Asian Journal of Psychiatry 31 (2018) 27–35

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Development of a multi-dimensional scale to measure trauma associated with child sexual abuse (MSCSA) and its ramifying impacts on children: A pilot study

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ARTICLE INFO

Keywords:
Child sexual abuse
Multidimensional impact of trauma
Psychometric properties
Qualitative research

ABSTRACT

Background: With the rising incidence of CSA in India and absence of culturally competent tool to assess the impact of trauma, there is a dire need for development of a comprehensive scale to assess the impact of trauma on children. Thus, the present study aims to develop a multi-dimensional CSA tool for children aged between 7 and 13 years.

Method: Qualitative research method of FGD/Key Interviews with 4 group participants (Parents, counsellors, mental health and medical professionals) and in-depth interview with children having history of CSA was conducted along with item pooling from existing scales. Scale domain and sub-constructs were identified through thematic analysis of the qualitative data and statements extracted through item pooling. Face and content validity was obtained followed by the administration of the scale on pilot sample of 30 children meeting selection criteria of the study.

Results: 6 domains of the multi-dimensional impact of trauma was identified (i.e. Behavioral, Emotional, Cognition, Biological, Psychopathology and Social Functioning) which was constructed in the form of 85 scale statements across 6 domains and 48 sub-constructs on a 3-point Likert scale of response in both Hindi as well as English language. The scale was found to be having high reliability and average inter-item and inter-domain correlation. Modification of scale items based on pilot study findings and expert feedback analysis done to obtain a final scale containing 78 items.

Discussion: Discussion done primarily in terms of scale's psychometric properties, its clinical & research implications, especially focusing on cultural competency of the scale.

1. Introduction

Sexual abuse, including sexual assault or rape, of children, is a major global public health problem, a violation of human rights, many health consequences (Responding to children and adolescents who have been sexually abused, 2017) including psychological trauma.Often such trauma symptoms manifests in children in varied forms (Deb 2006, 2009; Deb and Mukherjee, 2009; Kacker and Kumar, 2008; Priyabadini, 2007). However, in absence of other visible physical signs for which people generally seek treatment, impact of psychological trauma on child remains often hidden and misunderstood by most as absence of trauma. It also gets affected by the caregivers' perception of children that they forget such incidents with time, hence delay in treatment seeking is an expected behaviour in India. Multiple factors associated with the incidence of abuse as well as child's family and socio-cultural background can determine the nature and extent of trauma. Interplay of various socio-cultural factors like low socio-economic status (Ministry of Women and Child development Government of India, 2007), stigma (Haile et al., 2013; Verelst et al., 2014), lack of awareness, resulting school withdrawal or marriage related difficulties after abuse, attribution on victim for undergoing abuse, social ostracism of the victim as well as family and extensive legal procedures to get the justice etc. (Deb and Walsh, 2012; Gilligan and Akhtar, 2006), delay the disclosure as well as reporting of such cases. Thus, as the time passes, delay in disclosure and non-seeking/availability of professional trauma treatment result in the development of psychosocial-behavioural problems and psychopathology in children. However, in a majority of cases, treatment/services to CSA survivors are limited to legal justice and surgical

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https://doi.org/10.1016/j.ajp.2017.12.020
Received 31 October 2017; Received in revised form 28 December 2017; Accepted 28 December 2017

interventions for external injuries due to sexual assault. Assessment of resulting psychological symptoms or intervention reaches only handful of children (Choudhary et al., 2016). Further due to limitation posed with preadolescent children in expression of the trauma verbally, the trauma can remain disguised till overt symptoms of any psychopathology or significant deterioration of functioning are noticed by family members. Thus, CSA related psychological trauma is multidimensional therefore assessment of trauma and its associated symptoms by a counsellor or clinician play a key role in the treatment and recovery of child.

Currently, there are numerous scales used worldwide to measure various dimensions of trauma associated with CSA, each varying in terms of trauma domains, target population, item length and type, response format, psychometric properties, cultural compatibility status, and clinical utility. Using different tools to measure different types of effects/symptoms posing a big challenge for the clinicians to present an overview of the multidimensional trauma impact. Deciding upon the appropriateness of the tool is often challenging in clinical practice due to cultural compatibility status and psychometric norms for Indian children. As per the International Society for the Prevention of Child Abuse and Neglect (IPSCAN, 2015), a significant barrier to research worldwide has been a lack of suitable tools to use in local surveys with children and young people.

In fact, in one of the recent systematic analysis on CSA tools across world with a focus on Asian context (Satapathy et al., 2016), it was found that out of 52 scales reviewed, only 9 scales were available in India language, but none of them are specific to CSA context, neither any adaptation study has been carried out on any of them to be used for our population. Further, the study indicates continuous and remarkable efforts from Western countries such as America and Canada in scale development but an alarming absence of any such efforts in Asian countries particularly in view of the increase in reporting of CSA cases recently. Additionally, clinically also, it has been found that Asian victims of CSA shows a distinct demographic profile than those from other countries. For example, they are more likely to express suicidality, less likely to display anger and sexual acting out, and had less supportive primary caretakers than non-Asians (Rao et al., 1992) which must be urgently captured in an indigenous tool developed in India. Thus, in the absence of culturally appropriate tool to measure wide range of symptoms associated with impact of trauma after CSA in India, need to develop a multi-dimensional CSA tool was realized.

Further, one of the most intractable problems in this research field is the difficulty in defining nature of the symptoms child displays after the incident (DiLillo, 2001; Goldman and Padayachi, 2000; Senn et al., 2008). Since there is a wide variability in the meaning and interpretations given to the symptoms in our country, abuse experiences and resulting symptoms varies with each case of CSA and the nature of trauma associated is hidden between various levels of shame, guilt, embarrassment, fear and silence. Further, in a country like India, where sexual abuse is actually considered a shame, embarrassment and loss of respect to a family (Gilligan and Akhtar, 2006), the dynamics of how a case of sexual abuse is dealt with depends on perception of various other people, chiefly the child, their family members and mental health professionals dealing with it. Thus, while quantitative research has established the fact that CSA has detrimental effects, the nature of these effects and the variations need to be explored in greater detail utilizing qualitative research methodology.

Keeping this in mind these perspectives, it was realized that the scale for the assessment of trauma in children after CSA is essential and would have few qualities:

1. Scale should be simple, easy to understand and administer such that it minimizes the trauma of undergoing lengthy processes of assessment.
2. It should be a multi-dimensional scale which will assess all the significant aspects of trauma in children after sexual abuse.
3. Perspective of children who have undergone abusive experiences must be incorporated while constructing scale items.
4. Perspectives of wide range of stakeholders in CSA should also be incorporated while constructing the scale items (Parents/caretakers as well as Professionals dealing with CSA).
5. The scale should have language and cultural compatibility to be used for the target population.

Thus, the objective of present study is to develop and pilot test a multidimensional scale for CSA (MSCSA) to measure the impact of trauma on children from either gender in the age range from 7 to 13 years.

2. Methodology

2.1. Study design

The study adopted a mixed method study design to construct and validate a screening instrument for assessment of impact psychological trauma and its correlates on children surviving sexual abuse. CSA survivors were included prospectively in the study between January 2016 and January 2017. The study protocol was approved by the Institutional Ethics Committee (IEC). All survivors included in the study provided their written informed assent and consent (by the legal guardian/parents) to participate.

2.2. Study population

There were 4 groups of participants for Focused Group Discussion (FGD) and Key Interviews, namely *Group 1:* Parents/Guardian/Caretakers of a the child with CSA, *Group 2:* Counsellors/Psychotherapists dealing with CSA, *Group 3:* Mental Health Professionals dealing with CSA and *Group 4:* Health Professionals dealing with CSA. Participants in each group were selected based on their relevant experience in CSA and consent for participation.

Children with CSA were recruited at 2 phases in the present study. Firstly, during In-depth interview for generating themes of the scale which was done only on consenting children between 7 and 13 years of age with a history of CSA in the past 2 years and average IQ. They were attending the outpatients and in-patient's facilities of the Department of Psychiatry, Paediatric Surgery, Paediatric Emergency and Gynaecology of the a large tertiary care public hospital in India. Samples were also taken from Child Care Institutes (CCI) and Non-Governmental Organizations (NGOs) of the state with permission through proper channel from concerned regulatory bodies. Secondly, during Pilot Testing phase where 30 children with similar selection criteria as above mentioned were sampled and MSCSA was applied.

2.3. Procedure for data collection

The demographic details along with details of critical information associated with CSA were collected. This was followed by the administration of the newly developed scale. A verbal feedback at the end of the scale was obtained from the participants regarding their opinion about the questions being asked and whether they faced any difficulty while answering the questions. The time taken to complete the questionnaire was also noted down.

Following table (Table 1) provides a comprehensive view of procedural steps taken to develop the scale through III phases:

2.4. Description of the phases of scale development

2.4.1. Phase I- identifying constructs of the psychological impact of trauma on children with CSA by conducting qualitative research method

For the purpose, it was considered to collect data from not only those who dealing with CSA cases but also include those who have