DEPRESSION AND COPING STRATEGIES AMONG SEXUALLY ABUSED CHILDREN: A PRELIMINARY STUDY

by

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ABBREVIATIONS

CDI	:	Children Depression Inventory
CSA	:	Child sexual abuse
DSM	:	Diagnostic and Statistical Manual of Mental Disorders
e.g.	:	example
et al	:	and the rest
HUSM	:	Hospital Universiti Sains Malaysia
I/C	:	Identification Card
i.e	:	that is to say
MINI	:	Mini International Neuropsychiatric Interview
OSCC	:	One Stop Crisis Centre
PPSP	:	Pusat Pengajian Sains Perubatan
SD	:	Standard deviation
SPSS	:	Statistic Package for Social Sciences
RN	:	Registration number
2TD	:	2 Timur Depan

ABSTRAK

LATARBELAKANG: Penderaan seksual kanak-kanak adalah satu pengalaman hidup yang kompleks dan ianya berkaitan dengan kemurungan. Kanak-kanak yang didera secara seksual menangani pengalaman sedemikian secara berbeza-beza. Kemurungan adalah satu masalah kesihatan mental di seluruh dunia. Penyaringan untuk kemurungan dan cara menanganinya masih belum di jalankan di kalangan kanak-kanak yang didera secara seksual di Malaysia.

OBJEKTIF: Kajian ini bertujuan untuk menghuraikan faktor-faktor psikososial dan cara-cara yang di gunakan untuk menangani penderaan seksual serta kaitannya dengan kemurungan di kalangan kanak-kanak yang didera secara seksual.

METODOLOGI: Kajian ini terdiri dari dua peringkat. Pertama, pengesahan Inventori Kemurungan Kanak-kanak (CDI) versi Melayu, dan di ikuti oleh kajian keratan lintang untuk kemurungan dan cara-cara yang digunakan untuk menangani penderaan seksual yang disertai oleh 65 kanak-kanak yang didera secara seksual menghadiri Hospital Universiti Sains Malaysia. Ukuran- ukuran berikut di gunakan: soalan umum, soalan separa- struktur untuk menangani penderaan seksual dan pengesahan CDI versi Melayu. Kemurungan didefinisi

sebagai pencatatan mata yang melebihi titik potong optimum pada CDI versi Melayu yang ditentukan semasa kajian pengesahan inventori.

KEPUTUSAN: Kajian pengesahan menunjukkan bahawa pada titik potong 18, CDI mempunyai kepekaan 90% dan kekhususan 98% dalam mengesan kemurungan.

Dalam kajian sampel, 16 (24.6%) peserta ada kemurungan dan 49 (75.4%) peserta tiada kemurungan. Dalam strategi menangani masalah, 57 (87.7%) menggunakan fokus emosi, 6 (9.2%) menggunakan fokus masalah/ tugasan dan 2 (3.1%) menggunakan kedua-dua fokus iaitu emosi dan masalah/ tugasan. Di kalangan fokus emosi, peserta menggunakan: (i) membuat keputusan bahawa tiada apa yang dapat mengubahnya, (ii) menafikannya- berpura-pura bahawa ianya tidak berlaku dan (iii) menenggelamkan perasaan ke lubuk hati.

KESIMPULAN: Penyaringan kemurungan di kalangan golongan sensitif seperti kanak-kanak yang didera secara seksual adalah penting sebagai pengesanan dan rawatan awal. Dengan mengenali strategi menangani masalah di kalangan kanak-kanak yang didera secara seksual dapat menolong pakar klinikal dan kaunselor semasa sesi kaunseling.

ABSTRACT

DEPRESSION AND COPING STRATEGIES AMONG SEXUALLY ABUSED CHILDREN: A PRELIMINARY STUDY.

Background: Child sexual abuse is a complex life experience and it is associated with depression. Sexually abused children cope with the experiences differently. Depression is a major mental health concern worldwide. There is no previous local study on screening for depression and coping strategies used in child sexual abuse in Malaysia.

Objectives: This study aimed to describe the psychosocial factors and coping strategies used and its association with depression in sexually abused children.

Methods: The study consisted of 2 stages. First, the validation of the Malay version of CDI and followed by a cross sectional study of depression and coping strategies used, participated by 65 sexually abused children and adolescents attending HUSM. The following measures were used: general questionnaire, semi-structured questionnaire of coping strategies and the validated Malay version-CDI. Depression was defined as score above the optimum cut-off point on Malay version-CDI determined at the validation study.

Results: The validation study showed that at the cut-off score of 18, the CDI had 90% sensitivity and 98% specificity in detecting depression.

In the study sample, 16 (24.6%) participants had been depressed and 49 (75.4%) participants had not been depressed. In coping strategies, 57 (87.7%) used emotion-focused coping strategies, 6 (9.2%) used problem or task-focused coping strategies and 2 (3.1%) used both emotion and problem-focused. Among emotion-focused coping strategies, participants used (i) deciding than nothing can be done to change things, (ii) denial and (iii) suppression.

Conclusion: The screening of depression in the vulnerable group such as child sexual abuse was important, as for early detection and treatment. By recognizing the coping strategies used in sexually abused children, it can be helpful for clinician and counselor in their counseling session.

Key words: Child sexual abuse, Children Depression Inventory, depression, coping strategies.

INTRODUCTION

CHAPTER 1

INTRODUCTION

1.1 Child sexual abuse (CSA)

Child sexual abuse (CSA) is a complex life experience, not a diagnosis or a disorder. It has been with us for generations. Whilst public and professional awareness has only been achieved in recent years, it is not a new phenomenon.

Research began exposing sexual abuse of children as a problem of sizable proportions in the late 1960s and early l970s (Watson, 1984). One theme remains consistent in the research: sexual abuse is extensively undisclosed and underreported (Tsai & Wagner 1978; Swanson & Biaggio 1985; Finkelhor & Browne, 1986; Ferguson et al 1996; Putnam 2003).

Finkelhor & Browne (1986) proposed traumagenic model (traumatic sexualization, stigma, betrayal and powerlessness) which links trauma-producing abuse characteristics to long-term outcome. Health professionals need to be aware of this model in understanding the dynamics conflicts in the sexually abused victims.

1.1.1 Definition of child

Child Act 2001 (Malaysia) defines child as a person under age of 18 years old, whereas Federal Child Abuse Prevention and Treatment Act (CAPTA) in United State defines child as a person who has not attained the age of 18, except

in cases of sexual abuse, or the age specified by the child protection law of the State in which the child resides.

1.1.2 Definition of child sexual abuse (CSA)

It is important to define what sexual abuse is because there are variations in definitions across professional disciplines. However, there is no clear-cut answer when it comes to definitions of child sexual abuse.

In general, The American Medical Association (1992) defines child sexual abuse as "the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent".

Sexual abuse can include fondling, genital exposure, intimate kissing, forced masturbation oral, penile or digital penetration of the mouth, vagina or anus (National Research Council, 1993)

The National Center on Child Abuse and Neglect defines child sexual assault as: "Contacts or interactions between a child and an adult when the child is being used for sexual stimulation of the perpetrator or another person when the perpetrator or another person is in a position of power or control over the victim".

Fleming & Bammer (1997) defined CSA as all experiences of sexual contact occurring before the age of 12 with the a person 5 or more years older, irrespective of consent, and all experiences of sexual contact occurring between 12 and 16 years with a person 5 or more years older, unless wanted or not distressing at the time.

Conte (1986) further characterized child sexual abuse into deception, force or coercion.

Andrews et al (2002) subdivided CSA into three levels of severity. Firstly, non-contact abuse includes sexual solicitation or exposure by an older person; secondly, contact abuse involves genital touching or fondling; and thirdly penetrative abuse includes oral, anal or vaginal intercourse by an older person.

United State Department of Health and Human services (1998) defines CSA in term of criminal and clinical. Criminally, it concerned on prohibition certain sexual acts and specifies the penalties, whereas clinically, it concerned about the traumatic impact on the children as the child progresses through the developmental stages.

1.1.3 Child Act in Malaysia on Child Abuse and Neglect

Child Act is an Act to consolidate and amend the laws relating to the care, protection and rehabilitation of children and to provide for matters connected therewith and incidental there to. This Act may be cited as the Child Act 2001

and applies throughout Malaysia. This Act comes into operation on a date to be appointed by the Minister by notification in the Gazette.

The Act acknowledges that a child, by reason of his physical, mental and emotional immaturity, is in need of special safeguards, care and assistance after birth, to enable him to participate in and contribute positively towards the attainment of the ideas of a civil Malaysian society.

In Child Act 2001, Part V (Chapter 3), Section 31:

(1) "Any person who, being a person having the care of a child

(a) abuses, neglects, abandons or exposes the child in a manner likely to cause him physical or emotional injury or causes or permits him to be so abused, neglected, abandoned or exposed; or

(b) sexually abuses the child or causes or permits him to be so abused,

commits an offence and shall on coiwiction be liable to a fine not exceeding twenty thousands ringgit or to imprisonment for a term not exceeding ten years or to both.

(2) The court –

(a) shall, in addition to any punishment specified in subsection (1), order the person coiwicted of an offence under that subsection a bond with sureties to be of good behaviour for such period as the Court thinks fit; and

(b) may include in the bond executed under paragraph (a) such conditions as the Court thinks fit.

(3) If a person who is ordered to execute a bond to be of a good behaviour under subsection (2) fails to comply with any of the conditions of such bond, he shall be liable to a further fine not exceeding ten thousands ringgit or to a further imprisonment for a term not exceeding 5 years or to both.

(4) A parent or guardian or other person legally liable to maintain a child shall be deemed to have neglected him in a manner likely to cause him physical or emotional injury if, being able to so provide from his own resources, he fails to provide adequate food, clothing, medical or dental treatment, lodging or care for the child.

(5) A person may be coiwicted of an offence against this section notwithstanding that –

(a) suffering or injury to the health of the child in question or the likelihood of suffering or injury to the health of the child in question was avoided by the action of another person; or

(b) the child in question has died.

Child Protection Act 2001 in Malaysian law includes: (1) public are obliged to report cases and they are guaranteed anonymity, (2) compulsory for doctors to notify authorities, (3) guarantees doctors and those involved that the child is protected, (4) authorities can protect the abused child or remove child from premises and (5) offenders are punishable.

1.1.4 Rape laws in Malaysia

Rape is one form of sexual abuse. In Malaysia, the laws on rape come under the Criminal Penal Code. The particular laws pertaining to rape are: The Penal Code (F.M.S. Cap.45) (Kanun Keseksaan), Criminal Procedure Code (F.M.S.6) 1935 (Kanun Acara Jenayah) and Evidence Act 1950 (Akta Keterangan).

According to the Malaysian Penal Code Section 376 a man is said to have committed rape if he has sexual intercourse with a woman under the following conditions or circumstances:

First - Against her will. Although the woman is capable of giving her consent, she willfully and consciously rejects sexual intercourse with a man, but is forced into it.

Secondly – Without her consent. Sexual intercourse may take place without the woman's consent because she is incapable of giving her consent. For example, she may have been drugged and as such may have been unconscious at the time the incident.

Thirdly – With her consent, but the consent was obtained as a result of putting fear in the woman of hurt or death to herself or any other person, or when the consent obtained under a misconception of fact and the man knows or has reason to believe that the consent was given in consequence of such a misconception. For example, when a bomoh promises to cure a girl of some form

of ailment provided she has sex with him, even though he knows that the sexual act does in no way contribute towards the healing.

Fourthly – With her consent, but the man knows that he is not her husband, and her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married or to whom she would consent.

Fifthly – With her consent, but at the time of consent, she is unable to understand the nature and consequence of that to which she gives consent. This could be if she is drunk or is high on drugs.

Sixthly – With or without her consent, when she is under sixteen years of age. This is because children and teenagers below this age are deemed by the nature of their immature judgment, legally unable to give consent.

Section 376A defines incest as sexual intercourse with a person whom he/she is not permitted to marry under law, religion, custom or usage applicable to them.

1.1.5 Prevalence of child sexual abuse

Statistics on the prevalence of child sexual abuse are derived primarily from retrospective accounts by adults. It is not surprising that prevalence figures vary widely as a function of the selection and response rate, the definition used, and the method (e.g., self-report versus structured interview) by which an abuse history is obtained.

Incidents of rape and sexual abuse are on the rise in Malaysia. In 1999 a women's Non Government Organization (NGO) in Malaysia reported that the

incidence of sexual abuse had increased 48% in the 5-year period from 1993 to 1998; more than 50% of all sexual abuse victims were under 16 years of age (Country Reports on Human Rights Practices 2002).

The statistic attendances of clients to One Stop Crisis Centre (OSCC) at Hospital Universiti Sains Malaysia were 153 in year 2003, 173 in year 2004 and 190 for year 2005. It showed the increasing trend every year. The reported child sexual abuse was 104 in year 2003, 112 in year 2004 and 107 in year 2005 (unpublished report –OSCC registry)

A retrospective self-administered questionnaire answered by 616 paramedical students conducted in the Ipoh School of Nursing and Hospital Bahagia Medical Assistant Training School stated that 6.8% admitted as having been sexually abused in their childhood, 2.1% of males and 8.3% of females (Singh et al 1996).

Another retrospective study conducted in Queensland, Australia showed that the prevalence of child sexual abuse was 19% for males and 45% for females (Goldman & Padayachi 1997).

Prevalence in Asian countries was low compared to Western countries probably because of Asian adolescents are especially unlikely to reveal the truth when asked in anonymous, self-report surveys. In contrast, the study by Chen et al. (2002) found that high school students in Liaoning province do disclose unwanted sexual experiences, with up to 25% of girls and 23% of boys reporting at least some type of non-contact event, including where a person exposed their genitals or they witnessed masturbation. In addition, among university students in

the USA, Meston et al (1999) have found that the lower prevalence of abuse reported by students of Asian background compared to other ethnic groups is not accounted for by cultural differences in socially desirable responding during surveys.

Alikasifoglu et al (2006) found that at least 13.4% of female high school students disclosed having experienced sexual abuse during childhood (defined sexual abuse as unwanted sexual experience i.e. touching and intercourse)

An integrative review of 16 cross-sectional communities retrospective sample surveys showed that the calculated prevalence of child sexual abuse as 16.8% for women and 7.9% for men after adjusted for sample-related variation, response rates and differences in definitions (Gorey & Lesley1997).

The National Resource Council 1993 estimated the percent of the U.S. population which has been sexually abused to range from a low of 20-24 percent to a high of 54-62 percent of the population; the higher estimate includes sexualized exposure without touching, such as masturbating in front of the child.

The National Resource Centre on Child Sexual Abuse 1994 reported a largest retrospective study on the prevalence of child sexual abuse was 27% of women and 16% of men reported abuse.

Prevalence studies from different cultures, Madu & Peltzer (2000) and Haj-Yahia &Tamish (2001) found equivalence in the prevalence of CSA between males and females. Interestingly, Zeira et al (2002) reported that sexual harassment to be more common among males than females.

1.1.6 Risk factors for child sexual abuse

Gisese et al (1998) stated that CSA occurs across all socioeconomic and ethnic groups and rose with age. Girls are at about 2.5 to 3 times higher risks than boys, although approximately 22% to 29% of all CSA victims are male (Finkelhor 1993, Gisese et al 1998).

Wyatt (1985) designed questionnaires such as information on the type of abuse, age at the time of abuse, relationship to the abuser, duration and frequency of the abuse, whether or not force or coercion was used, whether or not the abuse was disclosed, and the self-perceived short and long term effects of the abuse in assessing the risk factors.

Factors that influence the outcomes in cases of childhood sexual abuse include the age of the victim, the frequency and extent of the abuse, the relationship of the victim to the abuser (incest has the worst outcomes), the use of force, the presence of severe injury, and the number of different perpetrators. The response of the victim's family has a tremendous effect on the outcome.

Abuse-related characteristics (perpetrator identity, duration of the abuse, abuse severity) appeared to exert a secondary role in determining the outcome of the children experiencing sexual abuse.

Finkelhor & Browne (1986) documented that the primary markers for increased risk for child sexual abuse for girls are having few friends, absent or unavailable parents, a stepfather and conflict with or between parents.

Other risk factors include: physical or mental disability; separate living arrangements from both biological parents; mental illness, alcoholic or drug abuse in the family; a parent who was physically or sexually abused as a child; homes with other forms of abuse, prostitution or transient adults (Conte 1986, Finkelhor & Browne 1986, Gutman et al 1991, Sobsey 1992).

A growing consensus in the research literature is that the most serious health consequences arise when the sexual abuse is penetrative, protracted, and occurs at a young age (Fergusson & Mullen 1999 & Tyler 2002).

1.2 Psychological outcome in child sexual abuse

Sexually abused children experience clinically significant symptoms in the affective, cognitive, physical and behavioural domains (Shaw et al 2000). The acute psychological response to sexual abuse may include anxiety, fears, regressive behaviors, nightmares, withdrawn behavior, internalizing and externalizing disorders, delinquency, cruelty, self-injurious behavior, general behavioral problems, post-traumatic stress disorder, low self-esteem, and sexualized behaviors (Kendall-Tackett et al 1993).

Major depression, a leading public health problem with high prevalence rates and substantial morbidity and mortality provides a useful example of the converging lines of evidence linking a history of child sexual abuse to serious adult psychiatric psychopathology. Major depression and dysthymia have been strongly associated with child sexual abuse in numerous studies (Neumann et al

1996, Polusky & Follette 1995). Lifetime prevalence of major depression in women with a history of child sexual abuse is typically three to five times more common than in woman without such a history. Gisese et al 1998 stated that women with a history of child sexual abuse have been associated with earlier onset of affective episodes.

A review of 45 studies indicated that the two most common patterns of psychological response are those associated with post-traumatic stress symptomatology and an increase in sexualized behaviors (Kendall-Tackett et al., 1993). Sexualized behaviors may include sexualized play with dolls, putting objects into anuses or vaginas, excessive or public masturbation, seductive behavior, and age inappropriate sexual knowledge and behavior (Kendall-Tackett et al., 1993).

Long-term psychological sequelae of sexual abuse may include depressive and anxiety disorders, psychiatric hospitalization, drug and alcohol use, suicidal behavior, borderline personality disorder, somatization disorder, eroticization, learning difficulties, post-traumatic stress disorder, dissociative disorders and conversion reactions, running away/prostitution, revictimization, poor parenting, and an increased likelihood of becoming a perpetrator (Schetky 1990, Silverman et al 1996).

The frequency and severity of psychological sequelae secondary to sexual abuse has been related to a number of factors including: frequency and duration of the sexual abuse, relationship to the perpetrator, use of force, type of sexual

abuse, penetration, age of the victim, age difference between victim and offender, and the parental support variable (Schetky 1990).

Children's experience of abuse has many deleterious consequences including depression, behavioural problems, poor self esteem, feeling of isolation, self injurious behaviours such as substance abuse, suicidal ideas and behaviours, revictimization, academic and vocational problems, sexual dysfunctions and criminal behaviours (Beitchman et al 1992, Browne & Finkelhor 1986, DiLilo et al 1994), prostitution, eating disorders, multiple personality disorder (Conte 1986, Finkelhor 1986).

The prevailing standard for the diagnosis of depression is the opinion of an examining psychiatrist that a patient's symptoms meet the criteria described in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). For research purposes, psychiatric diagnoses have been operationalized through the development of structured diagnostic interview instruments such as the Diagnostic Interview Schedule (DIS) (Robin et al 1981)

A retrospective study by Andrews et al (2002) reported that the attributed risk calculations suggest that 11% of depression in women and 3% of depression in men could be attributed to contact or penetrative abuse in childhood. It suggested that the nature and severity of the abuse played role in depression.

In addition, Long & Jackson (1993) estimated that one quarter to one half of children remained asymptomatic at the time of their assessments. This does not negate the possibility of late effects. Diaz et al 2002 surveyed a large cross-

sectional sample of girls from grades 5 through 12 and found that depressive symptoms were increased in those who reporting experiencing only sexual abuse.

Finkelhor et al 1988 stated that child sexual abuse often negatively affects long-term psychological and social well-being, even though more than half of all sexual abuse survivors do not suffer the most extreme forms of psychiatric trauma.

1.3 Coping strategies in child sexual abuse

Burt & Katz (1988) defined coping as 'efforts made in response to stimuli experienced as threatening or stressful-efforts aimed both at reducing the anxiety that those stimuli create and at reducing the interference of the stimuli with one's capacity to function'.

There are two major ways to cope with stress: problem-focused and emotion-focused coping. Problem-focused is a mental process an individual may use to assess whether a stressor is threatening or if he or she has the means to deal with that stress. Emotion focused coping is directed at governing the emotional response to these stressful situations.

Unfortunately, our understanding of the relationship between coping strategies and sexual abuse related outcome is quite limited. Much of the available research relies on retrospective studies of adults molested as children (Wyatt & Newcomb 1990, Leitenberg et al 1992). Furthermore, only three studies

have specifically examined how children or adolescents cope with sexual abuse (Conte & Shuerman 1987, Gomez-Schwartz et al 1990, Johnson & Kenkel 1991). Only one (Johnson & Kenkel 1991) utilized a coping assessment instrument and related it to multiple outcome measures. However, this study was limited to adolescents and no similar studies have focused on school-aged 7-12 sexually abused children (Tingus et al 1996).

Chaffin et al (1997) studied sexually abused children, ages 7-12 and yielded four coping strategies which were labeled avoidant, internalized, angry and active/social. Chaffin et al (1997) found that avoidant coping associated with fewer behavioural symptoms as reported by parent and teachers.

A qualitative study on cognitive coping styles of women sexually abused in childhood by Perrott et al (1998) classified them into six: deliberately suppressing, reframing the abuse (minimization and comparing to others), working through the abuse experience, seeking support, talking about their abuse experiences as adults and coping on own. They found that women who "reframed" were significantly less likely to have a psychiatric diagnosis.

Many coping or self-regulating strategies work in some ways, but also limit people in other ways. The socialization theory of coping skills (Rosario, Shinn, March, & Huckabee, 1988) mentioned that males and females are socialized differently in the acquisition of more active and emotion-focused coping strategies, respectively. It would predict that males socialized to be more active and self-reliant and more likely to use problem-focused coping strategies

to reduce stress by changing the situation. In contrast, females are more likely to utilize emotion-focused coping to manage stress-related emotions.

Sigmon et al (1996) divided coping strategies into four distinct coping styles, including the two predicted by socialization theory (i.e., problem-focused and emotion-focused) and two alternatives, avoidance and acceptance. In addition, only avoidance and emotion-focused coping strategies used in response to sexual abuse predicted significant variance in current psychological adjustment. For the research purpose, avoidance and acceptance coping will be categorized into emotion-focused coping strategies.

Leitenberg et al (1992) found that female survivors reported using denial, emotional suppression, social support, and avoidance strategies to cope with their experiences of childhood sexual abuse. Further analyses revealed that greater reported use of denial, emotional suppression, cognitive rumination, and avoidance as long-term coping methods was related to increased levels of psychological distress.

Coping strategies and social support were found to have a direct effect on children's adjustment (Gorey & Lesley 1997). Diaz et al 2002 gave an example that the victims ignored their painful feeling in order to reduce their conscious experience of the event. However, this will prevent them from learning how to manage in smaller doses which make one vulnerable to alternating between feeling little or no emotions and being overwhelmed. Some cope by avoiding getting close to people and trying to hide all of one's pain and vulnerabilities may create a sense of safety.

Finkelhor et al 1986 found that powerlessness damages coping skills and reduces ability to protect oneself from further abuse. Being a female and trusting the perpetrator made the respondents vulnerable and powerless.

1.4 Social support in child sexual abuse

Social support can be receive from four sources such as parents, close friends, teachers and classmate. Supportive responses from the victims family and friends can go far to lessen the impact of the abuse while negative responses (seen commonly in cases of incest where one parent tries to protect the other parent) will compound the damage done. Tremblay et al (1999) conducted a study which showed that self esteem tended to be higher and behavioural problems lower when children reported feeling supported by parents.

Empirical investigations in the CSA field validate social support as a significant variable in the association between CSA and psychological adjustment (Esparza 1993; Wyatt & Newcomb 1990). Across studies, positive social support is significantly associated with fewer negative psychological outcomes for CSA survivors (Spaccarelli & Fuchs 1997).

Garmezy et al (1984), Rutter (1985) and Masten et al (1990) demonstrated developmental model which specified child's immediate environment or circumstances played important role in protecting the child's development when emotional or physical abuse present.

These protective factors such as quality of child's relationships with parents (Bifulco et al 1991, Romans et al 1995, Spacarelli & Kim 1995); secure parent-child attachment (Alexander 1987, 1992); lack of family conflict and family cohesiveness (Conte & Schuerman 1987, 1988) played important role in the adjustment of adults who have experienced child sexual abuse.

1.5 Children Depression Inventory (CDI)

The CDI was created in the United State in 1977 and its last edition dates from 1992. It was developed because depression in young children is often difficult to diagnose, and also because depression was regarded as an adult disorder until the 1970s. It was thought that children's nervous systems were not sufficiently mature to manifest the neurochemical changes in brain function associated with depression (Shemesh et al 2005).

It is a self-report, symptom-oriented scale which requires at least a first grade reading level and was designed for school-aged children and adolescents. It has 27 items, each of which consists of three choices. The child or adolescent is instructed to select one sentence for each item that best describes him or her for the past two weeks. It measures depressive symptoms in children and adolescent students, aged 7 to 17. The CDI profile contains the following five factors plus a total score normed according to age and sex: negative mood, interpersonal problems, ineffectiveness, anhedonia and negative symptoms.

Previous study used CDI (Fristad et al 1988, Hodges- Kay & Ypsilanti 1990, Bahls 2002, Timbremont et al 2004) intended to detect and evaluate the symptoms of a major depressive disorder or dysthymic disorder in children or adolescents, and to distinguish between children with those disorders and children with other psychiatric conditions. The CDI can be administered repeatedly in order to measure changes in the depression over time and to evaluate the results of treatment for depressive disorders. It is regarded as adequate for assessing the severity of the depressive symptoms (Shemesh et al 2005).

The validation of instrument e.g CDI across different cultural groups is crucial to provide evidence of the scale sensibility to cultural diversity and to help identify symptomatic difference between groups (Abdul-Khalec & Soliman 1999). Some studies (Saylor et al 1984, Carey et al 1987) examined the discriminant validity of the CDI and found that it can successfully discriminate psychiatric patients from non referred youth. CDI also differentiate a depressive disorder from an anxiety and a disruptive behaviour disorder (Timbremont & Braet 2004). The CDI also differentiates children and adolescents with major depression or dysthymia from those with other psychiatric disorders or from the normal ones (Kovacs 1992).

Studies about depressive symptoms on adolescents in community samples show that they are commonly present, although results differ greatly. In researches using the Children Depression Inventory (CDI), the most widely used self-assessment scale of depressive symptoms in young adolescents (Charman

1994) there is a great variability in the cut-off score used that ranged from 12 to 25. Shemesh et al (2005) found that at cut-off score of 11, the inventory correctly identified 80 per cent of cases, with a specificity of 70 per cent.

Bahls (2002) chose cut-off score of 19 and found that the rate of depressive symptoms of 20.3% which is greater than that reported in the study of Doerfler et al (1988) in the United State, which amounted to 10%, among 1,207 students aged 10 to 18; and to that of Chartier & Lassen (1994) in the US, of 8.3%. Other researchers using different cut-off score obtained the following results: Charman (1994) in Britain obtained a rate of 8% in 286 students aged 12 to 13, with the cut-off score of 15. Donnelly (1995) in Northern Ireland, in 887 students, aged 11 to 15, with the cut-off score of 13, found results of 26.8% whereas with the cut-off score of 17 the results were of 11.6%.

1.6 Rationale of the study

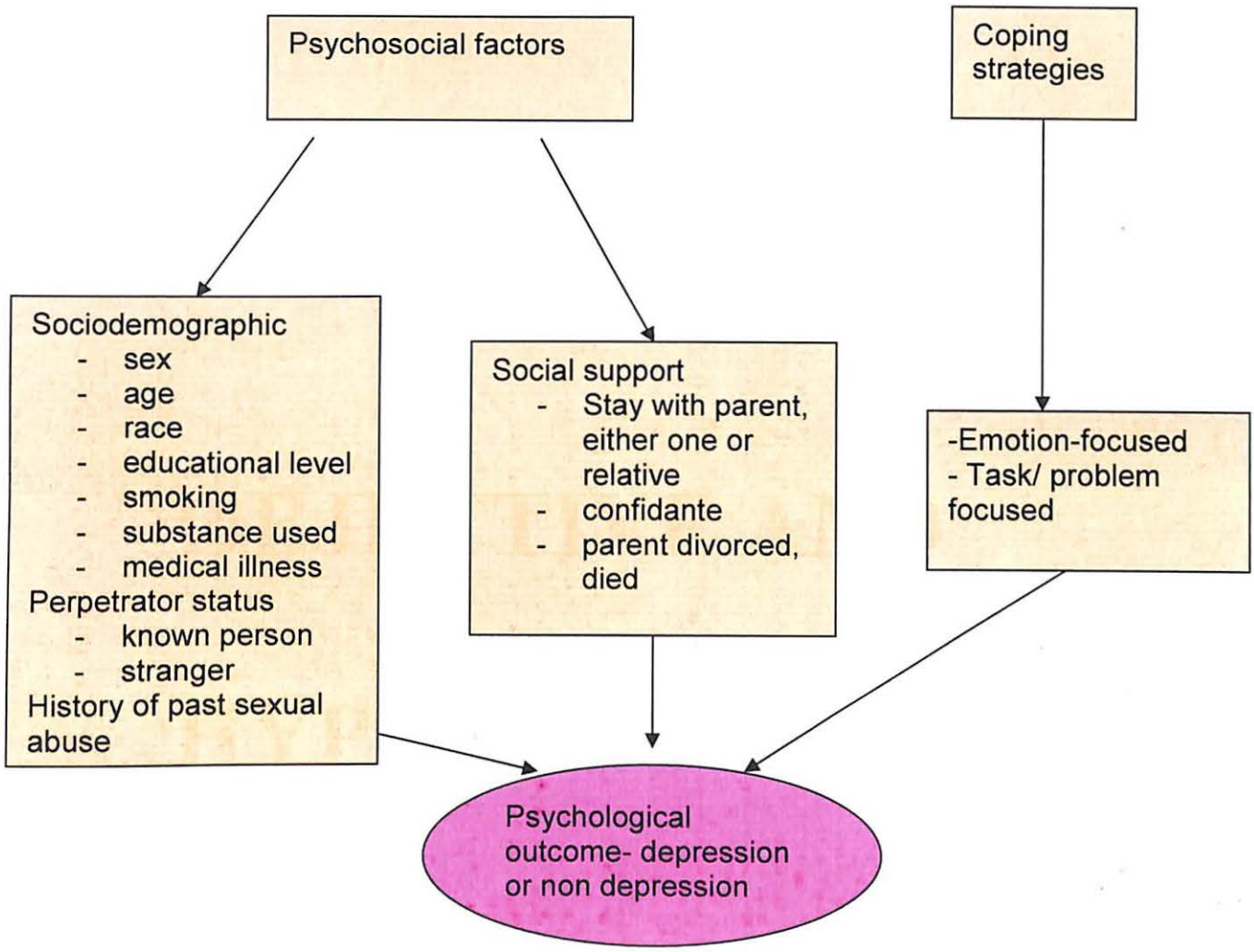
1. Similar studies had not been conducted in the local setting in Malaysia.
2. Our understanding of the relationship between the coping strategies and abuse related outcome is quite limited, therefore this study will be conducted to obtain type of coping in child sexual abuse and its relation in focus to depression.
3. Much of the available research relies on the retrospective studies of adult who survive from sexual abuse. Therefore this cross-sectional study will focus on the children and adolescents between the ages of 7 to 17 who had been sexually abused (Appendix II (A)).

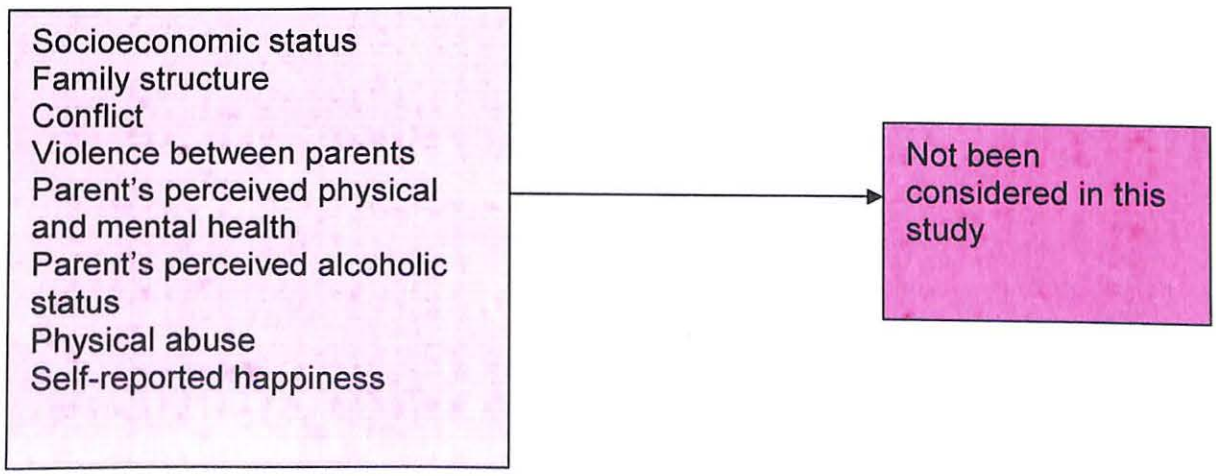
4. Study of short term psychological sequelae (depression) in child sexual abuse (within 6 months).

1.7 Scope of the study

1. The children and adolescents between the ages of 7 to 17.
2. Depression among sexually abused children.
3. Coping strategies either emotion-focused or task/problem-focused among sexually abused children.

1.8 Conceptual framework





OBJECTIVE AND HYPOTHESES

CHAPTER 2

OBJECTIVES AND HYPOTHESES

2.1 General Objective

To determine the relationship between sexual abuse with coping strategies and depression in children attending Hospital Universiti Sains Malaysia (HUSM) from June 2005 to March 2006.

2.2 Specific objectives

1. To translate and validate the Children Depression Inventory (CDI) for children and adolescents.

2. To describe psychosocial factors associated with sexually abused children.

3. To determine types of coping strategies used and the occurrence of depression among sexually abused children.

4. To determine the relationship between psychosocial factors and depression among sexually abused children.

5. To determine the relationship between coping strategies and depression among sexually abused children.

2.3 Hypotheses

1. There is a relationship between psychosocial factors and depression among sexually abused children.
2. There is a relationship between coping strategies and depression among sexually abused children.