

Peer-Reviewed Letter

CHILDHOOD ABUSE, DEPRESSION, AND ANXIETY IN ADULT PSYCHIATRIC OUTPATIENTS

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Theorists have long thought that negative experiences in childhood (e.g., abuse) may contribute to the development of psychopathology in adolescence and adulthood [e.g., Beck, 1967; Bowlby, 1973, 1980]. More recently, they have hypothesized that different types of childhood abuse may contribute specific vulnerability to certain forms of psychopathology. Specifically, theorists have suggested that childhood emotional abuse may be most strongly related to the development of depression, whereas physical abuse may be most strongly related to the development of anxiety [e.g., Ladd and Ladd, 2001; Rose and Abramson, 1992]. In contrast, childhood sexual abuse appears to be relatively nonspecific in terms of its psychopathological correlates [e.g., Kendler et al., 2000].

Despite the number of studies that have examined the long-term correlates of childhood abuse [e.g., Gibb et al., 2001; Kendler et al., 2000; Silverman et al., 1996], no study of which we are aware has directly examined the relative specificity of each form of abuse to depression vs. anxiety in a clinical sample. In this study, we examined the relation between adult psychiatric outpatients' reports of childhood emotional, physical, and sexual abuse and their current symptoms and diagnoses of depression and anxiety. We hypothesized that reports of childhood emotional abuse would be more strongly related to patients' current depression than anxiety and that reports of childhood physical abuse would show the opposite pattern. In contrast, we predicted that reports of childhood sexual abuse would demonstrate no evidence of specificity.

Participants were 552 psychiatric outpatients (mean age = 40.59 years, $sd = 14.30$; 57.1% women; 87.7% Caucasian). Two hundred seventy-three (49.5%) of the patients received a principal Diagnostic and Statistical Manual, 4th Edition [DSM-IV; American Psychiatric Association (APA), 1994] Axis I diagnosis of a depressive disorder (e.g., major depression and dysthymia). One hundred seventy-seven (32.1%) received a principal Axis I diagnosis of an anxiety disorder (e.g., generalized anxiety disorder or panic). One hundred one (18.3%) of the patients received other diagnoses (e.g., bipolar disorder or substance dependence).

All measures were administered as part of the intake assessment. Reports of childhood emotional, physical, and sexual abuse were obtained via three dichotomously coded items. Specifically, patients were asked,

"Did you ever experience emotional or verbal abuse as a child?" Similar questions were used to assess for childhood physical or sexual abuse. Patients were also administered the Beck Anxiety Inventory [BAI; Beck et al., 1988], Beck Depression Inventory-II [BDI-II; Beck et al., 1996], and the 24-item Hamilton Rating Scale for Depression [HRSD-24; Guy, 1976; Hamilton, 1960]. Finally, diagnoses of depressive and anxiety disorders were obtained using the Structured Clinical Interview for DSM-IV Axis I Disorders [SCID-I; First et al., 1995].

Descriptive statistics including rates of reported childhood abuse, as well as correlations among the study variables, are presented in Table 1. As can be seen in the table, reports of each type of childhood abuse were significantly related to patients' symptoms of depression and anxiety. As hypothesized, however, reports of childhood emotional abuse were significantly more strongly correlated with outpatients' BDI-II ($Z = 2.25, P = .01$) and HRSD-24 ($Z = 2.79, P = .003$) scores than with their BAI scores. Also as hypothesized, outpatients' reports of childhood physical abuse were significantly more strongly correlated with their BAI scores than with their BDI-II ($Z = 1.86, P = .03$) or HRSD-24 ($Z = 1.89, P = .03$) scores. In contrast, the differences in the magnitude of the correlations between outpatients' reports of childhood sexual abuse and their BAI vs. BDI-II ($Z = 0.42, P = .34$) or HRSD-24 ($Z = 0.48, P = .32$) scores were not significant.

Next, χ^2 analyses were used to examine the relation between patients' reports of childhood abuse and their diagnoses of depressive vs. anxiety disorders. Patients

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Contract grant sponsor: National Institute of Mental Health; Contract grant number: F31 MH64301

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Received for publication 10 August 2002; Accepted 14 March 2003

Published online in Wiley InterScience (www.interscience.wiley.com). DOI 10.1002/da.10111

TABLE 1. Correlations and Descriptive Statistics

Variable ^a	1	2	3	4	5	Percent endorsing	Mean	sd
1. Child emotional abuse	—					34.78		
2. Child physical abuse	.50**	—				11.23		
3. Child sexual abuse	.27**	.32**	—			6.88		
4. BAI	.11*	.20**	.14*	—			16.04	11.92
5. BDI-II	.22**	.11*	.12*	.46**	—		21.34	12.33
6. HRSD-24	.23**	.12*	.12*	.58**	.78**		17.22	9.12

^aBAI, Beck Anxiety Inventory; BDI-II, Beck Depression Inventory-II; HRSD-24, 24-item Hamilton Rating Scale for Depression.

* $P < .01$; ** $P < .001$.

with a principal diagnosis of a depressive disorder were significantly more likely to report a history of childhood emotional abuse than were patients with a principal diagnosis of an anxiety disorder (45.3% vs. 30.2%; χ^2 [1; $N = 392$] = 8.77, $P = .003$). In contrast, the percent differences in patients with principal diagnoses of depressive vs. anxiety disorders reporting childhood physical (13.2% vs. 9.2%; χ^2 [1; $N = 405$] = 1.54, $P = .22$) or sexual (9.1% vs. 4.2%; χ^2 [1; $N = 420$] = 3.54, $P = .06$) abuse were not significant.

In all of the analyses, the results for emotional abuse were maintained even after (a) statistically controlling for the effects of the other forms of abuse and (b) limiting our analyses to patients reporting only emotional abuse vs. those reporting no abuse. In addition, patients reporting emotional abuse only did not differ significantly from those reporting other/multiple forms of abuse in terms of their symptoms or diagnoses of depression or anxiety.

As hypothesized, therefore, outpatients' reports of childhood emotional abuse were more strongly related to their symptoms and diagnoses of depression than anxiety. In addition, partially supporting our hypothesis, patients' reports of childhood physical abuse were more strongly related to their symptoms of anxiety than depression, although the difference was not significant when diagnoses were considered. Finally, as expected, patients' reports of childhood sexual abuse were equally strongly related to their symptoms and diagnoses of depression and anxiety.

These results support the importance of assessing patients' histories of each type of childhood abuse. Conclusions from this study must remain tentative, however, given the method used to assess childhood abuse and the study's retrospective design. Specifically, studies have suggested that reports of childhood abuse are more reliable when based upon the recall of specific events rather than individuals' global recall [Brewin et al., 1993]. Future studies, therefore, should use standardized measures assessing a variety of specific events rather than relying on patients' global recall of childhood abuse. In addition, the results speak only to correlates rather than causes. Developmental conclusions must remain tentative pending the results of longitudinal studies. Finally, research is needed to

understand the process by which emotional abuse, for example, may contribute to the development of depression [cf. Gibb et al., in press]. This said, however, this study represents an initial step in evaluating the specific developmental antecedents of adult psychopathology.

Acknowledgments. This project was supported by the National Institute of Mental Health (F31 MH64301 to B.E.G.). An earlier version of this paper was presented at the annual meeting of the Association for the Advancement of Behavior Therapy, Philadelphia, PA, 2001.

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