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Childhood Sexual Abuse among Adults with First-Episode Depression and Generalized Anxiety Disorder: Comparison with Healthy Controls

Shradha Khatri[1*], Sunil Goyal[2]

[1]*Graded Specialist, MD, DNB (Psychiatry), AFMS, Pune, Maharashtra, India.*
[2]*Former Professor and Head, Dept of Psychiatry, Institute of Naval Medicine, Mumbai, India.*

Abstract

Background: Childhood Sexual Abuse (CSA) has been identified as a serious public health concern and has been a global challenge. The severe, chronic and frequent the abuse, more likely the abused adults are to show symptoms of Psychiatric disorders.

Aim: To study the prevalence of CSA among adults presenting first time with a depressive episode or Generalized Anxiety Disorder.

Methods: 64 consecutive consenting adults among Armed Forces personnel and their families, diagnosed as first depressive episode or Generalized Anxiety Disorder as per International Classification of Diseases, 10th edition (ICD-10) checklist and a control group of gender and age-group matched adults were assessed for CSA using a 28-item retrospective, self-report Childhood Trauma Questionnaire (CTQ-28) at an Armed Forces hospital.

Results: Majority of cases reported no CSA, whereas majority of the control group reported moderate severity of CSA. Among the cases, statistically significant co-relation was neither observed between the diagnosis and severity of CSA nor the severity of illness with severity of CSA.

Conclusion: Absence of any signs of psychopathology could perhaps be due to psychological endurance, resilience and higher stress tolerance developed in the aftermath of early age traumatic incidents.

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***Correspondence:**
Shradha Khatri
shradhakhatri2@gmail.com
Graded Specialist, MD, DNB (Psychiatry), AFMS, Pune, Maharashtra, India.

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Introduction

The World Health Organization (WHO) defines Child Sexual Abuse (CSA) as a coercive act involving a child who is unable to comprehend or provide consent, often resulting in serious physical and psychological harm.[1] CSA is widely recognized as a major public health concern with significant developmental and mental health consequences.[2] It includes a broad spectrum of acts such as inappropriate touching, molestation, sodomy, exhibitionism, pornography, and cyber-sexual activities.[3] Such acts are regarded as offensive across all cultures. Prevalence rates vary between 8–31% among females and 3–17% among males, with some studies indicating higher rates among boys.[4] Childhood abuse has cumulative effects on the developing brain, mind, and

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interpersonal relationships and is an important determinant of health outcomes.[5] Early traumatic experiences are known contributors to the etio-pathogenesis of depression, anxiety, and other stress-related disorders.[6] The severity of abuse has a direct correlation with the intensity of depressive and anxiety symptoms in later life.[7] Multiple meta-analyses have consistently demonstrated a strong association between CSA and a broad range of adult psychological disorders.[8]

Trauma has been conceptualized as a relational phenomenon that links an external event to its specific consequences for the inner psychic world.[9] Cooper described psychic trauma as an event that overwhelms an individual's capacity to maintain safety and psychological integration, resulting in enduring psychic change.[10] Chronic or repeated trauma often has compounded effects, leading to a higher lifetime prevalence of depression and anxiety disorders.[11]

In India, children below 18 years constitute nearly 37% of the total population, many of whom lack adequate nutrition, education, and access to healthcare.[12] A national survey reported that 53% of Indian children have experienced some form of abuse, including sexual abuse.[13] In primary care settings, 20–50% of adults report experiences of childhood physical or sexual abuse, and this prevalence rises to up to 70% among individuals with depression, post-traumatic stress disorder (PTSD), chronic pain, or substance use disorders.[14,15] Notable gender differences exist in both prevalence and severity of CSA experiences, and a temporal relationship has been observed between the number and severity of childhood abuse and the subsequent development of psychiatric disorders.[11,16]

Over the past two decades, extensive evidence has confirmed the relationship between childhood trauma and the onset, symptom severity, and clinical course of depressive and anxiety disorders.[17] Although definitions of abuse and age cut-offs differ across studies, the cumulative evidence fulfills multiple criteria for a causal association between CSA and later psychopathology.[18]

Despite high national rates of child abuse, Indian studies focusing on CSA among adults presenting with first-episode depressive disorder or generalized anxiety disorder (GAD) remain limited. The present study aims to estimate the prevalence and severity of CSA among such patients, compare these findings with age- and gender-matched healthy controls, and explore correlations between CSA severity, psychiatric diagnosis, and illness severity. Additionally, it seeks to identify socio-demographic and contextual factors such as education, income, family structure, and peer support that may confer resilience or vulnerability among individuals with CSA histories.

Materials and Methods

This was a comparative, cross-sectional observational study conducted in the psychiatry department of a tertiary care hospital in Mumbai. Data were collected between September 2019 and March 2021.

The case group comprised 64 consecutive adults who presented for the first time with a diagnosis of either a Depressive episode (ICD-10 F32) or GAD (ICD-10 F41.1). Diagnoses were established by a consultant psychiatrist using a clinical interview anchored to the ICD-10 symptom checklist. Individuals with past psychiatric diagnoses were excluded to focus on first-episode presentations and to reduce recall or reporting distortions associated with prior psychiatric care.

The control group consisted of 64 age- and gender-matched healthy adults drawn from the same principal population, comprising of the patient attendants and volunteers, who consented for the study. They were screened using the General Health Questionnaire-12 (GHQ-12) and were included only if there was no indication of current psychopathology.

Inclusion criteria for cases were: adults aged 18 years and above; first-episode depressive disorder or GAD; ability and willingness to provide informed consent. Exclusion criteria for both cases and controls included: history of psychiatric illness (for controls) or comorbid severe psychiatric conditions (psychotic disorders, bipolar disorder), significant cognitive impairment, chronic debilitating medical illness, or refusal to provide informed consent.

Measures

- A Socio-demographic and Clinical Proforma was used to capture age, gender, marital status, educational attainment, occupation, monthly income, family type (nuclear/joint), and rural/urban/semi-urban background.
- Beck Depression Inventory (BDI)[19] and Hamilton Anxiety Rating Scale (HAM-A) [20] were used to assess the severity of depressive and anxiety severity respectively.
- Childhood Trauma Questionnaire (CTQ-28),[21] a 28-item retrospective self-report instrument was used to assess multiple subtypes of childhood maltreatment, including sexual abuse, on a five-point Likert scale. Higher scores indicate greater severity of traumatic experiences.
- A study-specific Semi-Structured Interview on CSA was conducted to elicit age at first incident, number of episodes, nature of abuse, relationship to perpetrator, setting of the abuse, disclosure patterns, and responses received from confidants.
- No scale was used to measure the objective or the subjective parameters of resilience for cases or controls.

After obtaining written informed consent, participants underwent structured clinical assessment. Cases completed the BDI and HAM-A to quantify symptom severity. All participants completed the CTQ-28 and the semi-structured CSA interview. Information with clinical implications was communicated to the treating psychiatrist to ensure appropriate care. Index individual's distress related to recall of CSA was addressed in an empathetic and sensitive manner. The individual psychotherapy sessions were are tailor-made to address the distress. The study was approved by the Institutional Ethics Committee with reference number MECM/17 obtained on 29 August 2019. Data were entered and analysed using GNU PSPP (version 1.2.0).[22] A p-value of <0.05 was considered statistically significant.

Results

From September 2019 to August 2021, a total of 128 adults participated: 64 cases and 64 controls. The mean age of the overall sample was 29.5 years (SD = 3.48). Males constituted 64.1% of the sample, and the majority were aged 25–29 years (57.8%). Socio-demographic differences between cases and controls were notable as cases had a lower mean monthly income (₹29,680) and years of education (14.15 years) compared with controls (₹46,870,15.78 years). Most cases were married (56.3%) and came from nuclear families (64.1%) and rural backgrounds (50%). Most controls were unmarried (67.2%), were living in occupational settings with colleagues (34.4%) and half originated from semi-urban backgrounds. These socio-demographic differences were statistically significant, highlighting potentially important contextual disparities between groups (Table 1).

Among the 64 cases, a majority (75.0%) reported no history of CSA. The remainder reported mild (12.5%), moderate (9.4%), or severe (3.1%) CSA. In stark contrast, among the 64 controls, only 14.1% denied CSA; 26.6% reported mild, 37.5% moderate, and 21.9% severe CSA. The resilience measures were hypothesized to be the reason for this paradoxical finding, and this between-group difference in CSA severity distribution was statistically significant ($p < 0.001$). Additional confounding details emerged from the semi-structured interviews revealed that among the 44 cases who reported any form of childhood trauma (not limited to sexual abuse), 25% reported the first incident occurred between the ages of 6 and 8 years. Of those, 15.6% identified sexual abuse as the specific nature of trauma. A large majority (77.3%) reported more than six incidents. Abuse most commonly took place at home (88.6%), followed by school and outdoor locations (4.54% each), and other/unknown areas (2.27%). Only four participants reported disclosing the abuse to a family member before age 8, most commonly to the mother. In each of these cases, no action was reportedly taken and the abuse continued. (Table 2) (Table 3) (Graph 1) However, the multivariate of these numerous factors was not carried out.

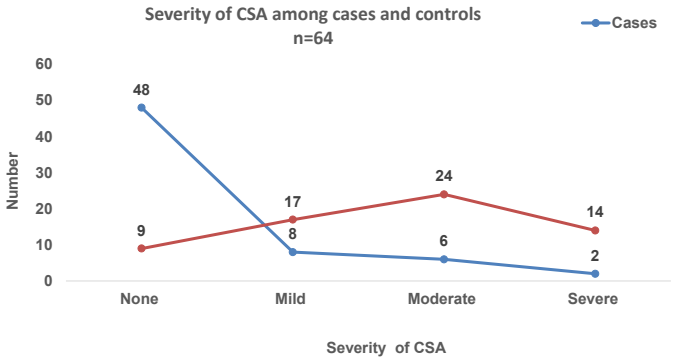
Within the case group, 35 (54.7%) had a depressive episode and 29 (45.3%) had GAD. When stratified by diagnosis, 48 presented with moderate and 16 with severe illness severity. The distribution of CSA severity across diagnoses did not differ significantly ($p = 0.438$). Similarly, no significant association was detected between illness severity (moderate vs.

Table 1: Descriptive data of cases and (age & gender matched) controls

Monthly Income (Rs)	*Cases (n=64) n (%)*	*Controls (n=64) n (%)*	*Social support*	*Cases (n=64) n (%)*	*Controls (n=64) n (%)*
Nil	8 (12.5)	00	Nuclear Family	41 (64.1)	20 (31.3)
<20,000	15 (23.4)	4 (6.3)	Joint Family	9 (14.1)	5 (7.8)
20,000-50,000	29 (45.3)	18 (28.1)	Living in Occupational Setting	4 (6.3)	22 (34.4)
>50,000	12 (18.8)	42 (65.6)	Chi-Square Test, P Value <0.001, Significant		
Mean	29.68	46.87	Place of Origin		
Chi-Square Test, P Value <0.001, Significant			Urban	11 (17.2)	10 (15.6)
Education			Rural	32 (50.0)	22 (34.4)
10^{th} std	1 (1.6)	00	Semi-Urban	21 (32.8)	32 (50.0)
12^{th} std	11 (17.2)	00	Chi-Square Test, P Value = 0.124, Not Significant		
12^{th} std-Graduate	40 (62.5)	26 (40.6)	Marital Status		
Post-graduate	12 (18.8)	38 (59.4)	Single	26 (40.6)	43 (67.2)
Chi-Square Test, P Value <0.001, Significant			Married	36 (56.3)	21 (32.8)
Social support			Others	2 (3.1)	00
Living Alone	10 (15.6)	17 (26.6)	Chi-Square Test, P Value = 0.006, Significant		

Table 2: Diagnosis and self-report data of cases

Diagnosis	*No.*	*Percent*	*Nature of abuse*	*No.*	*Percent*
Depression	35	54.7	None	20	31.3
Generalized Anxiety Disorder	29	45.3	Sexual Abuse	10	15.6
Stressors			Other abuse/neglect	34	53.12
Acute	42	65.6	Self-reported no of incidents: (N=44)		
Long-Standing	22	34.4	1	3	6.8
Cases self-reporting abuse:			2-3	7	15.9
During data collection	44	68.7	>6	34	77.3
Cases self-reporting abuse during childhood: (N = 44)			Perpetrators (Multiple incidents)		
Reported to familymember	4	9.1	1^{st} degree relative	2	4.5
Reported before age 8	4	100.0	2^{nd} degree relative	2	4.5
Action taken	0	0.0	Parent	32	72.7
Abuse stopped later	0	0.00	Friend	7	15.9
1^{st} Incident age (Inyears)			Sibling	10	22.7
Did not report	20	31.3	Place of incidents		
3-5 yrs.	5	7.8	Home	39	88.6
6-8 yrs.	16	25.0	School	2	4.54
9-12 yrs.	13	20.3	Outdoors	2	4.54
13-15 yrs.	10	15.6	Unknown	1	2.27



Graph 1: Severity of childhood sexual abuse between cases and controls

Table 3: Severity of childhood sexual abuse

Severity of Sexual Abuse	*Group*	
	Cases (n=64) n (%)	*Controls (n=64) n (%)*
None	48 (75.0)	9 (14.1)
Mild	8 (12.5)	17 (26.6)
Moderate	6 (9.4)	24 (37.5)
Severe	2 (3.1)	14 (21.9)

Chi-Square Test, P Value <0.001, Significant

severe) and CSA severity (p = 0.149). Thus, in this sample, neither diagnostic category nor symptom severity among cases correlated with the severity of CSA (Table 4).

Discussion

This study examined the prevalence and severity of childhood sexual abuse (CSA) among adults with first-episode depressive disorder or generalized anxiety disorder (GAD), compared with matched healthy controls. Contrary to existing literature linking CSA with psychopathology, the control group in our sample reported higher CSA prevalence and severity, despite absence of psychiatric morbidity. Within the clinical group, CSA severity did not significantly correlate with diagnosis or illness severity.

Several explanations may account for this paradoxical observation. First, resilience and adaptive coping may have mitigated adverse effects of CSA in controls. Higher education, income, and social support among controls possibly enhanced affect regulation and stress tolerance. Second, differential reporting bias could have influenced results, as individuals with psychopathology might underreport CSA due to shame, avoidance, or stigma, while psychologically stable individuals could disclose more freely. Third, diagnostic limitation to depression and GAD may have excluded other psychopathologies, such as subclinical PTSD or personality disorder traits, not captured by GHQ-12 screening. Finally, the cross-sectional design precludes temporal inference; some controls may develop psychopathology later, while some cases may have been influenced by non-CSA stressors, including genetic and environmental vulnerabilities.

Socio-demographic differences further contextualize findings. Cases were predominantly married, less educated, and from rural, nuclear families, whereas controls were unmarried, with higher income and education, and often lived with peers. Peer-based social networks might promote adaptive functioning and resilience, contrasting with literature suggesting marriage as protective against stress-related disorders.[23]

Table 4: Outcome variables: Severity of childhood sexual abuse and illness

Severity of Sexual Abuse	*Diagnosis*		*Severity of Illness*	
	Depression (n = 35) n (%)	*Anxiety (n = 29) n (%)*	*Moderate (n=48) n (%)*	*Severe (n=16) n (%)*
None	29 (82.9)	19 (65.5)	36 (75.0)	12 (75.0)
Mild	3 (8.6)	5 (17.2)	4 (8.3)	4 (25.0)
Moderate	2 (5.7)	4 (13.8)	6 (12.5)	00
Severe	1 (2.9)	1 (3.4)	2 (4.2)	00
Chi-Square Test	P Value = 0.438, Not Significant		P Value = 0.149, Not Significant	

The absence of a dose–response relationship between CSA severity and psychopathology within the case group may reflect limited statistical power, narrow trauma focus, and retrospective self-report limitations. Additional unmeasured variables—such as temperament, family psychiatric history, substance use, or ongoing stressors—could have moderated outcomes.

Previous studies affirm strong associations between childhood adversities and adult psychiatric disorders. Kessler et al[24] found robust correlations between childhood adversities and all DSM-IV disorder classes. Huh et al[25] reported significant links between sexual abuse and interpersonal distress among adults with depression and anxiety. Khan et al[26] identified sensitive developmental windows where abuse exposure maximally increased depression risk. Kessler and McLaughlin[27] estimated that nearly 30% of psychiatric disorders arise from early adversities. CSA has further been implicated in intimacy dysfunction, social maladjustment, and poor treatment outcomes.[3,28]

However, resilience studies indicate that trauma exposure does not universally result in psychopathology. Cicchetti et al[23] highlighted that maltreated individuals may develop adaptive coping, emotion regulation, and self-organization capacities under chronic stress. Rehan et al[29] similarly observed that most severely abused individuals (72%) did not exhibit clinical depression or anxiety, attributing this to resilience mechanisms.

Consistent with these frameworks, the present findings suggest that socio-demographic and contextual variables—particularly education, income, and peer support—significantly influence whether CSA leads to psychopathology or adaptive functioning. While CSA remains a potent risk factor for mental illness, resilience and social context appear equally critical in determining psychological outcomes.

This study included first-episode patients with closely matched controls and employed validated instruments to assess depression, anxiety, and childhood trauma. Recruiting controls from the same institutional population minimized sampling bias, and the focus on first-episode presentations reduced confounding from chronicity or treatment exposure.

However, certain limitations warrant consideration. The cross-sectional design precludes causal inference, and the modest, single-centre sample limits generalizability. Significant socio-demographic differences between cases and controls and unmeasured resilience-related variables (e.g., coping, social support, temperament) may have influenced findings. The reliance on retrospective self-report introduces potential recall and response bias, possibly leading to minimization or exaggeration of CSA experiences. Restricting inclusion to depressive and anxiety disorders may have excluded conditions where CSA exerts stronger effects, such as PTSD, dissociative, or personality disorders. Furthermore, variables such as personality organization, family psychiatric history, and ongoing stressors were not systematically assessed, constraining interpretation of resilience and vulnerability mechanisms.

Future research should adopt longitudinal, multi-centre designs with larger samples and multivariate modelling to examine developmental trajectories and delayed psychopathology. Expanding diagnostic coverage to include PTSD, complex PTSD, dissociative and substance use disorders, and incorporating biomarkers, neurocognitive profiling, and neuroimaging could enhance understanding of biological underpinnings. Assessing resilience, coping strategies, and social support through validated tools would further clarify protective factors mitigating psychopathology after CSA.

Conclusion

Despite its limitations, this study represents one of the first efforts to explore trauma-informed psychiatric assessment among adults with first-episode depression and GAD in an Indian tertiary care context. The findings underscore that a history of CSA does not invariably predict psychopathology and that socio-demographic and contextual resilience factors may buffer psychological outcomes. Routine trauma-informed screening should therefore be integrated into psychiatric and primary care settings, even among asymptomatic individuals reporting CSA. Clinicians should maintain a low threshold for CSA inquiry while recognizing that absence of overt symptoms does not equate to absence of distress.

Community and clinical interventions must emphasize education, peer support, and socio-economic stability as protective domains. Strengthening resilience-oriented public health strategies may hold promise in reducing psychiatric morbidity and enhancing adaptive recovery among CSA survivors.

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Conflicts of Interest

There are no conflicts of interest.

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