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Sexual victimization in women with schizophrenia and bipolar disorder

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Abstract Exposure of populations with psychosis to traumatic events (among them sexual trauma) has seldom been studied. In addition, the clinical features developed by victims with psychosis after a traumatic event are rarely taken into account. Sixty-four women with schizophrenia and 26 women with bipolar disorder (DSM-III-R diagnosed, 18–45 years, inpatients and outpatients) were interviewed using a clinician-rated battery of instruments, including a semi-structured questionnaire concerning sexual victimization and its impact. In childhood or adolescence, 36 % of women with schizophrenia (vs 28 % of those with bipolar disorder) had been victims of sexual abuse involving body contact. In the women with schizophrenia, this sexual abuse was associated with addictions, suicide attempts and becoming psychiatric patients earlier. Over their lifetime, the prevalence of rape was 23 % in the two clinical groups. In women with schizophrenia, rape was associated with a greater severity of their disorder and addictions. Moreover, a frequent repetition of sexual trauma was observed in women with schizophrenia, whereas such repeated traumas were less frequent in those with bipolar disorder. The results suggest that these two clinical groups are at risk of rape and the study highlight clinical features in victims with schizophrenia that have been described for other groups of victims of sexual abuse.

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Introduction

The place of psychic trauma, particularly that of sexual origin, in the pathogenesis of mental disorders was a major question for nineteenth-century psychiatry (Briquet 1859; Charcot 1884; Janet 1889; Freud and Breuer 1895). After a long period of quiescence and for different social and scientific reasons, the question of sexual victimization has risen again (Hobbs and Wynne 1987).

Many recent Anglo-Saxon epidemiological studies report high rates of sexual abuse in the general population, whether occurring in childhood (Russell 1983; Wyatt 1985; Baker and Duncan 1985; Bagley and Ramsey 1986; Winfield et al. 1990; Anderson et al. 1993) or in adulthood (Di Vasto et al. 1984; Winfield et al. 1990). It is thought that at least one-third of women and 15 % of men had sexual contacts with a much older person when they were children (Sheldrick 1991; Demauze 1991). If adulthood is considered as well as childhood, the recent French survey, conducted by the INSERM, reports that 7 % of women under 35 years are victims of "sexual relationships imposed under constraint" (Spira and Bajos 1993). Another survey carried out in the North Carolina NIMH Epidemiologic Catchment Area Program (Winfield et al. 1990) points out that 7 % of women under 45 years are victims of sexual assaults (defined as "being pressured into doing sexually more than they wanted to do"). Di Vasto et al. (1984) note likewise that in their sample (New Mexico), 8 % were subjected to rape.

Beside these surveys in the general population, studies of clinical populations have been carried out. Most of the research has concerned female inpatients. When populations of men are studied, they are found to be less often sexually victimized (Carmen et al. 1984; Jacobson and Richardson 1987; Swett et al. 1990). The frequency of sexual abuse in psychiatric patients considered as a whole (i.e. whatever their precise diagnosis) is high (Rosenfeld 1979; Carmen et al. 1984; Jacobson and Richardson 1987; Bryer et al. 1987; Goodwin et al. 1988; Briere and Zaidi 1989). The study by Bryer et al. (1987) was a turning-point regarding this issue. In their

sample of 66 female psychiatric inpatients, these authors found a rate of sexual abuse victims of 54 % (defined as people who had been a pressured into doing more than they wanted to do"). The corresponding rate was 44 % for incidents occurring in childhood. In addition, these authors showed that there was a correlation between the existence of sexual abuse in childhood and the severity of adult psychiatric symptoms. Considering the difficulties the victims of sexual trauma have in managing their relationships with others, it is understandable that sexual trauma could increase psychiatric problems of all kinds (Van der Kolk et al. 1993).

The existence of histories of trauma, in particular sexual trauma, has been well documented for certain categories of mental disorder. It has been highlighted in borderline personality disorders (Ogata et al. 1990; Shearer et al. 1990). Briquet (1859), Charcot (1884), Janet (1889), and Freud and Breuer (1895) had noted such histories in many hysterical neuroses and these results are currently being rediscovered (Chu and Dill 1990). The way in which these disorders are related to post-traumatic stress disorder and to the co-morbidity of this syndrome is an unsolved problem.

There has been little research concerning sexual victimization of women with schizophrenia, whether the abuse occurred in childhood or in adulthood. Clinical psychiatrists, particularly those responsible for long-term treatment of chronic schizophrenia, as well as researchers interested in this field, are beginning to appreciate the possible importance of such victimization (Friedman and Harrison 1984; Beck and Van der Kolk 1987).

The aim of our present study was to study two populations, women with schizophrenia and those with bipolar disorder, with reference to sexual victimization. Schizophrenia and to a lesser extent bipolar disorder are severe psychiatric disorders leading to great social vulnerability. For that reason, it appeared interesting to study them simultaneously. The study reports psychological trauma of sexual origin occurring during two periods in the life of women with schizophrenia and bipolar disorder: childhood and adulthood. Indeed, the origin of sexual abuse in these patients may be of a different nature according to whether it occurred in childhood, before the manifest onset of the disorder or in adulthood, possibly a long time after the onset of the disorder. We also paralleled sexual trauma and some clinical characteristics developed by certain subgroups of women with schizophrenia, such as earlier onset and greater chronicity of their psychosis, as well as addictive and autoaggressive behaviours. Indeed, these are clinical features often attributed to any victim.

Methods

Twelve public hospital departments of psychiatry located in the Paris and Tours areas volunteered to take part in the study. Subjects included in the investigation were systematically recruited over a short period (ranging from days to months, depending on the centres), and were female in- or outpatients with schizophrenia and bipolar disorder, aged from 18 to 45 years.

Among the 79 women with schizophrenia and the 27 women with bipolar disorder likely to have been included in the study, 15 women with schizophrenia (19 %) and 1 woman with bipolar disorder (4 %) refused immediately when asked to participate in the investigation. The samples consisted therefore of 64 schizophrenic patients (mean age = 34.3 years, min. = 18, max. = 45) and 26 with bipolar disorder (mean age = 32.7 years, min. = 18, max. = 44). The mean age at first hospitalization was 26.9 years (min. = 14, max. = 41) for schizophrenics and 28.2 years (min. = 16, max. = 43) for subjects with bipolar disorder. The duration of the two types of disorder was not too different. On the other hand, the patients whose accumulated periods of hospitalization amounted to less than 6 months accounted for 36 % of the patients with schizophrenia and 65 % of those with bipolar disorder. At the time of the interview, the proportion of inpatients was 52 % of the schizophrenic group and 50 % of the bipolar disorder group. The diagnosis of the mental disorders was based on DSM-III-R criteria for bipolar disorder and schizophrenia (paranoid 34 %, disorganized 16 %, undifferentiated 36 %, residual 14 %), and was made by the patients' usual psychiatrist and the authors. In addition, the positive and negative syndrome scale (PANSS) described by Kay et al. (1987) and the criteria for schizophrenia with deficit syndrome described by Carpenter et al. (1988) were used (28 % of the schizophrenic group). The usual psychiatrists asked their patients if they would agree to be interviewed by a clinician on "several aspects of their sex life". The data were collected in semi-structured interviews (lasting for more than 1 h) all conducted by the same psychiatrist (J. M. Darves-Bornoz). For the schizophrenics, the interviews took place as soon as they could answer questions, and patients in the bipolar group were interviewed at the end of pathologic episodes or during intercritical periods. The questionnaire included about 250 questions concerning sociodemographic and clinical elements (approximately 60 % of the questions), sex life (25 %) and sexual victimization (15 %).

In order to be consistent with our aim, relatively severe sexual abuse in childhood and rapes in adulthood were noted. Sexual abuse in childhood (before the age of 16 years) may be classified according to three levels of severity (Russell 1983; Wyatt 1985). A first level is constituted by sexual abuse without body contact: telephone calls, presentation of pornographic pictures, proposition of sexual intercourse, exhibitionism, etc. As the most severe sexual abuse was to be studied, this was not retained. A second level is constituted by sexual abuse including body contact with the perpetrator: touching, fondling, masturbation of the perpetrator, participation in pornographic scenes, etc. – referred to from now on as "level 2". The third level of sexual abuse is constituted by rape and attempted rape, i.e. sexual penetration or attempted penetration – referred to below as "level 3". The first screening question concerning sexual abuse was: "were you ever a victim of sexual abuse when you were a child or an adolescent?" The sexual relationships of consenting girls when they were 13 years of age or older were not included, though legally consent does not exist before 16 years. A particular case is intra-family sexual abuse. What is involved here is less the prohibition of marriage and sexual relationships with this or that relative, but more the added trauma caused by sexual assaults perpetrated by people who are supposed to be protectors and not aggressors.

Rape in adulthood (from 16 years) is sexual penetration against the will of the woman. Rape is not the only type of sexual assault in adulthood but it is the most severe. The present rape statistics did not include, for instance, attempted rape. Therefore, these statistics represented an indicator of serious sexual victimizations and were not an exhaustive inventory of sexual assaults. The first screening question raising this topic was: "were you ever a victim of rape?".

Table 1 Sexual abuse in childhood or adolescence (before 16 years)

Sexual abuse in childhood	Schizophrenics ($n = 64$)		Bipolars ($n = 26$)		General population[a]	
	n	[%]	n	[%]	Russell (1983) [%]	Wyatt (1985) [%]
Without answer	–	–	1	4		
Level 2 (body contact)	11	17	3	12	21	29
Level 3 (penetration or attempt)	12	19	4	16	17	16
Total	23	36	7	28	38	45
Intra-family abuse	12	19	4	16	11	13
Extra-family abuse	11	17	3	12	27	32
Age of child at first sexual abuse						
< 13 years	18	28	4	16		Peak at
13–16 years	5	8	3	12		± 9 years

[a] The results of Russell and Wyatt in the general population include abuse up to the age of 17 years

Results

Sexual abuse in childhood or adolescence (before 16 years)

Sexual abuse in childhood or adolescence at levels 2 and 3 are presented in Table 1, which shows the number of patients who were victims (once or several times) and not the number of incidents of sexual abuse. If several incidents had occurred, the victim was classified according to the highest level of severity. Table 1 integrates the results of two reference studies conducted in the general population by Russell (1983) and Wyatt (1985). Methods analogous to theirs were used (interviews lasting for more than 1 h, analogous classification of abuse). Unfortunately, there are no equivalent French data. Indeed, even Spira et al. (1993), who studied rape and verbal assaults, did not look for the other types of sexual abuse in childhood.

Thirty-six percent of schizophrenics ($n = 23$) and 28 % of patients with bipolar disorders ($n = 7$) were victims of sexual abuse in childhood (levels 2 and 3). Among these assaults, three were rape with vaginal penetration: one schizophrenic (aged 14 years with a stranger) and two bipolar disorder patients (aged 13 years with a grandfather for one and aged 15 years with a stranger for the other). These rates may appear high (in both groups), but they were not significantly different from each other and were not significantly different from the general population figure of 33 % according to Sheldrick (1991).

In both clinical groups, intra-family sexual abuse represented approximately half of the sexual abuse (vs 30 % in both reference investigations in the general population). Daughter-father incest was reported once (without any penetration attempt, i.e. level 2, in one schizophrenic). Level 2 intra-family sexual abuse (body contact) was reported by three subjects (12 %) with bipolar disorder: one brother, one cousin and one great-uncle, and by eight subjects (13 %) with schizophrenia: in addition to the father mentioned above, two grandfathers, two uncles, two brothers and one stepfather were reported. Level 3 (penetration or attempted penetration) abuse was reported by one subject (4 %) with bipolar disorder: a grandfather, and by four subjects (6 %) with schizophrenia: one grandfather, one uncle, one brother and one assault by both a sister and a cousin.

Table 2 presents some clinical manifestations associated with sexual abuse before the age of 16 years. The data suggest that in schizophrenics, the victims of such sexual abuse become psychiatric patients earlier. Indeed, if the schizophrenics are divided into two groups according to whether their first hospitalization occurred before the median age of 26 years ($n = 34$) or after ($n = 30$), the first hospitalization of victims of sexual abuse in childhood or adolescence was found to have occurred more often before 26 years than after. Furthermore, among the schizophrenics, the victims of sexual abuse in childhood or adolescence were significantly more subject to addictions (alcohol, drugs) – current or past, including dependence or abuse – than the non-victims. Self-destructive behaviour in the form of suicide attempts was more strongly represented in schizophrenics who were victims of sexual abuse before 16 years than in the non-victims. Lastly, it should be noted that women with schizophrenia who were victims of sexual abuse did not belong to productive subtypes any more frequently than the non-victims.

Sexual trauma after the age of 16 years

After this age, rape was the main type of sexual abuse that constituted a traumatic event. The prevalence of rape occurring after the age of 16 years was 22 % in women with schizophrenia and 15 % in those with bipolar disorder. Furthermore, it may be noted here that an incestuous sexual relationship occurred in adulthood in some subjects from these two clinical groups. These relationships were sometimes consented to but this con-

Table 2 Clinical manifestations and sexual abuse in childhood or adolescence (before 16 years) in women with schizophrenia (*S* significant, *NS* not significant)

Schizophrenics ($n = 64$)	Victimized before 16 years ($n = 23$)		Not victimized before 16 years ($n = 41$)		
Clinical manifestations	*n*	[%]	*n*	[%]	
First hospitalization before 26 years	16	70	18	44	S, $chi^2 = 3.89$, $P < 5\,\%$
Alcohol	10	43	8	20	S, $chi^2 = 4.19$, $P < 5\,\%$
Drugs[a]	11	48	8	20	S, $chi^2 = 6.32$, $P < 2\,\%$
Alcohol or drugs	13	57	12	29	S, $chi^2 = 4.60$, $P < 4\,\%$
Suicide attempt	18	78	21	51	S, $chi^2 = 4.53$, $P < 4\,\%$
Paranoid subtype	10	43	12	29	NS, $chi^2 = 1.32$
Non-deficit subtype	19	83	27	66	NS, $chi^2 = 2.05$

[a] One victimized woman did not answer

Table 3 Rape

Rape	Schizophrenics ($n = 64$)		Bipolars ($n = 26$)	
	n	[%]	*n*	[%]
Rape occurred once	6	9	6	23
Rape occurred several times	9	14	–	–
Total	15	23	6	23
Age when raped (first time)				
13–19 years	7	11	3	12
19–25 years	3	5	1	4
25–40 years	5	8	2	8
Intra-family rape	1	2	1	4
By whom? When?	Uncle, at 16 years		Grandfather, at 13 years	
Rape as first sexual act	4	6	2	8

sent did not make them innocuous. They were reported by three schizophrenics, i.e. 5 % (two level 3 incidents with cousins and one level 2 incident with the mother) and two patients with bipolar disorder, i.e. 8 % (one level 2 incident and one level 3 incident with brothers).

Rape before or after the age of 16 years

Rape deserves to be studied specifically, because it is the most severe sexual trauma. Therefore, Table 3 includes rapes occurring after 16 years also and the rarer instances occurring before 16 years and already mentioned for one women with schizophrenia and two women with bipolar disorder. The lifetime prevalence of rape appeared to be 23 % ($n = 15$) in women with schizophrenia and 23 % ($n = 6$) in those with bipolar disorder, while the prevalence in the general population for this age bracket may be estimated at 7 % or 8 % (Di Vasto et al. 1984; Winfield et al. 1990; Spira et al. 1993). Using the general population estimate of 8 %, comparison tests for the prevalence of rape among women with schizophrenia revealed the following: $chi^2 = 5.57$, $d.f. = 1$, $P < 2\,\%$, and for those with bipolar disorder (applying Yates' correction): $chi^2 = 6.11$, $d.f. = 1$, $P < 2\,\%$. Therefore, both these clinical populations were at risk for the occurrence of rape. Schizophrenics and patients with bipolar disorder (treated in the same departments) reporting rape were numerous and the level of frequency was about the same in both groups, but they were significantly more common than in the general population.

Schizophrenic women who were victims of rape were significantly more subject to addictions (alcohol or drugs) – current or past, and including dependence or abuse – than the non-victims ($n = 10$ vs $n = 15$, $chi^2 = 4.42$, $d.f. = 1$, $P < 4\,\%$). The group of schizophrenics whose accumulated periods of hospitalization exceeded 6 months ($n = 41$, mean age = 34.1 years, min. = 18 years, max. = 45 years) was more subject to rape than the other group ($n = 23$, mean age = 32.6 years, min. = 19 years, max. = 42 years). Indeed, there were 13 victims of rape in the first group and 2 in the second ($chi^2 = 4.35$, $d.f. = 1$, $P < 4\,\%$). This result suggests a significant link between the occurrence of rape and greater chronicity of the disorder. It should be noted that in schizophrenics, the rape victims did not belong to the paranoid subtype ($n = 5$ vs $n = 17$, $chi^2 = 0.01$, $d.f. = 1$) or to a non-deficit subtype ($n = 11$ vs $n = 35$, $chi^2 = 0.02$, $d.f. = 1$) any more often than the non-victims.

The repetition of trauma

The proportion of subjects affected by sexual abuse in childhood or adolescence, or by rape after 16 years was 47 % ($n = 30$) in schizophrenics and 35 % ($n = 9$) in patients with bipolar disorder. In 33 % ($n = 10$) of schizophrenics victimized in this way, the first trauma (sexual abuse in childhood or rape after 16 years) was followed by another extreme sexual assault (that is to say rape). A logistic regression (using the BMDP program) with the following variables: childhood abuse, disorder, chronicity (indicated by a total length of hospitalizations exceeding 6 months), experiences of prostitution, rape and repetition of rape showed that, all other variables being equal, the occurrence of a sexual abuse act in childhood was a risk factor for the subsequent occurrence of repeated rapes (odds ratio = 6.88, 95 % C.I. = 1.26–37.4, $P = 0.014$).

A logistic regression showed that there were two risk factors for chronicity: schizophrenic disorder (odds ra-

tio = 0.274, 95 % C.I. = 0.1–0.756, $P = 0.011$) and occurrence of rape (odds ratio = 3.63, 95 % C.I. = 1.12–11.8, $P = 0.021$). Table 3 confirms that schizophrenic women were at risk of rape (but no more than those with bipolar disorder) and, on the other hand, that the phenomenon of repeated rape was important in schizophrenic women (unlike bipolars). In women with schizophrenia who were victims of rape ($n = 15$), 60 % ($n = 9$) were affected by another rape, whereas in those with bipolar disorder ($n = 6$) no repetition occurred. This difference between these two clinical populations was significant (applying Yates' correction, $chi^2 = 4.08$, $d.f. = 1$, $P < 5\,\%$).

Eleven schizophrenic women (17 %) and 1 bipolar women (4 %) reported having had experience of prostitution ("receiving payment for sexual intercourse"). These experiences were repeated and regular for three schizophrenics (5 %), but occurred only once for the eight other women with schizophrenia and the one with bipolar disorder. Experiences of prostitution in women with schizophrenia only occurred in patients with more than 6 months total hospitalization, which makes the association with this group of the most chronic patients ($n = 41$) statistically significant (after Yates' correction, $chi^2 = 5.68$, $d.f. = 1$, $P < 2\,\%$). The experience of prostitution and the notion of repeated traumatic experiences may be related. Indeed, 10 of these 11 women with schizophrenia were previously victims of sexual abuse in childhood or adolescence, or of rape after 16 years ($chi^2 = 10.33$, $d.f. = 1$, $P < 1\,\%$). In addition, repetition of trauma and prostitution should be put into perspective along with the "risk-taking behaviours". Indeed, as mentionned above, some risk-taking behaviours (addictions, suicide attempts) were associated with the sexual victimization of women with schizophrenia.

Discussion

In order to establish firmly and to interpret the results we have presented, the credibility of the victims must be questioned and several types of explanatory factors put forward: family factors, social factors and individual factors.

The credibility of the victims

The prevalence of sexual victimization found in women with schizophrenia was consistent with that reported in two other publications (Friedman and Harrison 1984; Beck et al. 1987). These authors found rather higher rates for slightly different populations (only inpatients in their cases).

However, one important methodological issue concerns the bias of recall, possibly with a specific expression in psychotics. Before starting such a study, clinicians often express doubts about the reliability of the material that can be collected among such disordered people. Nevertheless, as soon as the work starts, the clinician realizes that interviews are of good quality, with good cooperation on the part of the patients and that, as Schneider has said, it is a "preconceived idea" to believe "that the psychiatric patient is not able to answer validly such delicate questions" (Schneider et al. 1964). In support of this point of view, the present results indicate that there is no statistically significant link between the presence of productive schizophrenia and the allegation of a sexual assault. Moreover, it must be underlined that in our investigation, the schizophrenic women (as well those with bipolar disorder) did not speak in of their victimization in querulous terms, thus weakening, in their case, the hypothesis of fantasies that have sometimes been put forward for other populations. In addition, the women with bipolar disorder were interviewed while in a stabilized psychological state, and thus for them delusional talk did not apply; yet they reported frequencies of sexual abuse and rape close to those of schizophrenics. Lastly, the allegations of sexual assaults made by schizophrenics were at the same level of frequency (and even rather less frequent) than those found, for instance, by Bryer et al. (1987) in a population of all psychiatric inpatients. Thus, the problem of incorrect allegations of sexual assaults was no different for the schizophrenics than for the general population. Since it has not so far been possible to conduct any long-term prospective studies on the psychiatric outcome of sexual abuse victims, controlled retrospective studies in these clinical populations and in the general population retain their interest. Moreover, it should be noted that false allegations, if they exist, are marginal. Moreover, Herman and Schatzow (1987) have shown that 80 % of a sample of women reporting sexual abuse in childhood were able to back up their statements with confirmation from several sources. Deltaglia (1986) has also reached the conclusion that in judicial matters, 76 % of child testimonies concerning sexual abuse in childhood have a very high credibility.

Family factors

It must be pointed out that in the cases studied, father-daughter incest remained an exception, even if other types of intra-family sexual abuse existed. What emerges from the present study is that the prevalence of intra-family sexual assaults in schizophrenics is no higher than in other clinical groups and even in the general population.

Social factors

Findings of high assault rates do not necessarily mean that the side-effects of mental disorder that these victimizations may represent are ignored, focusing instead on the psychopathologic stigma left by victimization. For instance, it is known that not only schizophrenic

women, but women with bipolar disorder too, are vulnerable subjects in their social lives. Social factors (linked to the chronicity of the disorders and to the social drift that results from it), such as lack of safe housing and transportation or low income (or even homelessness and no income at all), themselves have an important role in exposure to the risk of sexual victimization. From this point of view, it should be noted that in our samples there were twice as many chronic patients in the schizophrenic as in the bipolar group, which may indicate a more severe form of mental disorder among the schizophrenics. Experiences of prostitution among schizophrenic women were generally of an occasional nature. They may also be considered as minor prostitution on the edge of other forms of venality. They were rarely organized by a third party (landlady, relatives). This practice did not seem ostentatious or to reveal psychopathic features; it testified rather to a great impoverishment in every sense of the word. It happens in psychiatric inpatient units more frequently than medical staff usually think. Chronicity is strongly associated with such practices. These experiences are not victimization proper, but neither are they free choice.

Individual factors

Among individual factors allowing an understanding of the present results, some were consequences that can be observed in all the victims whatever the nosological category with which they are connected in other respects. These transnosographic aspects concerned the tendency to repetition of trauma (including prostitution) and the tendency to addiction and suicide attempts. Such risk-taking behaviour could have an acquired organic basis (Van der Kolk et al. 1993). Women with schizophrenia seem particularly at risk for this repetition of trauma. Beyond the determiners shared by all victims, victims with schizophrenia develop their own reasons to repeat all kinds of trauma. From this point of view, it should be noted that the circumstances in which the rape of schizophrenic women occurs are not simple. Benoit and Bardet (1983), in a forensic psychiatric study, have emphasized how the pathologic attitude of a psychotic woman who was raped could lead the perpetrator of the rape to commit it: "she was looking strange and he thought she had smoked hashish; she was silent and he understood it as a sign of consent." We can impute the occurrence of several rapes of schizophrenic women from our sample to this type of mechanism, that is to say, to inappropriateness in interpersonal relations (enhanced sometimes by passivity in patients with deficit subtypes of schizophrenia). In such cases, the schizophrenic disorder itself becomes an individual factor that induces risk situations and explains the occurrence of sexual trauma.

Conclusion

It is likely that women with schizophrenia and bipolar disorder are not much more subject to sexual abuse in childhood than the general population. On the other hand, these two populations are populations at risk of rape that usually occurs at the end of adolescence or in adulthood. Sexual victimization is associated with risk-taking behaviour and repetition of traumas. The schizophrenics who were raped belonged mainly to the group of schizophrenics with the longest duration of hospitalization, that is to say, probably to the most chronically and severely ill group. This fact is partly the consequence and partly the cause of the psychological trauma to which they had been subjected. In adult schizophrenics, rape and prostitution appear to be primarily indicators of their social vulnerability, along with many other factors. Their flattened or inappropriate emotional expression creates risk situations, and because of a lack of coping skills, prevents them from protecting themselves.

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