

ORIGINAL ARTICLE

DEPRESSION AND COPING STRATEGIES AMONG SEXUALLY
ABUSED CHILDREN IN A MALAY COMMUNITY IN MALAYSIA

*Rohayah Husain, **Rosliwati Md Yusoff, *** Mohd Jamil Yaacob,
****Zaharah Sulaiman

* Faculty of Medicine and Health Sciences, Universiti Darul Iman Malaysia,
Kampus Kota, 20040 Kuala Terengganu, Terengganu ** Department of
Psychiatry, Hospital Sentosa, 93250 Kuching, Sarawak *** Department of
Psychiatry, School of Medical Sciences, Universiti Sains Malaysia, 16150
Kubang Kerian, Kelantan**** Women's Health Development Unit, School
of Medical Sciences, Universiti Sains Malaysia, 16150 Kubang Kerian,
Kelantan

Abstract

Objective: The fact that childhood sexual abuse is associated with depression is well-known. To date, there is no proper study done on screening for depression and coping strategies among sexually abused children in Malaysia. This study aimed to determine the prevalence of depression and examine the association of depression with the socio-demographics and coping strategies used by sexually abused children. **Methods:** Sixty-five sexually abused children who attended the One Stop Crisis Centre (OSCC) services at Hospital Universiti Sains Malaysia and fulfilled the study criteria were screened for depression using a validated Malay version of Children Depression Inventory (CDI). Depression was determined by a positive score of the Malay-CDI with depression being indicated in scores of more than 18. **Results:** In the study sample, 16 (24.6 %) participants had been depressed and 49 (75.4 %) participants had not been depressed. Having a confidante was a protective factor against depression. Short duration of time between the abuse incident and the clinical interview was significantly associated with depression. With respect to coping strategies, 59 (90.8 %) used emotion-focused strategies and 6 (9.2 %) used problem or task-focused strategies. Among emotion-focused coping strategies, participants did the following: deciding that nothing could be done to change things, were in denial, and suppressed their feelings. **Conclusion:** Twenty five percent of the sample suffered from depression. The screening of depression in the vulnerable group such as sexually abused children is important, particularly for early detection and treatment. By recognizing the coping strategies used in sexually abused children, the clinician could understand them better and plan for their psychological management. *ASEAN Journal of Psychiatry, Vol.10 (2): July- Dec 2009: XX – XX.*

Keywords: sexually abused children, Malay-Children Depression Inventory, depression, coping strategies

Introduction

Incidents of rape and sexual abuse are on the rise in Malaysia. In 1999 a women's Non Government Organization (NGO) in Malaysia reported the incidence of sexual abuse had increased to 48% in a 5-year period from 1993 to 1998. More than 50% of all sexual abuse victims were under 16 years of age [1]. The prevalence of child sexual abuse worldwide is underreported and is derived primarily from retrospective accounts by adults. Sexually abused children experience clinically significant symptoms in the affective, cognitive, physical and behavioural domains [2]. 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 [3].

The previous data were mostly retrospective in nature whereby the history of sexual abuse was only revealed when people developed psychiatric illness. The lifetime prevalence of major depression in women with a history of child sexual abuse is typically three to five times more common than in women without such a history. Major depression and dysthymia have been strongly associated with childhood sexual abuse in previous studies [4,5].

Based on case reports and our clinical experience, depression do occur after incidents of sexual abuse. However there

were no systematic research and screening done on the victims. We think that it is crucial to identify those sexually abused children who have depression to help us in the long term management of the affected patients. Furthermore, our understanding of the relationship between coping strategies and sexual abuse related outcome is quite limited. There were three previous studies which specifically examined how children or adolescents cope with sexual abuse [6-8]. In this study, we explore descriptively the type of coping used by the sexually abused children and its' relationship to depression. We limit the scope of coping strategies to emotion focused and problem focused coping strategies.

This study aimed to determine the prevalence of depression using the Malay-CDI and to examine the association of depression with the socio-demographics and coping strategies used in sexually abused children.

Methods

Samples

The samples were children aged 7 to 17 who attended the One Stop Crisis Centre (OSCC) services at Hospital Universiti Sains Malaysia for being sexually abused. We included those victims who were literate, not mentally retarded and with the duration of the incidence of abuse to the time of the clinical interview of within 6 months. Those who were categorized under incest cases were excluded. The research design was approved by the Universiti Sains Malaysia Research and Ethics Committee.

Procedure

The entire participants were assessed by a single researcher who was trained in performing psychiatric interview and mental state examination. The nature of the study was explained to the patient and her parents before a written consent taken. Both participant and a parent must give written consent before any assessment was made.

Instruments

A. Assessment of depression

Participants were asked to fill in the Malay-Children Depression Inventory. It is a self rated inventory used to assess depression in children age 7 -17 years [8]. The local validation study of Malay-CDI suggest the optimum score of 18 with good reliability (Cronbach's alpha coefficient = 0.83) and a good concurrent validity compared to MINI kid for the diagnosis of depression (Kappa agreement 0.88, $p < 0.05$). It has 90% sensitivity and 98% specificity in detecting depression [10]. Participants will then be classified as having depression or no depression, based on their score on the validated Malay version of CDI, above or below the optimum cut-off point.

B. Assessment of coping strategies

Coping strategies were measured by the semi-structured questionnaires based on the socialization theory, which had been categorized to emotion-focused and problem-focused for the purpose of the research criteria [11]. It is a mixture of open-ended and close-ended questions where by the researcher later categorized the answers given. As an exploratory study, the researcher tried to get the patients' answers spontaneously and they were only asked close- ended questions if they were unable

to give any answer. Participants could give more than a single answer.

C. Assessment of related psycho-social factors

A semi-structured questionnaire was developed to determine the psychosocial variables which included basic demographic data, as well as information on social support (with whom the participant live and either he/she has confidante; i.e. someone to confide with when he/she has problems), relationship with the perpetrator and duration between the clinical interview and the incidence.

Data analyses

The data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 12.0.1. The presence of psychological distress (depression or not) was taken as dependent variable. The socio-demographic variables (age, gender, race and education level, smoking, substance used), social support (living condition, confidante), relationship with the perpetrator (either known person or stranger), duration between the clinical interview and the incidence of sexual abuse and coping strategies were taken as independent variables.

Results

Demographic data

A total of 103 sexually abused children and adolescents who attended the OSCC HUSM from June 2005 to March 2006 had the interval of the incidence to the time of the study interview of less than 6 months. Eighty five participants fulfilled the study criteria but 20 participants refused to

participate. These left only 65 participants for the study. All participants were Malay female. The mean age was 14.7 (SD 1.99), ranged from 8 to 17 years. 15.4% and 84.6% of them were in primary and secondary school respectively.

Depression

The mean Malay-CDI scores was 12.58 (SD 8.78) and ranged from 0 to 54. Using the cut-off score of 18 of the Malay-CDI, 16 (24.6%) participants had been depressed and 49 (75.4%) participants had not been depressed.

Depression and demographics variables

Majority of participants, 47 (72.3%) stayed with both parents, 11 (16.9%) stayed with either mother or father and 7 (10.8%) stayed with guardian such as grandparent or relatives. Fifty (76.9%) of the participants confided to someone such as close friends, relatives, siblings and only 15 (23.1%) participants did not confide to anyone. None of the socio-demographic variables showed any significant association with depression except not having confidante. In the study sample, not having confidante was significantly associated with depression, as showed in Table 1.

Table 1: Association between depression and confidante status

	Depression status				P value Chi-square
	Depressed		Non Depressed		
	Frequency	%	Frequency	%	
Having confidante	8	12.3	42	64.6	0.006
Not having confidante	8	12.3	7	10.8	

*P< 0.05, significant

Majority of the perpetrator, 48 (73.8%) was known to the participants as boyfriends or close friends and the rest 17 (26.2%) was strangers. Seven participants had history of previous sexual abuse. Both perpetrator status and history of sexual abuse were not significantly associated with depression. The study revealed that 4 (6.2%) participants misused substance prior to the incident of abuse however only two participants who

misuse substances were depressed. Eight participants (12.3%) were smokers. The interval (days) between the interview and event were tested using independent t test and showed a mean difference between the groups. (Table 2) A shorter interval (less than 28 days), with mean = 27days was associated with depression as compared to a longer interval (more than 28 days) with mean = 107 days for the non depressed groups. (p=0.001)

Table 2: Interval (days) between the clinical interview and event in relation to depression status

Variable	Depression status				95% CI of mean difference		T statistics	p value
	Depressed (n= 16)		Non depressed (n=49)					
	mean	SD	mean	SD				
Interval	27.0	28.28	49.0	93.63	-129.93	-34.56	-3.446	0.001

*P< 0.05, significant; CI = Confidence Interval

Coping strategies

Most of the participants, 57 (87.7%) used emotion-focused coping strategies, 6 (9.2%) participants used problem or task-focused coping strategies and 2 (3.1%) used both emotion and problem-focused. Type of

coping strategies and the frequency used were as in Table 3 and Table 4. Three most common emotion-focused coping strategies used were “trying to forget about it”, “deciding that nothing can be done to change things” and “denial”.

Table 3: Type of emotion-focused coping used by respondent

Types of Emotion-focused strategies	Frequency	Percentage (%)
Trying to forget about it	43	66.2
Staying away from people or things that are upsetting	9	13.8
Ventilating feeling of anger and frustration	3	4.6
Deciding that nothing can be done to change things	33	50.8
Emotional support	9	13.8
Denial – pretending it was not happening	27	41.5
Suppression	15	23.1
Acceptance	12	18.5
Humor	0	0
Alcohol/drug –self destructive	0	0
Self blame	3	4.6

*More than one type of coping might be used

Table 4: Type of problem-focused coping used by respondent

Type of problem-focused coping strategies	Frequency	Percentage (%)
Planning -deciding priorities and acting so as to deal directly with the stress	1	1.5
Negotiating to reach agreement	3	4.6
Religion	2	3.1
Positive interpretation	8	12.8

*More than one type of coping might be used

Problem-focused coping strategies were not used frequently as compared to emotion-focused. Two out of 8 participants who used emotion-focused coping in combination with problem-focused coping i.e. one participant used “denial with positive interpretation and negotiating to reach agreement” and one participant used “deciding that nothing can be done to change things with positive interpretation”. Using a Chi-square test, it was found that none of the type of coping strategies used was significantly associated with depression ($p = 0.623$).

Discussion

Depression occurs mainly at the first three months after the date of the sexual abused incidence. Sixteen (24.6%) respondents had been depressed and 49 (75.4%) respondents had not been depressed. Depression has been consistently reported to be the most common effect of child sexual abuse [12-15]. In one study, Koverola et al found that 67% of the children could be classified as experiencing symptoms consistent with a diagnosis of depression [16]. In this study, the advantages of using a self-rated interview for the sexual abuse population include a more accurate self admittance and

less traumatic as compared to interview-rated diagnostic scales. We assessed depression as an immediate sequel within 6 months after the abuse, however, child sexual abuse has consistently been linked to a range of other difficulties including; alexithymia, dissociation, post-traumatic stress disorder, personality disorders and substance abuse [3,17].

In this study, the socio-demographic factors such as age of onset, educational level, smoking and substance used were not significantly associated with depression. We thought that smoking and substance use were part of the victims coping strategies however for this sample they misused substance and start smoking prior to the incident of abuse. During analysis, smoking and substance used were not associated with depression. This is consistent with study by King et al who found that drug use and smoking were not significant predictor of sexual victimization [18]. In contrast, Moran et al reported that maltreatment such as sexual abuse was associated with increased levels of illicit drugs used. The involvement into this unhealthy behavior is part of the behavioral problem prior to the abused [19].

This study showed that perpetrator status, majority of them were known to the participants as boyfriends or close friends. This is consistent with previous studies which showed that majority of the rape survivors knew the perpetrator [20]. Perpetrator status was not found to be significantly associated with depression. In addition this study excluded incest cases due to ethical and medico legal purposes. If the incest cases included, the number of depressed participants might increase and the possibility of significant relationship will be higher. Other studies found that the relationship with the perpetrator contribute the negative psychological outcome in sexually abused survivors [3, 21].

Social support definitely is a very significant factor which can determine the outcome of abused, and finding in this study replicate this. Depression was significantly associated with not having confidante. By having confidante, who showed conditional positive regard, it can be a protective factor against depression for children and adolescents after their experience of sexual abuse. Koverola found that having a supportive mother is a variable that can be targeted for intervention [16]. This was supported by Runtz & Schallow; they recommended that perceived social support and family environment contribute to the positive psychological outcome in sexually abused survivors [22]. Social support has been found to play a positive role in psychological adjustment. This type of support contributes to positive personal development and provides a buffer against the negative effects of stress. It has also been reported that a strong support system serves as a protective buffer to child sexual abused [23-26]. Murthy & Espelage revealed that child sexual abuse survivors who perceive more support from family and

friends report fewer losses in term of self and optimism [27].

Emotion-focused coping strategies were used frequently by the participants compared to problem focused strategies. Majority of the sample, 57 (87.7%) used emotion-focused coping strategies. The first three most chosen strategies: were firstly, deciding that nothing can be done to change things, secondly denial and thirdly suppression. These types of coping strategies were chosen probably due to cultural differences and beliefs that the sexual abuse was a taboo and people were discouraged to disclose it. In fact in Malay culture who all are Muslim whenever bad thing occur they will accept it as the God planning and there might be a lesson for that.

On the other hand, only 6 (9.6%) respondents used problem-focused coping strategies. It consisted of planning-deciding priorities and acting so as to deal directly with the stress, negotiating to reach agreement, religion and positive interpretation and 2 (3.1%) respondents used both emotion and problem-focused coping strategies.

Our finding is similar to a study on childhood coping strategies of female sexual abuse victims by Kendal which showed that the victims used both type of coping; they attempt both to regulate their distress (with emotion focused coping strategies) and to impact the actual abuse situation (using problem focused coping strategies). However, the victims relied more on the use of emotion-focused strategies [3].

Perhaps since we measured the acute and intermediate after-effect of the abuse, the emotion- focused strategies were mostly used by the victims. Suls & Fletcher, found

emotion-focused coping to be helpful initially, yet it became less effective over time [28]. In addition, Chaffin et al generally viewed avoidance as a relatively ineffective coping strategy [29]. However by using avoidant strategy, it may be adaptive, at least temporarily to control the situation and the most practical and advantageous coping option in response to those traumatic situations. This was reported by the respondents in this study. They were more comfortable using avoidance coping as it was adaptive during their experience with the abuse.

Although avoidant strategies have been generally viewed as less adaptive coping responses by some researchers, given the lack of control and helplessness often associated with childhood sexual abuse, avoidance may be the most practical and advantageous coping option in response to those traumatic situations. Chaffin et al supported the idea that avoidant coping to at least some extent was associated with benefit measured such as less problematic at school [29].

Interestingly, Burt & Katz revealed that expressive coping after sexual assault tended to improve over time and was therefore an indication for long term recovery [30]. Similarly, this study found that majority of the respondents used emotion-focused coping in the time interval less than six months after the sexual abuse. Consistent with the finding by Pennebaker & Beall, who found that directly expressing one's feeling about a traumatic event has long-lasting positive effects on physical health [31]. This again proved by significant association between having confidante and depression as found in this study. This apparent discrepancy may be explained by the fact that emotion-focused coping can

involve both potentially positive (e.g., emotional expression) and negative behaviors (e.g., self blame).

None of our respondents used self-defeating strategies in coping such as self-destructive behaviors namely contemplating suicide, drinking alcohol and abused drug. Previous studies documented that those who used these maladaptive coping have an impaired psychosocial functioning [32,33].

People can regulate their emotional responses through behavioral and cognitive approaches. Ellison and George stated that religiosity may lower levels of depression, psychological distress, and may reduce the risk of certain types of serious chronic physical conditions. Religiosity or spiritual support provides a sense of meaning, coherence, and self esteem [34]. Again, in this study only two respondents practiced religiosity as their coping strategies.

In a sample of college women, Long and Jackson found that detachment and wishful thinking emerged as the most commonly utilized emotion-focused strategies. Results further suggested that adult psychological distress was associated with greater use of emotion-focused coping strategies in response to sexual abuse during childhood. In both of these studies assessing coping styles, the types of strategies most frequently reported by childhood sexual abuse survivors (e.g., denial, emotional suppression, detachment, wishful thinking) could loosely fit under the broader heading of "avoidance." Interestingly, these studies also suggest that use of avoidant strategies may be most harmful in terms of possible long-term and negative psychological effects

[35]. Two other studies found that coping strategies could be a predictor in

psychological outcome in sexually abused children [36,37]. However our finding did not suggest this association.

Children Depression Inventory could be used for the screening of depressive symptoms in sub-population such as sexual abused children, provided that the inventory should be validated in larger and more diverse samples in Malaysia.

The sample in this study were only female, though they are more vulnerable to being abused sexually, the result cannot be generalized to both sex. The depression was assessed using the Malay-CDI, as to avoid inducing further psychological trauma of interview to the victims. To diagnosed depressive disorder a structured interview scales should be used. However Malay-CDI had been validated and used to detect depression in a child and adolescent in Malaysia.

The description of coping strategies were basically a descriptive evaluation, further research using a more structured scales are needed in this area. Parent or teacher reports on children's coping tendencies are other reliable alternatives [38,39].

Conclusion

Twenty five percents of the sexually abused children in this study were depressed. The screening of depression in the vulnerable group such as sexually abused children is important, for the purpose of early detection and treatment. In most cases depression occur early after the traumatic incidence and having a confidante was inversely associated with depression. Majority of the respondents used emotion-focused coping strategies. By recognizing the coping strategies used in

sexually abused children, the clinician could understand them better and plan for their psychological management.

Acknowledgement

This research project has been supported by the Short-term Intensification of Research in Priority Areas Grant, Universiti Sains Malaysia.

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Corresponding Author: Rohayah Husain, Senior Lecturer, Faculty of Medicine and Health Sciences, Universiti Darul Iman Malaysia, Kampus Kota, 20040 Kuala Terengganu, Terengganu, Malaysia.

E-mail: rohayah@udm.edu.my or rohayahkt@gmail.com