studies, and among mentally ill women, 25–77%. These women often suffer from depression, anxiety, sexual and relationship problems. Suicide attempts and self-destructive behaviour are common. Within the Department of Psychiatry at Lund University Hospital, 45 women with experiences of childhood sexual abuse were offered a 2-year-long trauma-focused group therapy. They were well educated but 27% were unemployed. Nearly half of the group had made suicide attempts, 87% had had suicidal thoughts and, according to the questionnaire SCL-90, they were suffering from psychiatric symptoms significantly to a greater degree than both a general group and a clinical group with mixed diagnoses. According to the questionnaire ISSI, they were less well socially integrated than both a general group and a clinical group, and the degree of social adjustment according to the questionnaire SAS-SR was lower than in a general group. The study shows that childhood sexually abused women seeking therapy are a symptom-burdened group. These women probably need psychiatric treatment of a particular character. Special group therapy for these women can potentially improve their health.
• *Group therapy, Sexual abuse, Women's health.*

Gunilla Lundqvist, Psykiatrisk Öppenvård, St. Södergatan 47, SE-221 85 Lund, Sweden, E-mail: gunilla.lundqvist@skane.se; Accepted 28 August 2003.

Childhood sexual abuse is reported to be common and to be associated with psychosocial problems in the abused individual during both childhood and adulthood. Exactly what types of experiences should be called childhood sexual abuse are, however, not always clear. Many different definitions and terms have been used to characterize an experience as childhood sexual abuse. A possible general definition is that sexual abuse against a child or a teenager comprises all acts or situations with a sexual meaning, where an adult is interacting with a child/teenager (1). There is also a considerable difference between the incidence – the known cases – and the prevalence – occurrence in the whole community. The prevalence of childhood sexual abuse among adult women is estimated to be 15–30% (2). In Scandinavian studies, prevalence figures have been reported for Norway to be 19% (3) and 31% (4), for Denmark 14% (5), for Finland 8% (6) and for Sweden 10% (7). In approximately 10% of all sexual abuse cases (6–32%), the perpetrator is a family member: a parent, a stepparent or a sibling (2). The psychosocial consequences of sexual abuse are considered worse if the perpetrator has a close relationship to the victim, as e.g. a father or a stepfather (8). Many children dare not reveal the trauma to an adult (9–11), but keep it as their secret until they have grown up. Some never reveal this secret to anyone throughout their lives.

Symptoms studies

In both community and clinically based studies, adult women who were sexually abused in childhood have been found to suffer from depression, anxiety and eating disorder. They often make suicide attempts and have a self-destructive behaviour. Substance abuse can be a problem for these women, as well as sexual disturbances and difficulties in relationships to men, women and their own children. Low self-esteem is common as well as somatization symptoms and post-traumatic stress disorder. They often display poor social adjustment (9, 11–19).

A review of 12 community-based studies (2) found, in an odds ratio analysis between sexual abuse cases and non-sexual abuse cases regarding psychiatric symptoms, about two to four times increased risk for a great variety of psychiatric disorders such as depression, anxiety, phobias, eating disorders and substance abuse. Suicidal behaviour and post-traumatic stress disorder showed the highest association with childhood sexual abuse.

Another review of 29 studies, representing both clinical and community samples, found strong evidence

 DOI: 10.1080/08039480310000752

of a link between childhood sexual and/or physical abuse and self-harm and suicidal behaviour. The link was strongest to abuse of long duration, to a known perpetrator and to force and penetration (20).

A study of healthcare costs for women showed that childhood sexually maltreated women had median annual healthcare costs that were $245 greater compared to the costs among women who did not report childhood abuse (21).

Prevalence of childhood sexual abuse among female psychiatric patients

As the studies named above indicate, women who have been sexually abused in childhood suffer from a greater number of psychiatric symptoms than do others. Therefore, the prevalence of childhood sexual abuse among psychiatric patients would be interesting to study. A literature search in *Medline* and *PsychInfo* for the period 1985–2001 showed 33 studies. To be able to compare the studies, quality inclusion criteria were set up. First, there needed to be a clear description of the type of sexual abuse, the child's age and the child's relationship to the perpetrator. Secondly, there was a need to know what diagnoses had been investigated and if the investigation comprised inpatients or outpatients. Fifteen studies met the inclusion criteria (22–36). These 15 studies showed a prevalence of childhood sexual abuse ranging from 25% to 77%, with a mean value of 45% (Table 1). In these studies, the sexual abuse was defined as "any sexual activity" (six studies), "any sexual physical contact/experience" (six studies) and "sexual contact with the sexual parts of your/his/her body" (three studies). The child's age when the child was sexually abused ranged from 0 up to 13 years at the least, and for some studies up to the age of 18 years. The relationship between victim and perpetrator varied. The perpetrator could be a person within the family, a known person outside the family or any person 2, 4 or 5 years older. The studies included both inpatients and outpatients, for whom a variety of diagnoses had been made, including e.g. psychoses, depressions, personality disorders and substance-abuse disorders. Of the eight studies with mixed diagnoses, six studies mentioned both psychosis and neurosis in their investigation groups, and the other two studies defined the group as "all patients admitted to a private psychiatric hospital".

The highest prevalence of childhood sexual abuse is among inpatients. Two groups having the same diagnosis can show very different prevalence. Concerning prevalence in different countries, the USA shows the highest prevalence figures, but studies from England also show high scores. Other countries, as Denmark and France, show lower scores. No study has been found for Sweden.

Aim

Since 1993, the Department of Psychiatry at Lund University Hospital has offered a 2-year phase-divided trauma-focused group therapy programme for adult female psychiatric outpatients who have been sexually abused in childhood (37). Forty-five women have taken part in this treatment. This paper focuses on presenting the health situation of these women before they entered

Table 1. Prevalence of childhood sexual abuse among adult female psychiatric patients, different studies.

Study (reference)	*n*	Prevalence	Sample	Country
Inpatients				
Chu & Dill (22)	98	36%	Mixed diagnoses	USA
Shearer et al. (23)	40	40%	Borderline	USA
Bryer et al. (24)	66	44%	Mixed diagnoses	USA
Beck & van der Kolk (25)	26	46%	Active psychosis	USA
Wurr & Partridge (26)	63	52%	Mixed diagnoses	England
Margo & Mcleeds (27)	38	58%	Mixed diagnoses	USA
Figueroa et al. (28)	47	77%	Borderline and/or major depression	USA
Total	378	48%		
Outpatients				
Grilo & Masheba (29)	111	34%	Binge eating	USA
Jacobson (30)	26	42%	Mixed diagnoses excl. schizophrenic	USA
Muenzenmaier (31)	78	45%	Mixed diagnoses	USA
Lipschitz (32)	86	55%	Mixed diagnoses	USA
Total	301	44%		
Inpatients/outpatients				
Glyngdal et al. (33)	92	25%	Mixed diagnoses	Denmark
Darves-Bornoz (34)	90	33%	Schizophrenic, bipolar	France
Palmer et al. (35)	115	50%	Mixed diagnoses	England
Mueser et al. (36)	153	52%	Severe psychiatric illness	USA
Total	450	42%		
Total all groups	1129	45%		

treatment. Evaluation of the outcome of treatment will be described in other papers.

Material and Methods

Subjects

Between 1993 and 2001, 45 women were treated in 10 different 2-year-long therapy groups, focused on childhood sexual abuse. *Sexual abuse* was defined as all physical *contact* and visual or verbal *interaction* between a child/teenager up to 18 years old, and a family member, a relative or a person who, in the place of a relative, has a position of trust in the family, in which the child/teenager is used to sexually stimulate the perpetrator or someone else (38, 39). For the first 22 women, the group leaders examined the diagnosis "Post-traumatic stress disorder" under the supervision of a senior psychiatrist. If the women were already known to the unit at the hospital, there could be other diagnoses too. The remaining 23 women were examined by a psychiatrist who made one or more diagnoses. For the purpose of the research, diagnoses according to the DSM-IV system were used (40).

The 45 women in the study group had at the start of the treatment a mean age of 34 years, with a range from 20 to 54 years. Twenty-four women (53%) were cohabits/married, 20 women (44%) were singles and one woman (2%) was living separately from her partner. Three women had never been married/cohabits. Twenty-four women (53%) had children. The women's education was compulsory school for seven women (16%), upper secondary school for 20 women (44%) and university/college for 18 women (40%). Thirty women (67%) were engaged in work or studies, three had sheltered work (7%) and 12 were unemployed (27%). Seventeen women were workers, 12 women were lower-level employees, seven women were higher-level employees, four were studying at upper secondary school and five were studying at university/college (41).

Of the 45 women in the study group 24 (53%) had sexual abuse experiences of penetration in an oral, anal or genital way, and 18 (40%) had experiences of body contacts without penetration. Of the remaining three women (7%), two had been forced to look at the perpetrator when he was satisfying himself, and one had been forced to look at pornographic photos and films together with the perpetrator. Thirty-six women (80%) were sexually abused in more than one way. Twenty-three women (51%) were sexually abused before school age at 7 years. The biological father was the perpetrator for 20 women (44%). Sexual abuse by more than one perpetrator had occurred for 15 (33%) of the 45 women.

Methods

An interview of admission of 2 hours was done by the group leaders with each woman about her present life, the sexual abuse history and the family of origin. At the end of the interview, a questionnaire was filled in to provide socio-demographic data, and to answer questions about health, relationships, earlier psychiatric contacts and history of sexual abuse.

Before and after group therapy, questionnaires were answered. In this paper, three instruments are presented. The study group is compared with general and clinical groups.

The Symptom Check List (SCL-90) is a self-rating scale with 90 questions measuring present psychiatric symptoms. The questionnaire reflects nine dimensions of psychiatric symptoms and a total score, the Global Severity Index (GSI). The nine subscales are somatization, obsessive–compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The answer alternatives are from "not at all" (0 points) to "very much" (4 points). In each subscale, the scores for the included questions are added and then divided with the number of questions. For the GSI, the 90 questions are added and then divided by 90. A low score shows good psychiatric health. It is a commonly used scale with high validity. In a Swedish general population, the instrument has provided Cronbach's alpha 0.73–0.91 for the subscales and 0.97 for the GSI (42–45).

The comparing general group comprises a population of 707 women with mixed ages (45). The age range is from 18 to 63 years and the women are mostly studying at university/college or working within healthcare. The comparing clinical group comprises 955 female in- and outpatients with mixed diagnoses and ages (45). The diagnoses include borderline personality disorder, neurosis, schizophrenia, eating disorder, suicide attempt, somatic pain, panic disorder, alcoholic and narcotic abuse and patients in psychotherapy. The age range is from 17 to 77 years.

The Interview Schedule of Social Interaction (ISSI) has 30 items measuring social integration and attachment. The scale is subdivided into four subscales: availability of social integration (AVSI; 0–6 points), availability of attachment (AVAT; 0–6 points), adequacy of social integration (ADSI; 0–8 points) and adequacy of attachment (ADAT; 0–10 points). This can give a total score of 30 points. A high score shows good social integration and attachment. The reliability, measured with Cronbach's alpha, has been shown to be 0.67–0.79 for the four subscales. The validity of this scale is found to be satisfactory (46–48).

The comparing general group comprises 180 mothers (53). The comparing clinical group comprises 42 female

inpatients who have all made a suicide attempt (54). The age range is from 19 to 81 years.

The Social Adjustment Scale (SAS-SR) is a self-rating scale with 54 variables measuring social situation and adjustment overall and within the subscales work/studies/homework, social and leisure, family unit, marital, parental and extended family. The answer alternatives are from about "manage very well" (1 point) to "manage very badly" (5 points). In each subscale, the scores for the included questions are added and then divided with the number of questions, and the same for the overall scale. A low score shows good social adjustment. The reliability, measured with Cronbach's alpha, has been shown to be 0.74. The validity is found to be satisfactory (49–51).

The comparing general group comprises 277 women in mixed ages (50). The age range is from 25 to 65 years and more. The comparing clinical group comprises 155 female acute depressive patients (50). The age range is from 18 to 64 years.

Ethics

The study was carried out at an outpatient treatment unit at the Department of Psychiatry at Lund University Hospital, and was approved by the Ethics committee of the Lund University Hospital (LU 274-92 and LU 398-97).

Statistics

Group comparisons have been made with unpaired *t*-tests (SPSS).

Results

Health questions

At the admission interview, the women answered health questions about symptoms and problems in their present life (relationships, sexual and eating problems, self-confidence, somatic pain, alcohol problems), in the past year (alcohol and narcotic) and in their life history (suicidal thoughts and attempts) (Table 2). The most frequent problem was suicidal thoughts, which amounted to 87%. Concerning suicide attempts, nearly half of the group (47%) had made one attempt. Relationship problems, with both men and women, sexual problems and low self-confidence amounted to 64–82%. Somatic pain was a problem for 64% of the women.

Table 2. The outcome of health questions at the interview of admission

Questions	Women ($n = 45$) n (%)
Suicidal thoughts	39 (87)
Relation problems to men	37 (82)
Sexual problems	36 (80)
Low self-confidence	36 (80)
Relation problems to women	29 (64)
Somatic pain	29 (64)
Suicide attempts	21 (47)
Eating problems	20 (44)
Alcohol the latest year*	13 (29)
Sober alcoholic	7 (16)
Narcotic the latest year	2 (4)

*The women's own experiences of having had too much alcohol. It ranged from 32 g alcohol to 195 g alcohol during 1–240 days.

Diagnoses

At least one psychiatric diagnosis was recorded for all the women, but one or two additional diagnoses were recorded for 24 women. The first diagnosis recorded for 44 women was "Post-traumatic stress disorder" (309.81) and for one woman "Problem related to alleged sexual abuse of child by person outside primary support group" (995.5). In the category of second diagnosis (24 women) and third diagnosis (six women), 15 women obtained the diagnosis "Depression" (296.23, 296.24, 300.4, 311), 10 women "Personality disorder" (301.81, 301.83, 301.9), four women "Anxiety" (300.01, 300.02, 300.23), and one woman "Bulimia nervosa" (307.51).

The women had to a large extent been searching for help before the contact with the therapy group. Forty-one women (91%) had tried individual psychotherapy, 10 women (22%) group psychotherapy and three women (7%) family psychotherapy. At the admission interview, 19 women (42%) were using psychopharmaceuticals.

Psychiatric symptoms

The women were suffering from many psychiatric symptoms covered in the Symptom Check List (SCL-90) (Table 3). A high score for psychiatric symptoms shows poor psychiatric health. The GSI scale and all subscales showed statistical significance in relation to the general group. It was the same in relation to the clinical group with exception for the subscale phobic anxiety, where no statistical significance was found. The subscale with the highest score was depression, followed by interpersonal sensitivity and anxiety.

Social interaction

The women's social interaction measured by Interview Schedule of Social Interaction (ISSI) was low (Table 4). A low score of social interaction indicates dissatisfaction with the social network. The study group's total interaction score was nearly half of the general group and somewhat lower than the clinical group. Both the total interaction and the four subscales showed statistical significance in relation to the general group, but there was no statistical significance in relation to the clinical group. The subscale with the lowest score was

Table 3. Psychiatric symptoms in comparison between the study group, a general group and a clinical group.

	Study group† (mean ± *s*)	General group‡ (mean ± *s*)	Clinical group§ (mean ± *s*)
SCL-90, total score (GSI)	1.58 ± 0.73	0.49 ± 0.44***	1.21 ± 0.73***
Somatization	1.62 ± 0.80	0.49 ± 0.48***	1.11 ± 0.87***
Obsessive-compulsive	1.62 ± 0.80	0.65 ± 0.61***	1.36 ± 0.87*
Interpersonal sensitivity	1.77 ± 0.92	0.55 ± 0.57***	1.35 ± 0.92***
Depression	2.15 ± 0.86	0.72 ± 0.74***	1.64 ± 0.95***
Anxiety	1.68 ± 0.89	0.56 ± 0.54***	1.31 ± 0.90***
Hostility	1.16 ± 0.81	0.39 ± 0.50***	0.80 ± 0.81***
Phobic anxiety	1.05 ± 1.04	0.16 ± 0.40***	0.82 ± 0.93 n.s.
Paranoid ideation	1.53 ± 0.87	0.41 ± 0.54***	1.09 ± 0.92***
Psychoticism	1.20 ± 0.78	0.23 ± 0.37***	0.83 ± 0.75***

s, standard deviation.
†Female outpatients, sexually abused in childhood, $n = 45$.
‡Women, general population with mixed ages, $n = 707$ (45).
§Female patients, mixed diagnoses and ages, $n = 955$ (45).
t-Test study group/general group and study group/clinical group: statistical significant level.
*$P < 0.05$, ***$P < 0.001$, n.s., no statistical significance (52).

availability for social integration (AVSI), which means that the women were lacking people to share interests with and lacking support in difficult situations.

Social adjustment

The social adjustment category, as measured by the Social Adjustment Scale (SAS-SR), was impaired (Table 5). A high score on social adjustment shows dissatisfaction. The study group's overall score was 1.5 times higher than the general group but lower than the clinical group. Both the overall scale and all the subscales were statistically significant in relation to the general group, but there was no statistical significance in relation to the clinical group. Two subscales, "marital" and "extended family", had higher scores and were therefore more dissatisfied for the study group than for the clinical group. Another subscale, "family unit", a designation that refers to children not living at home and to the ex-partner, had a lower score and was therefore seen to be more satisfied than the clinical group.

Table 4. Social interaction in comparison between the study group, a general group and a clinical group.

	Study group† (mean ± *s*)	General group‡ (mean ± *s*)	Clinical group§ (mean ± *s*)
ISSI, total interaction score	14.2 ± 7.2	23.9 ± 5.2***	16.9 ± 7.2 n.s.
AVSI (max 6 points)	1.8 ± 1.8	4.2 ± 1.5***	2.4 ± 1.6 n.s.
ADSI (max 8 points)	3.7 ± 2.5	6.9 ± 1.6***	4.6 ± 2.9 n.s.
AVAT (max 6 points)	4.4 ± 1.6	5.4 ± 1.1***	4.7 ± 1.5 n.s.
ADAT (max 10 points)	4.2 ± 3.1	7.4 ± 2.6***	5.1 ± 3.2 n.s.

s, standard deviation; AVSI, Availability for social integration; ADSI, Adequacy of social integration; AVAT, Availability of attachment; ADAT, Adequacy of attachment.
†Female outpatients, sexually abused in childhood, $n = 45$.
‡Mothers, general population, $n = 180$ (53).
§Female inpatients, suicide attempters, mixed ages, $n = 42$ (54).
t-Test study group/general group and study group/clinical group: statistical significant level.
***$P < 0.001$, n.s., no statistical significance (52).

Discussion

Women with experiences of childhood sexual abuse have a high prevalence in the community. Some of them feel relatively well. Others suffer from impaired mental health and are seeking psychiatric help. On average, 45% of the female psychiatric patients in the referred prevalence studies have experienced childhood sexual abuse. They suffer from a large variety of psychiatric symptoms, e.g. depression, psychosis and substance abuse, and they need treatment both as inpatients and outpatients. The 45 women in the study group suffered from a greater number of psychiatric symptoms, and showed deteriorated social interaction and a poor social adjustment compared to different general populations studied. However, we have to remember that the study population was rather extreme and in a way not representative for all women with the experience of childhood sexual abuse, either within or without the population known to psychiatry. The study group consisted of a clinical group with earlier psychiatric records, and the majority, 93%, had had psychotherapy earlier and almost half of them were on psychopharmaceutical medication. This means that the women were not fully satisfied with their lives, did not feel better after earlier treatment, and that they had continued seeking healthcare. According to SCL-90, they suffered from psychiatric symptom scores significantly more than both a general group and a clinical group. The mean value is more than plus two standard deviations in comparison with the general group. High scores are confirmed in another study, which compares women and men sexually abused as children (55).

At the admission interview, 87% of the 45 women reported suicidal thoughts, which can be compared with 22% for Australian women in a community-based twin study (56), and with 39% for bipolar depressed inpatients of both genders (57). Forty-seven per cent had made at least one suicide attempt. In a study from the USA, the association between sexual assault and attempted suicide has been studied and a statistically significant association has been found (58). Concerning suicide attempts in a general population, a European epidemiological study including 16 centres in 13 countries, shows a prevalence of suicide attempts in Stockholm and Umeå of 0.23% and 0.15%, respectively (59). According to the results in a recent Swedish dissertation, suicide attempts are indications for eventual suicide, and

Table 5. Social adjustment in comparison between the study group, a general group and a clinical group.

	Study group† (mean ± *s*)	General group‡ (mean ± *s*)	Clinical group§ (mean ± *s*)
SAS-SR, overall	2.39 ± 0.47	1.61 ± 0.34***	2.53 ± 0.46 n.s.
Work/studies/homework	2.44 ± 1.07	1.46 ± 0.50*** ($n = 272$)	2.47 ± 0.74 n.s. ($n = 149$)
Social and leisure	2.59 ± 0.74	1.83 ± 0.53***	2.83 ± 0.65 n.s.
Family unit	1.87 ± 0.53 ($n = 30$)	1.54 ± 0.62*** ($n = 270$)	2.86 ± 0.91 n.s. ($n = 140$)
Marital	2.53 ± 0.58 ($n = 31$)	1.77 ± 0.49*** ($n = 191$)	2.46 ± 0.58 n.s. ($n = 93$)
Parental	2.02 ± 0.77 ($n = 21$)	1.43 ± 0.43*** ($n = 175$)	2.25 ± 0.82 n.s. ($n = 101$)
Extended family	2.26 ± 0.52	1.34 ± 0.35*** ($n = 274$)	2.15 ± 0.69 n.s.

†Female outpatients, sexually abused in childhood, $n = 45$.
‡Women, community population, mixed ages, $n = 277$ (50).
§Female patients, acute depressive, mixed ages, $n = 155$ (50).
t-Test study group/general group and study group/clinical group: statistical significant level.
***$P < 0.001$, n.s., no statistical significance (52).

the highest risk for suicide is in the younger ages, for both men and women. The dissertation also reports that women make new suicide attempts in the age of 50–60 years, in contrast to men (60). Therefore, the actual group of women with a mean age of 34 years must be considered as a high-risk group.

Somatic pain also showed itself to be a major problem for this group of women who had been sexually abused in childhood, and this is in accordance with other studies. Walker (61) investigated pain among 201 women who had been sexually maltreated in childhood. She found six different areas of pain, where the most common were joint pain (38%), back pain (36%) and headache (26%). Another study found that 69% of the women sexually abused in childhood were suffering from a chronic painful condition in comparison with only 43% of the control group (62).

Many (80%) of the women in the study group had sexual problems. In an Australian study (63), 47% of women who had experienced childhood sexual abuse reported sexual problems. Of the women with experiences of penetration, the figure was 68%. The control group reported 28%. The women in the study group also had difficulties in their relationships to men and to women, and they reported low self-confidence. These problems are also reported in the symptom studies referred to earlier. The low level of satisfaction with social interaction in the study group could be compared with statistically significant scores for higher degree of loneliness and a lower level of network orientation among sexually abused women (64). These women seem to socially isolate themselves. Social adjustment was also a difficult area for this group of women. This is confirmed in a study from the USA, where women sexually abused in childhood were compared with women who had not been sexually abused (65).

The earlier mentioned symptom studies report that the sexually abused women have jobs to a high degree, 63–76% (12–14), and many are cohabits, 27–73% (12–14). The women in the study group have a similar pattern. Concerning college and higher education, the symptom studies report 50–82% to have this education level (12, 16–18). The study group had a lower percentage. In comparison with the general female population in Sweden, the percentage in the study group who had university/college education was higher, 40% in the study group vs. 27% in general population (66). This higher percentage of college/university-educated women could perhaps be explained by the fact that Lund is a university town. In addition, it is likely that those who are better educated make a greater effort in searching for help to find a programme offering special group therapy. Rathsman reports the same experience as concerns those with a higher level of education (67).

The special programme of group therapy within psychiatry in Lund is difficult to find, because it is only advertised through contacts with health personnel and personnel working within social welfare. Once these women find out about the therapy groups, they have to phone for information themselves. Then, after taking this step, they probably have to wait nearly a whole year for the group to start, and then they have to face their own feelings of distaste and reluctance at telling other individuals and a group for the first time about their experiences. Thus the women coming for this special trauma-focused group therapy probably have a stronger will and a more serious wish to get rid of their symptoms. Therefore, perhaps these women are not representative for all women who have experienced childhood sexual abuse and who enter the mental healthcare system at some point.

Women who have come in to the mental healthcare system and who have experienced childhood sexual abuse are suffering mentally, and they display poor social adjustment and interaction. Today there is little specialist help offered to this group in Sweden. Society and its institutions such as the social welfare system and psychiatry have a responsibility to develop different

kinds of service for sexually traumatized children and adults. As the healthcare costs for these adult women are higher than for women who have not been sexually abused (21) it seems cost effective to invest and develop treatment programmes created for this group. A focused group-treatment programme could be one of them.

Acknowledgements—This study was supported by The Lindhaga Foundation for psychical care and research, Helge Axson Johnson Foundation and Skane County Council's research and development foundation.

References

1. Svedin CG. Sexual abuse of children. Definitions and prevalence. Expert report. Stockholm: The Swedish National Board of Health and Welfare; 2001.
2. Fergusson DM, Mullen PE. Childhood sexual abuse. An evidence based perspective. Thousand Oaks, London, New Delhi: Sage Publications Inc; 1999.
3. Satre M, Holter H, Jebsen E. Tvang til seksualitet. En undersøkelse av seksuelle overgrep mot barn. Oslo: Cappelens forlag; 1986.
4. Tambs K. Noen resultater fra Folkehelsas undersøkelse av seksuelle overgrep mot barn. Oslo: Statens institutt for folkehelse; 1994.
5. Leth I, Stenvig B, Pedersen A. Seksuelle overgreb mod børn og unge: Omfang og karakter. Nordisk Psykologi 1988;40:383–93.
6. Sariola H, Uutela A. The prevalence of child sexual abuse in Finland. Child Abuse Neglect 1994;18:827–35.
7. Spak L, Spak F, Allebeck P. Sexual abuse and alcoholism in a female population. Addiction 1998;93:1365–73.
8. Beitchman JH, Zucker KJ, Hood JE, DaCosta GA, Akman D, Cassavia E. A review of the long-term effects of child sexual abuse. Child abuse Neglect 1992;16:101–18.
9. Albach F, Everaerd W. Posttraumatic stress symptoms in victims of childhood incest. 2nd Europ Conf on Traumatic Stress Psychother Psychosom 1992;57:143–51.
10. Anderson J, Martin J, Mullen P, Romans S, Herbison P. Prevalence of childhood sexual abuse experiences in a community sample of women. J Am Acad Child Adolesc Psychiatry 1993;32:911–19.
11. Boudewyn AC, Liem JH. Childhood sexual abuse as a precursor to depression and self-destructive behavior in adulthood. J Traumatic Stress 1995;8:445–59.
12. Elliott DM. Sexual abuse trauma among professional women: validating the trauma symptom checklist-40 (TSC-40). Child Abuse Neglect 1992;16:391–8.
13. Finkelhor D. A sourcebook on child sexual abuse. London: Sage Publications; 1986.
14. Polusny MA, Follette VM. Long-term correlates of child sexual abuse: Theory and review of the empirical literature. Appl Preventive Psychol 1995;4:143–66.
15. Pribor EF, Dinwiddie SH. Psychiatric correlates of incest in childhood. Am J Psychiatry 1992;149:52–6.
16. Rodriguez N, Ryan SW, vande Kemp H, Foy DW. Posttraumatic stress disorder in adult female survivors of childhood sexual abuse: A comparison study. J Consult Clin Psychol 1997;65:53–9.
17. Rowan AB, Foy D, Rodrigues N, Ryan S. Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. Child Abuse Neglect 1994;18:51–61.
18. Saunders BE, Villeponteaux LA, Lipovsky JA, Kilpatrick DG, Veronen LJ. Child sexual assault as a risk factor for mental disorders among women. J Interpers Violence 1992;7:189–204.
19. Weiss EL, Longhurst JG, Mazure CM. Childhood sexual abuse as a risk factor for depression in women: Psychosocial and neurobiological correlates. Am J Psychiatry 1999;156:816–28.
20. Santa Mina EE, Gallop RM. Childhood sexual and physical abuse and adult self-harm and suicidal behaviour: A literature review. Can J Psychiatry 1998;43:793–800.
21. Walker EA, Unutzer J, Rutter C, Gelfand A, Saunders K, VonKorff M, et al. Costs of health care use by women HMO members with a history of childhood abuse and neglect. Arch Gen Psychiatry 1999;56:609–13.
22. Chu JA, Dill DL. Dissociative symptoms in relation to childhood physical and sexual abuse. Am J Psychiatry 1990;147:887–92.
23. Shearer SL, Peters CP, Quaytman MS, Ogden RL. Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. Am J Psychiatry 1990;147:214–6.
24. Bryer JB, Nelson BA, Miller JB, Krol PA. Childhood sexual and physical abuse as factors in adult psychiatric illness. Am J Psychiatry 1987;144:1426–30.
25. Beck JC, van der Kolk B. Reports of childhood incest and current behavior of chronically hospitalized psychotic women. Am J Psychiatry 1987;144:1474–6.
26. Wurr CJ, Partridge IM. The prevalence of history of childhood sexual abuse in an acute adult inpatient population. Child Abuse Neglect 1996;20:867–72.
27. Margo GM, McLees EM. Further evidence for the significance of a childhood abuse history in psychiatric inpatients. Compr Psychiatry 1991;32:362–6.
28. Figueroa EF, Silk KR, Huth A, Lohr NE. History of childhood sexual abuse and general psychopathology. Compr Psychiatry 1997;38:23–30.
29. Grilo CM, Masheb RM. Childhood psychological, physical and sexual maltreatment in outpatients with binge eating disorder: Frequency and associations with gender, obesity and eating-related psychopathology. Obesity Res 2001;9:320–5.
30. Jacobson A. Physical and sexual assault histories among psychiatric outpatients. Am J Psychiatry 1989;146:755–8.
31. Muenzenmaier K, Meyer I, Struening E, Ferber J. Childhood abuse and neglect among women outpatients with chronic mental illness. Hospital Commun Psychiatry 1993;44:666–70.
32. Lipschitz DB, Kaplan ML, Sorkenn JB, Faedda GL, Chorney P, Asnis G. Prevalence and characteristics of physical and sexual abuse among psychiatric outpatients. Psychiatr Serv 1996;47:189–91.
33. Glyngdal P, Friis T, Malver AM. Incest og seksuelt misbrug. Ugeskr laeger 1989;151:877–80.
34. Darves-Bornoz JM, Lempérière T, Degiovanni A. Sexual victimization in women with schizophrenia and bipolar disorder. Soc Psychiatry Psychiatr Epidemiol 1995;30:78–84.
35. Palmer RL, Chaloner DA, Oppenheimer R. Childhood sexual experiences with adults reported by female psychiatric patients. Br J Psychiatry 1992;160:261–5.
36. Mueser KT, Goodman LB, Trumbetta SL, Rosenberg SD, Osher FC, Vidaver R, et al. Trauma and posttraumatic stress disorder in severe mental illness. J Consult Clin Psychol 1998;66:493–9.
37. Lundqvist G, Hansson K, Svedin CG. Childhood sexual abuse. A group therapy method and consumers' satisfaction. 2001 (Not published).
38. Allender D. Kränkt som barn, sårad för livet? (The wounded heart). KM-förlag; 1993.
39. Courtois CA. Healing the incest wound. New York: WW Norton and Co; 1988.
40. Diagnostic and statistical manual of mental disorder. DSM-IV. Washington, DC: APA; 1994.
41. SCB. Meddelanden i samordningsfrågor. Socioekonomisk indelning (SEI). 1982:4. Nytryck 1995.
42. Derogatis LR, Lipman RS, Covi L. SCL-90. An outpatient psychiatric rating scale–preliminary report. Psychopharmac Bull 1973;9:13–28.
43. Derogatis LR, Cleary PA. Confirmation of the dimensional structure of the SCL-90: A study in construct validation. J Clin Psychol 1977;33:981–9.
44. Derogatis LR. SCL-90: Administration, scoring and procedure manual for the revised version of the SCL-90. The John Hopkins University School of Medicines, Baltimore; 1979.
45. Fridell M, Cesarec Z, Johansson M, Malling Andersen S. Symptom checklist 90, SCL-90. Svensk normering, standardisering och validering av symtomskattningsskalan. Statens Institutionsstyrelse SiS; 2002.
46. Henderson S, Duncan-Jones P, Byrne DG, Scott R. Measuring social relationships. The interview schedule for social interaction. Psychol Med 1980;10:723–34.

47. Henderson S, Byrne DG, Duncan-Jones P. Neurosis and the social environment. Academic Press Australia; 1981.
48. Undén A-L, Orth-Gomér K. Development of a social support instrument for use in population surveys. Soc Sci Med 1989;29:1387–92.
49. Weissman MM, Bothwell S. Assessment of social adjustment by patient self report. Arch Gen Psychiatry 1976;33:1111–5.
50. Weissman MM, Psrusoff BA, Thompson WD, Harding PS, Myers JK. Social adjustment by self report in a community sample and in psychiatric outpatients. J Nerv Ment Dis 1978;166:317–26.
51. Weissman MM, Sholomskas D, John K. The assessment of social adjustment. An update. Arch Gen Psychiatry 1981;38:1250–8.
52. Ferguson G. Statistical analysis in psychology and education. New York: McGraw-Hill; 1959.
53. Samuelsson M. The social network and its importance for the mental health of children in single parent families. A comparison between a clinical group and a control group. Department of Child and Youth Psychiatry, University of Lund; 1995.
54. Magne Ingvar U. Persons who attempt suicide – social characteristics, social network and significant others. Department of Clinical Neuroscience, Division of Psychiatry, University of Lund; 1999.
55. Gold S, Lucenko B, Elhai J, Swingle J, Sellers A. A comparison of psychological/psychiatric symptomatology of women and men sexually abused as children. Child Abuse Neglect 1999;23:683–92.
56. Statham DJ, Heath AC, Madden PAF, Bucholz KK, Bierut L, Dinwiddie SH, et al. Suicidal behaviour: an epidemiological and genetic study. Psychological Med 1998;28:839–55.
57. Bottlender R, Jäger M, Strauss A, Möller HJ. Suicidality in bipolar compared to unipolar depressed inpatients. Eur Arch Psychiatry Clin Neurosci 2000;250:257–61.
58. Davidson J, Hughes D, George L, Blazer D. The association of sexual assault and attempted suicide within the community. Arch Gen Psychiatry 1996;53:550–5.
59. Schmidtke A, Bille-Brahe U, Deleo D, Kerkhof A, Bjerke T, Crepet P, et al. Attempted suicide in Europe: rates, trends and socio-demographic characteristics of suicide attempters during the period 1989–1992. Results of the WHO/EURO Multicentre Study on parasuicide. Acta Psychiatr Scand 1996;93:327–38.
60. Brådvik L. Suicide in severe depression. A longitudinal case–control study. Department of Clinical Neuroscience, Division of Psychiatry, Lund University; 2000.
61. Walker E, Gelfand A, Katon W, Koss M, von Korff M, Bernstein D, et al. Adult health status of women with histories of childhood abuse and neglect. Am J Med 1999;107:332–9.
62. Finestone HM, Stenn P, Davies F, Stalker C, Fry R, Koumanis J. Chronic pain and health care utilization in women with a history of childhood sexual abuse. Child Abuse Neglect 2000;24:547–56.
63. Mullen P, Martin L, Anderson J, Romans S, Herbison G. The effect of child sexual abuse on social, interpersonal and sexual function in adult life. Br J Psychiatry 1994;165:35–47.
64. Gibson R, Hartshorne T. Childhood sexual abuse and adult loneliness and network orientation. Child Abuse Neglect 1996;20:1087–93.
65. Jackson J, Calhoun K, Amick A, Maddever H, Habif V. Young adult women who report childhood intrafamilial sexual abuse: Subsequent adjustment. Arch Sexual Behav 1990;19:211–21.
66. SCB. www.scb.se.
67. Rathsman K. Incest: Residing in a stolen body. Dissertation, Department of Sociology, Uppsala University (in Swedish with an English summary); 2000.

Gunilla Lundqvist, Master of Social Work, Inst for Molecular and Clinical Medicine, Faculty of Health Sciences, Linköping University, SE-581 85 Linköping, Sweden.
Carl Göran Svedin, Associate Professor, Inst for Molecular and Clinical Medicine, Faculty of Health Sciences, Linköping University, SE-581 85 Linköping, Sweden.
Kjell Hansson, Professor, School of Social Work, Lund University, SE-221 00 Lund, Sweden.