

Barriers and Challenges in Seeking Psychiatric Intervention in a General Hospital, by the Collaborative Child Response Unit, (A Multidisciplinary Team Approach to Handling Child Abuse) A Qualitative Analysis

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ABSTRACT

Child abuse is a serious criminal act against children in our country and punishable according to protection of children from sexual offenses act 2012. No one agency has the ability to respond completely to the abuse. Hence a multidisciplinary team approach was developed in India. Aim is to narrate the collaborative effort among the multiple disciplines in a general hospital to deliver child protection services and explore the barriers to integrate psychiatric services. **Methodology:** Members of the team were recruited from different disciplines and trained by experts. A mission statement, protocol to assess the victims and provide treatment was formulated as an algorithm. The barriers to psychiatric treatment among the stakeholders were analyzed using framework method of qualitative analysis. Results (After 20 months) the unit received 27 referrals in 20 months, 24 females, and 3 males. Age of the victims was between 8 months and 17 years. Two cases found to be physically abused. Penetrative sexual abuse was found in 23 cases, pregnant victims were 4. Most referrals were by police, trafficking found in 6 cases. **Discussion:** It was possible to provide multidisciplinary care to the victims and families. Recurrent themes of barriers to psychiatric treatment were stigma, victim blaming; focus on termination of pregnancy, minimization of abuse in males by stakeholders. Conclusion is collaboration needs more effort to integrate psychiatric services but can minimize the reduplication of services.

Key words: Barriers to psychiatric treatment, child abuse, multidisciplinary team, protection of children from sexual offenses act, qualitative analysis

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INTRODUCTION

Child abuse is a broad term that encompasses physical, emotional ill treatment, neglect and sexual abuse, commercial or other exploitation of a child resulting in actual or potential harm to the child's health, survival, and development, affecting their dignity in the context of a relationship of responsibility, trust, or power.^[1]

Nineteen percent of the world's children live in India constituting 25% as per the census 2011 of the total population. In 2007, the Ministry of Women and Child Development published the "Study on Child Abuse India 2007."^[2] It sampled 12,447 children, 2324 young adults, and 2449 stakeholders across 13 states. It looked at different forms of abuse, physical, emotional, sexual, and girl child neglect in five evidence groups, namely, children in a family environment, children in school, children at work, children on the street, and children in institutions.

The study's main findings were:

- Two out of every three children are physically abused
- Every second child reported emotional abuse
- 53.22% children reported sexual abuse
- Among them, 52.94% were boys and 47.06% were girls
- Children on the street, at work and in institutional care reported highest incidence of sexual abuse
- The study also reported 50% of abusers were known to the victim and were in a position of responsibility towards the child
- And most children had not reported it to anyone.

However, in general, not much was done to safeguard and protect or to prevent such abuse. Protocols and standard operating procedures were for dealing with the victims. Families and the perpetrators, but were not fully implemented either in immediate postincident timeframes or for long term. This could be attributed to a lack of will, funding, facilities, legal guidelines, and adequately trained manpower in equal amounts. The law was in itself ambiguous about the definitions of the various terms and actions in the words.

Today, child abuse is considered a serious criminal act against children in our country, the Protection of Children from Sexual Offenses Act 2012 (POCSO) was passed by the Lok Sabha in May 2012. Under its definitions, an offense is treated as aggravated when committed by a person in a position of trust or authority of child. A child is defined as any person below the age of 18 years, and most important of all, the offenses of sexual assault, sexual harassment, and pornography are clearly defined for the first time in law. In addition, the

Act provides for stringent punishments which have been graded as per the gravity of the offense.^[3]

Due to the complex and sensitive nature of child abuse, treatment must be comprehensive to meet the needs of the affected children and their families. No single profession or state agency can respond adequately to deal with any allegation of child maltreatment. Hence, multiple professionals are required to meet the challenge.^[4] As a result, multidisciplinary child protection teams began to form in the late 1950s in the west, and such a service approach has become normative in the west.^[5] In fact, failure to provide a multidisciplinary approach is considered to be a form of malpractice^[6] in some countries. The first contact/response multidisciplinary team (MDT) is only now being set up in some parts of our country. Some of these have official government backing while some are purely run by nongovernmental organizations (NGOs), others by the government and rest a mix of both.

An MDT consists of a group of professionals, who work together in a coordinated and collaborative manner, with a shared purpose, clear goals, external support, recognition, under impartial leadership to ensure an effective response to reports of child abuse. In the west, pediatricians, social workers, and police officers constitute the team, apart from other professionals.

As per the protocols adopted for its first contact, the MDT may focus on investigations to assist the judiciary, policy issues, treatment of victims and their families and perpetrators or a combination of these. The MDT approach often extends beyond joint investigations and inter-agency co-ordination into team decision-making. Team investigations require full participation and collaboration of team members who share their knowledge, skills, and abilities. Team members remain responsible for fulfilling their own professional roles while learning to take cognizance of other team member's roles and responsibilities in consideration.^[7] Since antagonisms are known to occur in professional territory, equal representation of all team members needs to be worked at constantly.^[8]

An effective MDT causes less "system inflicted" trauma to the children and their families, better agency decisions leading to accurate investigations and more appropriate interventions, lesser number of interviews, efficient use of limited agency resources, better trained, more capable professionals, less stigma, and less burn out^[9] among child abuse professionals. These benefits can translate into safer communities.^[6,7] NGO's often provide counseling and temporary care of the victims if specialists are not available. In developing countries, psychological assessment and psychotherapy to the child and family is usually offered by psychiatrists.

However in our country (and elsewhere too), it is often noticed that there is an obvious attitude of all, the victim, the family, and the other law enforcement officers involved in one major aspect of this unfortunate incident, and that is of acute discomfort and resistance on the subject of seeking psychiatric intervention from the first contact itself.

This is unfortunate as this resistance puts up barriers to the much-needed help and succor that both the affected child and the family needs on an immediate basis. This leads to an inordinate amount of misery and morbidity in the victims as well as in the families.

Aims and objectives

- To narrate the collaborative effort among the professionals of pediatrics obstetrics, forensic medicine, psychiatry, emergency medicine, and social work disciplines as part of the MDT of First response team, in a General Hospital, to deliver effective and sensitive child protection services from November 2011 up to July 2013
- To explore the barriers for effective integration and delivery of psychiatric services by applying qualitative analysis.

MATERIALS AND METHODS

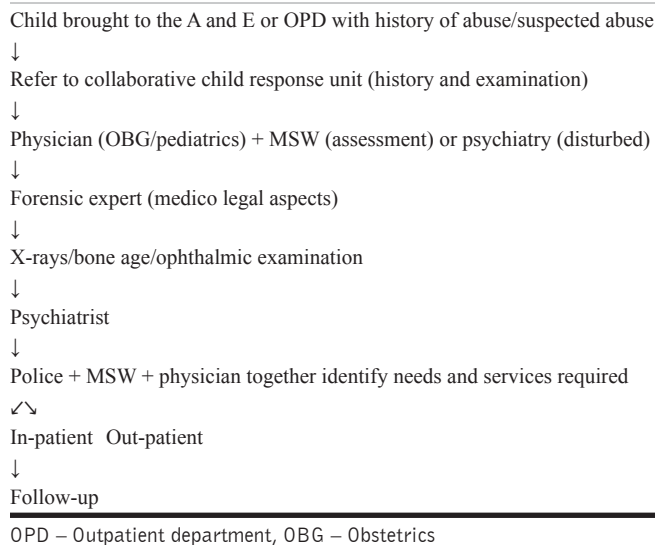
Constituting the multidisciplinary team

The members of the team were identified and recruited among the professionals of pediatrics, obstetrics, forensic medicine, psychiatry, emergency medicine, social work disciplines of the hospital among doctors and nursing staff. The rich inputs of Enfold trust, an NGO, Karnataka State Commission for protection of child rights Child Welfare Committee and Child Guidance Clinic of NIMHANS Bangalore were taken to train multidisciplinary professionals to form the team.

The collaborative child response unit at the hospital aimed to provide children a safe and nurturing environment with compassionate diagnostic assessment and intervention services at the first contact. It sought to co-ordinate the efforts of the various stakeholders, namely, the police, doctors, NGOs, lawyers, and other child protection services, assisting the abused children and their families. It addressed the abused child's need for safety, dignity, and privacy. The mission statement and a protocol to assess child abuse victims, conduct forensic evaluations, and provide appropriate physical, psychological treatment, and support to the families, while evaluating their attitudes (resistance) to the psychological intervention offered, were formulated by the unit.

A standard interview format was designed to assess the child, including a mental status examination. Although

Table 1: Algorithm



taping the sessions could reduce the repetition of questioning,^[10] it was not done as one of the barriers to seeking help was fear of loss of confidentiality and also 96% of children receive only one interview when they are taped, and this may be counterproductive to the interests of children who may have done partial or reluctant disclosure during the initial session.^[11,12] An algorithm was drawn for the management of cases as outlined below [Table 1]. This follows the standard operating procedures as laid down by the MDT.

The sample

Sample sizes are typically small in qualitative work. One way of identifying how many people are needed is to keep interviewing until, in analysis, nothing new comes from the data this point is called the “saturation.”^[21]

All the notes made of the interviews were cut and pasted on a KG cardboard, so as to see the major themes clearly, some words appearing repeatedly indicated the major theme. Since the sample size was small, the computer package for analysis <http://www.caqdas.soc.survey.ac.uk> was not purchased. Instead, coding for all the statements was made manually in different color pens. For the sake of confidentiality, these transcripts are not exhibited here.

The interview

All the statements made by the stakeholders regarding psychiatric assessment and treatment were recorded in each referral made to the psychiatrist. Semi-structured interviews and in-depth interviews were conducted to explore the topic of understanding the nature, aims, and need for psychiatric treatment to the victims. Small talks, verbal, and nonverbal behavior of the stakeholders were also recorded as observations. Subjective emotions of the interviewer were recorded so as to understand the

subjective bias. Notes were written usually immediately after the interview, though cues and some points were noted even during the interview.

The framework of themes and patterns generated an index of major themes. This index was applied to all the statements recorded in brief summaries of the interviewee's thoughts about abuse, victim, and victimization. The sample size required to reach saturation based on data collection method of in-depth interview was thirty for the parents and other focus groups of law enforcement, and team members of MDT was ten.^[20]

The topic guide for semi-structured interview composed of the following questions.

Do you think counseling or psychotherapy could be helpful or useful to the victim and the family?

Aims and process of psychotherapy was explained to the caregivers as bidirectional, providing a holding environment for the child to narrate the context of the relationship in which abuse occurred and the sensorineural description of the abusive act (this required rapport of several sessions of normalization of her routine) and to educate the child consequences in her own behavior due to the trauma of abuse.

The designated staff was available round the clock; referrals to the unit could be by anybody including the police, family members of the victim, NGO, other hospital staff and professionals.

Outpatient referrals were between 9.00 am and 1.00 pm, emergency outpatient referrals were addressed by an on-call pediatrician, forensic expert, and any other professional immediately needed. The study was approved by the Hospital Research Ethics Committee.

The MDT-Critical Care Resuscitation Unit (CCRU) received 27 referrals in 20 months, between ages 8 months and 17 years. The nature of abuse was sexual in 25 cases, physical abuse in one case, both physical and sexual in one case. The gender of the 24 victims was female and three was male. Seven cases were <10 years of age and 20 were between 13 and 17 years of age [Table 2].

The youngest victim of sexual abuse was of familial abuse in a child 1 year and 8 months old. The other young victim was 1 year 9 months old, also familial abuse and was placed in pediatric intensive care. Another girl child of 2 years with repeated rib fractures referred from a hospital that had treated her 3 times in the past, also had head injuries with suspected physical

Table 2: Results after 20 months n=27

Socio-demographic data + Features of abuse	n=27 (%)
Age of the victim (years)	
<10 (7)	25.93
Between 10 and 17 (20)	74.07
Gender of the victim	
Female (24)	88.9
Male (3)	11.2
Nature of abuse	
Sexual (25)	92
Physical (1)	8
Both (1)	-
Penetrative abuse (oral sex, sodomy included)	
Penetrative (23)	85.2
Nonpenetrative (4)	14.8
Pregnancy	
Present (4)	14.8
Absent (16)	59.25
Trafficking	
Present (6)	22.2
Absent (21)	77.7
Grooming	
Female victims of extra-familial abuse-compliant (16)	59.2
Not confirmed, including coercion (11)	40.7
Police referrals (23)	85.1
Other referrals (4)	14.8

Table 3: Topic guide of the interview for qualitative analysis

	Yes	No
Does the child need psychotherapy?	25	39

Table 4: Results of the interview

	Yes	No	Total
Police/law maker	4	4	08
MDT member from CCRU	12	3	15
Family member of victim	9	32	41

MDT – Multidisciplinary team; CCRU – Child response unit

abuse by parents died after discharge. The victims below the age of five had sustained more severe abuse than victims above that age [Tables 3 and 4].

Nonpenetrative sexual abuse was found in cases of four females. There was grooming by the offender in 16 cases of female victims referred by police; they were all perpetrated by extrafamilial offenders. In girls aged 13–17, pregnancy caused disclosure of abuse in four cases. Kidnapping and Elopement of the victim with the abuser was also a consequence of grooming found in 16 cases. Trafficking was the cause of abuse in 6 cases of girls between 16 and 17 years of age, rescued by police.

Among the three male victims, one was coerced to perform oral sex; another was subjected to sodomy, and the third victim was referred by pediatrician for

the dissociative episodes displayed by the victim during hospitalization for urinary tract infection.

All cases seen by the psychiatrist were diagnosed with axis one disorders including acute stress disorder, posttraumatic stress disorder, dissociative disorder, mixed anxiety, and depression. Psychiatric services could not be delivered in six cases, referred by the police who came for forensic examination and left the hospital soon after. Debriefing for the acute trauma, psycho-education to the family regarding personal safety behaviors in the very young, was done.^[13,14] In cases of adolescent victims, the concept of “grooming” and “child abuse accommodation syndrome” was explained to the family.^[15,16] The follow-up for psychiatric treatment services was poor, with high attrition rates. Hence, a qualitative analysis was undertaken simultaneously to explore the barriers to receive psychiatric treatment.

It was possible to deliver gynecological services for MTP, forensic examination to assist the judiciary, pediatric, and intensive care for victims of physical abuse, and psychiatric evaluation and debriefing to all victims by the collaboration of team members. Facilities to preserve the collected evidence (aborted fetus) were provided as and when required. MTP was required in 4 of the cases referred by the police. In all the cases, the aborted fetus was collected from the hospital by the police. All cases brought by the police did undergo forensic evaluation in the hospital, and collecting techniques were refined, appropriate to the situation to avoid contamination, ensuring chain of continuity.

Qualitative data analysis to explore the barriers to psychiatric treatment in the collaborative child response unit

Qualitative analysis was done, using “framework” method.^[19] The hypothesis/framework was that barriers to psychiatric treatment were exhibited by all the stakeholders, namely, the law enforcement personnel of 8 members, 15 members of the MDT, and family consisted of 41 members. Combination or mixed purposeful sampling (in qualitative analysis, the sample reflects the barrier to treatment is selected) was made; using both stratified purposeful sampling of subgroups (focus groups) of pregnant victims, familial abuse, extra-familial abuse trafficking, grooming/compliant victims and male victims and intensity sampling was also done choosing information rich cases that manifest the phenomenon intensely.^[20]

All the notes made of the interviews were cut and pasted on a KG cardboard, so as to see the major themes clearly, some words appearing repeatedly indicated the major theme. Since the sample size was small, the computer package for analysis <http://www.caqdas.soc>

survey.ac.uk was not purchased. Instead, coding for all the statements was made manually in different color pens. For the sake of confidentiality, these transcripts are not exhibited here.

Stigmatizing the victim for the experience and blaming the victim were the frequently found themes among family. Both strategic and operational barriers to psychiatric treatment were identified as outlined below. Each theme is discussed separately specific to the subgroup.

To reduce the bias and increase the validity of the data, methods like triangulation (asking the same questions of topic guide to different focus groups of families of victim, law enforcement personnel, and obtaining similar answers) and deviant case analysis were done. Member checking a method of giving the feedback to the interviewee could not be done as many members were not available for follow-up.

Deviant case analysis of familial physical abuse leading to death of the infant

The case of battered baby which died soon after discharge displayed features noted elsewhere of filicide. There was prior agency contact by the parents for physical abuse.^[17] This case was referred from another general hospital where there was no child protection service, the parents were isolated, it was inter-caste marriage with poor social support and mother was depressed. There was also domestic violence, but denial by parents of child abuse. The mother said, “I ran away and got married to him, I can’t go back. He does not get work sometimes, he does hit me. She cries a lot, is very stubborn like him. But we both love her, we have never hit her. I was really surprised when doctor in the previous hospital asked me these questions, like you. I just want her to become well, why will I get her to a hospital otherwise? No one is there to look after her except me.”

Mother did not follow up with psychiatric treatment and child died after discharge. Rehabilitation of very young victims in danger of homicide by parents is an important issue to be considered by the government and child advocacy committee.^[17,18]

Attitudes of the law-enforcement about trafficking as a barrier to psychiatric treatment

Collaboration failed in providing psychiatric assessment, in 6 cases brought by the police, they left immediately after forensic evaluation. These were cases of trafficking rescued by police, and there was a history of multiple abuses sustained by these victims. Here, the victims suffered the stigma of law enforcement,^[22,23] needed vigorous efforts for psycho-social rehabilitation.

“These girls are more experienced than adults. Counseling cannot take the experience out of them.”

(Female constable aged 30 years)

The vicious cycle of treatment deferred till rehabilitation and rehabilitation deferred due to legal delay in releasing the victim (who is also an offender in trafficking, until age determination by medical investigation) occurred.^[24]

According to the UNICEF, 12.6 million children are in hazardous occupation. Ten percent of human trafficking in India is international, but 90% is interstate. Nearly 40,000 children are abducted every year of which 11,000 remain untraced as per the report of National Human Rights Commission of India. Psychiatric morbidity of the trauma could be high in these victims.^[25]

Barriers to psychiatric treatment among team members-beliefs that psychiatric treatment is needed only if there is evidence of psychological distress

Effective communication with other professionals regarded as critical to collaboration had to be negotiated. It was brought to the notice of the team leader^[7] that algorithm drawn up was not followed due to ineffective time management. Moreover, necessary amends were made.

Physicians felt psychiatric services were needed only if the child was disturbed.

Dissociation, conversion, child sexual abuse accommodation syndrome did not reveal acute psychological distress to a nonpsychiatrist or psychologist.^[26,27]

Moreover, these consequences of child sexual abuse could not be addressed by other team members who collected history, which was insufficient and increasing the barrier as the family felt that reduplication of services occurred.

“We have already told one doctor, how many times should we tell this same story? To how many people?”

To eliminate duplication of services, psychiatric interview and examination was done as soon as the patient was received; it served to collect history and also extended supportive care for the victim and family.

Beliefs that psychiatric diagnosis would hinder the delivery of justice

Both the family of the victim and the police expressed their misgivings about psychiatric treatment as quoted below.

“Once you give a certificate of mental illness, people think her to be insane and not believe any of her statements. They will send her to mental hospital, he will go scot free, and next he will get his hands on my other daughter.”

Lack of confidentiality and media publicity given to few cases was a barrier to seek psychiatric treatment^[4]

“You will ask, how it happened, who did it, were you careless? Did they know each other? Next you will show his picture in TV, paper. Whoever knows him and us will guess it is our child. Then, we can neither send her to school, nor get her married. And we can’t show our faces to the world.”

Normalization of patient’s activities was thought to be important by some families and seeking medical help, including psychiatric intervention was looked upon as intrusive and judgmental.

“As long as she is being seen by a psychiatrist, who will call her as normal?”

Blaming the victim and not understanding the grooming (strategies to bribe or befriend the victim) by the abuser or child abuse accommodation syndrome (compliance, secrecy, guilt could be motivating this behavior) were also barriers to the treatment among teen victims^[29-31]

“She was back-answering from quite a while, did whatever we did not want her to do, wore the clothes we disapproved, talked to friends all the time. This was going on for months, she lied to us. Cheated us and eloped with him, now how can we say that she is innocent or will not do this again?” (49-year-old father of a victim of 14 years)

Since the offender had taken advantage of the rebelliousness and separation-individuation phase of psychosexual development of the adolescent and parents had been punitive toward these efforts to individuate by the girl child even before the disclosure of abuse.^[28,29] Barriers to psychiatric treatment inclusive of stigma had to be handled strategically. Here, the family did not recognize the need for normalization, did not wish for the victim to resume her education, and was unwilling to let her have free social interactions hereafter.

Secondary trauma following accidental disclosure was prominent in these cases^[29] and was a cultural barrier to psychiatric intervention. As the adolescent girls are subjected to stringent behavioral restrictions stemming from patriarchal social standards of virtue, digressing them, responding to the grooming was enough to blame the girl; hence, they were doubly victimized, both by the abuser and the family.

Familial offender is a barrier to psychiatric treatment as re-organization of the family is not always possible

The abuse was very severe in younger victims below the age of five, where the grooming was perhaps ineffective or nonexistent, and children had severe injuries.

In the younger victims with extensive physical abuse, in-patient care did focus on the injuries, and psychiatric intervention had to be delayed and deferred to outpatient follow-up.

In all three cases, the offender was familial and known to the family, in one case the offender had also sexually abused the mother as a child, and she evinced “de-catastrophisation” the cognitive distortion in a victim of incest that predisposes her to re-victimization, in this case, it victimized her child.^[30]

“My brother-in-law would touch me also inappropriately when I was a child, he did that to all my cousins. My sister is childless, I thought she can baby sit my daughter. My child is less than 2 years, did not think he could abuse such a small baby.”

There was fear of repeated abuse and need for psychosocial rehabilitation in cases of familial abuse, that could not be effectively addressed by the CCRU. In three cases, the family relocated to another city, hence follow-up of psychiatric care was not possible. However, reporting of minor offenses could result in paradoxical situation when the solution is worse than crime.^[23]

Pregnancy was a barrier to psychiatric treatment as the family's focus was on termination

In pregnant victims, the focus was on termination of the pregnancy and subsequent physical well-being of the victim.^[31] There was resistance to talk about the abuse both by the victim and the family, self-blame in the victim for terminating pregnancy, as well as self-blame in the caregiver for not having identified grooming and also the pregnancy.^[32]

“If she did not get pregnant, no one would know about her activities. I was too trusting, how did I know she was getting pregnant? Let me get rid of this disgrace, don't talk to me.”

Minimization of abuse in nonpenetrative abuse

“All women are touched badly some time or the other, that can't be termed abuse and all of us can't go to court for such things. Nothing has happened”

(45-year-old mother of a victim of 12 years)

There was minimization of abuse in cases of nonpenetrative abuse, where perpetrator was almost declared innocent by the police and family was

reluctant for follow-up of psychiatric care.^[33] Forensic tests being based on Locard's principle^[34] that every contact leaves a trace on another; nongenital contacts could not be proved easily, as important samples were destroyed or washed and there was a delay in reporting.

Male child sexual abuse, silence of patriarchy

“He is a male; he will learn to fight back. Men can't be raped nor get pregnant”

(47-year-old father)

Male child sexual abuse referrals were only three. And here there was minimization of abuse that was gender related, patriarchal social system dominating the perception of caregivers since he is a boy he will not require psychiatric intervention, though victims were diagnosed with posttraumatic stress disorder and dissociative disorders.^[35-37]

DISCUSSION

Although the 2007 survey by the Government of India reported higher number of sexual abuses to be familial and by persons in position of authority (50%) in origin, the cases of extra-familial abuse was reported more (22 out of 27) to the CCRU.

Referrals were mostly by police, and this may be a welcome development following the POCSO. Hence, the majority of abuse as claimed by the survey to be familial was under-represented in the referrals.

Referral by the family was only one and referral by the pediatrician was two. One child with the help of a relative had approached the police, in a case of familial nonpenetrative abuse and child had awareness of her rights through the education program in the media, there was fear of repetition of abuse, patient's nonoffending parent was also abused by the perpetrator and was compliant, so patient confided in another parental figure.^[38,39]

Although boys are reportedly more abused physically and equally abused sexually, reporting was very low. Disclosure of abuse was mostly accidental in the referrals received, and though system inflicted trauma^[40] to the victim was minimized by the CCRU, the secondary trauma to the victim following disclosure in the social context was significant,^[41] acting as a barrier to psychiatric intervention.

CONCLUSION

Collaboration needs more effort to effectively integrate psychiatric services, ensure total representation to all team members and follow-up care for the victims. It

needs to incorporate evaluation of services and requires active participation and home visits by the social workers to ensure initial and subsequent follow-up of psychiatric care.

Collaborative child response unit can minimize reduplication of services, reduce system-induced secondary trauma, and assist judiciary in bringing the offender to justice by systematic assessment and collection of forensic evidence. It can render sensitive, complete, and effective child protection.

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Conflicts of interest

There are no conflicts of interest.

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