Children experience complex, continuous trauma from living in violent environments

Many children experience and/or witness multiple forms of violence in the home, family, community and school, often at the hands of someone they know. When abuse is perpetrated by a caregiver or repeatedly by someone in a close relationship to the child, *complex trauma* may result.[8] Perpetrators often remain in the child's environment. Recent advances in our understanding of trauma suggest that such ongoing or repeated exposure to trauma and "real" danger leads to *continuous traumatic stress* rather than post-traumatic stress disorder. Caregivers' ability to provide nurturing care and support is influenced by their own experiences of trauma, such as child-maltreatment and intimate partner violence. And their child's trauma is likely to trigger a re-experience of their own trauma. The parent-child relationship is likely to be adversely affected in these cases. In this way, intergenerational violence reduces the chances of creating an enabling environment that is supportive and conducive to recovery.

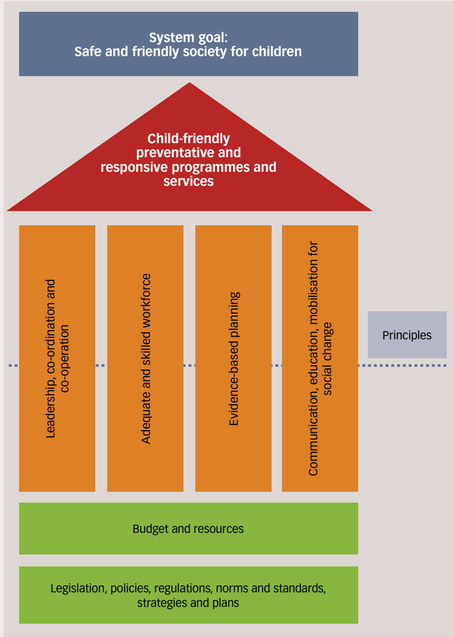
Complex trauma:

When perpetrators are known to the child, it is likely to prolong the healing process. *Complex trauma* develops when the interpersonal trauma is recurrent and perpetrated by a trusted person.

Continuous traumatic stress:

Children and their families experience multiple incidents and forms of trauma, with ongoing exposure to trauma and "real" danger when perpetrators remain in the child's environment.

Figure 2: Overview of the child protection system



Source: Save the Children UK (2009) A 'Rough Guide' to Child Protection Systems. London: SCUK.

The effects of violence

Children who experience or witness violence are at increased risk of revictimisation or becoming perpetrators themselves later in life. Early detection and therapeutic interventions minimise long-term effects such as violence and risky behaviour, depression, anxiety and suicide, and help break the intergenerational cycle.[9] Conversely, a poor response can lead to secondary trauma and increased risks of revictimisation and perpetration.[10] Child abuse also carries an economic burden; research across various parts of the world has shown the numerous costs (in childhood and adulthood) for healthcare, special education and criminal justice, as well as productivity losses associated with child maltreatment.[11] Therefore, it is essential that South Africa develops a responsive child protection system.

Child protection system in theory

The Children's Act outlines government's obligation to prevent violence against children, to children at risk, to protect child victims from further harm, and to support and treat children who have experienced violence in order to restore them to physical and psychological well-being. Other laws, policies and protocols provide for a properly resourced and co-ordinated national child protection system, where skilled professionals from civil society organisations, the South African Police Service, and the Departments of Social Development, Health, and Basic Education work together.

About the Children's Institute

The Children's Institute is a leader in child policy research and advocacy in South Africa. The Institute is based at the University of Cape Town. The CI aims to contribute to policies, laws and interventions that promote equality and improve the conditions of all children in South Africa, through research, advocacy, education and technical support.

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Modelling alternative practices

The South African Child Death Review Pilot – effective intersectoral collaboration

The CDR pilot is a multi-agency approach modelled on international practice that aims to understand and prevent child deaths. The pilot facilitates a co-ordinated response between the police, forensic pathology services, prosecution authorities, paediatricians, and social services in the management of child deaths. It further tests the effectiveness of such teams in strengthening the health and child protection response systems in the local setting. This multi-agency approach brings together evidence from medical records, autopsy reports, police and social services investigations, and enables more effective identification of child abuse and neglect. It helps identify systems failures within different departments and opportunities to strengthen communication and co-ordination between them. The CDR pilot has demonstrated how a multi-agency approach can enhance reporting and enable a real-time response to ensure children are safer in their homes. The value of making joint decisions also took the burden off the forensic pathologist and police as investigating child deaths in the home is incredibly difficult, particularly when there is a suspicion of a non-accidental injury at the hands of someone close to the child. Social services investigations have also proved crucial in identifying families in distress who require ongoing support to prevent further negative outcomes.

Therapeutic models in low resource settings using para professionals

Dominant Western models generally provide therapeutic support on an individual basis for sustained periods, depending on the individual needs of the client. These models follow evidence-based treatment protocols after a comprehensive assessment of trauma impact, and where cases are complex, multi-disciplinary teams of professionals collaborate to offer structured services. Yet to date mental health interventions in LMIC have followed Westernised approaches, showing limited efficacy and resulting in challenges of feasibility and appropriateness. There are a few innovative approaches being tested in LMIC. The use of trauma-focused cognitive behaviour therapy (TF-CBT) to address trauma symptoms in HIV-affected children and their families was tested in a low-resourced setting in Zambia.[22] The intervention was delivered over 11 weeks: Sessions included a trained lay counsellor working with the child, caregiver, and the family together, following a task-shifting model. The treatment model showed symptom reduction for trauma and stress-related symptoms, although the follow-up period was only one month. Nevertheless, the use of TF-CBT is an evidence-based practice worth considering for the treatment of traumatised children in the South African setting. A task-shifting approach using para-professionals with limited formal mental health training is also proving to be effective in evidence-based interventions implemented in other settings in LMIC.[23]

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Policy brief

Strengthening the child protection system in South Africa.

Children have a constitutional right to protection from maltreatment, abuse, and neglect and a right to responsive protection services following abuse. However, three research studies conducted by the Children's Institute, University of Cape Town, all conclude that the child protection system is failing to protect children. This brief summarises the cross-cutting findings from the studies that show that the law and policy is comprehensive, but implementation is poor. It concludes with a set of recommendations to strengthen the child protection system through improved practice and programming.

The nature and scale of violence

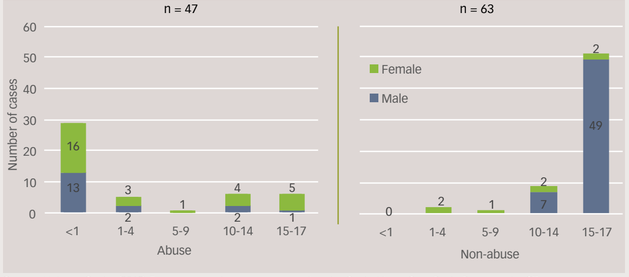
Although definitions vary, we now know more than ever before about the magnitude and impact of child abuse. In 2016, a national prevalence study estimated that 1 in 3 children are victims of sexual violence and physical abuse before they reach the age of 18, whilst 12% of children report neglect and 16% report emotional abuse[1]. In 2013/2014 national crime statistics showed that 29% (18,524) of sexual offences reported to the police were children under the age of 18 years – equating to 51 cases a day.[2]

Community-based studies suggest that violence is even more widespread:

- Over half of children (56%) in Mpumalanga and the Western Cape report lifetime prevalence of physical abuse by caregivers, teachers or relatives[3];
- In the Eastern Cape 53% girls vs 56% boys reported emotional abuse and neglect[4]; and
- 35-45% of children witness violence against a mother by her intimate partner.[5]

Violence and abuse are also leading causes of child deaths; where young children die from abuse and neglect in the home, whilst adolescent males die as a result of interpersonal male on male violence.[6] A large proportion (85%) of unnatural infant deaths were due to abandonment shortly after birth.[7] Nearly half (45%) of under-five deaths occurred at home and murders were more likely to occur in a public space as children got older and started to spend more time outside the home. Poverty, poor living conditions, mental health and substance abuse and limited support for new mothers compromise care and increase the chances of abandonment, abuse and neglect.

Figure 1: Number of child abuse and neglect homicides compared to non-abuse homicides by age and sex, Salt River mortuary, 2014



Source: Mathews S, *et al* (2015) *Every child counts: Lessons learned from the South African Child Death Review pilot.* UCT.

Child protection system in practice

To prevent violence against children and strengthen the country's health and child protection systems, the Children's Institute has engaged in a programme of research to understand the nature of violence, risk and protective factors; to evaluate prevention and protection programmes; and to pilot best-practice models.

This brief draws on the findings of the Child Death Review Pilot, the Child Abuse Tracking Study, and an evaluation of a therapeutic programme for sexually abused children.[12] The findings show how the child protection system is failing to protect children in practice. Practitioners fail to identify children at risk and they manage cases poorly, few children and families have access to therapeutic care and support to combat complex trauma, and the different professions don't work together.

Case study 1:

CASE 1: An eight-month-old baby presented as a sudden infant death at the mortuary. The cause of death was gastroenteritis and severe dehydration. The mother claimed that she had bottle-fed the baby before putting him to sleep in the evening. He was found unresponsive the following morning. On examination at autopsy, the infant had foetal alcohol syndrome and was underweight for age. The mother had taken the baby to the local clinic for immunisations, yet no medical assistance was sought when the baby was ill. Based on these indicators of neglect, the case was referred to the local child protection agency (CPA) for further investigation of the home circumstances of the remaining children. It was established that two other children had died in 2009 and 2011, despite the CPA being familiar with the family since 2008, when they had first investigated the care of the children because of the mother's alcohol abuse. (Child Death Review, 2014).

Identification of children at risk

The tracking study found that families frequently protect perpetrators, leaving children at risk of further abuse. However, prevention and early-intervention programmes, such as Isibindi, are having a positive effect on the number of children reporting abuse. Children in the programme also report abuse earlier than children who are not in programmes. The child protection system response is poor, social work assessments are not comprehensive and there is a lack information on parental capacity, including mental health or family functioning – at times with catastrophic results (see Case 1).There seems to be a deep-seated reluctance to prosecute parents or even compel them to participate in programmes to change their behaviour.

Protecting child victims from further harm

Children are at risk in their own homes from people they know. The tracking study found that social workers are not assessing risk and few perpetrators are ever brought to justice. Out of 131 child abuse and neglect cases reported to police, only 89 arrests were made, and at least 38% of the offenders were released on bail or with a warning shortly afterwards.[13] 13% of cases reported to the police resulted in a conviction, with prosecutors withdrawing most cases. The continued presence of the perpetrator compromises the safety of children in their homes and communities (see Case 2), and ongoing exposure to the perpetrator, i.e. "real" danger, is a major barrier to psychological recovery and leads to *continuous traumatic stress*.[14] Our findings also indicate that child protection plans are largely absent or inadequate.

Case study 2:

Pretty (17–year-old) was raped by an older man living in her area. She lives with four siblings and their caregiver. Pretty displays worrying behaviour as she absconds from school and often stays away from home for days without informing her caregiver. She has shared with the child and youth care worker (CYCW) her desire to leave her community as she fears seeing the offender. Pretty's caregiver reports that she is also very careful when she walks alone. She has on occasion met the offender, who then intimidates her. The offender has apparently raped other girls in the community and was arrested, but has repeatedly been released on bail. (Therapeutic programme evaluation, 2016).

Support for recovery

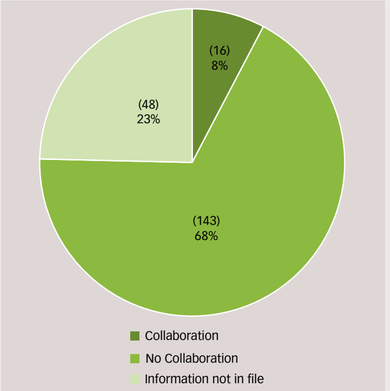
Therapeutic services for abused children are insufficient to meet the demand, and children are placed on lengthy waiting lists to access services. Most services are concentrated in urban centres, and service provider responses are not necessarily appropriate to facilitate healing and recovery for traumatised children.[15] Standard child protection services offer general psychosocial support services that may include home visits, counselling and psycho-educational support to the child.[16] Intergenerational trauma compromises parenting capacity, but caregivers are rarely given the support they need. Therapeutic services are often not appropriate to address complex, continuous trauma. Shifting perceptions of child trauma and redesigning therapeutic responses to meet the needs of traumatised children and their families is critical.

Lack of coordination and cooperation

The results of the tracking study show that very few (19%) of the cases reported to social services were cross-referred to the police, and although the police claimed to have referred 35% of their cases to social services, intersectoral collaboration was confirmed in only 8% of all reported cases (see Figure 3). For example one police unit had referred 10 children to social services. The police dockets contained the social work case numbers and/or the names of social workers to whom the cases had been referred, but the social workers could not find a single case file or even identify the children on their intake register; furthermore, they claimed that they had not received any child abuse cases during the reporting period, whilst police had over 30 cases on record.

The absence of effective co-ordination and communication between health, criminal justice, and child protection systems was detected in all three studies, resulting in failures to protect children and support families in crisis (see Case 3).

Figure 3: Verified intersectoral collaboration on cases



Source: Child Abuse Tracking Study (2017), Children's Institute, UCT.

Case study 3:

Whilst bathing her six-month-old baby, a young mother (18-year-old) noticed that something was wrong, but she did not suspect abuse at first. A neighbour stated, "I was called by the mother to come and see if the child's vagina was attacked by evil spirits as it was wide open." Four days later the mother reported the matter to the police and took the child to hospital. There is no evidence that a paediatric rape kit was completed - it was four days after the mother noticed her daughter's injuries – but the J88 confirms chronic sexual abuse.

There were no witnesses to the sexual abuse, but, in a second statement, the mother revealed that she suspected her stepfather, who the mother claimed had raped her when she was eight years old. The grandmother testified that she never left the baby alone with her husband. The man was never questioned. The prosecutor withdrew the case on the grounds that there was insufficient evidence. The case is not on record with the Department of Social Development. There is no evidence that the child or her mother received any form of therapy or psychosocial support. (Child abuse tracking study, 2017).

CONCLUSION

The child protection system is failing to protect children. The law and policy is comprehensive, but implementation is poor. Professionals are not identifying strain in families, and reported cases are poorly handled. Children are receiving fragmented services that offers little support for their long-term physical and psychological wellbeing. The lack of inter-sectoral collaboration, human resources and lack of appropriate action by service providers is preventing children from accessing therapeutic and support services, and allows perpetrators to continue to abuse children without any form of criminal investigation. Few children receive therapeutic services, and those who do receive interventions, receive limited support that is often inadequate to deal with the nature of trauma experienced by children in South Africa. Framing trauma as complex and continuous is a relatively new approach to understanding children's trauma in South Africa, and it is necessary to adapt therapeutic responses accordingly. Consequently, we can expect children to continue displaying symptoms of trauma, leading to revictimisation and perpetration, allowing the cycle of violence to continue long into the future. Individual children will be denied the opportunity to develop to their full potential, and at a societal level we can expect violence, and the psychological impacts of violence, to continue unabated. Developing models of interagency management is critical as current practices are insufficient to meet the needs of children.

RECOMMENDATIONS

1. Strengthen early identification and prevention services

The Children's Act provides for a range of prevention and early-intervention services to support vulnerable children and families. The scale-up of parenting programmes in both homes and other settings is welcome as they improve parenting practices and reduce risky behaviours in children and caregivers.[17] However, the expansion of services should also include targeted support for pregnant women; mothers of young children; and boys. Early identification of at-risk mothers during pregnancy or at birth, and the provision of support services and home-visiting programmes (in accordance the National Integrated Early Childhood Development Policy) are essential. These interventions should ideally be integrated with community health services as this is often a key point of entry for children into the system. Teaching young boys conflict management skills, providing sport and recreational activities in communities, and developing peer-support systems at school have the potential to keep young men off the street with a focus on shifting social norms will have a longer-term effect on their ability to manage conflict in the community and in their personal relationships.[18]

2. Assessing the needs of children who have been abused and neglected, and siblings

Child protection services have to act speedily in the investigation of reported cases to protect children from continued abuse and neglect, and to prevent fatalities. Social service professionals require training to identify which children in the household are at risk, assess the needs of children within the family environment and the capacities of carers to create an environment that is conducive to recovery. Based on these assessments, social workers must develop concrete protection plans to secure children's safety and access to therapy to prevent secondary victimisation and long-term harm. Social workers require adequate supervision and those responsible for case management reviews should be held accountable for poor case management. Professionals should be trained in the use of standardised assessment tools to measure PTSD, anxiety, depression and parenting capacity to enable targeted interventions.[19]

3. Ensure safe environments for abused children

Continuous exposure to risk or harm is detrimental to the psychological well-being of traumatised children, undermines therapeutic support and inhibits recovery. In many cases, perpetrators are released back into the child's home or community where they continue to pose a threat to children's physical and/or psychological safety. Social workers need to be trained to assess risk and liaise closely with the SAPS to track what is happening to the perpetrators. Police officers should be encouraged to exercise their powers under the Children's Act (s153) to remove perpetrators when there is a risk to the child's safety as assessed by the social worker. Criminal justice system outcomes must improve, and the CDR pilot has shown that intersectoral collaboration can help. While efforts to remove the perpetrator are underway, the child and caregiver need to be adequately supported within their environment. Strengthening the child-caregiver relationship is crucial for buffering the effects of child trauma.

4. Review treatment and intervention responses

Traumatised children are entitled to access quality therapeutic support in a timely manner. It is critical to review the design, content and impact of existing therapeutic programmes to ensure they respond to the multi-faceted and continuous nature of trauma. As trauma is often intergenerational, and family or community members are often involved in the abuse, it is necessary to adopt a social-ecological approach and design therapeutic programmes that include caregivers, families and communities. South Africa should test models showing effectiveness in addressing complex and continuous trauma in other low- and middle-income country contexts, for example trauma-focused cognitive behaviour therapy.[20]

There is also an urgent need to improve practitioners' capacity to identify and respond appropriately to continuous, complex and intergenerational trauma. Firstly, it is essential to clarify specific roles and responsibilities for different cadres of social service and mental health practitioners to ensure effective collaboration and coordination. Secondly, the use of para-professionals to deliver mental health programmes is showing potential in low-income settings,[21] and should be explored to address resource constraints.

5. Intersectoral collaboration/ Multi-disciplinary teams

Child protection requires a multi-agency response that enables government departments and civil society organisations to work collaboratively to identify families who show signs of strain, and to respond to abuse. The tracking study highlighted the need for intersectoral collaboration in the child protection system, whilst the CDR tested a multi-agency approach that showed improved outcomes in the investigation of child deaths. Similar pilots should be established to model ways of collaborative case management for children when the first signs of strain are identified and before the circumstances result in child deaths.