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Hospitalized youth and child abuse: A systematic examination of psychiatric morbidity and clinical severity☆

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ABSTRACT

Many children and adolescents who require psychiatric hospitalization have been physically or sexually abused, yet the association between reported histories of abuse and the complexity and severity of mental illness among psychiatrically hospitalized youth is poorly described with regard to current inpatient psychiatric practice. We sought to determine the association between histories of abuse and psychiatric complexity and severity in psychiatrically hospitalized youth including comorbidity patterns, psychotropic medication use, reason for admission and length of hospitalization. A systematic chart review was performed on 1433 consecutive psychiatric hospitalizations of children and adolescents that occurred over a 10-month period. Children with a history of abuse were more likely to be diagnosed with multiple DSM-IV-TR disorders than non-traumatized children. A history of sexual abuse was associated with more medication use than in their non-traumatized peers and a higher likelihood of treatment with antipsychotic medications, both at admission and discharge. Physical and sexual abuse were independently associated with increased length of stays, with exposure to both physical and sexual abuse associated with a 2-day increase in duration of hospitalization compared to non-traumatized patients. The findings from this study draw attention to the adverse impact of abuse on psychiatric morbidity and complexity and suggest the need for trauma-informed treatment in psychiatric hospital settings.

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Introduction

In the United States, 0.3% of children and nearly 1% of all adolescents are psychiatrically hospitalized every year (Blader, 2011). These hospitalizations are frequently the result of mood disorders, suicidal ideation or suicide attempts, psychotic disorders, substance use, and anxiety disorders (Blader, 2004; Harpaz-Rotem, Leslie, Martin, & Rosenheck, 2005). Treatment of psychiatrically hospitalized children results in the use of significant healthcare and family resources, and it is often unclear which potential variables contribute to hospitalization outcomes. However, despite the clinical and demographic heterogeneity of youth requiring psychiatric hospitalization, understanding potential predictors of psychiatric course and treatment utilization has broad implications for treatment, public health, and perhaps even secondary intervention strategies (Tulloch, Fearon, & David, 2011).

To date, cross-sectional and longitudinal data suggest an association between child abuse and psychiatric diagnosis as well as numerous physical and mental health outcomes (Cisler et al., 2012; C. Clark, Caldwell, Power, & Stansfeld, 2010; D.B. Clark, D.E. Bellis, Lynch, Cornelius, & Martin, 2003; Fergusson, Horwood, & Lynskey, 1996; Kilpatrick et al., 2003). Frequency, duration and severity of childhood abuse increase the risk of having a primary Axis I disorder and further increase the risk of suicide attempts among adults (Pérez-Fuentes et al., 2013; Sugaya et al., 2012). Similar relationships have been observed in youth where child maltreatment may be associated with poorer treatment response to psychiatric intervention and may predict greater morbidity. For example, in the Treatment for Adolescents with Depression Study (March et al., 2004), adolescents with a history of abuse reported higher baseline suicidality than nontraumatized, depressed adolescents (Lewis et al., 2010). Additionally, in the Treatment of Resistant Depression in Adolescent Study (Brent et al., 2008), youth with histories of physical abuse experienced poorer responses to treatment compared to nonabused adolescents (Shamseddeen et al., 2011).

Physical and sexual abuse may be independently associated with a variety of potential psychiatric outcomes among children with significant emotional and behavioral challenges (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996). Among psychiatrically hospitalized children, a history of significant adversity predicts worse externalizing behaviors and psychosocial impairment (Ford, Connor, & Hawke, 2009). A history of sexual abuse is associated with an increased risk of parasominias (Sadeh, Hayden, McGuire, Sachs, & Civita, 1994), sexualized behavior (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989), and being overweight or obese (Keeshin et al., 2013). Additionally, sexual abuse is associated with an increased use of negative coping strategies (Cohen et al., 1996) and an increased risk of suicide attempt and an earlier emergence of suicidality (Brent et al., 2009). However, the degree to which specific forms of child abuse impact the complexity and severity of mental illness among psychiatrically hospitalized youth has not been explored in the context of current practices in hospitalization.

With this consideration in mind, we sought to evaluate the relationship between a history of physical or sexual abuse and objective markers of treatment complexity and illness severity among psychiatrically hospitalized youth. Specifically, the aims of this study were to: (a) determine the association between histories of abuse and presence of comorbid psychiatric diagnoses, (b) explore possible relationships between abuse histories and quantity of prescribed psychotropic and nonpsychotropic medications and (c) describe the correlation between histories of abuse and documented length of hospitalization, a proxy for clinical severity. We hypothesized that, among psychiatrically hospitalized youth, patients with a history of abuse would have more psychiatric diagnoses, be prescribed more medications, and experience longer hospitalizations compared to nontraumatized youth.

Method

Participants

The medical records of youth consecutively admitted to acute-care, inpatient psychiatric units at a urban, academic medical center over a period of 10 months ($N = 1433$) were manually reviewed and the extracted data were reviewed by a board-certified child and adolescent psychiatrist (JRS). Histories of previous maltreatment and trauma were systematically documented for all patients prior to admission and could be reported by parent/caregiver, child, or both. Chart review consisted of reviewing the systematically obtained emergency department intake form as well as reviewing the admission note, interim progress notes, and discharge summary for subsequent case findings of abuse and trauma exposure noted after admission. Sexual abuse was defined as any inappropriate or forced sexual contact as perceived by the patient, and physical abuse was defined as intrafamiliar assaultive victimization toward the patient, either documented broadly as physical abuse or by a specific action (e.g., hitting, kicking) that resulted in a report to child protective services. This study was reviewed by the Cincinnati Children's Hospital Medical Center Institutional Review Board.

Consecutively admitted inpatient psychiatric patients ages 3–18 were included in the study. Youth were excluded from the current study if they were above the age of 18 years ($N = 15$), or received a discharge diagnosis of any pervasive developmental disorder (e.g., autism) or moderate or severe mental retardation ($N = 145$). Because we were interested in isolating the effects of physical or sexual *abuse* compared to no abuse exposure, any eligible youth reporting having only *witnessed* the physical or sexual abuse of someone else or experiencing a noninterpersonal form of traumatic experience (e.g., car collision) was excluded ($N = 194$). Thus, after exclusions, the final sample for analyses was 1079 youth (i.e., 75% of those originally admitted). Table 1 lists subject characteristics for the overall sample as well as separately by abuse status.