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Research article

Psychometric properties of the Adverse Childhood Experiences Abuse Short Form (ACE-ASF) among Romanian high school students



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ABSTRACT

Child abuse is a major public health problem. In order to establish the prevalence of abuse exposure among children, measures need to be age-appropriate, sensitive, reliable and valid. This study aimed to investigate the psychometric properties of the Adverse Childhood Experiences Questionnaire Abuse Short Form (ACE-ASF). The ACE-ASF is an 8-item, retrospective self-report questionnaire measuring lifetime physical, emotional and sexual abuse. Data from a nationally representative sample of 15-year-old, school-going adolescents ($n = 1733$, 55.5% female) from the Romanian Health Behavior in School-Based Children Study 2014 (HBSC) were analyzed. The factorial structure of the ACE-ASF was tested with Exploratory Factor Analysis (EFA) and confirmed using Confirmatory Factor Analysis (CFA). Measurement invariance was examined across sex, and internal reliability and concurrent criterion validity were established. Violence exposure was high: 39.7% physical, 32.2% emotional and 13.1% sexual abuse. EFA established a two-factor structure: physical/emotional abuse and sexual abuse. CFA confirmed this model fitted the data well [$\chi^2(df) = 60.526(19)$; RMSEA = 0.036; CFI/TLI = 0.990/0.986]. Metric invariance was supported across sexes. Internal consistency was good (0.83) for the sexual abuse scale and poor (0.57) for the physical/emotional abuse scale. Concurrent criterion validity confirmed hypothesized relationships between childhood abuse and health-related quality of life, life satisfaction, self-perceived health, bullying victimization and perpetration, externalizing and internalizing behaviors, and multiple health complaints. Results support the ACE-ASF as a valid measure of physical, emotional and sexual abuse in school-aged adolescents. However, the ACE-ASF combines spanking with other types of physical abuse when this should be assessed separately instead. Future research is needed to replicate findings in different youth populations and across age groups.

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1. Background

Violence against children is a major public health problem affecting an estimated one billion children annually (Hillis, Mercy, Amobi, & Kress, 2016). In particular, the experience of physical, emotional and sexual abuse and neglect in childhood is associated with poor long-term physical, mental and reproductive health outcomes (Kessler et al., 2010; Leeb, Lewis, & Zolotor, 2011; Norman et al., 2012; Paolucci, Genuis, & Violato, 2001), reduced academic performance, social and cognitive functioning, and changes in brain development (Case & Ardington, 2006; Kim & Cicchetti, 2009; Teicher, Samson, Anderson, & Ohashi, 2016). Violence exposure in childhood is also associated with a number of high-risk behaviors such as smoking, alcohol and drug use, and sexual risk behaviors, which in turn increase risk for cancer and other non-communicable diseases and sexually transmitted infections (Danese et al., 2009; Jewkes, Dunkle, Nduna, Jama, & Puren, 2010; Miller, Chen, & Parker, 2011). Furthermore, violence exposure in childhood increases the risk for perpetration and re-victimization throughout the life span and the intergenerational transmission of violence (Capaldi, Knoble, Shortt, & Kim, 2012; Coid et al., 2001; Maker, Kemmelmeier, & Peterson, 2001; Widom, Czaja, & Dutton, 2008; Widom et al., 2015).

To estimate the number of children exposed to violence in a society and monitor trends in exposure, data on incidence and prevalence is needed (Sethi et al., 2013). To date, there are only a limited number of countries that collect such data on a regular basis, including the Netherlands, the United States and Canada (Euser et al., 2013; Public Health Agency of Canada, 2010; Sedlak, 2001). Different countries adopt a variety of methods to collect data on child maltreatment. An increasing number of studies ask participants directly about the abuse or neglect they may have experienced in childhood.

These self-report studies follow four main formats: 1) large-scale cross-sectional studies with an exclusive focus on childhood victimization, its perpetrators, some socio-demographic data and a small number of outcomes (e.g., Violence Against Children Surveys [Centers for Disease Control and Prevention, 2015] or Optimus Studies [UBS Optimus Foundation, 2015]); 2) large-scale repeated cross-sectional studies which almost exclusively focus on the prevalence of child abuse, such as the National Society for the Prevention of Cruelty to Children (NSPCC) studies in the UK (May-Chahal & Cawson, 2005; Radford et al., 2011); 3) longitudinal studies that follow a cohort of children and re-interview the same children at different ages (LONGSCAN Consortium, 1990); and 4) multi-country health surveys that include a small number of items on child abuse and multiple other questionnaire components on other health problems repeated at regular intervals with children of the same age group as previous years (e.g., Health Behavior in School-aged Children or Demographic and Health Survey (Currie et al., 2014; ICF International, 1984)). These multi-country, multi-component studies have several advantages: large, nationally representative samples; regular occurrence so trends can be detected; lower-cost; and the involvement of multiple different interest groups due to the variety of topics covered. However, data on the validity and reliability of the child abuse measures used in each of these approaches is limited (Meinck and Steinert, 2015; Meinck et al., 2016a).

One of the most commonly used, non-proprietary instruments to measure child abuse exposure in surveys is the Adverse Childhood Experiences Questionnaire (ACE) (CDC, 1997; Felitti et al., 1998). The ACE Questionnaire measures the domains of physical, emotional and sexual abuse; neglect; domestic, community, and peer violence; and various dimensions of household dysfunction, such as growing up in a household where substance abuse, mental illness, or parental separation or divorce occurred (Dube, Williamson, Thompson, Felitti, & Anda, 2004; Felitti et al., 1998). It has mostly been used in the United States and other High Income Countries (HICs) but has also been used in Low and Middle Income Countries (LMICS) (Baban et al., 2013; Raleva, Peshevska, & Sethi, 2013). Thus far, psychometric testing has only been carried out on a shorter, 11-item version of the ACE which established a three-factor structure: physical/emotional abuse, household dysfunction and sexual victimization. It has good construct validity and adequate internal consistency (Ford et al., 2014).

There is also a short, 10-item screening version of the ACE that covers 10 dimensions with single-item questions. Internal consistency of the 10-item measure and construct validity were good, showing high correlations with mental and physical health measures and childhood trauma inventories (Wingenfeld et al., 2011). Given the wide cultural range in which the ACE questionnaire has been used, however, knowledge about its psychometric properties is still limited.

In response to the use of ACE in various cultural contexts, WHO developed the ACE-International Questionnaire (ACE-IQ, 43 items) to measure ACEs around the world, including low- and middle-income countries, and to be integrated into broader health surveys (World Health Organization, 2012). Although the ACE-IQ has been used in several countries, e.g. Kenya (Goodman, Martinez, Keiser, Gitari, & Seidel, 2017), Brazil (Soares et al., 2016), Saudi Arabia (Almuneef, Qayad, Aleissa, & Albuhairan, 2014), Iraq (Al-Shawi & Lafta, 2015) and Vietnam (Tran, Dunne, Vo, & Luu, 2015), data on its psychometric properties are currently also very limited.

In addition to the measures mentioned above, a short form of the ACE questionnaire (ACE-ASF) with eight items focusing solely on abuse was developed in 2012 by the World Health Organization (WHO) for use in studies with adolescents and adults. This measure does not include items on household dysfunction. No information is currently available on the psychometric properties of this instrument. This current study therefore has two aims: 1) to assess the psychometric properties of the ACE-ASF, and 2) to validate the ACE-ASF within a representative sample of Romanian youth.

2. Methods

The analysis is based on data collected as part of the 2014 “Health Behavior in School-Aged Children (HBSC)” survey in Romania. The HBSC is a WHO collaborative, cross-sectional study of adolescent health behaviors, well-being and social environment. Cross-sectional surveys of 11-, 13- and 15-year-old adolescents are carried out every four years in line with a standardized research protocol

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