

Psychiatric Diagnosis as a Risk Marker for Victimization in a National Sample of Children

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Research examining childhood abuse has shown an association between victimization and psychiatric diagnoses (e.g., posttraumatic stress disorder, depression). Historically, psychiatric diagnoses have been emphasized as a consequence of victimization, with less research examining if it also functions as a risk factor for further victimization, perhaps making diagnoses a general victimization risk marker. In addition, much of this research has emphasized particular types of victimization such as childhood physical or sexual abuse. Researchers have given less attention to other forms of victimization (e.g., peer victimization, witnessed violence) or a diverse victimization history. Using the Juvenile Victimization Questionnaire (JVQ) we surveyed parents and children between the ages of 2 and 17 using a random digit dial (RDD) methodology. We examined the relationship between a number of different forms of victimization (termed *poly-victimization*) in the preceding year and parent-reported lifetime psychiatric diagnosis. Results show that children with a psychiatric diagnosis have significantly higher rates of victimization than children without a psychiatric diagnosis. In addition, using logistic regression models, we find that psychiatric diagnosis was associated with increased risk for poly-victimization, conventional crime victimization, maltreatment, peer or sibling victimization, and witnessing violence, but not sexual abuse. The results highlight the need to consider psychiatric diagnoses as a risk marker for past and possible future victimization. In addition, the importance of obtaining a comprehensive and more diverse victimization history when working with children is highlighted.

Keywords: *victimization; child abuse; psychiatric diagnosis; Juvenile Victimization Questionnaire*

Research has shown that victimized children are reluctant to disclose victimization with many episodes of victimization, such as sexual abuse and violent crime, going unreported (Finkelhor & Dziuba-Leatherman, 1994; Finkelhor, Hotaling, Lewis, & Smith, 1990; Finkelhor & Ormrod, 2001). This occurs even when victimized children have had prior encounters with professionals that might have afforded opportunities to make disclosures, encourage reporting, or engage in prevention. In an effort to better serve children, it may be important to identify victimization risk markers and proactively inquire about victimization so as to help with disclosure, prevention, and intervention. Some of the more effective prevention programs, such as those aimed at preventing suicide or HIV infection function by targeting individuals who exhibit risk markers and providing them with preventive and intervention services (Centers for Disease Control, 2006; National Institute of Mental Health, 2003). We analyzed data from a national survey of child victimization to explore the utility of using psychiatric diagnosis as a risk marker given its relationship to victimization. A special feature of this analysis will be to expand the different types of victimizations associated with diagnoses beyond those more commonly studied, such as physical abuse, sexual abuse, and neglect.

There are a number of child behaviors associated with victimization including academic problems, behavioral difficulties, aggressive/delinquent behavior, sexualized or sexually risky behavior, substance use, and emotional difficulties (Finkelhor & Hashima, 2001). These behaviors, which are worrisome to parents, caretakers, and school personnel, are frequently the reason, independent of victimization, that children are referred to psychological services and receive a diagnosis. This is of note given that many assume that it is the disclosure of victimization that results in mental health services, when, in fact, victimization on its own is a rather infrequent reason for referral (Kopiec, Finkelhor, & Wolak, 2004). One reason why psychiatric diagnosis has been overlooked as a risk marker may be the tendency to view it primarily as an outcome of victimization (Boney-McCoy & Finkelhor, 1995b). However, many of the problem behaviors that a diagnosis designates can put a child at risk for victimization, making a diagnosis a risk factor as

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well as a consequence. In addition, a diagnosis may also be a good marker for other circumstances or adversities—from family problems to community disorganization—that may be correlated with victimization even if not causally related to it (Turner, Finkelhor, & Ormrod, 2007). As we will discuss, it may be the psychiatric symptomatology that is associated with the diagnosis that is the key issue. However, because our data are on reported diagnosis, we will use *psychiatric diagnosis* in this writing.

Another reason why psychiatric diagnosis may have been overlooked as a risk marker is that specific diagnoses are emphasized in their association with victimization, such as posttraumatic stress disorder (PTSD) or major depression (Briere, Woo, McRae, Foltz, & Sitzman, 1997; Kessler, Sonnega, Bromet, & Hughes, 1995). Overemphasizing particular diagnoses might blind service providers to the complex interplay of psychiatric diagnoses and victimization and overlook other diagnoses that are not commonly thought to be associated with childhood victimization. For example, attention deficit hyperactivity disorder (ADHD) is one of the most common diagnoses given to children (Barkley, 1998; Rowland, Lesesne, & Abramowitz, 2002; Staller, 2006), yet little research has focused on the association between this diagnosis and childhood victimization, with few works found that systematically examined the issue (Ford et al., 1999; Merry & Andrews, 1994). Another reason for considering psychiatric diagnosis as a risk marker is because it indicates that a child has been in contact with a trained professional who potentially might have access to resources that may prevent victimization. It is a potential marker that has some reliability, given that in today's environment, certain reliable and professionally evaluated criteria are required to obtain a diagnosis.

There is substantial literature supporting the association between psychiatric diagnoses and childhood victimization and abuse. Research has shown that victims of abuse exhibit higher rates of a variety of diagnoses, including PTSD, depression, anxiety disorders, and substance use disorders (Afifi, Brownridge, Cox, & Sareen, 2006; Kessler et al., 1995; Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000). Also, in a review of the literature, Veltman and Browne (2001) found a relationship between maltreatment and cognitive delays or low intelligence. Individuals in psychiatric populations also exhibit higher rates of abuse and victimization than is found in the general population (Briere et al., 1997; Mueser et al., 1998). Research examining diagnoses as a risk factor is more limited. In the research literature studying adults with a mental health diagnosis, substantial support has emerged indicating that those with a psychiatric diagnosis are at increased risk of interpersonal violence (Goodman et al., 2001; Teplin, McClelland, Abram, & Weiner, 2005; Walsh et al., 2003). Few have examined this in

children, although some have explored the possibility of psychiatric diagnosis such as oppositional defiant disorder (ODD), attention deficit disorder (ADD) and developmental delay as creating a susceptibility to various forms of victimization (Ford et al., 1999; Shea & Wiener, 2003; Strickler, 2001). Furthermore, some research has also highlighted how children with mental retardation have higher rates of certain forms of maltreatment and longer duration of maltreatment (Brown & Schormans, 2003).

There are a number of behavioral components associated with diagnoses that may make children susceptible to victimization because of their role in eroding protective qualities or increasing the possibility of risky behaviors or situations. Some examples include inattentiveness and impulsivity in ADHD; temper, volatility, and argumentativeness in ODD; avoidance and numbing in PTSD; and fatigue and difficulty concentrating in major depression (American Psychiatric Association, 1994). The complex interplay of victimization and diagnosis, with each playing the role of consequence and risk, supports the notion that psychiatric diagnosis merits attention as a victimization risk marker.

Much of the research examining the relationship between psychiatric diagnoses and victimization has emphasized the “big three” victimizations: physical abuse, neglect, and sexual abuse. For example, the American Professional Society on the Abuse of Children (APSAC) Handbook focuses on child neglect, physical abuse, sexual abuse, psychological maltreatment, and includes a chapter on “Child Abuse in the Context of Domestic Violence” (Myers et al., 2002). Although this has provided a valuable knowledge base for researchers and clinicians, it has not addressed other forms of witnessed victimization, peer and sibling violence, and conventional forms of crime that can also have a deleterious impact on children, perhaps leading these to be overlooked as research emphasis. Attention to the other forms of victimization such as peer assaults, sibling assaults, bullying, witnessed victimization, and property theft also merit attention, and research efforts have begun to provide evidence of their association with psychological distress and psychopathology (Boney-McCoy & Finkelhor, 1995a; Finkelhor, Ormrod, & Turner, 2007; Finkelhor, Turner, & Ormrod, 2006). In addition, researchers need to explore the association between psychiatric diagnosis and the experience of multiple forms of victimization. In the literature, there has been increasing interest in identifying and understanding those who experience multiple adverse and traumatic victimization (Leventhal, 2007). Some have referred to this phenomenon as *poly-victimization* (Finkelhor et al., 2007) or *multitype maltreatment* (Higgins & McCabe, 2001a, 2001b), terms that refer

to experiencing multiple different forms of victimization and/or abuse experiences. Others emphasize the concept of *complex trauma*, which is described as a more chronic and complicated victimization history (Herman, 1992). Part of the importance of shifting toward examining poly-victimization comes from recent research that indicates that experiencing multiple forms of childhood victimization is a stronger predictor of psychological distress than any one particular type of victimization (Finkelhor et al., 2007; Turner, Finkelhor, & Ormrod, 2006; Vranceanu, Hobfoll, & Johnson, 2007). It is this group of highly victimized children who may be most likely to have diagnoses and therefore be of particular importance to be identified by clinicians and service providers. In addition, the notion of poly-victimization allows practitioners to better understand the overall victimization picture, rather than emphasizing a single trauma, such as sexual or physical abuse. Finally, it is this pattern of chronic victimization that underlies the importance of diagnosis as a victimization risk marker, rather than simply focusing on a particular causal relationship between victimization and diagnosis.

This article aims to tackle two key components that have been discussed. First, it will examine the association between victimization and psychiatric diagnosis as a way of indicating the importance of diagnosis as a risk marker for victimization. Second, we will emphasize the importance of examining a more diverse range of victimizations, beyond the more commonly studied forms of abuse.

Methods

Participants

Participants for this study were individuals who participated in the Developmental Victimization Survey (DVS), a national telephone sample concerning the experiences of children ages 2 to 17. The first wave of the DVS was a survey conducted from December 2002 to February 2003, which assessed the victimization experiences of a nationally representative sample of children between the ages of 2 and 17 years. The total sample from the DVS was 2,030 children.

Measures

Demographic questionnaire. Background information on child and household characteristics, including child age, gender, ethnicity and race,

family structure, measures of socioeconomic status, and the character of residential locale, was obtained in an initial parental interview.

Psychiatric diagnosis. Parents were asked if their child had ever been diagnosed by a doctor, therapist, or other professional with any of nine different types of disorders. Of the nine disorders, those of interest for this analysis were ADHD, ODD/conduct disorder (CD), depression, PTSD, anxiety disorders (other than PTSD), learning disorders, and mental retardation. Because of the emphasis on psychiatric diagnoses that have been associated with victimization in the research literature, autism was not counted toward diagnosis.

Juvenile Victimization Questionnaire (JVQ). The JVQ is an instrument developed by Hamby, Finkelhor, Ormrod, and Turner (2004) that allows for a comprehensive evaluation of childhood victimization. The instrument covers five general areas of victimization: Conventional Crime, Child Maltreatment, Peer and Sibling Victimization, Sexual Assault, and Witnessing and Indirect Victimization. These areas are assessed by asking about 34 forms of offenses, which are the "screener" questions asking whether the event occurred or not in the past year. Each of these screeners has follow-up questions, asking about the perpetrator(s), weapon use, injury, and whether it was in conjunction with one of the other events asked about in the survey. For the purposes of this analysis, the items that asks about statutory victimization and dating violence were not included because it was only asked of children who were 12 years of age or older. The JVQ has shown acceptable psychometric properties with an alpha of .80 and overall test-retest reliability kappas averaging .59, with the average kappa for the child self-report version being .63 (Finkelhor, Hamby, Ormrod, & Turner, 2005). Validity has been supported by moderate correlations between victimization and trauma symptoms (Finkelhor, Hamby, et al., 2005).

Procedures

The participants were contacted using random-digit dial (RDD) telephone survey methodology, and the survey was conducted by an experienced survey research firm using a Computer Assisted Telephone Interview (CATI) system. Initially, an adult caregiver (usually a parent) responded to questions about family demographic information. After that, one child was randomly selected for the interview by choosing the child with the most recent birthday. For children between the ages of 2 and 9, the caregiver "most familiar with the child's daily routine and experiences" was interviewed, whereas children

ages 10 and older self-reported on their experiences. In the case of a child interview, consent was obtained from both the parent and the child prior to the interview. In evaluating the JVQ, there is no evidence to support that parents were poorer reporters than children (Finkelhor, Hamby, et al., 2005). Respondents were promised complete confidentiality, and were paid \$10 for their participation. Interviews were completed with 79.5% of the eligible persons. Children or parents who disclosed a situation of serious threat or ongoing victimization were recontacted by a clinical member of the research team, trained in telephone crisis counseling, whose responsibility was to stay in contact with the respondent until the situation was resolved or brought to the attention of appropriate authorities. All procedures were authorized by the Institutional Review Board of the University of New Hampshire. Detailed description of the data collection procedures can be found in Finkelhor, Hamby, et al. (2005).

Analysis Strategy

Prior to conducting the main analysis, the data was examined to determine if diagnoses should be analyzed separately or collapsed together. The diagnoses of interest were ADHD, ODD/CD, depression, PTSD, anxiety disorders (other than PTSD), learning disorders, and mental retardation. The review suggested that diagnoses should be grouped together and a variable simply designate child as *diagnosed* and *not diagnosed*. The decision was based on the fact that the cell sizes were very small for certain individual diagnoses (e.g., $n = 3$ for PTSD, $n = 8$ for ODD/CD).

Previous analysis with this data established the concept of poly-victimization, which came from research examining victimization in this national sample (Finkelhor et al., 2007). Poly-victimization refers to the children who experienced an above-average number of different forms of victimizations (four or more) within the past year. For the purpose of some of the subsequent analyses, children were divided into *poly-victim* and *not poly-victim* categories.

The main statistical analysis was a 2 (diagnosis) x 2 (gender) analysis of covariance (ANCOVA) controlling for age and socioeconomic status (SES) with number of different types of victimizations (i.e., the sum of JVQ "screeners") as the dependent variable. In addition, chi-square tests were conducted to compare rates of victimization between children with and without a diagnosis. Logistic regression models were then conducted to examine the relationship between diagnosis and victimization including poly-victimization, conventional crime, maltreatment, peer/sibling victimization, sexual victimization,

and witnessed victimization, and provide subsequent odds ratios (OR), while controlling for gender, age, SES, and race/ethnicity. For events that have a high base rate, as was the case for many of the different victimization types, ORs, which indicate the relative odds of an event (victimization) given a particular condition (diagnosis), do not accurately represent the change in risk (Zhang & Yu, 1998). The risk ratio (RR; also known as relative risk), which computes the probability of an event given a condition, is a more accurate indicator of change in risk. The main difference between the two statistics is that risk ratios take into account the base rate (or frequency of occurrence) of a particular event. This means that in a positive relationship ($OR > 1$) ORs will overestimate the risk and underestimate the risk in negative ($OR < 1$) relationships (Zhang & Yu, 1998). Hence, the ORs for mental health diagnosis were converted to RRs to better illustrate the associated risk between mental health diagnosis and the different forms of victimization.

Results

Descriptives

The total number of participants was 2,030 children between the ages of 2 and 17 years of age. Average age was 9.5 years of age, with the sample evenly split between girls (49.7%) and boys (50.3%). The study sample was primarily Caucasian (75.7%), followed by African American (10.8%), and Latino/Hispanic (8.9%). Of the total sample, 274 (13.5%) children had received at least one of the identified mental health diagnoses at some point in their lives. The two most frequently reported diagnoses were ADD/ADHD, which was reported by 51.5% of the diagnosed group followed by learning disorders reported by 45.3% of the diagnosed group. Detailed demographic data are presented in Table 1.

Diagnosis Group Differences

Results of the 2 (diagnosis) \times 2 (gender) ANCOVA indicated that children who had a mental health diagnosis (mean [M] = 3.60, standard deviation [SD] = 3.67) had a significantly higher number of victimizations than children without a diagnosis ($M = 2.21$, $SD = 2.70$), $F(1, 2024) = 27.99$, $p < .001$. Neither the main effect for gender, nor the diagnosis by gender interaction was significant.

Table 1
Sample Descriptives

Variable	Full Sample	Psychiatric Diagnosis	No Diagnosis	<i>t/χ²</i>
Total <i>N</i>	2,030	274	1,756	—
Age	9.5	11.6	9.2	7.78***
Gender (% female)	49.7	32.5	51.6	25.87***
SES (<i>z</i> score)	0.01	-0.2	0.05	4.40***
Ethnicity/race (%)				
Caucasian	75.7	79.9	75.0	3.12
African American	10.8	8.9	11.2	1.96
Latino/Hispanic	8.9	7.3	9.2	1.02
Other	3.5	3.7	3.5	0.02
Psychiatric diagnoses (<i>n</i>)				
Any diagnosis	—	274	—	—
PTSD	—	10	—	—
ODD/CD	—	23	—	—
Anxiety disorder	—	30	—	—
Depression	—	57	—	—
ADD/ADHD	—	141	—	—
Learning disorder	—	124	—	—
Mental retardation	—	32	—	—
Two or more diagnoses	—	92	—	—

Note: SES = socioeconomic status; PTSD = posttraumatic stress disorder; ODD/CD = oppositional defiant/conduct disorder; ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder.

* $p < .05$. ** $p < .01$. *** $p < .001$.

In examining each of the different types of victimization, children who have a mental health diagnosis have a significantly higher rate of various victimizations across the five victimization categories. Table 2 presents the victimization rates for each of the JVQ questions for both groups.

Multivariate Models

Logistic regression models were conducted to examine the association between ever having a psychiatric diagnosis and the various victimization categories—poly-victimization, conventional crime, maltreatment, peer/sibling victimization, sexual victimization, and witnessing/indirect victimization—while controlling for demographic variables including age, gender, SES, and race/ethnicity. Results show that psychiatric diagnosis was significantly associated with poly-victimization (OR = 1.68, $p < .001$), conventional

Table 2
Victimization Rates by Psychiatric Diagnosis
for Each Victimization Type

Victimization Type	Victimization Rate (%)		
	Psychiatric Diagnosis	No Diagnosis	χ^2
Conventional crime	49.3	33.9	24.17***
Robbery	8.8	7.1	0.97
Personal theft	26.7	18.4	8.99**
Vandalism	19.9	12.8	10.16**
Assault with weapon	9.5	4.5	12.12***
Assault without weapon	26.0	15.1	18.98***
Attempted assault	18.5	6.6	43.86***
Kidnap	1.8	0.4	8.20**
Bias attack	2.2	1.5	0.77
Maltreatment	19.3	12.1	11.04***
Physical abuse	6.2	2.6	10.68**
Psychological/emotional abuse	13.9	9.6	4.90*
Neglect	2.9	1.3	4.16*
Custodial interference	1.8	1.3	0.60
Peer/sibling victimization	67.5	53.9	17.74***
Gang/group assault	3.7	2.0	3.00
Peer/sibling assault	50.6	39.4	12.16***
Nonsexual genital assault	8.5	4.3	8.91**
Bullying	21.8	21.0	0.09
Emotional bullying	37.4	22.4	28.37***
Sexual victimization	10.2	7.0	3.56
Sexual assault by known adult	0.4	0.3	0.05
Nonspecific sexual assault	0.0	0.3	0.94
Sexual assault by peer	1.5	0.9	0.94
Rape (completed/attempted)	2.2	1.9	0.08
Flashing/sexual exposure	5.5	3.1	4.11*
Verbal sexual harassment	6.0	4.3	1.42
Witness/indirect victimization	48.2	32.1	27.33***
Witness domestic violence	7.0	2.8	12.61***
Witness physical abuse	1.5	0.9	0.94
Witness assault with weapon	21.5	11.8	19.65***
Witness assault without weapon	35.7	23.5	18.56***
Burglary/household theft	11.7	8.8	2.40
Murder of family/friend	2.2	1.8	0.17
Witness to murder	0.4	0.3	0.05
Exposure to shooting/riots	6.2	4.5	1.53
Exposure to war	0.4	0.1	1.01
Any victimization	82.1	66.5	26.79***
Poly-victim	32.9	18.4	30.55***

* $p < .05$. ** $p < .01$. *** $p < .001$.

crime (OR = 1.57, $p < .001$), maltreatment (OR = 1.49, $p < .05$), peer/sibling victimization (OR = 1.76, $p < .001$), and witnessed victimization (OR = 1.38, $p < .05$). Mental health diagnosis was not significantly associated with sexual victimization (OR = 1.12, ns). Detailed regression results are presented in Table 3. For the significant relationships, the resultant RRs were 1.24 for poly-victimization, 1.21 for conventional crime, 1.19 for maltreatment, 1.26 for peer/sibling victimization, and 1.15 for witnessed victimization. Detailed risk ratio figures are presented in Table 4.

Discussion

The results supported an association between victimization and psychiatric diagnosis. Children who have had a diagnosis showed significantly higher levels of victimization than those without a diagnosis. This suggests that children with mental health diagnoses should be asked about experienced victimization, as they are likely to have a higher, and perhaps more consequential, victimization profile than other youth. This is not to assume that victimization is inevitable, as almost 20% of diagnosed children had no victimization of any kind. However, in the context of a thorough diagnostic assessment, it is clearly important to evaluate different forms of victimization as a way to better determine the therapeutic needs of the child.

What is more notable is that the differences in victimization were differences in number of different types of victimization. Hence, children with a mental health diagnosis had a larger number of different forms of victimization. This adds to some of the previous research that has emphasized particular types of victimization (e.g., physical or sexual abuse) or greater severity. This suggests that clinicians need to expand the range of victimizations they inquire about when working with children with psychiatric diagnoses. In the clinical arena, we not only need to be asking children about physical abuse, neglect, and sexual abuse, but also inquiring about victimization by peers and siblings, and conventional forms of crime. The JVQ was in part designed to help practitioners and researchers evaluate a greater range of victimization experiences. We also need to be attentive to the risk that diagnosed children are more likely to qualify as polyvictims who represent a group of highly victimized children, and may be simultaneously experiencing victimization on multiple fronts.

Interestingly, sexual violence, which has received substantial research attention, was not significantly associated with psychiatric diagnosis when controlling for demographic variables. There are a number of possibilities as

Table 3
Logistic Regression Models

Predictor	Dependent Variable (Victimization Type)					
	Poly-victim OR (95% CI)	Conventional Crime OR (95% CI)	Maltreatment OR (95% CI)	Peer/Sibling OR (95% CI)	Sexual OR (95% CI)	Witness OR (95% CI)
Age	1.14*** (1.11–1.17)	1.07*** (1.05–1.09)	1.06*** (1.03–1.10)	1.00 (.98–1.02)	1.25*** (1.20–1.31)	1.18*** (1.15–1.21)
Gender (female)	0.87 (0.69–1.08)	0.80* (0.67 - 0.97)	1.19 (0.91–1.55)	0.85* (0.71–1.01)	1.53* (1.08–2.17)	0.87 (0.71–1.06)
Caucasian	1.32 (0.73–2.40)	1.26 (0.80–2.01)	.99 (0.54–1.79)	1.20 (0.79–1.81)	1.50 (0.53–4.25)	0.83 (0.43–1.58)
African American	1.86 (0.95–3.63)	1.72* (1.01–2.92)	0.97 (0.48–1.95)	1.09 (0.67–1.76)	1.81 (0.58–5.67)	1.38 (0.68–2.79)
Hispanic	1.38 (0.68–2.77)	1.23 (0.71–2.13)	0.67 (0.31–1.44)	1.02 (0.67–1.76)	1.80 (0.56–5.78)	0.99 (0.41–2.40)
SES	0.95 (0.84–1.06)	0.98 (0.88–1.08)	0.83** (0.72 - 0.95)	1.12* (1.02–1.23)	0.91 (0.76–1.08)	0.83*** (0.75–0.92)
Psychiatric diagnosis	1.68*** (1.25–2.26)	1.57*** (1.20–2.05)	1.49** (1.05–2.11)	1.76*** (1.33–2.33)	1.15 (0.73–1.80)	1.38* (1.04–1.83)
Full model χ^2	138.59***	82.89***	40.00***	31.65***	128.53***	286.61***

Note: OR = odds ratio; CI = confidence interval; SES = socioeconomic status.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4
Psychiatric Diagnosis Odds Ratio (OR)
Conversion to Risk Ratios (RR)

Dependent Variable (Victimization Type)	Polyvictim RR (95% CI)	Conventional Crime RR (95% CI)	Maltreatment RR (95% CI)	Peer/ Sibling RR (95% CI)	Witness RR (95% CI)
Psychiatric diagnosis	1.24*** (1.11–1.37)	1.21*** (1.09–1.33)	1.19** (1.08–1.34)	1.26*** (1.14–1.38)	1.15* (1.04–1.28)

* $p < .05$. ** $p < .01$. *** $p < .001$.

to why there was no identified relationship between sexual abuse and diagnosis. Given the previous findings that have supported the association between sexual abuse severity and psychological distress (Briere & Elliott, 2003; Kendall-Tackett, Williams, & Finkelhor, 1993), it is possible that because sexual abuse severity was not evaluated, the sensitivity of this variable was

limited in being able to detect a relationship. Another issue, given the study sample, is that there is a low rate of reporting of sexual violence, particularly for younger children, possibly affecting the overall power for that particular aspect of the analysis (Finkelhor, Ormrod, Turner, & Hamby, 2005). In addition, the dichotomous nature of the data may have been more susceptible to the impact of underreporting in sexual victimization (Finkelhor et al., 1990). Finally, there is the issue of the source of the data given that diagnosis information was reported for all children by their parents, with the younger children also having the parents report their victimization, whereas the older children self-reported on victimization. This varying source of information may also contribute to the strength of association between diagnosis and victimization. Given the other issues associated with sexual victimization, it may be that these factors account for the lack of relationship rather than a real lack of association between sexual violence and mental health diagnosis.

Although not directly addressed in our analysis, an argument could be made that psychiatric diagnosis is just as much a result of victimization as it is a possible risk factor. The cross-sectional design does not allow us to make causal assumptions. However, individuals were asked about lifetime diagnosis history and victimization in the past year. Clinicians are likely to assume that psychopathology is a result of having been victimized, and they are often correct in making that assumption. However, this overlooks the possibility that a psychiatric diagnosis, and by association psychological distress, may make an individual more vulnerable to victimization. For example, children who have a diagnosis may be stigmatized, possibly resulting in assaults and bullying by peers. Also, certain symptomatology may erode protective qualities that lead to increased vulnerability or prevent children from avoiding risky situations. From a practical standpoint, the causal direction(s) of the diagnosis–victimization relationship is less relevant as it is clear that the presence of a diagnosis shows an increased risk for the presence of victimization. Taking that into consideration, recuperative and preventive efforts should be put in place when children have access to services from clinicians.

One limitation of the study is that the presence of a diagnosis was reported by the parents. No records were obtained, and no independent effort made to validate the diagnosis. It is probable that some parents did not recall diagnoses that had been given their children, particularly at an earlier time, and that parents may have reported diagnoses incorrectly, focused on only one particular diagnosis, or even diagnoses not made by properly trained professionals. Although validation from medical records might have been useful, these records also have limitations in their completeness and accuracy and would have been virtually impossible to obtain. Attempts to assess diagnoses with

diagnostic interviews are also problematic for a lifetime measure because many of the children may no longer be symptomatic. Another limitation is that we cannot be confident that the diagnosis preceded the victimizations, because not enough information was obtained to establish the temporal sequence of these events. However, given that the diagnosis was a lifetime measure and victimization pertained simply to the last year, we are inclined to believe that most of the diagnoses preceded most of the victimizations. Also, ADD/ADHD was the prominent diagnosis in this sample. Although this is consistent with general mental health diagnoses in children (Barkley, 1998; Rowland et al., 2002; Staller, 2006), it limits how sure we can be that the diagnosis–victimization relationship is consistent across diagnostic categories.

A final limitation in our analysis was our inability to examine individual diagnoses or individual symptoms. This would have made it possible to look at whether children with certain diagnoses had differential levels of victimization or tended to experience certain types of victimizations. Examining the data at the symptom level may have helped in evaluating the possibility that certain symptoms erode protective mechanisms or are particularly salient in the risk of being victimized. Future research with clinical or service-seeking populations would allow examination of differences across various diagnostic categories.

In spite of the mentioned limitations, it is clear that psychiatric diagnosis is associated with a more diverse victimization profile than has been previously recognized. The results highlight the need for clinicians to broaden their assessment of victimization in the context of a comprehensive diagnostic and mental health assessment, as well as recognize the potential risk of future victimization in youth experiencing these forms of mental health difficulties. Investigators should continue to work towards gaining a better understanding of the interplay between various forms of victimization and psychiatric diagnosis.

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