ABSTRACT
This Chapter considers the particular nature and context of child traumatisation in South Africa, the documented psycho-social impacts of trauma and violence in South Africa and elsewhere, the factors that may increase or reduce the risk of adverse psycho-social consequences among children who have experienced trauma and violence, and the intervention approaches that have been advocated to assist traumatised children. While South African research on the psycho-social impact of trauma has grown in recent years, there is still a lack of local data on developmental aspects of trauma, on risk and protective factors, as well as effective intervention strategies. Localised, context-specific knowledge is necessary in order to inform mental health policy and service provision. Recommendations for future research to advance this goal, and for strategies to improve psycho-social support for traumatised children in South Africa, are suggested.

Keywords: trauma, violence, South Africa

INTRODUCTION
Given South Africa’s high rates of child physical and sexual abuse, criminal victimisation of children, and school-based violence (Burton, 2006; Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009), together with a high burden of childhood accidental injury both within and outside the home (Matzopoulos, du Toit, Dawad & Van As, 2008; Van Niekerk, du Toit, Nowell, Moore & Van As, 2004), many young South Africans are at risk of poly-victimisation, or exposure to different types of trauma across multiple settings. For children living in these circumstances, traumatisation is more of a ‘condition’ than an ‘event’ (Finkelhor, Ormrod & Turner, 2007).

Living within a context of multiple and continuous trauma exposure, with few safe spaces, poses a different set of psychological challenges and requires different intervention approaches to those that have been well-documented for children and adolescents who experience single traumas or those who experience ongoing abuse in only one setting. Furthermore, for many South African children, multiple traumatisation occurs within a broader resource context of poverty, with its attendant burden on family structures and parental coping capacities (Kiser & Black, 2005; Klebanov, Brooks-Gunn & Duncan, 1994), an inadequate educational system (Fiske & Ladd, 2004) and limited mental health services for children (Lund, Boyce, Flisher, Kafaar & Dawes, 2009). These factors may compound the impact of trauma exposure and place constraints on intervention options. However, not all South African children who repeatedly experience potentially traumatic events will suffer mental health difficulties. The development of mental health policy
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for children affected by trauma and violence in South Africa must, therefore, be grounded in a careful analysis of the mental health risks posed by different forms of trauma exposure and by cumulative traumatisation, the factors that buffer the impact of such exposure, and a systematic evaluation of the effectiveness of intervention programmes that are contextually responsive. This Chapter reviews:

a. The current state of knowledge about the impact of trauma on children’s mental health and development.
b. The risk and protective factors that moderate the impact of trauma exposure, with an emphasis on findings from South African research.
c. The intervention approaches for assisting traumatised children and the evidence to support them.

The Chapter also offers some recommendations for enhancing our understanding of the impact and treatment of childhood traumatisation in South Africa, and for improving psycho-social services.

PSYCHO-SOCIAL IMPACT OF TRAUMA EXPOSURE ON CHILDREN

Defining trauma
The term ‘trauma’ has several meanings. In a medical sense, it refers to a physical wound or injury. However, this Chapter is concerned with psychological trauma. In the contemporary psychological literature, the term ‘trauma’ refers to external experiences that place excessive demands on people’s existing coping strategies and create severe disruptions to many aspects of psychological functioning. Research has found that events involving some form of physical threat to oneself or someone else are most likely to result in symptoms of Post-Traumatic Stress Disorder (PTSD), (American Psychiatric Association, 2000). These events may, occasionally, involve actual physical injuries. However, whether or not a physically threatening event such as a sexual assault by a teacher, a burn injury, witnessing an act of family violence, or receiving a severe beating by a parent will constitute a ‘trauma’ depends on the child’s psychological response to the event. Many children experience physically threatening or extremely distressing events without suffering any significant disruption to their psychological functioning. When referring to ‘trauma’, it is therefore important to distinguish between potentially traumatic events and the traumatic stress symptoms that sometimes develop in the wake of such events.

Psycho-social consequences of exposure to potentially traumatic events
PTSD is the most extensively researched post-traumatic response amongst both adults and children. The DSM-IV-TR (American Psychiatric Association, 2000) describes three symptom clusters in PTSD: persistent re-experiencing of the trauma (for example, intrusive memories and flashback experiences, often triggered by exposure to traumatic reminders), avoidance of traumatic reminders (including places, people and conversations) together with a general numbing of emotional responsiveness, and chronic physiological hyperarousal, including sleep disturbances, poor concentration, and hypervigilance to threat. The DSM-IV-TR notes that, in children, re-experiencing may occur through repetitive play involving trauma-related themes, rather than through memories. Following a traumatic experience, it is normal and expectable for both children and adults to exhibit some transitory intrusive, avoidance and hyperarousal symptoms, which usually remit spontaneously within a few days or weeks. In order to meet the PTSD diagnosis, symptoms should be present for at least one month, and must cause the child significant distress or substantially impair their daily functioning.

Epidemiological studies of childhood PTSD in economically developed countries like the United States (Breslau, Wilcox, Storr, Lucia & Anthony, 2004; Kilpatrick & Saunders, 1997) and Germany (Perkonigg
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et al., 2005) tended to include adolescents rather than younger children, and have reported prevalence rates of between 1% and 6.3% for boys, and 2.2% and 7.9% for girls. Similar epidemiological data for child and adolescent PTSD is still lacking in South Africa. However, several studies with school-going samples aged 10 years and older have found that over 20% of participants have enough symptoms for a PTSD diagnosis (Ensink, Robertson, Zissis & Leger, 1997; Seedat, Nyamai, Njenga, Vythilingum & Stein, 2004; Suliman et al., 2009). Some other studies of post-traumatic symptoms among children in South Africa have yielded lower rates of risk for full-blown PTSD, such as 8% in a study of children in the Northern Province (Peltzer, 1999) and 5.8% of adolescents in a study of private schools in Cape Town (Ward, Flisher, Zissis, Muller & Lombard, 2001), but found high rates of sub-clinical traumatic stress symptoms. In line with international findings (Margolin & Gordis, 2000; Turner, Finkelhor & Ormrod, 2006), trauma-exposed youth in South Africa also frequently report symptoms of depression and anxiety (Ensink et al., 1997; Suliman et al., 2009; Ward et al., 2001). Because the majority of South African studies have relied on self-report symptom scales rather than structured psychiatric interviews and the collateral reports of parents and teachers, it is unclear to what extent the psychiatric symptoms reported by trauma-exposed children are of clinical significance and would require intervention. It is also not yet clear which specific forms of trauma exposure create the greatest risk for particular psychiatric symptoms. Some studies have found that the overall level of exposure to community violence is more strongly predictive of emotional and behavioural symptoms amongst children (Barbarin, Richter & de Wet, 2001) and adolescents (Fincham, Korthals Altes, Stein & Seedat, 2009) than overall levels of domestic violence, but these studies did not explore the contributions of specific forms of community and domestic violence to mental health outcomes. Such information would assist with prioritising prevention and intervention programmes in a context where resources are limited.

While traumatised children sometimes display symptoms of PTSD and other psychiatric disorders, they also commonly present with an array of other signs of traumatic stress that may vary according to their developmental level. Children between the ages of 0-2 years tend to portray primarily physical distress, such as sleeping or eating difficulties. Children between the ages of 3-6 years who have experienced a trauma may present with the loss of recently acquired developmental skills (such as the ability to feed or dress themselves), separation anxiety (manifested through clingy behaviour, fear of sleeping by themselves, or worry about something happening to their parents), the onset of new fears or the re-activation of old ones, and psychosomatic complaints such as stomach aches and headaches (Herbert, 1996; Yule, 1995). In children of primary school age, traumatic stress may manifest in sleep disturbances and somatic complaints, feelings of guilt and responsibility for the traumatic event, and repetitive play or re-telling of the traumatic experience. Traumatised children in this age group are also likely to display hyperactivity, distractibility and increased impulsivity, symptoms that may be mistakenly attributed to an attention-deficit or conduct disorder (Husain, Allwood & Bell, 2008; Weinstein, Staffelbach & Biaggio, 2000). These responses can interfere significantly with learning and place traumatised children on a trajectory towards school failure and drop out. A recent South African epidemiological study with adults found that trauma exposure and PTSD are associated with an increased risk of failing to complete secondary education (Myer et al., 2009). Youth who drop out of school are at increased risk of involvement in gang and criminal activity, and subsequently of further violence exposure, as well as perpetration. To date, South African research on the impact of trauma on children has tended to focus on psychiatric symptoms of PTSD, depression and anxiety, rather than other manifestations that may be characteristic of traumatic stress in early and middle childhood. Adolescents who have been exposed to trauma may
become withdrawn and non-communicative, or
defiant, aggressive and display reckless behaviour
patterns that place them at increased risk for the
development of substance abuse, criminal activity,
vioence perpetration and further violence exposure
(Jewkes et al., 2006; Pat-Horenczyk et al., 2007). In
the international literature, aggressive behaviour
amongst youth is consistently associated with a
history of childhood physical abuse and less so
with childhood sexual abuse, witnessing domestic
violence and exposure to community violence
(Margolin & Gordis, 2000). South African research has
reported that direct exposure to trauma is associated
with an increased risk of conduct problems among
Grade 6 (Ward, Martin, Theron & Distiller, 2007) and
Grade 7 (van der Merwe & Dawes, 2000) learners,
but the forms of direct traumatisation that carry
the highest risk have not yet been disaggregated.
To understand the relationship between violence
exposure and violence perpetration amongst youth,
the broader context of trauma exposure must also
be considered: some authors have argued that in a
context where the child or adolescent feels ashamed
of their identity, as may be the case in historically
oppressed and socio-economically marginalised
communities in South Africa, the risk of rage and
aggression increases (Garbarino, 1999; Seedat et al.,
2009).

Impact of trauma exposure on development
Children need to invest psychological resources
in mastering normative developmental tasks. Experiences of trauma can interfere with the child’s
negotiation of critical developmental transitions, as
well as prevent the mastery of key developmental
competencies (Pynoos, Steinberg & Goenjian, 1996).
For example, exposure to family and community
violence amongst pre-school children is associated
with deficits in narrative coherence, a developmental
competency that is necessary for reading, writing
and communication skills (Osofsky, 1993). Trauma
exposure may also delay, or inappropriately hasten,
the development of independence and autonomy
among young children and again in adolescence
(Pynoos et al., 1996). There is also substantial
evidence that children who have been exposed to
violence and abuse have difficulties in their peer
relationships, due to being overly sensitised to
anger, hostility or threat (Margolin & Gordis, 2000).

Some American studies have suggested that youth
who are chronically exposed to violence may develop
a dissociation or disengagement response as a way
of coping (Fitzpatrick, 1993; Hill, Levermore, Twaite
& Jones, 1996). Whilst being protective in some
ways, this coping strategy may also result in long-
term social and emotional maladjustment. It has
further been proposed that experiences of chronic
community violence combined with harsh parenting
(thus, an absence of parental regulation of children’s
fearful emotions) can lead to a “defeat reaction”
in children, a long-lasting form of dissociation
characterised by lowered blood pressure and heart
rate (Perry & Pollard, 1998). A pattern of terminal
thinking has also been observed in chronically
traumatised youth, whereby they are unable to
envision any long-term future and become resigned
to the belief that a violent death is inevitable
(Garbarino, 1999). Defeat reactions and terminal
thinking may have a negative impact on children’s
moral development, resulting in a lack of empathy
and concern about the consequences of one’s
actions towards others. This may increase the risk
of engaging in violent behaviour or illegal activities.
Anecdotal observations from service providers in
violence-riddled communities in South Africa suggest
that dissociation, disengagement and defeatism
are common amongst children and adolescents.
However, these responses have not yet been
well-documented in local research studies. Some
American (McCart et al., 2007; Turner et al., 2006)
and South African (Suliman et al., 2009) studies have
found that levels of psychiatric symptoms, such as
PTSD and depression, increase with more exposure

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to violent events, which appears to contradict the desensitisation hypothesis. More research on the impact of cumulative trauma is needed to better clarify these processes.

Children who grow up in situations of prolonged domestic abuse are particularly vulnerable to developing long-term psychological difficulties. Growing neurobiological evidence has demonstrated that when the emerging brain of the infant or young child is subjected to prolonged conditions of threat, the brain pathways that focus on identifying danger and developing survival or defence strategies are strengthened, while those that enable creative exploration of the environment, the development of secure relational attachments, and the capacity for emotional regulation or reflective self-awareness are compromised (Ford, 2009). Once laid down, these neural networks are difficult to alter, particularly in the absence of safe spaces or supportive relationships outside the home. Therefore the impact of childhood abuse often persists into adolescence and adulthood in complex forms that extend well beyond psychiatric symptoms of PTSD, depression and anxiety (Ford & Courtois, 2009). For example, it has been established in both international and South African research that adult perpetrators of intimate partner violence more frequently report having suffered direct abuse and witnessing domestic violence in their own childhoods than non-abusers (Gupta et al., 2008; Hotaling & Sugarman, 1986). Women who experienced child sexual abuse are at higher risk of being sexually victimised, and of experiencing intimate partner violence, in adulthood (Jewkes, Sikweyiya, Morrell & Dunkle, 2009; Koss & Dinero, 1989).

The developmental impact of childhood trauma exposure is thus both proximal and distal. Although some of the long-term consequences of early childhood trauma have been explored with adult samples, there has been little South African research that explores the developmental impact and consequences of exposure to trauma among children of different age groups.

Risk and protective factors
The relationship between trauma exposure and psychological or behavioural outcomes is not necessarily linear and appears to be moderated by a number of factors. These include factors that have been characterised as intrinsic to the child, as well as external systemic and contextual influences.

The PTSD literature has identified ‘intrinsic’ child characteristics such as an easy-going temperament, high intellectual ability, an internal locus of control (the belief that one can control one’s external events), trust and optimism as being associated with a reduced risk of developing PTSD after trauma exposure (Pat-Horenczyk, Rabinowitz, Rice & Tucker-Levin, 2009). However, these ‘intrinsic’ qualities are likely to be greatly shaped and influenced by the child’s family, educational and community milieu – living in a context of multiple adversities may place limitations on the development of these traits and abilities, and children who grow up in impoverished and disempowered communities may develop belief systems of helplessness and pessimism, which are associated with an increased risk of post-traumatic symptoms (Pat-Horenczyk et al., 2009). However, South African research has found that individual child characteristics of adaptability and frustration tolerance protect against the negative impact of violence amongst young children (Barbarin et al., 2001), while tolerance of negative feelings, perceptions of social support and feelings of self-efficacy reduce the risk of PTSD among trauma-exposed adolescents (Fincham et al., 2009).

The nature of the attachment relationship between child and parent, and the quality of family functioning, have consistently been found as the most important predictors of whether a child's exposure to community violence will result in the
development of emotional or behavioural difficulties (Pat-Horenczyk et al., 2009). A secure attachment relationship and supportive parenting practices can protect children by helping them to regulate their emotional responses to violence outside the home and to develop appropriate coping strategies (Kiser & Black, 2005). However, families living in contexts of multiple adversity and chronically harsh, traumatic circumstances, as many South African families do, are vulnerable to gradual erosion in their capacity to offer a supportive environment to their children. For some families, experiences of adversity and trauma can enhance family cohesion and support, and prompt creative strategies for dealing with potential threats and stressors. However, research evidence suggests that for many families, environmental poverty and chronic trauma exposure increase the risk of punitive parenting styles and of child maltreatment (Krenichyn, Saegert & Evans, 2001), parental mental illness (Klebanov et al., 1994), as well as chaotic and unpredictable family roles and routines and frequent changes in family membership (Kiser & Black, 2005). These systemic factors may place trauma-exposed children at greater risk for developing emotional and behavioural problems. Furthermore, the positive impact that social support from friends and relatives can have on parenting practices appears to become eroded as neighbourhood poverty and crime increase (Ceballo & McLoyd, 2002). Additionally, parents living in communities where levels of violence are high are also frequently exposed to trauma. Parental trauma-related distress decreases parents’ capacity to create a climate of safety and security for their children and to emotionally contain their children’s fear and anxiety (American Academy of Child and Adolescent Psychiatry, 1998). Despite the demonstrated importance of family factors as predictors of the psychological adjustment of children exposed to trauma, few South African studies have examined this issue. The limited findings to date suggest that maternal coping (Barbarin et al., 2001) and family organisation (Shields, Nadasen & Pierce, 2008) may mitigate the adverse effects of violence in younger children, but that parent support may not be related to psychological outcomes in adolescents (Ward et al., 2007). However, further research is needed to better understand the role of the family system in the psychological adjustment of trauma-exposed children in South Africa.

Perceptions of a supportive school environment are associated with resilience amongst children who have been exposed to community violence in urban American communities (O’Donnell, Schwab-Stone & Muyeed, 2002), and, similarly, with a reduction in depression symptoms and conduct problems in South African adolescents (Ward et al., 2007). However, in poorly resourced school environments characterised by overcrowded classrooms and overburdened teachers, the quality of social support that can be offered to learners may be limited.

Finally, the role of peer group support in the psychological well-being of children in violent communities remains equivocal. While peers may provide an alternative source of support for children living in conflictual or violent families, it is also apparent that strong peer relationships can be associated with an increased risk of substance abuse and delinquency (O’Donnell et al., 2002). The protective or harmful influences of peer relationships for children living in high-violence contexts warrant further attention in South African research.

**INTERVENTION APPROACHES**

The prevention or reduction of the occurrence of violence and accidental trauma is the most important priority in attempting to address the high rates of trauma exposure among South African children and adolescents. However, at present, most violence preventative programmes in South Africa are offered by the non-governmental sector rather than by the state. Tertiary prevention, or mental health
services for children and families already affected by trauma and violence, is currently provided by an inadequately resourced state mental health service (Lund et al., 2009). Despite being in line with international standards for mental health service provision, existing policy guidelines have largely remained unimplemented at provincial level (Draper et al., 2009). Existing interventions are largely offered by over-burdened social workers with very high case loads. There is a paucity of psychologists and psychiatrists within the state mental health system (Lund et al., 2009) and the bulk of the population most beset by violence cannot afford private mental health services. The early detection and containment of traumatic responses in children that could be offered by schools is hampered by the dearth of school-based counsellors in the current education system, and children living in high violence, low-income communities are therefore likely to be referred for intervention only once symptoms are impacting severely on their functioning.

The under-funded and under-staffed mental health system is not the only obstacle to effective service provision for traumatised children. Similar to other countries, South African research data on the types and efficacy of interventions with traumatised children and adolescents is limited, making it difficult to offer clear intervention guidelines or to draw conclusions about the appropriateness of existing services. In 1999, William Yule, one of the key British theorists on childhood trauma, observed in an overview of PTSD in children and adolescents that “above all, the time has come to institute proper treatment studies with children” (Yule, Perrin & Smith, 1999, p.45), citing the lack of published “randomised, controlled studies” as a key problem. Ten years later, it seems that, while there have been advances in this regard, there remains a marked dearth of empirically based, quantitative studies into the efficacy of child interventions in the broad trauma field. A recent examination of the best practice guidelines of the International Society for Traumatic Stress Studies (ISTSS) reveals that in almost every category of intervention discussed, there is concern about the basis on which particular practices can be recommended, given the paucity of gold standard research into child and adolescent interventions (Foa, 2009). The one possible exception is trauma-focused cognitive behaviour therapy (TF-CBT), based on the fact that several international control-based studies have demonstrated efficacy in the use of this intervention method (Foa, 2009). However, all of these studies have been conducted on the fairly restricted population of sexually abused children and adolescents (Foa, 2009; Ruggerio, Morris & Scotti, 2001). Other than these studies it is generally the case that documented evidence for the treatment of childhood trauma consists of individual case studies and more subjective types of evaluations, such as reports on community projects.

While there is a paucity of scientifically sound international studies on child trauma treatment (Ruggerio et al., 2001), there is even less evidence available for South African interventions (Edwards, 2005). One of the few studies employing a control group design was also conducted on a population of sexually abused girls and involved the use of a structured, group-art therapy programme (Pretorius & Pfeifer, 2010). Reports of local interventions are predominantly case study-based (for example, Kekae-Moletsane, 2006; Leibowitz-Levy, 2005; McDermott, 2005) or of a report type nature in which anecdotal or observational accounts of improvement may be offered (Killian & Brakarsh, 2004).

Part of the difficulty of undertaking good quality research in this area lies in variation in the types of trauma that children and adolescents may have been exposed to, differences in developmental level, the role of contextual factors (such as parental traumatisation and loss) and limited availability of appropriate, standardised assessment tools.
Although it has been difficult to control these kinds of extraneous variables even in adult trauma intervention studies, it will be apparent that there are particularly salient problems in establishing the validity of interventions in the case of child populations. The prior discussion of trauma prevalence and impact illustrates just how complex it is to address childhood and adolescent traumatisation and the wide variety of factors that are implicated in child maladjustment and resilience. With this proviso in mind, it is useful to discuss the range of interventions that is generally available and employed in the treatment of traumatised children, both internationally and in South Africa.

While there is some overlap between the two types of trauma, there is generally some distinction between treatment directed towards dealing with a single traumatic event of either human or ‘natural origin’ (rape or severe burn accident), as well as treatment directed at dealing with the impact of multiple, continuous or complex forms of trauma (ongoing physical or sexual abuse). There is also some recognition that, in the latter forms of trauma, there may be a combination of negative environmental and traumatic factors that need to be simultaneously addressed in treatment, including when to administer treatment for a low-income family in which there is ongoing domestic and child-directed abuse, as well as parental substance abuse. Child trauma treatment may also be offered in different modalities, including individual psychotherapy, group psychotherapy, caregiver-child counselling, family systems interventions, and school based programmes (Foa, 2009; Friedman, 2003; Leibowitz-Levy, 2005).

Most of the treatment approaches used with children and adolescents, other than play therapy, are based on modifications to interventions used with adults. In the case of acute traumatic events there are a range of recognised short-term interventions. Various debriefing protocols may be employed, as well as trauma support (including psycho-education and psychological first aid or PFA [Brymer et al., 2006]) and eye movement desensitisation and reprocessing (EMDR). In many instances parents or caregivers may be counselled simultaneously, usually involving psycho-education to assist them to anticipate signs of distress in their child/ren and to manage the impact meaningfully (Foa, 2009; Leibowitz, Mendelsohn & Michelson, 1999). Where groups of children have been affected in the same geographical and scholastic context, school-based debriefing interventions may be offered with a view to minimising fall-out from the traumatic event and identifying children who may be particularly at risk for the development of subsequent debilitating pathology. Despite some of the concerns about the efficacy and role of debriefing interventions (Bisson, 2003; Bisson & Cohen, 2006; Rose, Bisson & Wessely, 2003), adults feel a sense of responsibility in attempting to assist children to deal with difficult traumatic experiences. Given that adult mediation of anxiety evoking experiences is fundamental to optimal child development (Levy & Lemma, 2004), it is important that significant caregivers engage with children who have experienced traumatising events (Papaikonomou & Niewoudt, 2004). While it is unclear which components of an intervention may be most helpful, it would seem that in the initial aftermath of a trauma, supportive rather than deeply exploratory approaches are preferable (Bisson & Cohen, 2006; Stallard et al., 2006).

Beyond the initial containment of acute trauma treatment, there are a range of interventions that may be used to address the long-term consequences of single, and less complex, traumatic exposure (Cohen, Berliner & March, 2000). The dominant individual approaches employed in these instances are trauma-focused CBT and trauma-focused play therapy (Leibowitz-Levy, 2005). Play therapy is commonly used with early and middle childhood
aged children, employing drawing, creative activities and playing with objects representing the trauma, which are then responded to and interpreted by the therapist. One of the most widely-cited, brief-term approaches is “the child interview”, developed by Pynoos and Eth (1986) for child witnesses or victims of violent incidents. Although designed as a brief-term model for early intervention, it can be used to assist children to work through single event traumas more generally. The model facilitates the processing of trauma, by using common principles to guide such interventions aimed at children. It helps them to face and process the event, gain insight into what took place, as well as regain their sense of control, trust and hope. In a small survey conducted amongst several key trauma treatment providers in South Africa, Leibowitz-Levy (2005) established that most practitioners used “the child interview” to inform their interventions, sometimes complemented by the Wits Trauma Model (Eagle, 2000), which is a five-stage brief-term intervention model developed for adult survivors of trauma in the South African context, informed by caregiver counselling or psycho-education. However, as discussed previously, the efficacy of such interventions could only be described anecdotally based on clinical judgements. Leibowitz-Levy (2005) proposes a modified trauma intervention model for the South African context, highlighting the art therapy or expressive component of the Pynoos and Eth (1986) model and adding a more narrative component in which the “ongoing self” or “self in context” of the child is emphasised in the therapy. McDermott (2005) makes the case for a greater indigenisation of approach in her child therapy case study, arguing that cultural symbolism and practices should be appreciated and incorporated into South African child trauma treatment, with respect to certain populations. Kekae-Moletsane (2008) makes a similar argument about the usefulness of employing “traditional play”, based on her treatment of a traumatically bereaved boy. To reiterate, however, these kinds of proposals, though theoretically and clinically credible, have no proven scientific base and require systematic evaluation. It is apparent across the child trauma treatment literature, and more particularly in the limited South African literature on the topic, that flexible, eclectic and multidimensional approaches are often favoured (Foa, 2009; Kriegler, 2004; Leibowitz-Levy, 2005; Nader, 2001; Parson, 1997). It is also worth noting that there is room for pharmacological interventions with individual children (Seedat et al., 2002), although this should be prescribed with great caution, since the evidence base is still very limited (Foa, 2009).

Trauma-focused CBT approaches tend to share common components, including repeated exposure to traumatic memories and reminders until the anxiety and fear associated with these are reduced, cognitive processing and reframing of trauma-related beliefs about oneself, others and the world, stress management and parental treatment (Cohen, Mannarino, Berliner & Deblinger, 2000). However, while there is evidence that the approach as a whole is beneficial, “there are inadequate data to indicate the relative contribution of the individual CBT components” (Cohen et al., 2000, p. 1202). There do not appear to be any South African studies that have systematically examined the use of trauma-focused CBT with child or adolescent populations. Instead, it seems that, while practitioners are aware of the benefits of components of CBT interventions, they work in an eclectic rather than a protocol-based manner, combining a range of therapeutic modalities, including aspects of CBT, in a composite intervention. This may be appropriate to meet the complex and unique needs of individual trauma survivors, but renders it more difficult to conduct rigorous efficacy studies.

A third type of trauma-focused intervention is that involving group psychotherapy (DeRosa et al., 2003; Friedman, 2003; Goenjian, Karavan & Pynoos, 1997;
and/or school-based interventions (Foa, 2009). These interventions are generally designed to provide containment, as well as identify at-risk children, respectively. They can, therefore, serve secondary treatment and primary prevention functions. School programmes may be implemented specifically in the wake of a traumatic incident (for example, Goenjian et al., 1997) or may form part of a general life-skills curriculum in which, for example, dealing with unanticipated bereavement or unwanted sexual advances may be addressed. The latter types of interventions fall out of the ambit of clinical evaluation studies, however. Once again, although both trauma intervention and preventative psycho-educational programmes have been implemented in South African schools, there do not appear to be any reliable outcome studies substantiating the efficacy of such interventions.

Given the context of poly-victimisation in which many South African children grow up, interventions designed to tackle multiple and complex forms of traumatisation are crucial. In such contexts it is generally recognised that a two-pronged approach is required, one aspect dealing with processing the immediate stress experience/s and the other attempting to create some buffer against future such stressors, considering “both the child and the context as targets of intervention” (Cook, Blaustein, Spinazzola & van der Kolk, 2003, p. 26). To address the impact of community violence among children from inner-city areas in America, Parson (1996, 1997) provides a detailed description of what each phase of treatment involves, thus allowing for replication of his approach – he also illustrates the use of the model through an empirical case study (1997) - there is a lack of sound evidence concerning the efficacy of P-TCT.

Also recognising the need to formulate impact and intervention differently in the case of child populations who face multiple trauma and other adversities, the National Child Trauma Stress Network (NCTSN) in the United States of America set up a Complex Trauma Task Force that produced a comprehensive report on the issue, including approaches to treatment. Combining both clinical and community-based intervention approaches, the report argues that four central goals need to be achieved: “(1) safety in one’s environment, including home, school and community; (2) skills development in emotion regulation and interpersonal functioning; (3) meaning-making about past traumatic events they have experienced so that youth can consider more positive, adaptive views about themselves in the present, and experience hope about the future; and (4) enhancing resilience and integration into social networks (Cook et al., 2003, p.23)”. The second goal may be achieved through the use of a milieu, community-based approach focusing on building secure attachments, enhancing self regulatory capacities and increasing competencies (ARC) (Cook et al., 2003). It is suggested that intervention should be developmentally attuned and phase-based, each successive phase building on the gains of the previous intervention component. The US NCTSN task force report provides a comprehensive explication of the varied kinds of difficulties that need to be tackled in the case of complex traumatisation and advocates a multi-level, multi-interventionist approach. The report also provides some positive data on the efficacy of the ARC approach, such as improved concentration and less aggressive outbursts (Cook et al., 2003). In South Africa, while there is widespread...
appreciation of the complexity of interventions in communities affected by violence, research into community-based trauma interventions is still in its infancy. As with individual treatment, most of the existing reports of interventions are case study-based and employ subjective tools to evaluate efficacy. Researchers and interventionists would be well-served by systematically following some of the NCTSN principles to guide their practice, although it is important to take account of resource constraints and contextual particularities.

In summary, while there is quite a large body of evidence describing and documenting intervention approaches for both simple and complex forms of traumatisation in children and adolescents internationally and locally, there is a marked lack of strong evidence-based studies. Current practice in South Africa appears to be based on the adoption of a rather eclectic approach, relying on modifications to documented models of treatment for both adults and children and on clinician-led innovations, creating difficulties for conducting outcome-based research. There remains a strong need for good empirical studies in the area.

Summary of key legislation

1) Legislation governing protection of children from violence, abuse and exploitation:
   - The Bill of Rights in the South African Constitution states that everyone has the right to freedom and security of person, which includes the right “to be free from all forms of violence from either public or private sources” [Section 12(1)(c)] and “not to be treated or punished in a cruel, inhuman or degrading way” [Section 12(1)(e)], and that every child has the right “to be protected from maltreatment, neglect, abuse or degradation” [Section 28(1)(d)].
   - South Africa has ratified the United Nations Convention on the Rights of the Child (CRC), which states that “State Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse” [Article 19(1)].

2) Legislation governing social and health service provision for children:
   - The Bill of Rights states that every child has the right “to basic health care services and social services” [Section 28(1)(c)].
   - The Convention on the Rights of the Child states that “protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment” [Article 19(2)] and that “state Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse....Such recovery should take place in an environment which fosters the health, self-respect and dignity of the child” (Article 39).
   - The Children’s Act has replaced the old Child Care Act, and aims to bring South African law in line with the Bill of Rights and international laws and conventions such as the CRC. It commits to providing primary prevention and early intervention programmes for vulnerable children, in addition to protective services for those who have experienced abuse, neglect or exploitation. The Children’s Institute at the University of Cape Town argues that these policy shifts have not yet been translated into practice due to a number of factors, including absence of qualified social service practitioners, the prioritising of statutory protection services or alternative care over preventive and early identification services, and poor inter-departmental collaboration (Giese, 2008). It also notes a “worrying tendency to use the justice system to deal with children manifesting social problems” (Jamieson, Proudluck & Warehouse, 2008, p. 14) that is inappropriate in the absence of adequate preventative and rehabilitative services.
CONCLUSION
Despite South African legislation protecting children’s rights (see the Box on the previous page), many children continue to experience multiple forms of victimisation, while existing mental health and social services remain inadequate to meet the needs of the youngest members of the South African society. As these children grow up to become adults in their communities, the consequences of untreated trauma are likely to be passed on to the next generation of South African children. A more focused and prioritised prevention and intervention strategy is therefore urgently required, which needs to be informed by robust research.

While we have some research data on the impact of violence and trauma on children and adolescents, it is apparent that there is a need for a great deal more, and better designed, research. Developmental aspects of childhood traumatisation require more careful understanding, as do the context specific contributions to risk and resilience. For example, cultural attributions about damage and risk may play a role in child and family adaptations to traumatic events. The identification of children and families who are most at risk of developing trauma-related difficulties is crucial in a context of limited prevention and intervention resources. There is also a striking need for more systematic documentation of, and research into, intervention approaches employed by South African practitioners working with traumatised children. At present, while there may be some merit in allowing for creativity and innovation, there is also considerable space for clumsy or inadequately informed interventions. Practitioners need to be able to defend their interventions by grounding these in sound theory and more rigorous research, even if resource constraints prevent the attainment of what might be considered gold standard research internationally. It is also important to document the necessary modifications to international frameworks or models of impact and intervention, in order for a more indigenised shared body of knowledge to be generated and validated. There is room for both qualitative and quantitative research in achieving

Key messages
- Many children in South Africa experience multiple and continuous trauma exposure across different sites, including home, school and neighbourhood.
- Both international and South African research has found that symptoms of PTSD, depression and anxiety are common amongst trauma-exposed children and adolescents, but South African research has not yet clearly established which specific forms of trauma exposure carry the highest risk for particular psychiatric difficulties.
- South African research on the broader developmental consequences of trauma exposure amongst children of different ages lags behind research on the psychiatric consequences of trauma exposure.
- Dissociative, disengaged or defeatist responses amongst youth living in high-violence communities have been suggested by the findings of some international literature and by the anecdotal observations of trauma service providers in South Africa. These responses may compromise moral development and contribute to an escalation in violent behaviour and illegal activities, and warrant further research.
- In economically developed countries, systemic and contextual factors, such as levels of family and school support, have been found to play an important role in determining whether high levels of trauma exposure will result in emotional and behavioural difficulties amongst children and adolescents. However, conditions of poverty and chronic trauma may erode the protective capacities of the family and educational systems. There is little local research on these issues.
- A number of intervention models for treating traumatised children have emerged from economically developed contexts, but the evidence base to support them is still limited.
- Intervention research with trauma-exposed children in South Africa is almost non-existent. This absence needs to be urgently addressed, given the scope and complexity of childhood traumatisation in this country.
this goal, and the former would be valuable in supplementing existing broad-based survey data.

The prevention or reduction of domestic, school and community violence, and of accidental childhood injuries, is an important long-term goal in decreasing mental health risks for children and adolescents in South Africa. However, for the many children who already have been, and continue to be, exposed to trauma and violence, ameliorative interventions that are informed by systematic data collection are also vital. In our context of poly-victimisation and complex traumatisation, the understanding of the psycho-social impact and associated interventions needs to extend beyond the scope of existing conceptualisations of trauma to incorporate concerns about cognitive capacities, the quality of emotional attachments and social bonds, and the regulation of emotion. Theory in this area is becoming increasingly sophisticated and there is a much greater appreciation of how these kinds of more pervasive developmental impacts may be implicated in fuelling a cycle of violence and deprivation.

Too many children and adolescents in South Africa are living in conditions of chronic trauma, with little access to ameliorative interventions. There is a danger of fairly extensive intergenerational transmission of trauma, with growing societal costs. Intervention would require dedicated and informed resources with an emphasis on prevention and early identification, wherever possible. There is a need for greater coordination and complementarities between state, NGO and community-based sectors in addressing child and youth victimisation. It must be recognised that investment in both programmatic and more clinical interventions is worthwhile, not only because of the statutory and moral imperatives to assist such children, but also in order to build a healthy, happy and stable future population.

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