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Research Paper

Clinical Correlates of Children and Adolescents with History of Abuse Presenting in A Tertiary Care Hospital in India

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ABSTRACT

The current study aimed to assess the clinical features of children and adolescents with exposure to trauma. Objective assessment of children adolescents (age below 15 years of age) with history of abuse (physical, emotional, sexual and neglect) evaluated at the Erna Hoch Centre for Child and Adolescent Psychiatry at CIP, Ranchi (Jharkhand, India) during a 3-month period was conducted. The most common form of abuse was emotional abuse (64%) followed by physical abuse (34%). All children and adolescents presented with psychiatric symptoms. The commonest diagnoses were Anxiety-disorders (38%), and Depressive Disorder (28%) followed by Dissociative disorders (14%) and disruptive disorders (12%). Vast majority (62.2%) had exposure to more than one form of trauma event. Children had poor global functioning and well-being, with significant reduction in positive emotional state and positive outlook in them. Psychiatric morbidity is a crucial reality in the clinical group of children with a history of any type of abuse. A significant number of these youngsters experience multiple forms of abuse. Anxiety and depressive disorders, coupled with diminished global functioning and well-being, are widespread among abuse victims. During the initial consultation, it is essential to evaluate risk factors, circumstances of misuse, and psychiatric morbidity to deliver customized interventions for this population. In the present context, proactive involvement with caregivers and adaptability in delivering therapies may be crucial for maintaining consistent communication between these families and the mental health system. Future study should concentrate on risk factors, resilience factors, and the efficacy of interventions tailored to the Indian context.

Keywords: *Child abuse, India, Adverse experiences, Maltreatment, Psychiatric disorders*

The influence of trauma on society is becoming increasingly recognized. Childhood abuse in India constitutes a substantial and underreported concern, with prevalence figures underscoring the gravity of the issue. More than 30 years ago years ago, India adopted the Convention on the Rights of the Child (United Nations; Assembly U.G., 1989), which includes the right to be free from violence. In the 2030 Agenda for Sustainable Development, "*stop abuse, exploitation, trafficking, and all kinds of violence against and torture of children*" was added to reinforce the legal requirement to protect children from

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violence (United Nations; Agreement 2015). Still, nothing is known regarding national child abuse trends.

In a meta-analysis (Barth et al., 2013) of global childhood maltreatment, only two Indian studies (Banerjee, 2001; Hasnain & Kumar 2006) were included due to small sample size, non-representative individuals, and non-validated survey questions. A study estimates that every second Indian child is sexually abused and violent (Behere et al., 2013). Another research of runaway boys found 62% domestic violence, 72% physical abuse, and 35% sexual abuse (Bhat et al., 2012). A 2015 Puducherry study found that 48% of students were mocked for their appearance, 56% were beaten as children, 13.4% of whom needed medical treatment, 10% were exposed to another person's private parts, and 6.4% were forced to expose them. In a large study of 1060 adolescent girls from semi-urban parts of Capital Delhi, 42.6% were physically assaulted, 26.6% sexually abused, 37.9% emotionally abused, and 40.1% neglected (Daral et al., 2016). In a sample of 600 teenagers in Kerala (South India), Damodaran and Paul (2017) found that 91% reported at least one adverse childhood event (ACE) and more than half reported three or more, and physical and sexual abuse have been reported higher by boys than girls. The National Crime Records Bureau Report (NCRB, 2022) reported 1,49,404 child-related crimes in 2021, up 16.2% from 2020.

The effect of abuse on children and adolescents are extensive, primarily encompassing neurobiological and cognitive alterations, as well as modifications in stress responses, physiological patterns, and behavior. The robust correlations between childhood maltreatment and many psychiatric health outcomes have indicated that abuse may impart a non-specific risk for psychopathology (Carpenter & Chung, 2011; Janiri et al., 2023; Üçok & Bikmaz 2007). A meta-analysis 190 studies, encompassing 68,830 individuals with childhood abuse, revealed an elevated risk for higher depression symptom scores and depressive disorders (Humphreys et al., 2020). Carr et al. (2013) examined studies concerning the correlation between early life adversities and adult mental disorders. Twenty investigations in the review revealed a correlation between sexual abuse and post-traumatic stress disorder, panic disorder, agoraphobia, and obsessive-compulsive disorder, while anxiety disorders were seen to be a consequence of with physical abuse and neglect. Similarly numerous studies have found presence of PTSD (Gekker et al., 2018), Dissociation (Kate at al., 2020; Vonderlin et al., 2018), and Bipolar affective disorder (Benarous et al., 2017; Cazala et al., 2019) as clinical outcomes of childhood abuse.

Given the scarcity of research regarding the mental health ramifications of child abuse in India, there is an immediate necessity to comprehend the clinical attributes and mental health requirements of the children and adolescents. A hospital based cross-sectional study of children and adolescents with a history of abuse (physical abuse, sexual abuse, emotional abuse, and neglect) was conducted to comprehend the needs of this population and to inform therapies suitable for our socio-cultural environment.

MATERIALS AND METHOD

Venue and period of study

The study was conducted at the outpatient department of the Erna Hoch Centre for Child and Adolescent Psychiatry (EHCCAP), at the Central Institute of Psychiatry (CIP) in Ranchi city of Jharkhand state (India). It offers tertiary care clinical services for children and adolescents from all over the country. Data was collected from children and adolescents below 15 years of age with history of physical abuse or sexual abuse or emotional abuse or neglect (either

one or more), who utilized the outpatient department of the EHCCAP during the period of December 2019 to February 2020, was collected.

PROCEDURE

Children and adolescents who presented to the EHCCAP Out-patient Department were evaluated in detail on case record sheet. The case record sheet included baseline demographic and clinical characteristics (presenting complaints, family history, temperament, past and personal history, general physical examination and investigation details). All patients with history of abuse underwent a thorough interview on Traumatic Events Screening Inventory (TESI; Ford & Rogers, 1997) to ascertain presence of significant abuse. The socio-economic status was measured using Modified Kuppuswamy socio-economic scale (Bairwa et al., 2013). Presence of psychiatric disorders was ascertained using the M.I.N.I International Neuropsychiatric Interview for children and adolescents *(*M.I.N.I- K.I.D. 7.0; Sheehan & Lecrubier, 2010). The functioning at the time of initial presentation was scored using the Clinical Global Assessment Scale (CGAS; Shaffer et al., 1983), which is rated from 0 to 100 scale rated based on all available information to assess the overall level of psychosocial functioning (higher scores reflect higher functioning). A score below 60 is often used as the threshold to mark overall impairment. The general well-being of the children and adolescents was assessed using the Stirling's Children Well-Being Scale (SCWBS; Lidder and Carter, 2015). It is a 12 item, Likert rating-based scale, which assesses positive emotional state and positive outlook of the rater. Limited access and disclosure of the data were done to ensure confidentiality. The Institute Ethics Committee approved this as a part of a larger doctoral study in the Institute. All study participants were provided psychotherapy and pharmacotherapy as part of the study.

Data Analysis

Results on continuous measurements are presented on mean and standard deviation and results on categorical measurements are presented in number (percentage), using SPSS version 29.

RESULTS

Sociodemographic and clinical characteristics:

A total of 50 children and adolescents, presenting at EHCCAP outpatient centre, with history of significant abuse as interviewed on TESI-C, were assessed for presence of psychiatric disorders, global functioning and general well-being. The mean age of the children was 13.86 (±2.42) years and mean years of education of 8 (±2.55) years, majority belonging to rural (64%), Hindu (88%), and middle socio-economic class (56%) with nuclear family type (86%). Vast majority of children had no significant past history of medical illness (88%) and no significant family history of medical (66%) and psychiatric illness (76%). Mean age of onset of psychiatric illness was 12.80 (± 2.11) years, and mean duration of illness was 3.08 (± 7.54) months.

Table 1: Comparison of socio-demographic and clinical characteristics of total sample (N=50).

Variables	**Total sample (N=50)** **Mean ± S.D. / n (%)**
Age (in years)	13.86 ± 2.42
Education (in years)	10.04 ± 2.55
Gender	

Variables	**Total sample (N=50)** **Mean ± S.D. / n (%)**
Female *Male*	25 (50) 25 (50)
Residence *Rural* *Urban*	 32 (64) 18 (36)
Socio-economic status *Lower* *Middle*	 22 (44) 28 (56)
Family Type *Nuclear* *Joint*	 43 (86) 7 (14)
Religion *Hindu* *Muslim* *Christian*	 44 (88) 2 (4) 4 (8)
Past history of medical illness *Absent* *Present*	 44 (88) 6 (12)
Past family history of medical illness *Absent* *Present*	 33 (66) 17 (34)
Past family history of psychiatric illness *Absent* *Present*	 38 (76) 12 (24)
Duration of illness (in months)	13.08 ± 7.54
Age of onset (in years)	± 2.11

Table 2: Type of trauma reported, Psychiatric diagnosis, global functioning and well-being of children and adolescents (N=50)

Variables	**Total sample (N=50)** **Mean ± S.D. / n (%)**
Type of Trauma reported *Physical* *Sexual* *Emotional* *Neglect* *More than one form of trauma*	 17 (34) 07 (14) 32 (64) 10 (20) 31 (62.2)
Psychiatric Diagnosis *Anxiety and OCD related disorders* *Mood disorders* *Disruptive disorders* *Dissociative disorders* *Others*	 19 (38) 14 (28) 6 (12) 7 (14) 4 (08)
CGAS	41.66 ± 4.63
SCWBS *Positive Emotional State* *Positive Outlook*	23.68 ± 4.07 9.92 ± 1.49 13.96 ± 2.68

Characteristics of abuse:

Table 1 lists the type of reported abuse by children and adolescents. Highest reported form of abuse was emotional abuse (64%), followed by physical abuse (34%), neglect (20%) and sexual abuse (14%). Vast majority (62.2%) of children experienced more than one form of abuse.

Characteristics of Psychiatric diagnosis

The distribution of psychiatric disorders across the sample presented in Table 2, as assessed by the M.I.N.I.-K.I.D. interview, revealed the presence of Major Depressive Disorder (35%), Social Anxiety Disorder (27%), Conduct Disorder (14%), Dissociative Disorder (10%), Bipolar-Disorder (6%), Panic-Disorder (6%), and obsessive-compulsive disorder (2%). The resulting diagnosis, based on M.I.N.I.-K.I.D. - 7.0, was divided into five broad categories: mood disorders, anxiety and OCD-related disorders, dissociative disorders, disruptive disorders and others. Anxiety disorders were the most common psychopathology, accounting for 38%, followed by mood disorders (28%), dissociative disorders (14%), and disruptive disorders (12%).

Global functioning and General well-being

The mean CGAS score of the children and adolescents was 41.66 ± 4.63, indicating impaired level of global functioning due to psychiatric symptoms. Also, on the SCWBS, mean general well-being score was 23.68 ± 4.07, indicating poor well-being, with low mean scores both on positive emotional state (9.92 ± 1.49) and positive outlook (13.96 ± 2.68).

DISCUSSION

There is lack of literature available on psychiatric consequences in children and adolescents exposed to various kinds of abuse. The present study was modest in size. The age range of the participants were broad from 8-15 years, including both sexes and well-established diagnostic tools were used for the diagnosis and assessment of severity of psychopathology and functioning. This study is an attempt to contribute to better treatment research and implications for the affected children.

The mean onset of illness of children in study was around 12 years, which is supported by prior literature stating that most childhood adverse events in India occur prior to the age of 12 years (Kumar et al., 2019). The study participants largely come from rural areas, which may be because the catchment area of the institution (where study was conducted) is mainly rural in nature. Furthermore, findings from other study on childhood trauma and related adverse events have identified rural domicile as a risk factor due to the presence of poverty, gender discrimination, increased exposure, and limited safety measures (Deb & Mukherjee, 2011).

Emotional abuse was the most commonly reported type of abuse, followed by physical abuse. Like-wise was found in the seminal survey conducted by the Indian Ministry of Women and Child Department in 2007. The fact that every second child, male or female, feels they have experienced emotional abuse is concerning, even if the symptoms of emotional abuse are less obvious and measurable than those of physical and sexual assault. Furthermore, adults, parents, and other caregivers do not consider many emotional abuse symptoms to be abuse since they are culturally acceptable forms of child discipline. According to a study also by Kumar et al. (2019), physical and emotional abuse are more common in other regions of India.

Most common psychopathology was noted to be anxiety and mood disorders. Landmark review studies have also identified an elevated risk of depression and anxiety symptoms (Gardner et al., 2019; Humphreys et al., 2020). Depression is firmly associated with exposure to emotional abuse (Mandelli et al., 2015) which was high in our study sample. Rose and Abramson (1992) postulated that emotional abuse renders individuals particularly susceptible to the development of a negative cognitive style, which, in turn, elevates the likelihood of depression. This formulation posits that children endeavor to comprehend the origin of the adverse life events they encounter. In the event of recurrent abuse instances, children may develop a more depressogenic causal attribution for the abuse (i.e., an attribution that is internal, stable, and global).

Potentially influential factors in the emergence of mental health problems in children who have experienced abuse include amygdala responsiveness, engagement of ventral prefrontal cortex, and connection within resting-state brain networks. The genesis of phobic fears is influenced by the amygdala system, while the maintenance of both particular fears and generalized anxiety is influenced by the frontal mechanism (Indovina et al, 2011). The aberrant network architecture in severe depressive disorders, together with the traumatic childhood experiences, may be explained by the underlying neurobiological mechanisms of symptoms as they relate to resting-state brain network connections (Yu et al., 2023). This highly impacts the overall functioning and well-being of the child who may grow as an adult with psychopathology.

This study emphasizes that recognizing all types of child abuse as risk factors for mental health disorders like depression and anxiety disorders, implicates the need for worldwide efforts to address this public health issue in children and adolescents. To determine the expected course and outcome of a child with a history of abuse, the initial evaluation should assess family and environmental factors, parenting and support, abuse conditions, and child symptoms and developmental needs. Psychoeducation and evidence-based therapy for safety, stabilization, and identity would benefit. Empathetic interviewing in clinical setting allows children to share their feelings in a secure and nonjudgmental atmosphere.

CONCLUSION

Psychiatric morbidity is a crucial reality in the clinical group of children with a history of any type of abuse. A significant number of these youngsters experience multiple forms of abuse. Anxiety and depressive disorders, coupled with diminished global functioning and well-being, are widespread among abuse victims. The traumatic experiences can significantly decline functioning and positive emotional state and outlook of the children. During the initial consultation, it is essential to evaluate risk factors, circumstances of misuse, and psychiatric morbidity to deliver customized interventions for this population. In the present context, proactive involvement with caregivers and adaptability in delivering therapies may be crucial for maintaining consistent communication between these families and the mental health system. Future study should concentrate on risk factors, resilience factors, and the efficacy of interventions tailored to the Indian context.

Limitations

Given that the venue of the study (CIP) functions as a tertiary treatment centre, referrals typically pertained to critical mental health conditions and severe abuse cases, so the data may not accurately reflect the general community. The findings do not accurately represent the real prevalence due to a limited sample size and the short duration of the study.

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Conflict of Interest

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