Violence and child and adolescent mental health: A whole-of-society response

Neziswa Titi,[i] Mark Tomlinson,[ii] Shanaaz Mathews,[i] Lucy Jamieson,[i] Debbie Kaminer,[iii] Soraya Seedat[iv] [ii] Lori Lake [i] and Amelia van der Merwe [ii]

Violence, as a way of solving the problems of daily life, is ubiquitous in South Africa. Harsh parenting, harmful social norms on parenting and children's position within the family, and high levels of substance abuse leave children extremely vulnerable in their homes and communities. We urgently need to engage all of society to shift the social norms that legitimise and normalise violence against children, to combine this with a comprehensive suite of interventions across the life course to prevent violence in children's home, schools and communities, and to ensure that children are able to access the care, protection and therapeutic support they need.

In this chapter, we examine the nature and impact of violence and trauma in childhood and adolescence, and identify risk and protective factors across a variety of settings, drawing attention to the intersections between violence against children (VAC) and violence against women (VAW). We highlight how interventions need to extend beyond treatment to include an emphasis on prevention and breaking the intergenerational cycle of violence. Finally, given the pervasiveness of violence in South African society, we call for the adoption of a trauma-sensitive approach to the delivery of education, health and social services for children, adolescents and their families.

What is the nature of the problem?

Violence against children in South Africa is all-pervasive. The 2016 Optimus Study, which provided the first national prevalence data on child abuse, violence and neglect, found that 42% of children have experienced some form of violence – including sexual abuse (35%), physical violence (35%), emotional abuse (26%) and neglect (15%).[5] This is echoed in work from a cohort study of young children in South Africa which found that 43% of eight-year-olds had been exposed to violence in their community.[6] Data from the Birth to Thirty cohort study of more than 2,000 children born in Soweto found that by age 22 years, 99% of children had either experienced or witnessed some form of violence in their homes, schools and/or communities.[7] While in Khayelitsha, more than 80% of youth reported that they had been exposed to a severe trauma.[8]

Violence results not only in physical scars but also in psychosocial effects that are often hidden, with debilitating, long-lasting consequences. For example, post-traumatic stress disorder (PTSD) results in a variety of negative long-term outcomes in children. While PTSD is one of the most prevalent diagnoses presenting to local psychiatric services in South Africa,[9] there are no national prevalence data on the link between violence or trauma and PTSD in children.[10] Yet, community-based surveys have consistently reported PTSD rates of 20% – 38%,[11, 12] and in a community-based sample of children who had experienced sexual abuse, nearly a third (32%) had full symptom PTSD, while a further 50% had partial symptom PTSD.[13]

Violence across the life course

Violence shifts in its patterns and forms across the life course. In younger children in South Africa, violence in the home creates a significant risk for a range of mental health difficulties. Infanticide, abuse and neglect are common in the early years, but are likely to be under-reported as infants and most young children most young children have limited capacity to seek help capacity to seek help.[14] Young children are particularly vulnerable to violence in the home, including harsh physical punishment and witnessing domestic violence. For example, nearly 60% of caregivers reported hitting their children, with young children (aged 3 – 4) most likely to experience harsh physical punishment, including being hit with a stick, belt or hard object.[7, 15] Harsh discipline is often accompanied by verbal and emotional abuse[16] – with boys likely to receive higher levels of harsh verbal and physical discipline than girls.[17] For young children, the absence of a domestic 'island' of safety (and safe primary attachment

i Children's Institute, University of Cape Town
ii Institute for Life Course Health Research, Stellenbosch University and School of Nursing and Midwifery, Queens University, Belfast, UK
iii Department of Psychology, University of Cape Town
iv Department of Psychiatry, Stellenbosch University

Table 8: Definitions of key terms

Violence	The World Report on Violence and Health defines violence 'as the intentional use of physical force or power, threatened or actual, that results or is likely to result in injury, death, psychological harm, maldevelopment or deprivation (p5)',[1] while the United Nations Committee on the Rights of the Child defines violence against children as 'all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse'[2]. The World Health Organization extends this definition to include 'the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity (p29)'.[1]
Trauma	The Diagnostic and Statistical Manual of Mental Disorders V defines trauma as 'exposure to actual or threatened death, serious injury, or sexual violation'.[3] When a child experiences a deeply distressing, life-threatening or stressful event such as violence or injury (traumatic event), both acute and chronic stress responses such as fear, anxiety, panic, and shock commonly ensue.[3] Three main types of trauma exposure have been described, namely acute trauma (the immediate response to a single traumatic event), chronic trauma (recurrent and prolonged trauma) and complex trauma (exposure to multiple traumatic events, often severe, pervasive and of an interpersonal nature).[3]
Polyvictimization	Polyvictimization is defined as experiences of multiple forms of victimisation, not only child maltreatment but also victimisation perpetrated by peers and siblings; conventional crimes including property vandalism, robbery, theft, physical assault, and abduction; witnessing of family and community violence; and cyber bullying.[4]
Post-traumatic stress disorder (PTSD)	PTSD is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, serious accident or rape, or who have been threatened with death, sexual violence or serious injury. Symptoms can vary in severity and fall into four categories: 1. Intrusion: Intrusive thoughts such as repeated, involuntary memories, distressing dreams or flashbacks of the traumatic event. 2. Avoidance: Avoiding reminders of the traumatic event may include avoiding people, places, activities, objects or situations that may trigger distressing memories. 3. Alterations in cognition and mood: Inability to remember important aspects of the traumatic event, negative thoughts and feelings leading to ongoing and distorted beliefs about oneself or others; thoughts about the cause or consequences of the event leading to wrongly blaming self or other; or ongoing fear, horror, anger, guilt or shame. 4. Alterations in arousal and reactivity: Arousal and reactive symptoms may include being irritable and having angry outbursts, behaving recklessly or in a self-destructive way, or being easily startled. Many people who are exposed to a traumatic event experience symptoms like those described above in the days following the event. For a person to be diagnosed with PTSD, however, symptoms must last for more than a month and must cause significant distress or problems in the individual's daily functioning. Many individuals develop symptoms within three months of the trauma, but symptoms may appear later and often persist for months and sometimes years.

relationships) may significantly increase the risk for a range of mental health difficulties. On the other hand, parental warmth may protect children from poor outcomes and from adversity.[17, 18]

As children get older and engage in activities outside of the home, they are more likely to be exposed to violence in their schools and wider community – including corporal punishment, bullying and sexual violence from both known and unknown perpetrators. Boys who have, for example, been the victim of neglect and harsh punishment are more likely to engage in bullying behaviour, while girls may become withdrawn and isolated from their peer group.[6, 19] These differences are commonly referred to as 'internalising' and 'externalising' behaviours.

For adolescents, who spend more time outside the home and typically have more emotional separateness from their families, violence in the community is a more consistently toxic experience.[20, 21] Girls are twice as likely to be victims of forced penetrative sex, yet boys are also exposed to high levels of sexual abuse, including unwanted touching and coerced sex.[10] The prevalence of sexual violence also increases with age, with the Birth to Thirty cohort study noting an increase from 10% of children during primary school to 30% of adolescents and older youth.[7] Sexual victimisation rarely occurs in isolation and is often associated with other forms of violence such as physical abuse, emotional abuse, neglect and family violence,[10, 22] with 25% – 45% of children in South Africa witnessing domestic violence perpetrated by their mother's intimate partner[10].

Interpersonal violence amongst boys rises sharply during adolescence, with male-on-male violence being the leading cause of death amongst adolescent boys aged 15 – 17 years.[23] Older adolescent boys are more likely to be the victim of homicide than girls, while adolescent girls are at increased

risk of dating violence – with nearly one in three adolescent girls in community surveys reporting forced sexual initiation[24]. The ubiquity of violence, coupled with patriarchal social norms and violent masculinities, leads many adolescents to perceive sexual violence as a normal part of their intimate relationships.[25] Rates of polyvictimization[4] are also high among children in South Africa, with as many as 40% of children in the Birth to Thirty cohort being exposed to five or six categories of violence[7]. In short, South Africa's children are exposed to extremely high levels and multiple forms of violence, across multiple settings throughout their life course.

What are the drivers of VAC?

Violence against children is seldom random. The socio-ecological model illustrates how children's exposure to violence is shaped by a complex interplay of risk and protective factors that include the child's individual characteristics and the nature of their relationships, their communities and other factors within South African society, as illustrated in Table 9.

Violence exposure and mental health problems share many of the same risk and protective factors. A stable family, characterised by secure and caring relationships, creates an enabling environment for children to thrive and is hugely protective in the event of trauma or community violence. On the other hand, living in a home and community characterised by high levels of interpersonal and community violence increases the risk of mental health problems, and of children becoming victims or perpetrators of violence later in life.

Where children live also has an impact. The majority of South Africa's children live in townships, informal settlements and deep rural areas of the country where high levels of unemployment, poverty and food insecurity, coupled with overcrowding and inadequate infrastructure, policing and social services, increase the risk of interpersonal and gang violence and crime.

Many of these local challenges are shaped by broader societal and structural inequalities, and the ways in which apartheid policies such as the Group Areas Act and migrant labour system fractured family and community life.[26] More than 25 years into democracy, South Africa remains the most unequal country in the world, and the link between inequality and levels of crime in a society are true in South Africa as well as globally. Poverty increases stress and tension in the home and compromises families' mental health and capacity to care, protect and provide for their children's basic needs. And in many cities in South Africa, it also increases the risk of adolescents being drawn into gangs, engaging in criminal behaviour and using illegal substances.[27]

Figure 28: Types of violence across the life course

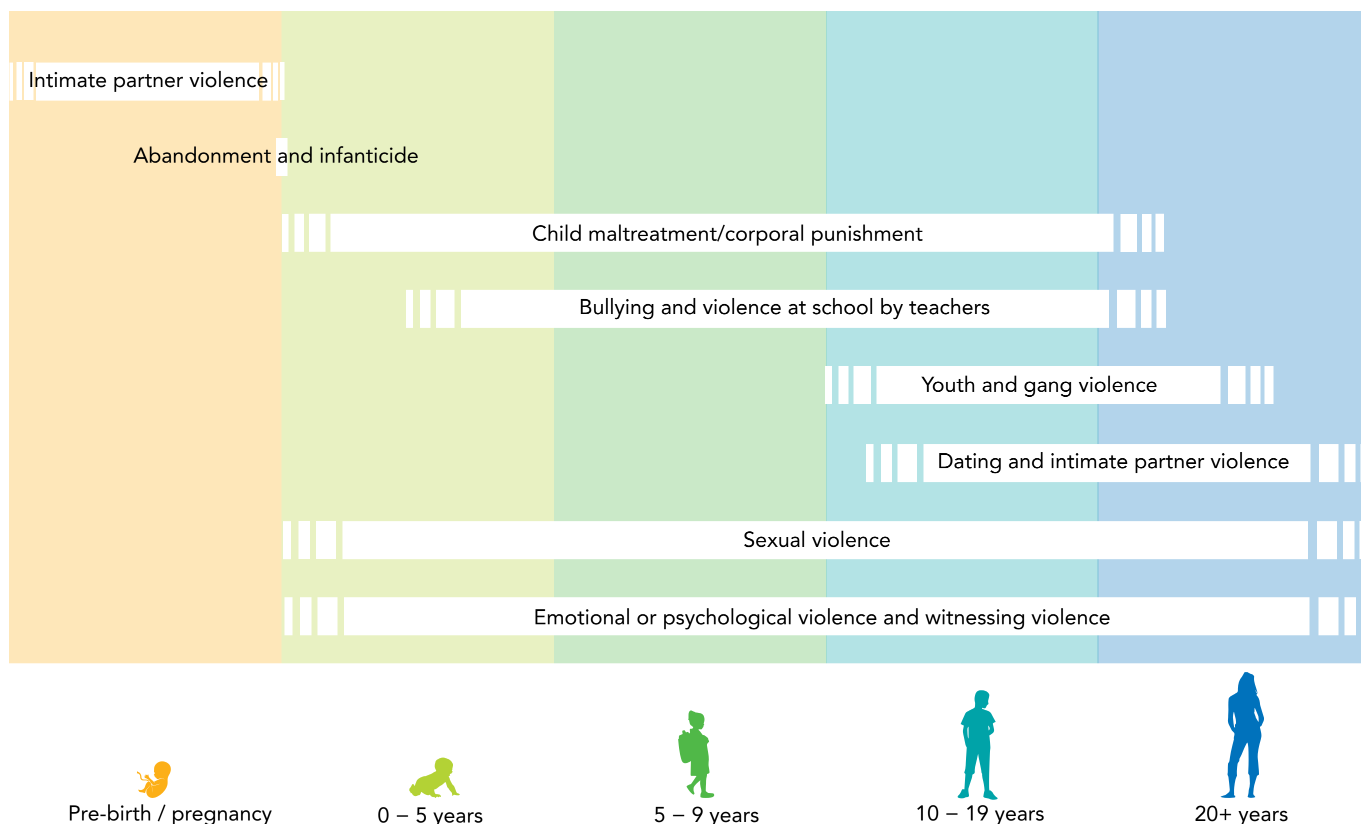

Table 9: Risk and protective factors for violence against children

	Societal	Community	Relationship/ family	Individual
Risk factors	• High unemployment rates • High inequality and social exclusion • Availability of firearms • Weak legal, policy and regulatory framework • Gender inequality and discrimination • Social and cultural norms that justify violence • Weak law enforcement	• High level of crime in communities • Poor and/or inadequate social services • High level of substance abuse	• Domestic violence • Substance abuse in the family • Friends that engage in violence • Harsh parenting • Parents with mental health problems • food insecurity in households	• Biological and personal history factors such as: • Gender, age, income • Substance abuse • Personal history of violence • Unwanted pregnancy • Physical and mental disability
Protective factors	• Legal and policy frameworks to create an enabling environment to support victims of violence • Enforced criminal justice sanctions for • perpetrators of violence • Policies to regulate gun ownership and alcohol use • Gender equity promoted at highest level • Job creation programmes • Social norms challenged through media	• Accessible health and social services to support families • Social protection programmes to mitigate poverty and unemployment • Cohesive communities with accountable • community leadership and structures • Responsive policing and functional criminal justice system with trained specialists • Adequate childcare facilities Supportive school environment with an inclusive teaching approach Child-focused support services • Trauma-informed services	• A cohesive and stable family unit • Adequate, accessible support for families • Healthy communication between parent and child; etc.	• Strong attachment • Responsive caregiving • Increased knowledge of protection against abuse • Education and literacy

Adapted from: Mathews S & Benvenuti P. Violence against children in South Africa: Developing a prevention agenda. In: Mathews S, Jamieson L, Lake L & Smith C (eds) *South African Child Gauge 2014*. Cape Town: Children's Institute, UCT. 2014.

Children's relationships with their peers, partners and family members can either be protective or increase children's exposure to violence. For example, a study on the determinants of VAC in South Africa has shown that conflict in the household, substance abuse by a family member and a family member involved in crime, all increase the risk for children to become victims of violence and for boy children to become perpetrators of violence.[28]

Intergenerational violence and the Intersections of violence against women and violence against children

Already we have seen how a child's age and sex have an impact on the types of violence they are exposed to, with early exposure to corporal punishment and domestic violence increasing the risk of girls becoming victimised later in life, and boys becoming perpetrators of violence. This also fuels an intergenerational cycle of violence by increasing the risk of both boys and girls using harsh physical punishment on their own children.[33]

The intergenerational cycle of violence is also driven by the intersections of VAC and VAW.[29] VAC and VAW co- occur in the same households, share similar risk factors and are more prevalent in communities where social norms condone violent discipline and promote violent masculinities, both of which are underscored by gender inequality.[30, 31] In South Africa, a gendered hierarchy places men in a position of power over women and children. In this milieu, men's violence towards women and children is widely tolerated, men then use violence to assert their masculinity, enforce gender norms and practices through violent discipline of children and IPV in the home.[32]

Research from a United Nations multi-country study in Asia and the South Pacific points to the pathways that drive

Case 25: The intergenerational effects of violence and trauma

A 17-year-old young woman disclosed sexual abuse by a male friend (a police officer), who was in his early thirties. It took her months to disclose the rape because she blamed herself. Her family life was fraught due to IPV between her parents and constant instability in the home. Her parents went through a difficult divorce a few months before her rape. This led to major behaviour changes in the young girl as she started mixing with the wrong friends, abusing substances and her grades dropped. Her mother noticed the behavioural changes but thought it was related to the divorce. When the young woman started counselling, the mother disclosed her own rape as a teenager for the first time. Although the young woman attended counselling sessions, she did not find them useful. She had intense anger towards the perpetrator, whom she had trusted, and she feared that he would not be convicted. The counselling service focused on the young woman's recovery and did not engage the mother in counselling, even though this had surfaced her own unresolved trauma. The mother's inability to support her child emotionally is of concern as it may be one of the factors undermining her daughter's recovery, as she continues to have severe psychosomatic symptoms with suicidal ideation.

an intergenerational cycle of violence for both girls and boys.[33] IPV and corporal punishment in the home can lay the foundations for later victimisation by girls and perpetration of violence against women and children by boy children.[34] Childhood trauma has also been shown to increase the risk for IPV victimisation and perpetration in adulthood.[33] In a study in Durban, more than two-thirds of women who had experienced childhood trauma had also experienced interpersonal violence in the past year.[34, 35] The pattern is the same in men, where almost 60% of men who had experienced some form of childhood trauma were also perpetrators of interpersonal violence.[34, 35] A community-based survey with men in South Africa also showed how exposure to childhood trauma increased the risk for perpetration of IPV,[34] while women who experience IPV are more likely to use corporal punishment in the home.[36] Children's experiences of violence and abuse are therefore likely to re-trigger their caregivers own experiences of trauma as illustrated in Case 25.

What are the mechanisms linking violence to negative outcomes?

When a child experiences a deeply distressing or stressful event such as violence, injury, or a life-threatening event, they may experience both acute and chronic stress responses such as fear, anxiety, panic, and shock.[3] Children may be exposed to acute trauma (usually resulting from a single incident), chronic trauma (recurrent and prolonged traumatic event) or complex trauma (where they are exposed to multiple traumatic events, often of an interpersonal nature, that are severe and pervasive).[3] Given the widespread nature of violence and the extent to which it has become normalised in South Africa, acute traumas may not be responded to appropriately, leading to a variety of physiological and psychological consequences (as illustrated in Case 25).

Children and adolescents who have been subjected to trauma may experience intrusive thoughts, dreams and flashbacks of the traumatic event; avoid people, places, activities and situations that remind them of the traumatic event; experience ongoing feelings of fear, anger, guilt or shame; wrongly blame themselves or others; feel detached or estranged from others and unable to feel joy and satisfaction; feel irritable, behave recklessly and self-destructively or become hypervigilant, easily startled and struggle to sleep or concentrate. These physical symptoms, thoughts and feelings may – without appropriate intervention and support – persist and give rise to PTSD, which undermines daily functioning and is often associated with depression, substance use and other mental health challenges. The same stress response may be triggered by further exposure to violence or give rise to a pervasive state of fear and hyperarousal due to threat of imminent violence, for example if a perpetrator is still present in the child's home or community.

Among youth in South Africa, cumulative exposure to multiple forms of violence also increases the likelihood of children engaging in aggressive behaviour,[19, 37] which may, in turn, elicit aggression from others. Children who are socialised into violence learn to condone or accept violence through verbal reinforcement of violence, being a witness to violence, and being victimised by violence perpetrated by others, such as members of the family and community.[38-40] In this manner, a vicious cycle emerges, where the aggressive behaviour of the developing child, which is both a function of psychological disorder and social learning, is typically met with an onslaught of violent learning experiences in multiple settings, often in the context of diminished examples of non-violent patterns of engagement and problem-solving.[41]

What needs to be done?

South Africa is one of the most violent countries in the world. Violence has become so ubiquitous as a response to solving problems and dealing with conflict, and is so intergenerational in nature, that any response needs to be preventive and promotive, as well as curative. In addition, the response must be multisectoral and include a whole-of-society and whole-of-government approach[42] to address the complex interplay of risk and protective factors at each level of the socio-ecological system. Most importantly, violence against children is preventable, and breaking the myriad links between violence in all its forms and the poor mental health of children and adolescents, will have multiple benefits for our country.

We need to integrate trauma-informed approaches in the delivery of services and move from the notion that the effects of violence and trauma can only be managed through dedicated psychological and/or psychiatric services. Services and settings where children find themselves, including health, education (schools, early childhood development programmes and universities), social services and the criminal justice system (police and courts), amongst others, must consider this approach in working with children and their families to break the intergenerational cycle of trauma. A trauma-informed approach begins with an understanding of the physical, social, and emotional impact of trauma on the individual, as well as on the professionals and caregivers who are there to help them.[43] Trauma-informed approaches to care shift the focus from "What's wrong with you?" to "What happened to you?", by considering the widespread impact of trauma; recognising the signs and symptoms of trauma in children, caregivers, and staff; and integrating knowledge about trauma and potential pathways to recovery into policies, procedures, and practices to prevent re-traumatisation.[44]

From prevention to treatment

Ideally, our first response should be to prevent violence and trauma, acting early in a child's life given our knowledge of how most mental health conditions in adult life have their roots in childhood.

Case 26: Using parenting programmes to promote positive parenting

Inge Vallance[i] and Cathy Ward[ii]

Parenting for Lifelong Health (PLH) for Young Children is a group-based parenting programme for caregivers of 2 – 9-year-olds that aims to establish and sustain positive parenting, reduce harsh parenting and promote children's well-being.

The original, South African, version is twelve sessions long. The first six sessions focus on developing a positive parent-child relationship and include content on establishing parent goals around child behaviour, spending quality time with children through child-led play, descriptive commenting,[iii] communicating about emotions, using labelled praise,[iv] and using rewards to encourage positive behaviour. The final six sessions then move on to limit setting and non-violent discipline strategies. These strategies include giving positive and clear instructions, establishing household rules, ignoring negative attention-seeking behaviour, using a 5-minute cool-down period after aggressive behaviour or non-compliance before discussing it, using realistic consequences, and involving children in problem-solving.

The sessions begin with a discussion where caregivers report on their experience of practicing the parenting skills that they learnt the previous week. Parents are then introduced to the session's core skill through the use of illustrated stories (i.e., cartoon strips depicting scenes of families using the parenting skills either correctly or incorrectly), and role plays (where they have the opportunity to practice these new skills). The sessions close with parents receiving exercises to practice at home with their children as this is considered to be a key mechanism in supporting a change in parenting practices.[66,67]

A randomised control trial, which enrolled caregivers who identified their children's behaviour as problematic, found that caregivers on the programme reported increases in positive parenting and decreases in harsh parenting and child conduct problems (relative to those who had not received the programme), with some positive effects enduring at a one-year follow-up.[68] Where those on the programme also reported more non-violent discipline than parents in the control arm of the study.

i Department of Social Policy and Intervention, University of Oxford
ii Department of Psychology and Safety and Violence Initiative, University of Cape Town
iii Describing aloud what you see the child doing (e.g.., "You're pushing your blue car on the red mat"), without comment or direction.
iv Giving clear and specific praise (e.g., "Thanks for tidying up your toys!", rather than something non-specific – "You're such a good boy!").

Case 27: Psychological First Aid – providing immediate mental health support at crises or disasters

Edith Kriel[i] and Joan van Niekerk[ii]

Trauma impacts children's immediate and long-term physical and emotional health, behaviours, relationships, and their ability to learn. The impact of trauma is different for every child. The first supportive response to trauma significantly impacts a child's perceptions and experience of how adults could provide safe and caring spaces for children's healing. Psychological First Aid provides support at a critical point in time that can minimise the long-term impact of the trauma on the child and family.

Most clinicians in South Africa have received training in one or more models of 'trauma debriefing'. One form is called 'critical incident debriefing'. Not only does this not work, in fact it worsens symptoms. Trauma debriefing does not reduce the prevalence of post-traumatic stress disorder (PTSD) and may in fact increase the possibility of PTSD. The World Health Organization does not support the use of trauma debriefing as an intervention.[69]

Psychological First Aid (PFA) on the other hand, is an empirical, evidence-informed, step-by-step approach to provide help in the immediate aftermath of disasters such as the loss of a parent or sibling, loss of the child's home and possessions through a fire or flood, or exposure to violent incidents in the home, school or community.[70-72]

Just like medical first aid is needed to address physical injuries at the scene of an accident, PFA provides immediate psychological care and support in response to trauma. It also offers long-term benefits enabling children and adults to cope more effectively after a trauma.

PFA should be provided by the first people to arrive on the scene of the trauma and who are able to assist. This could include health workers, teachers, early childhood development practitioners, child and youth care workers, community and religious leaders as well as first responder emergency personnel.

The impact of trauma is complex and PFA responders need to understand that when people feel threatened, they react with a fight-flight-freeze response: 'fight' (fight to protect themselves), 'flight (try to get away)' or 'freeze' (as if frozen on the spot, not able to quickly think of ways to get away or protect themselves). This neurobiological process is not something people are able to control and they may react in unpredictable ways. Some children may become hyper-aroused, overly emotional and irritable, exhibit difficult behaviour, or become aggressive and hard to reason with. Other children may be hypo-aroused or withdrawn, extremely anxious, or go into a complete shut down and dissociate. This may lead to poor concentration, cooperation and connections. First responders therefore need to know how to approach traumatised children in a way that helps soothe and calm the child. Given that many children in South Africa live in a constant state of arousal due to violent environments, such skills are vital for those working with and responding to crises.

There are multiple models of PFA that have been developed. Jelly Beanz is a non-profit organization that provides direct therapeutic support to children who have experienced trauma, abuse and neglect. It also develops resources to build the capacity of professionals working with children and their training programme focuses on the following key elements of PFA:

1. **Contact** with the child and adults must be done in a way that feels safe and supported and that is underpinned with an understanding of the body's neurobiological responses to threat.
2. **Containment** provides practical and psychological safety to calm the neurobiological threat system of the brain. This includes addressing the immediate physical needs, e.g., sitting next to the child and talking in a soothing voice, offering a hug, moving to a more comfortable space where the distressing sensory experiences may not be so overwhelming, connecting the child with their parent or caregiver, or helping the child focus on safe aspects of their environment.
3. **Current concerns** focus on identifying what the child and adults see as their immediate concerns so that the support offered respects their needs in the crisis.
4. **Connecting** children to formal and informal support systems for continued support is important, especially if the person providing the PFA will not be able to support the child long-term.
5. **Continued collaboration** with formal and informal support systems ensures that the child continues to benefit in the longer term from appropriate support.

PFA is important in providing psychological and practical support to children who are exposed to trauma and helps improve outcomes by minimising trauma, building children's internal resources and linking them with external support systems. For more information, see: *Psychological First Aid for children, Adolescents and Families – A guide for first responders.*[73]

i Jelly Beanz
ii Consultant: Child Protection

Prevention includes:

- Primary prevention to prevent violence before it starts;
- Secondary prevention, which focuses on the immediate response to violence including emergency services and holistic care; and
- Tertiary prevention, to reduce the impact of trauma in victims and rehabilitate offenders.

Primary prevention targets risk factors to prevent later negative outcomes. For example, universal parenting programmes that support the ban on corporal punishment in the home and promote positive discipline, as illustrated in Case 26. Multi-component, school-wide programmes have the potential to reach large numbers of children with good success.[45] Such programmes involve multiple stakeholders such as teachers, school administrators, parents, learners and community-based organisations in the planning and implementation of the programme, with a focus on shifting power relations, school culture and norms using a range of strategies.[46] For example, the 'Classrooms in Peace' (Aulas en Paz) elementary school programme in Colombia has shown success in preventing aggression and promoting peaceful relationships.[47] The programme promotes empathy, anger management, creative generation of alternatives and assertiveness. Gender transformative programming with men and boys is also critical to shift the gendered social norms that drive violence in South Africa. There are some promising programmes such as the Stepping Stones and Creating Futures programme targeting young men and women through a group approach, which has shown success in shifting men's use of violence.[48]

Secondary prevention involves the early detection of risk and difficulties and focuses on intervening to reduce impact. A good example of this is the use of psychological first aid to help children and families cope with the immediate impact of trauma (see Case 27). Targeting of at-risk families has also proved effective through programmes such as Sinovuyo Kids (see Case 26), which targets families and children who have screened positive for behavioural difficulties and aims to improve positive parenting and reduce harsh discipline. By intervening at the early signs of behavioural difficulty, the programme aims to prevent children engaging in ever more disruptive and aggressive behaviour.

Tertiary prevention uses treatment and care to manage disorders, to improve quality of life and to attempt to ensure that an acute response or disorder does not become chronic and can target both survivors and perpetrators. One such programme is the Support Programme for Abuse Reactive Children (SPARC), a diversion programme for young sexual offenders offered by the Teddy Bear Clinic in Gauteng, which has proven effective in disrupting the cycle of abuse and preventing long-term abusive behaviour.[49] However, access to secondary and tertiary treatment is often unattainable.[50]a Accessibility to services for survivors of trauma remains a key concern given that child and adolescent mental health services are critically under-resourced[51] (see health chapter).

First-line treatments for traumatic stress in children and adolescents in high-income countries involve repeated exposure to the traumatic memory in the safety of a therapeutic relationship and helping the child to reprocess unhelpful thoughts and feelings about the trauma.[52] There is growing evidence that such interventions can be successfully adapted for lower-income settings, including on the African continent[53, 54] but there is little evidence from South Africa to date. Only one local randomised control trial has been published. Roussow and colleagues found that 7 – 14 sessions

Case 28: Poor tertiary responses and barriers to therapeutic services

A female aged 15 reported to the South African Police Services that she had been abducted and raped. The perpetrator claimed that the sex was consensual and that, as he met the girl at a tavern, he had assumed she was an adult. The forensic science laboratory report was inconclusive and there was no physical evidence of, or witnesses to, the rape. Two months later, the perpetrator was arrested and charged with statutory rape, but bail was not opposed by the state so two days later he walked free. The child attempted suicide and was taken to the nearest psychiatric hospital in the neighbouring province.

She was discharged after four days with a recommendation that she get psychiatric support. Even though there was a psychiatrist one hour away, he was in the neighbouring province. The 'local' services were at least a four-hour drive each way. The local police could not spare an officer to drive her there for treatment. The final entry in the case file records that charges against the perpetrator were withdrawn by the prosecutor, whilst the girl's caregiver, her sister, reported behavioural changes and a drop in school performance. Despite showing clear signs of trauma, she was not referred to social services or mental health services.

Source: Jamieson L, Sambu W, Mathews S. Out of harm's way? Tracking child abuse cases through the child protection system at five selected sites in South Africa-Research Report. Cape Town: Children's Institute, University of Cape Town; 2017.

of prolonged exposure therapy, delivered by nurses in a school setting, was more effective than supportive therapy in reducing PTSD in adolescents.[55] Another recently completed but as yet unpublished study, conducted jointly by the University of Cape Town and Stellenbosch University, found that eight sessions of trauma-focused cognitive behavioural therapy (CBT) significantly reduced PTSD and depression in trauma-exposed adolescents. Growing this small local evidence base will be important for guiding mental health services for traumatised children and adolescents going forward.[56]

It is crucial to remember that treatments such as this – even when available – cannot be implemented on their own. Families require significant support to ensure that they have the capacity to manage the child. In addition, caregivers and families are themselves usually dealing with the same traumatic event (or at the very least the shock of what has happened to their child), and they require significant support. Hence, there is also a need to deal with the trauma of caregivers. Interventions to deal with trauma therefore need to be multi-dimensional. In addition, Titi has shown that children can articulate personal narrative accounts and rich descriptions of their lives, and that an African-centred, child-centric psychological approach can improve the experience of therapy for African children who are exposed to the most extreme forms of polyvictimization.[65]

While South African evidence may be thin, it is surely possible to adapt evidence-based programmes from other low- and middle-income countries for use in the South African setting. Mental health interventions for children include attachment-based therapies, intensive family supports, CBT and psychosocial treatments. Evidence-based, trauma-focused treatments have shown CBT techniques to be most effective in reducing serious trauma reactions, such as PTSD and behavioural problems.[57]

What are the implications for policy and practice?

While South Africa has put in place a suite of progressive laws and policies designed to promote children's optimal development and protect them from harm, implementation and enforcement remains weak and patchy.[58] Many crimes go unpunished – especially in poor communities where police services are under-resourced. For example, a study in KwaZulu-Natal and the Eastern Cape found that only 12% of reported cases resulted in a guilty verdict and only a handful of children were able to access therapeutic services,[58] as illustrated in Case 28.

The Children's Act gives effect to children's rights to protection from abuse, maltreatment and neglect and the right to social services. The Act and the supporting policy, namely the National Child Care and Protection Policy, provide for a continuum of care from primary prevention and early intervention programmes to child protection services, alternative care options such as foster care and rehabilitation and family reunification programmes. The Act also provides for intersectoral collaboration and, in theory, supports multi-disciplinary teamwork. However, the criminal justice system, school-based programmes and services for women are regulated by a largely separate and distinct policy framework, as are mental health services for children. As discussed above, the levels of intergenerational trauma and the high degree of exposure to violence require a holistic response. The National Strategic Plan on Gender-Based Violence and Femicide (NSP) claims to target both women and children but a detailed analysis reveals that children are a subsidiary focus.[59]

In addition to these conceptual weaknesses, service provision has always been hampered by a lack of human and financial resources.[60] The problem was exacerbated during the COVID-19 pandemic as funds were repurposed and many child protection services were refocused on humanitarian assistance.[61] Despite the high-level commitment to the NSP, it has not been backed with sufficient resources to improve services[61] and there are insufficient social service practitioners to support even the most basic level of implementation of the Children's Act[60]. The majority of professionals within the criminal justice system lack specialist training[62] and although most of the clients seen at Thuthuzela Care Centres are children, the centres are not child-friendly and offer only containment counselling services.[63] Children are referred to counselling services for longer-term care but typically have to wait months to be seen,[58] while integrated services for women and children who have experienced or witnessed violence are limited in the large metros and virtual non-existent in rural communities.[64]

Recommendations

- Interventions across the life course are needed to build resilience, prevent violence and trauma, promote healing and reduce the long-term psychosocial effects of exposure to violence.
- Early intervention is necessary to identify and support vulnerable parents, promote positive parenting and child development, with early childhood development programmes having a potential role in this process.
- School-based interventions are another essential part of the continuum to reduce the risks of violence and trauma to children in the school as well as in their homes and

Case 29: Young people's suicidal behaviour in South Africa

Jason Bantjes[i]

Suicide is a leading cause of death among adolescents globally,[74-77] accounting for 6% of fatalities among young people.[78] Worldwide, one-third of suicides occur among adolescents, with suicide being the second leading cause of death among 15 – 29-year-olds and the leading cause of death for females aged 15 – 19 years. Suicide among pre-pubescent children is relatively rare, partly because younger children typically lack the knowledge and agency to follow through with a lethal suicide plan. Non-fatal suicidal behaviours (i.e., suicidal ideation, plans and attempts) are also common among adolescents and are associated with significantly increased risk of future self-harm and suicide.[77, 79, 80] The first onset of suicidal behaviour invariably occurs in late adolescence, highlighting the importance of early identification and intervention in this developmental period.[81] In part, the emergence of suicide as a leading cause of death among young people is a consequence of the considerable medical and economic advances that have improved the physical health of children.

There is a dearth of reliable epidemiological data about suicidal behaviour among adolescents in South Africa, beyond descriptive studies which suggest that youth suicide prevention should be an important public mental health priority.[82-84] In the absence of reliable local data, policy makers in South Africa are mostly reliant on global data to inform suicide prevention policy and practices. Collecting accurate data about the prevalence and risk factors for youth suicidal behaviour is thus one of the most important priorities to advance evidence-based suicide prevention programmes in South Africa.

The Youth Risk Behaviours Surveys (YRBSs) are the most widely cited sources of data on youth suicidal behaviour in South Africa, however there are some inconsistencies in the survey data which raise questions about their accuracy. The YRBS data are presented in Table 10 along with a calculation of the mean prevalence estimates across the three surveys conducted to date. The mean 6-month prevalence rates for suicidal ideation, suicide plan and suicide attempt are 19%, 16% and 19%, respectively. It is not surprising that, on average, 19% of participants in the YRBSs reported suicidal ideation in the past 6-months, as this is congruent with international studies.[79] But the data for suicide plans and attempts should be treated with caution as it is highly improbable that every ideator made a suicide attempt, as is implied by the YRBS data.

Other South African data on youth suicidal behavior are more consistent with international trends. For example, data collected from first-year students at two universities yielded lifetime prevalence estimates for suicide plan, and attempt of 26.5% and 8.6% respectively,[82] while data from the South African National Mortality Surveillance System database show that 10% of all suicides occur among individuals younger than 20 years of age and that suicide in children younger than 11 is rare in South Africa.[85]

Understanding the risk factors and drivers of youth suicidal behaviour in South Africa is essential for planning effective programmes. Globally, suicidal behaviour is variably associated with a wide range of risk factors[86] and causes.[87] Psychopathology is strongly associated with adolescent suicidal behaviour,[88] therefore efforts to promote the mental health of children and adolescents should probably be the cornerstone of a national youth suicide prevention programme in South Africa. Actuarial analysis of non-fatal suicidal behaviour among first-year university students in South Africa showed that increased risk of suicidal behaviour was associated with major depressive disorder, generalised anxiety disorder and

Table 10: Prevalence rates for adolescent suicidal behaviour from the South African Youth Risk Behaviour Surveys

	2002 (N=10,699)	2008 (N=10,270)	2011 (N=10,997)	Mean prevalence rate (and range) across all three surveys
Considered attempting suicide[a]	19%	21%	18%	19% (18%-21%)
Made a plan to attempt suicide[a]	16%	17%	16%	16% (16%-17%)
Made 1 or more suicide attempts[a]	17%	21%	18%	19% (17%-21%)

[a] During the 6 months preceding the survey

i Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council, South Africa.
Institute for Life Course Health Research, Department of Global Health, Stellenbosch University, South Africa.

bipolar spectrum disorder, and that treating common mental disorders could yield absolute reductions in suicide ideation, planning, and attempt of 17.0%, 55.0% and 73.8% respectively.[83] However, psychopathology is not the only driver of suicidal behaviour; other risk factors for youth suicide include HIV infection, poverty, substance use, exposure to violence, and adverse childhood events, all of which are endemic in South Africa.1[79-91] Other modifiable risk factors include bullying, sexual assault, and impulsivity.[92-94] Given the array of risk factors, it seems improbable that any South African youth suicide prevention programme focused narrowly on increasing access to mental health care will be completely effective. Increasing adolescents' access to mental health care services will also not be easy to achieve given the marked mental health treatment gap among South African youth.[95]

Socio-cultural and contextual factors, such as gender norms and societal expectations can also play a role in youth suicidal behaviour. For example, qualitative studies have illustrated how young men in South Africa attribute suicidal behaviour to feelings of disconnectedness, thwarted belonging, pressure to conform to the gender regime, and feelings of shame when unable to achieve masculine ideals.[96] Young men in South Africa describe restrictive heteronormative gender roles that create a rigid gender regime which prevents authentic relating, disconnects young men from each other, and makes it difficult to receive emotional support when suicidal.[96, 97] Qualitative studies like these suggest that youth suicide prevention programmes should include systemic interventions that seek to disrupt the gender regime.

In the absence of local data, we need to rely on evidence from other countries to inform suicide prevention interventions for adolescents and children in South Africa.[98] These include:

- Increasing access to evidence-based treatments for common mental disorders and establishing accessible child and adolescent psychiatric services.
- Establishing community-based "child- and adolescent-friendly" counselling centres.
- Building the capacity of health workers to recognise and manage common childhood and adolescent mental health problems.
- Helping children and adolescents learn affect regulation, impulse control, and problem-solving skills.
- Reducing bullying and promoting belonging in schools.
- Reducing adolescent substance use.
- Training gatekeepers (such as teachers and youth workers) to recognise the warning signs of suicide, provide psychological first aid, and refer at risk youth to appropriate services.
- Providing children and adolescents with access to 24-hour anonymous helplines and text messaging services to access emotional support and guidance.
- Reducing stigma about mental illness and prompting adaptive help seeking.
- Using digital technologies to scale up access to effective treatments for common mental disorders as illustrated in Case 24.

While gatekeeper training is one of the most common suicide prevention strategies in high schools and universities, the evidence supporting these programmes is contradictory, suggesting that these programmes need to be context-sensitive.[98] At the same time many gatekeeper training programmes assume that there are appropriate and accessible community-based services for at-risk youths, but this is not the case in many parts of South Africa.

Similarly, introducing screening systems to identify and refer children and adolescents who are at risk of suicide is unlikely to be feasible in South Africa. Screening for suicide risk is very unreliable and most screening instruments produce an inordinate number of false positives.[99, 100] In addition, the South African health care system simply does not have the resources to respond to appropriately.

If you are concerned about a young person who is displaying warning signs for suicidal behaviour you can:

- Reach out to them and try to establish a connection.
- Offer them emotional support (listen empathetically, encourage them to express their feelings, don't minimise what they are saying, validate their experience, and remind them that help is available).
- Ask them directly if they are thinking about suicide. Talking to young people about suicide does not increase risk. Likewise, it is a myth that if someone is talking about suicide they are not going to act on their intention. If anyone expresses a desire to die and they say that they have a plan which they intend to carry out, you should take them immediately to the closest hospital emergency room.
- Encourage them to seek help from a professional.
- Provide them with contact details for 24-hour help lines (for example, Lifeline and SADAG).

communities. They can also run gender transformative programmes to help change gendered practices and entrenched gender roles.
- Integrated services for women and children are needed to respond to intergenerational trauma and support caregivers to help children heal.
- Trauma-informed approaches to services across a range of settings, including education, social services, the criminal justice system (police and courts) and health, amongst others, are critical for children, families and frontline workers to recover from trauma.

Conclusion

One of the most critical dynamics explored in this chapter is the intergenerational nature of violence and the impact on children's mental health and well-being across the life course. Children and adolescents who are exposed to violence tend to develop violent ways of interacting with others as a learned behaviour, and so violence is perpetuated. We note that measures identified to prevent and respond to violence need to adopt a life-course approach to ensure that the needs of children are adequately addressed and supported at each stage of development; and that there is a need to intervene early to disrupt the cycle of violence and re-traumatisation. We also have to address the risk factors that increase children's vulnerability, such as poverty, unemployment, parental alcohol and substance misuse, poor caregiver-child attachments, family conflict and high levels of community dysfunction, as they all interrelated.

Resources are therefore needed to support an integrated programme of prevention and response interventions in addition to the traditional treatments to disrupt the long-term, intergenerational effects of violence and trauma. Equipping parents to reduce harsh forms of parenting and promote nurturing care is critical in the early years. These interventions also provide an opportunity to consider how gender transformative programming can reduce violence towards intimate partners and children in the home. Schools present a unique opportunity to reach large numbers of children and to prevent VAC through the delivery of innovative interventions. For example, trauma-informed schools have the potential to identify children who need support, to prevent aggression and bullying, and to promote gender equitable attitudes and behaviours and prevent dating, intimate partner and sexual violence.

Most children and young people in South Africa experience ongoing violence and multiple adversities. There is therefore no easy solution or quick fix in terms of violence prevention and treatment of the effects of violence on child and adolescent mental health. The response should be systemic and trauma-informed, based on multi-component interventions across different levels of the socio-ecological system. We need to invest in the promotion of evidence-based programming that promotes resilience and recovery for children while enhancing the capabilities of families to protect children and young people and to unlock their full potential.

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