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Childhood maltreatment profile in a clinical population in China: A further analysis with existing data of an epidemiologic survey

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Abstract

To determine the lifetime prevalence and diverse profiles of types of childhood maltreatment (CM) in a high-risk clinical sample using standardized assessment tools (Child Trauma Questionnaire, CTQ) in China, Shanghai, 2090 subjects were sampled from the Shanghai Mental Health Centre. Personality disorder (PD) was assessed using the Personality Diagnostic Questionnaire (PDQ-4+) and subjects were interviewed using the Structured Clinical Interview (SCID-II). CTQ was used to assess CM in five domains (emotional abuse, EA; physical abuse, PA; sexual abuse, SA; emotional neglect, EN; and physical neglect, PN). The prevalence estimate of EA in the sample is 22.2%, followed by 17.8% of PA, and 12.5% of SA. The prevalence estimate was more frequent in PN (65.0%) and in EN (34.0%) than in childhood abuse (EA, PA and SA). It seems that males reported more PA and females reported more SA, the older subjects reported more neglect and the younger subjects reported more abuse. There was a higher prevalence of EA and SA in borderline PD patients (44.4%, 22.5%), PA in antisocial PD patients (38.9%). Multi-PD patients reported more forms of CM in childhood. Additionally, factor analysis of CTQ items confirmed factorial validity by identifying a five-factor structure that explained 50% of the total variance. These findings support the view that prevalence of CM was commonly experienced in clinical population during their childhood, especially for subjects with PDs. Factorial validity in PN needs to be further improved, and can in part be culturally explained.

1. Introduction

It is becoming increasingly important to consider gene–environment interaction in mental health research. Previous researches repeatedly reported that childhood maltreatment (CM) is associated with a broad range of mental disorders, for example, bipolar disorders [1–3], personality disorders (PDs)[4–7], and schizophrenia [3,8,9]. Current literature suggests that unhealthy childhood environments appear to have damaging effects on mental health in adulthood [10,11]. In particular, negative psychological impacts on an individual with a history of CM are detrimental [3,12,13]. For example, there is strong evidence that puts forward the associations between childhood traumatic experiences (in terms of abuse and neglect) with alcohol and drug dependence [14,15], post-traumatic stress disorder [16,17], depression [18,19], and psychosis [20–23]. The role of childhood traumatic experiences leading to different types of PDs, such as borderline PD [24–26] antisocial PD [27,28], schizotypal PD [29], and avoidant PD [30] is also evident.

Although previous studies have contributed to the understanding of the relationship between CM and mental disorders, most researches put forward a different definition of CM. Such disparity in the conceptual definition of CM influences the prevalence rates that were reported. For example, restrictive and objective definitions may result in significantly lower rates being reported, as compared to broader and subjective definitions, which include sexual, physical and emotional aspects of CM [31]. Although high prevalence rates were found in previous studies, it is likely that the rate in China could be higher. CM is generally under-reported, and some forms of CM are not considered as traumatic experiences in the Chinese culture. For

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example, for people born before the 70's, the lack of food was quite common due to political instability in China then. The unclear definition of CM closed the doors for further investigation of incidence rate. Accordingly, we regard information on the prevalence of CM in the Chinese population as incomplete and inconsistent. In fact, no surveys of this nature have yet been conducted on a national level.

It is clear that environmental factors largely account for the development of personality and psychiatric disorders. However it is important to recognize that the understanding of relationship between CM and mental disorders has mainly derived from Western perspectives and therefore results may not be effectively generalized onto a non-Western setting. Social values, attitudes and norms, and cultural beliefs play an important role in framing the society and dictate what constitutes symptoms of a psychiatric illness or a PD. Certainly, these also affect the estimates of incidence of CM in a particular society. The large population in China allows careful examination of CM in a society where cultural values are distinctly different from those of Western societies. Besides, China is a rapidly developing country, which has been experiencing a lot of economic and social changes since early 1990s. Such changes unquestionably have a potential notable impact on mental health [32]. As a result, nationwide examinations on the incidence of CM, as well as PDs, with standardized assessment measures, trained interviewers, and meticulous procedures are necessary. To the best of our knowledge, no large-scale survey of CM that employs standardized assessment tools and DSM-IV diagnostic criteria, involving mental health outpatients in both rural and urban areas, has been carried out in China.

Our previous paper has reported that early traumatic experiences are strongly related to the development of PDs, and in particular, cluster B PDs[7]. However we were unclear as to the extent of childhood maltreatment being experienced in individuals with PDs. The results then prompted the investigation of identifying CM in China. Hence, the current paper tried to apply the Western-derived concept of CM onto the Asian context and sought to explore prevalence rates and identification of CM in detail. As the impacts of CM are likely to be amplified in individuals with PD, the same sample was used. Nonetheless, data analysis was focused on individuals who reported experiencing CM. As such, we are more able to delineate the composition of CM and its impact on the development of PD. This paper aims to determine: (1) the incidence rates of self-reported CM in the clinical population aged 18 to 60 living in both urban and rural regions of Shanghai, China (2) the socio-demographic correlates of CM; (3) the relationship between experiences of multi-types of CM (sexual abuse, physical abuse, emotional abuse, physical neglect and emotional neglect) and development of DSM-IV PDs; and (4) the diverse profiles of emotional, physical and sexual CM from parents in the special specific Chinese historical background and cultural context.

2. Method

2.1. Sample Characteristics

The epidemiologic survey on PD was conducted in the largest mental health service setting in 2006 in Shanghai [33]. There are two outpatient departments in the hospital for various types of mental health service. The psycho-counseling clinic mainly offers counseling and psychotherapy for clients with non-psychotic disorders, and psychiatric clinic mainly offers medication for patients with psychosis. In this survey, 3402 participants were randomly sampled from psycho-counseling and psychiatric clinics. Considering the psychotic symptoms may impact the assessment of CM and PD, outpatients with acute attacks or recently relapsed psychoses were excluded. Detailed descriptions of the study population have been published previously [7,33,34] but are briefly reviewed here. 3075 patients seeking medical treatment were recruited between May and October 2006. Amongst them, 1673 outpatients were (54.4%) from the psychiatric clinic, and 1402 patients were (45.6%) from the psycho-counseling clinic. There were 1354 males (44.0%) and 1721 females (56.0%). The average age was 32.0 years (SD = 10.2).

Out of the 3075 patients included for PD assessment, 2090 (68.0%) subjects, with a mean age of 30.6 years (SD = 9.67), subsequently completed the CTQ self-report. Amongst the 2090 subjects (932 men, 1158 women), 592 outpatients (28.3%) had been diagnosed with schizophrenia and other psychosis at remission stage in our assessment; 581 outpatients (27.8%) had been diagnosed with mood disorders, and 447 outpatients (21.4%) had been diagnosed with neurosis disorder. For this paper, the data analyzed were mainly about the 2090 subjects.

2.2. Measures

2.2.1. Demographic details

A Demographic and Personal Details Questionnaire was used to collect participants' personal details, including: (a) demographics; (b) family and social background; and (c) physical and mental health conditions.

2.2.2. Assessment of personality disorders

As detailed in our other studies [7,33,34], The Personality Diagnostic Questionnaire fourth edition plus (PDQ-4+) is a concise structured self-report questionnaire that contains 107 true–false items and screens for 10 Axis II DSM-IV PDs. Furthermore, the PDQ-4+ seeks to discriminate between subjects with and without a formal diagnosis of PD [35–37]. The PDQ-4+ takes approximately 20–30 min to complete. The PDQ4+ is considered highly sensitive (.89), and is also a relatively specific (.65) test. The Structured Clinical Interview for DSM-IV Axis II (SCID-II) is used to diagnose PD in accordance to the DSM-IV criteria. PDs are considered more severe when more number of areas is marked positive during the interview. The SCID-II has a relatively strong test–retest reliability of .70, with a median of coefficient for