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Sexual Coercion and Abuse Among Women with a Severe Mental Illness in India: An Exploratory Investigation

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Abstract

Research from the west indicates that women living with a psychiatric disorder are particularly vulnerable to sexual coercion and abuse. However, there have been no published reports of sexual abuse among female psychiatric patients in India. This exploratory study sought (1) to determine the prevalence of sexual coercion in a representative sample of female psychiatric patients in India, (2) to identify clinical and sociodemographic correlates of sexual coercion, (3) to clarify the association between sexual coercion and human immunodeficiency virus (HIV)-related risk behaviour, and (4) to determine whether self-report of sexual coercion from these patients was recorded in their medical charts. Consecutive female inpatient admissions ($N = 146$) to a large psychiatric hospital in southern India were assessed using a structured interview and standardized measures. During structured clinical interviews, sexual coercion was reported by 30% of the 146 women. The most commonly reported experience was sexual intercourse involving threatened or actual physical force (reported by 14% of women), and the most commonly identified perpetrator was the woman's husband or intimate partner (15%), or a person in a position of authority in their community (10%). Women with a history of abuse were more likely to report HIV-related sexual behaviour ($p < .001$). In contrast to the 30% of women who reported sexual coercion during interviews, only 3.5% of the medical records contained this information. Thus, sexual coercion is a serious and prevalent concern among female Indian psychiatric patients, but is rarely reported in medical charts. Increased screening and reporting are indicated, as are sexual abuse prevention and treatment programs.

Keywords

Coercion; Sex Behaviour; Mentally Ill Persons; India; Women

Women living with a psychiatric illness often report that they have experienced sexual coercion or abuse. For example, Carmen et al.¹ reviewed the charts of 122 women receiving psychiatric care, and reported histories of abuse in 43% of these patients. Bryer et al.² found that 21% of 66 female patients reported sexual abuse, and 33% reported both physical and sexual abuse. Jacobson and Richardson³ compared the experiences of 100 male and female patients, and reported that 38% of women (but only 2% of men) reported abuse as an adult. Coverdale et al.⁴ found that abuse rates were higher among psychiatric patients compared to a matched sample of medical patients (28% versus 17%). Although these studies suggest a wide range of prevalence estimates (i.e., 21% to 43%), it is clear that women with a psychiatric disorder are particularly vulnerable to sexual coercion and abuse.

The variability in prevalence estimates might be explained, at least in part, by methodological differences across studies. Extant research has employed a variety of sampling strategies as well as different definitions of coercion and abuse, different developmental foci (i.e., childhood versus adult abuse), and use of medical records or patient charts versus more active surveillance approaches. Continued research is needed to increase awareness and enhance understanding of prevalence and determinants of sexual coercion among psychiatric patients in order to facilitate improved prevention and treatment efforts. Research is also needed to investigate the prevalence and correlates of sexual abuse among women in a wider range of social and cultural settings.

India is a large and populous country with a strong history of psychological and psychiatric research. Like their western counterparts, Indian women have struggled against traditional views in order to achieve increased freedoms and better access to health care; however, as in the west, sexual double standards and gender-based power imbalances still exist.⁵ And, despite India's strong scientific tradition, surprisingly little is known about the abuse experiences of female psychiatric patients. Our review of the literature revealed not a single published study on this topic. Recently, however, a few studies have provided estimates of the prevalence of sexual abuse among the general population of Indian women.

Patel and Andrew⁶ surveyed 811 high school students in Western India, and reported that one-third had experienced some form of sexual abuse and 6% reported coercive sex. Martin et al.⁷ sampled married men in North India in order to determine the prevalence of abuse in marital relationships. Of the 6,632 male participants, 22% reported sexual abuse of their wives without physical force, and 7% reported sexual abuse with physical force. Perhaps the limited research on sexual abuse in India reflects traditional cultural taboos, including the reluctance of women to discuss sexuality-related issues. Data regarding mentally ill women may be even more difficult to obtain because (a) mentally ill women often do not have access to proper family planning services, and (b) they may be less able (than psychiatrically healthy women) to communicate such potentially embarrassing and stigmatizing concerns owing to their illness. Regardless of the reasons for this lacuna, increased research on the topic is urgently needed.

The current study was designed to fill this gap in the literature. We conducted a hospital-wide screening of all women admitted into an inpatient psychiatric unit over a three-month period. All female patients were assessed to determine whether they had experienced sexual coercion as an adult. Sexual coercion was defined as the use of physical force or threat of force, emotional abuse, or financial incentives to result in sexual behaviour. The study had four objectives: (1) to determine the prevalence of sexual coercion, (2) to identify clinical and sociodemographic correlates of sexual coercion, (3) to clarify the association between sexual coercion and HIV-related risk behaviour, and (4) to determine whether self-report of sexual coercion from these patients was recorded in their medical charts.

Methods

Participants

Participants were 146 female inpatients admitted for treatment at the National Institute of Mental Health and Neurosciences (NIMHANS) hospital located in Bangalore, South India. NIMHANS is a 600-bed state psychiatric teaching hospital. Patients come to the hospital directly from urban, semi-urban, and rural areas of South India, or through referrals from other states of India. All women admitted between 25th September and 31st December 2001, ($n = 258$) were eligible. However, women who stayed in the hospital for less than a week ($n = 61$) and those who were too psychiatrically ill to be interviewed ($n = 47$) were excluded from the study. Of the 150 patients who were admitted and eligible, only 4 declined our invitation to participate; thus, 146 female patients participated.

Measures

Sexual Experiences Survey⁸—The SES is a 10-item instrument designed to identify instances of sexual aggression and victimization. The SES assesses coercive experiences ranging from unwanted sexual play to forced penetrative sexual acts in a progressive sequence. The SES is internally consistent ($\alpha = 0.74$), and stable (test-retest agreement rate between two administrations one week apart was 93%).⁹ The validity of the SES has also been demonstrated.⁹ In addition to the 10 items, age at which the coercive experience occurred was recorded to ascertain whether the coercion occurred in childhood (below 16 years of age), adulthood, or both.

Psychiatric status and history—A systematic review of the medical records provided the following information: *International Classification of Diseases (ICD)-10*¹⁰ diagnosis for the psychiatric and substance abuse or dependence conditions (made by two qualified psychiatrists), total duration of illness, and number of previous psychiatric admissions.

Sociodemographic information—Chart and interview were used to obtain information regarding age, place of residence (rural, semi-urban, or urban), living arrangement, marital status, education, income, and employment status.

Alcohol Use Disorders Identification Test¹¹—The AUDIT is a widely used 10 item screening measure designed to identify drinkers at risk for alcohol abuse and dependence. AUDIT scores range from 0 – 40 and correlate with other widely used screening tests.¹² A score of >7 identifies persons at higher risk for alcohol abuse in psychiatric settings.¹³

Drug Abuse Screening Test¹⁴—The DAST-10 is a short version of the 28-item DAST, designed to identify drug-use related problems in the previous year. The DAST-10 is internally consistent ($\alpha = .86$), temporally stable (intraclass correlation coefficient = .71), and able to discriminate between psychiatric outpatients with and without current drug abuse/dependence diagnoses.¹⁵ Sensitivity and specificity with this population are optimised with a score of > 2.¹³ The DAST score orders individuals along a continuum with respect to the risk of problems related to drug use.

HIV-Risk Screening Instrument¹⁶—The HSI contains 10 items that assess HIV-related risk; the HSI is internally consistent (Kuder-Richardson-20 coefficient = .73) and able to discriminate between low- and high-risk groups. Minor modifications were made to the HSI to make it more appropriate to the Indian context. A score of zero reflects low-risk, whereas a score of one or more reflects possible risk for HIV infection. Given the purposes of this study (and to allow us to compare our findings with previous research conducted before the HSI was available), we expanded the time frame assessed to include the past year as well as lifetime risk behaviour.

Procedures

The study had three phases: recruitment, assessment, and (post-discharge) chart review.

Recruitment—Female inpatients were approached by one of three women research staff who had extensive training in sexual health assessments. The nature of the investigation was explained, including assurances of confidentiality, and patients were invited to participate; those women who consented were scheduled for an in-depth assessment.

Inpatient assessment—The assessments were conducted after patients had stabilized psychiatrically. These assessments were implemented primarily as individual interviews conducted by one of three women assessors. Each assessor administered the SES, AUDIT,

DAST, and HSI as a structured interview, and also confirmed sociodemographic information. Each patient was also rated by the interviewer on DSM-IV Global Assessment of Functioning Scale (GAF).¹⁷ At another occasion; the assessor reviewed the medical record in order to obtain the psychiatric history information.

Given the sensitive nature of the study, the interviews were conducted only by women researchers in view of cultural taboos regarding talking about sexual matters to men among Indian women. In addition, all interviewers had undergone training in sexual interviewing, specifically in assessing abuse and coercion. They had also been trained to handle emotional reactions to disclosure. Finally, ongoing supervision was provided by the first author whenever there were clinically significant emotional reactions related to disclosure regarding abuse or coercion.

Post-discharge chart review—Medical records of those women who reported sexual abuse were reviewed following their discharge to determine if sexual coercion or abuse had been noted and recorded by the treating team. This review was done with the purpose of checking if chart review would have provided equivalent documentation of the prevalence of sexual coercion experiences.

Data Analysis

Data were entered and analysed with SPSS 7.5. Summary statistics were calculated to describe the sample. Data analyses included Chi-square, independent sample *t*-, and *z* tests for proportions to identify associations between sexual coercion and hypothesized sociodemographic and clinical correlates.

Results

Participant Characteristics

Participants ranged in age from 18 to 57 years ($M = 31.6$ years, $SD = 10.2$). The majority (54%) were currently married, 11% were separated or divorced, 8% were widowed, and 26% were not married; 66% reported having children. Most women lived in their own apartment or home (53%) or with their families (38%). Women came to the hospital from urban (42%), semi-urban (16%), and rural (41%) settings. Nearly all described themselves as Hindu (88%). Approximately 19% of them had no formal education, 23% had a primary education, 30% had a high school education, and 27% reported some college education. Most of the women described themselves as homemakers (51%) or as unemployed (27%). The average household income of the women was equivalent to \$89 (US) per month; average personal income was \$10 per month. The women were being treated for a variety of psychiatric disorders, including schizophrenia-spectrum disorders ($n = 57$, 39%), bipolar disorder ($n = 39$, 27%), major depression ($n = 29$, 20%), or other disorder ($n = 21$, 14%). Diagnosis with alcohol or other substance use diagnoses was infrequent ($n = 3$, 2%), and scores on the DAST and AUDIT were also low (M s = 0.0 and 0.5, respectively). GAF scores ranged from 9 to 90 ($M = 46.5$, $SD = 16.8$), suggesting that most of the women were moderately to severely impaired. Approximately 37% ($n=54$) of the patients reported a previous psychiatric admission; the average age of disease onset was 26.2 years ($SD = 8.9$ years) whereas the duration of illness ranged from 0.3 to 336 months ($M = 65.7$, $SD = 73.3$).

Substance use was infrequent in this sample. None of the women smoked cigarettes, only 1 smoked *beedis*, but 35 (24%) chewed betelnut. Of the 10 women (7%) who reported alcohol use, four drank less than once per month, one drank 2-4 times per month, three drank weekly, and two drank almost daily. Seventy-two percent of the women had been sexually active in the

past 10 years, but only 55% in the last year; however, 21 women (14%) reported high-risk sexual behaviour on the HSI.

Prevalence of Sexual Coercion

Sexual coercion was reported by 43 (30%) of the 146 women. Of these 43 women, 10 (7%) reported child sexual abuse, 23 (16%) reported adult sexual coercion, and 10 (7%) reported both. The prevalence and frequency of different forms of coercive sexual experience are indicated in Table 1. The most commonly reported experience involved sexual intercourse involving threatened or actual physical force (item # 9 in Table 1), which was reported by 21 (14%) of the sample. Involuntary intercourse resulting from continual argument or pressure (item # 6) was also commonly reported (11% of women). These events were not isolated incidents, and occurred more than 4 times for the majority of women reporting these experiences (see third column of Table 1). Sex play (non-penetrative but unwanted sexual activities; items # 1 and 3) were also common, with 12% of women reporting such events, as were unwanted and interrupted incidents of penetrative sex (item # 4), which was reported by 7% of the sample.

Women reported that they experienced abuse most commonly from (a) their husband or intimate partner (22 women, 15%), (b) a person in a position of authority in their community (e.g., house owner, village chief, teacher, religious leader, employer; 14 women; 10%), (c) a relative other than their husband (e.g., uncle, brother-in-law; 12 women, 8%), (d) a stranger (7 women, 5%), or (e) an acquaintance (4 women, 3%). As reflected by these data, some women reported abuse from more than one perpetrator.

Correlates of Sexual Coercion

To identify the correlates of sexual coercion, we divided the sample into two groups according to whether the women had ($n = 43$) or had not ($n = 103$) reported sexual coercion. These two groups were compared on the sociodemographic, psychiatric, substance use, and sexual risk variables listed in Table 2 using Chi-square, t test, and z test for proportions, as appropriate. Reporting a history of sexual coercion was not associated with any of the sociodemographic, psychiatric, or substance use variables listed in Table 2.

In a second set of exploratory analyses (Table 3), participants who had reported coercion were sub-divided into two groups depending on the severity of sexual coercion. Severity was determined using Koss's criteria with severe coercion indicated by endorsement of penetrative activities (i.e., forced intercourse/rape; items # 6-10 in Table 1) and less severe coercion indicated by non-penetrative sexual contact/attempted rape (items # 1-5 in Table 1). The only significant difference between the two groups was that women who reported more severe coercion were more likely to be diagnosed with a Bipolar disorder (52% versus 19%; $p = .02$).

Sexual Coercion and HIV-Related Risk Behaviour

Comparison of the women who reported coercion with those who did not indicated that abused women were more likely to report high-risk sexual behaviour for all three reporting intervals (lifetime: 40% vs. 4%, $p = .006$; ten years: 40% vs. 3%, $p = .005$; one year: 26% vs. 1%, $p = .022$; see Table 2, bottom). When the abused sub-sample was divided into severe versus milder coercion experiences and compared, those who reported severe coercion also had higher prevalence of HIV-related risk behaviour for all three reporting intervals than those who reported relatively milder coercion (lifetime: 56% vs. 12%, $p < .001$; ten years: 56% vs. 12%, $p = .004$; one year: 37% vs. 6%, $p = .017$; see Table 3, bottom).

Concordance Between Self-Report and Medical Records

Of the total of 43 participants who reported having undergone coercive sexual experiences, 40 case records were available for review. Among these records, only 5 (13%) mentioned that the patient had undergone sexual abuse or coercion.

Discussion

This study provides the first report of sexual abuse/coercion among female psychiatric patients in India. Structured interviews of women admitted to an inpatient psychiatric hospital in southern India indicated that 30% reported a history of sexual abuse/coercion. The prevalence of coercive sexual experience reported by women in the present study corroborates reports from other psychiatric settings in the west,¹⁻⁴ and provides additional evidence that sexual trauma frequently co-occurs with psychiatric illness for women.

Three additional findings were further troubling. First, the most commonly reported experience, reported by 14% of the sample, was sexual intercourse involving physical force. Second, the women in this sample tended to be victimized on several occasions, and abusive events occurred more than 4 times for the majority of abused women. Third, nearly 50% of women who reported coercive experiences attributed it to their spouse/partner. Collectively, these findings suggest a pattern of abuse that is severe, persistent, and difficult to avoid, increasing the likely traumatic effects for the victim.

Our findings are consistent with the limited previous data collected in India, particularly those obtained by Martin et al⁷ who reported a high prevalence of marital coercion including that associated with physical abuse in a survey of married men in the general population of a North Indian city. Martin et al. also found a high prevalence of HIV-related (risky) sexual behaviour among husbands who sexually abused their wives – a result that matches our finding of high-risk sexual behaviour being more common among female patients who reported coercion. Other studies have also reported a higher prevalence of risky sexual behaviour among women with history of sexual coercion or abuse.¹⁸ Indeed, it is increasingly recognized that most women infected with HIV became infected through heterosexual intercourse with their primary partner.¹⁹ This is true in African countries²⁰, the United States²¹, and India.^{22, 23}

Although several studies have reported a high prevalence of sexual abuse as a child in the psychiatric population, only a few studies have focused on adult sexual coercion. Adult coercion in women with a severe mental illness likely reflects vulnerability, poor negotiation skills, and lack of control over sexuality in these women.²⁴ Adult coercion was more commonly reported in our sample compared to childhood sexual abuse. However, we hypothesize that there may be under reporting of sexual coercion in our participants due to cultural reservations about reporting sexual experiences, memory difficulties, emotional reasons precluding disclosure, and illness-related factors (e.g., presence of psychotic symptoms, pharmacotherapy and/or cognitive dysfunction).¹⁸

Analyses completed to identify potential correlates of sexual coercion yielded few significant results. Other than the fact that abuse comes most often from an intimate partner/spouse, there were few indications that would clarify which women are at the greatest risk. Although substance use can often place women in particularly vulnerable situations, the level of alcohol and other drug use in this sample of women was low. Thus, no relationship was observed. Our finding that severe coercion was more common among women with a bipolar disorder may have clinical significance, and warrants further study. However, we hasten to add that, based on the constructs that we assessed, it appears that all women living with a severe mental illness are vulnerable to sexual coercion, and there are precious few psychiatric or demographic characteristics that seem to increase their vulnerability. This conclusion is consistent with the

notion that poverty, gender inequities, and disempowerment of women are universal risk factors for sexual vulnerability.²⁵

Comparison of the information that we obtained during interviews, and the patient's medical charts was alarming. Our results indicate that a majority of the case files had no mention of patients' coercive sexual experience. Because a much larger number of patients reported abuse during a clinically sensitive interview, our findings document the likelihood of under-recognition of sexual coercion and abuse, and indicates the need for routine but sensitive inquiry, consistent with the findings and recommendations of other investigators.^{3, 4}

Several methodological strengths of this study enhance confidence in the findings obtained. An important strength of the study is that nearly all women who were admitted to the inpatient ward were screened, eliminating the possibility of a self-selection bias. Second, the women belonged to a heterogeneous group and were not predominantly low income or homeless. This increases the generalisability of the study. Third, we used structured and psychometrically validated assessment instruments to assess sexual coercion, high-risk sexual behaviour, substance use, and current psychiatric functioning.

Our results also should be interpreted mindful of its limitations. One limitation is that women who were too psychiatrically ill could not be interviewed; we are concerned that these women may be even more vulnerable to sexual coercion due to their greater impairment, but this hypothesis requires further study. Second, as in all cross-sectional and retrospective studies, it is impossible to draw causal inferences, and it is possible that self-reported information is distorted by the frailty of human memory. It is our view that the self-reports in this study probably underestimate the true prevalence of sexual coercive experiences.

In conclusion, the results of this study indicate that coercive sexual experiences occur to a significant percentage of psychiatrically ill female patients. These findings emphasize the need for immediate attention to this problem. Clinicians need to be trained in identification and recording of sexual coercion. There is also a need to develop and evaluate preventive interventions to help women to protect themselves from sexual coercion, and rehabilitative interventions to help women who have already experienced such coercion.

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Table 1

Prevalence and Frequency of Sexually Coercive Experiences

	Prevalence (N = 146)	Fewer than four occasions	Four occasions or more
1. Given into sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?	18 (12%)	9 (21%)	9 (21%)
2. Had sex play (fondling, kissing, or petting but not intercourse) when you didn't want to because a man used his position of authority (boss, teacher, camp counsellor, supervisor) to make you?	14 (10%)	7 (16%)	7 (16%)
3. Had sex play (fondling, kissing, or petting but not intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down) to make you?	17 (12%)	8 (19%)	9 (21%)
4. Had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down), but intercourse <i>did not</i> occur?	10 (7%)	7 (16%)	3 (7%)
5. Had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by giving you alcohol or drugs, but intercourse <i>did not</i> occur?	3 (2%)	2 (5%)	1 (2%)
6. Given in to sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?	16 (11%)	4 (9%)	12 (28%)
7. Had sexual intercourse when you didn't want to because a man used his position of authority (boss, teacher, camp counsellor, supervisor) to make you?	9 (6%)	4 (9%)	5 (12%)
8. Had sexual intercourse when you didn't want to because a man gave you alcohol or drugs?	3 (2%)	0 (0%)	3 (7%)
9. Had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down) to make you?	21 (14%)	9 (21%)	12 (28%)
10. Had sex acts (anal or oral intercourse or penetration by objects other than a penis) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down) to make you?	4 (3%)	3 (7%)	1 (2%)

Table 2

Comparison of Patients Reporting History of Sexual Coercion to Other Patients

	Coerced (n = 43) M (SD) / n (%)	Not Coerced (n = 103) M (SD) / n (%)	$\chi^2/t/z$	p
Demographic Variables				
Age (yrs)	30.6 (9.8)	32.0 (10.3)	$t = .77$	ns
Residence			$\chi^2 = 1.48$	ns
Urban	21 (49%)	41 (40%)	$z = 0.57$	ns
Rural	17 (39%)	43 (42%)	$z = -0.19$	ns
Semi Urban	5 (12%)	19 (18%)	$z = -0.53$	ns
Marital Status (% currently married)	19 (44%)	60 (58%)	$z = -0.89$	ns
Occupation (% homemaker)	18 (42%)	56 (54%)	$z = -0.76$	ns
Education (years)	8.3 (4.6)	9.0 (5.2)	$t = 0.74$	ns
Annual Income (\$US) (household)	80 (107.4)	109 (193.4)	$t = 1.15$	ns
Annual Income (\$US) (personal)	8.92 (30.1)	10.4 (56.3)	$t = -0.17$	ns
Psychiatric Variables				
Psychiatric Diagnosis			$\chi^2 = 6.04$	ns
Schizophrenia Spectrum	12 (28%)	45 (44%)	$z = -1.06$	ns
Bipolar Disorder	17 (40%)	22 (21%)	$z = 1.31$	ns
Depression	9 (21%)	20 (19%)	$z = 0.16$	ns
Others	5 (12%)	16 (16%)	$z = -0.37$	ns
Previous Hospitalization	19 (44%)	35 (34%)	$z = 0.65$	ns
Age at 1 st Hospitalization (yrs)	27.4 (8.6)	30.6 (10.3)	$t = 1.8$	ns
Age of Disease Onset (yrs)	25.1 (8.8)	26.7 (9.0)	$t = .977$	ns
Duration of Illness (yrs)	5.6 (6.3)	5.4 (6.1)	$t = -.173$	ns
GAF (0 – 100)	48.1 (19.0)	45.8 (15.8)	$t = -0.77$	ns
Alcohol or Drug Diagnosis	0 (0%)	3 (3%)	-	-
DAST (> 2)	0 (0%)	0 (0%)	-	-
AUDIT (≥ 8)	0 (0%)	4 (4%)	-	-
Sexual Behavior				
Sexually Active (lifetime)	36 (84%)	76 (74%)	$z = 0.78$	ns
Sexually Active (10 yrs)	33 (77%)	72 (70%)	$z = 0.51$	ns
Sexually Active (1 yr)	25 (58%)	55 (53%)	$z = 0.32$	ns
High Risk Sexual Behaviour (lifetime)	17 (39%)	4 (4%)	$z = 2.76$	.006
High Risk Sexual Behaviour (10 yrs)	17 (39%)	3 (3%)	$z = 2.84$	.005
High Risk Sexual Behaviour (1 yr)	11 (26%)	1 (1%)	$z = 2.29$	.022

Table 3

Comparison of Patients Reporting History of Milder to Severe Sexual Coercion

	Milder Abuse (<i>n</i> = 16) <i>M</i> (SD) / <i>n</i> (%)	Severe Abuse (<i>n</i> = 27) <i>M</i> (SD) / <i>n</i> (%)	$\chi^2/t/z$	<i>p</i>
Demographic Variables				
Age (years)	27.2 (8.8)	32.6 (9.9)	<i>t</i> = -1.81	ns
Residence			$\chi^2 = 2.24$	ns
Urban	9 (56%)	12 (44%)	<i>z</i> = 0.76	ns
Rural	5 (31%)	12 (44%)	<i>z</i> = -0.85	ns
Semi Urban	2 (12%)	3 (11%)	<i>z</i> = 0.10	ns
Marital Status (% currently married)	6 (37%)	13 (48%)	<i>z</i> = -0.64	ns
Occupation (% homemaker)	5 (31%)	13 (48%)	<i>z</i> = -1.1	ns
Education (years)	9.6 (3.2)	7.6 (5.1)	<i>t</i> = 1.41	ns
Annual Income (\$US) (household)	170.1 (284.2)	7.2 (100.8)	<i>t</i> = 1.63	ns
Annual Income (\$US) (personal)	5.7 (21.7)	10.8 (34.4)	<i>t</i> = -0.53	ns
Psychiatric Variables				
Psychiatric Diagnosis				
Schizophrenia Spectrum	5 (31%)	7 (26%)	<i>z</i> = 0.35	ns
Bipolar Disorder	3 (18.7%)	14 (52%)	<i>z</i> = -2.4	.02
Depression	4 (25%)	5 (18%)	<i>z</i> = 0.45	ns
Others	4 (25%)	1 (4%)	<i>z</i> = 1.83	ns
Previous Hospitalization	5 (31%)	14 (52%)	<i>z</i> = -1.35	ns
Age at 1 st hospitalisation (yrs)	25.6 (8.2)	28.4 (8.8)	<i>t</i> = -1.10	ns
Age of Disease Onset (yrs)	23.6 (8.8)	26.0 (8.3)	<i>t</i> = -0.85	ns
Duration of Illness (yrs)	1.6 (1.1)	2.1 (1.0)	<i>t</i> = -1.5	ns
GAF (0 – 100)	50.2 (15.3)	46.9 (21.0)	<i>t</i> = 0.56	ns
Alcohol or Drug Diagnosis	0	0	-	-
DAST (> 2)	0	0	-	-
AUDIT (≥ 8)	2 (12.5%)	3 (11.1%)	-	-
Sexual Behavior				
Sexually Active (lifetime)	10 (62%)	26 (96%)	<i>z</i> = -1.62	ns
Sexually Active (10 yrs)	10 (62%)	23 (85%)	<i>z</i> = -1.59	ns
Sexually Active (1 yr)	8 (50%)	17 (63%)	<i>z</i> = -0.83	ns
High Risk Sexual Behaviour (lifetime)	2 (12%)	15 (56%)	<i>z</i> = -3.43	< .001
High Risk Sexual Behaviour (10 yrs)	2 (12%)	15 (56%)	<i>z</i> = -2.87	.004
High Risk Sexual Behaviour (1 yr)	1 (6%)	10 (37%)	<i>z</i> = -2.38	.017