A Situational Analysis of Psychological Services Provided for Children Exposed to and Affected by Violence and Trauma in Mamelodi

by

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DECLARATION OF ORIGINALITY

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ABSTRACT

South African children, particularly those exposed to multiple adversities are at risk for violence and trauma exposure. Violence against children is a significant cause of personal suffering and long-term mental ill-health, psychological and social maladjustment. The current study provides an overview of exposure to and experiences of violence against children. Furthermore, the study aims to provide information indicating existing psychological/therapeutical services provided to children affected by violence and trauma in Mamelodi Township. The study provides alternative approaches to address the shortage of resources for adequate and effective psychology-based mental health care services in Mamelodi. Survey interviews with open-and closed-ended questions were utilized to collect data from eleven (11) service providers, offering intervention services to violence and trauma-exposed children in Mamelodi. The service providers are registered with the Department of Social Services (DSS). Descriptive statistics and content analysis were both employed to analyse demographic information, quantitative and qualitative data. From the analysis, about 30% to 100% of children reporting to the service providers had been exposed to violence in their homes and communities. The most commonly reported forms of violence were sexual abuse, physical abuse, domestic abuse and community violence. Up to 320 affected children were handled in a given month in some organisations, with social workers handling very high caseloads. Trauma-focused interventions for both trauma-affected children and their caregivers/parents were reported to be scarce and costly in this resource-deprived community. Instead, semi-skilled professionals and non-therapeutic activities were generally used in the majority of the organizations. Even though the effectiveness of these interventions are not research-based, they are however serving as a first aid to those affected by violence and trauma. This provides some assistance to many children who may be on the waiting list for weeks, months and even years. The personal and social costs of violence are of great concern, resulting in mental health-related difficulties. There is an urgent need for more psychology-based mental health specialists to be trained and interventions at community level to be established. Furthermore, parental relationships need to be strengthened and the state could aid by supporting families and protecting the children.

Keywords: Psychological Services, Violence, Trauma, Children

ABBREVIATIONS AND ACRONYMS

ACPMH	-	Australian Centre for Posttraumatic Mental Health
ACRWC	-	African Charter on the Rights and Welfare of the Child
CBCL	-	Child Behavior Checklist
CBOs	-	Community-Based Organizations
CEO	-	Chief Executive Officer
CPP	-	Child-Parent Psychotherapy
CSBI	-	Child Sexual Behavior Inventory
ADHD	-	Attention Deficit Hyperactive Disorder
DoH	-	Department of Health
DSD	-	Department of Social Development
DSS	-	Department of Social Services
DWCPD	-	Department of Women, Children and People with Disabilities
EMDR	-	Eye Movement Desensitization Reprocessing
ET	-	Exposure Therapy
HIV/AIDS	-	Human Immune Virus/Acquired Immune Deficiency Syndrome
IPV	-	Intimate partner violence
KPMG	-	Klynveld Peat Marwick Goerdeler
LMICs	-	Low and Middle Income Countries
MHaPP	-	Mental Health and Poverty Project
MDG	-	Millennium Development Goals
NGO	-	Non-Governmental Organization
NICE	-	National Institute for Health and Care Excellence
NPA	-	National Prosecuting Authority
NPO	-	Non-Profit Organization
NREPP	-	National Registry of Evidence-Based Programs and Practices
NYDO	-	National Youth Development Outreach
PTSD	-	Posttraumatic Stress Disorder
SA	-	South Africa
SANCA	-	South African National Council on Alcoholism and Drug Dependency
SAPS	-	South African Police Service
SPARCS	-	Structured Psychotherapy for Adolescents Responding to Chronic Stress

STAIR	-	Skills Training in Affect and Interpersonal Regulation
STATS SA	-	Statistics South Africa
SRC	-	Self-Regulation and Competency
TARGET	-	Trauma Adaptive Recovery Group Education and Training
TF-CBT	-	Trauma Focused Cognitive Behavioral Therapy
TSCC	-	Trauma Symptom Checklist for Children
TSRT	-	Trauma System Readiness Tool
TST	-	Trauma Systems Therapy
UNCRC	-	United Nations Convention on the Rights of the Child
UNICEF	-	United Nations Children's Fund
UP	-	University of Pretoria
USA	-	United States of America
USAID	-	United States of America Aid
WHO	-	World Health Organization

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CHAPTER 1

INTRODUCTION

1.1 Background Information

Violence against children is reported to be pervasive worldwide (UNICEF, 2014; WHO, 2014). The pervasiveness however varies, depending on the country, the sampled populations, the number of reported cases, research methods and definitions used (Jamieson, Mathews, & Rohrs, 2018; Meinck, Cluver, & Boyes, 2015; WHO, 2010). Violence against children in Africa occurs under different contexts in comparison to westernized societies. War, high levels of poverty and HIV infections, poorly developed child protective systems, disruption of traditional, family and community structures and social norms are some of the explanations given (Lachman et al., 2002). The situation is further heightened by society's attitudes and beliefs of generally tolerating violence and accepting the notion that child violence remains a challenge and cannot be prevented (Department of Social Development [DSD], Department of Women, Children and People with Disabilities [DWCPD] & United Nations International Children's Emergency Fund [UNICEF], 2012).

Sub-Saharan Africa particularly suffers from elevated prevalence rates of abuse (Akmatov, 2011; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011), whilst post-apartheid South Africa is reported to have the highest rates of violent crimes in the world (Kaminer, Hardy, Heath, Mosdell, & Bawa, 2013; Seedat, van Niekerk, Jewkes, Sufla, & Ratele, 2009). Interpersonal violence or intimate partner violence and child abuse are prominent (Kaminer, du Plessis, Hardy, & Benjamin, 2013; Meinck, Cluver, Boyes, & Loaning Voysey, 2016; Richter, Mathews, Kagura, & Nonterah, 2018; Seedat et al., 2009; Sui et al., 2019; Ward, Artz, Leoschut, & Burton, 2018). South African studies show that sexual abuse of children is possibly worse than previously estimated (UBS Optimus Foundation, 2015). WHO (2006) estimates that nearly 40 million children aged 14 years and below are victims of abuse and neglect worldwide. Community violence, a form of interpersonal violence (WHO, 2018) is a social threat across South Africa (Collings, Valjee, & Penning, 2013; Donenberg et al., 2020; Kaminer et al., 2013; Skeen, Macedoc, Tomlinsona, Henselsc, & Sherrc, 2016).

Child homicide is estimated at five times more than the world average (Kaminer et al., 2013; UNICEF, 2014; WHO, 2010). Youth homicides (ages 15-19) and high rates of gang violence

are more prevalent in the Western Cape Province (Goga, 2014; Groenewald et al., 2008). These murders happen in the context of interpersonal violence outside the home setting (Mathews & Benvenuti, 2014). Meinck et al. (2016) states that children exposed to violence at home are at a greater risk of experiencing abuse outside the home environment. In 2016 for example, the child homicide rate increased to 5%, an average of 142 cases of sexual assaults, 52 murders and 470 physical assaults were recorded per day (South African Police Service [SAPS] Annual Report, 2017). Violence may also be experienced by some children from hearing about the injustices encountered by others known or unknown to them (Sui et al., 2018). The majority of children experience multiple forms of violence. Poly-victimization is therefore a normative experience for most of South Africa's children (Kaminer et al., 2013; Williams et al., 2007). These findings are comparable to international (Pereda, Guilera, Forns, & Gomez-Benito, 2009) and African research findings (UNICEF, 2012).

Cumulative violence exposure is associated with severe negative psychological and mental health outcomes (Humm, Kaminer, & Hardy, 2018; Norman et al., 2010; Mills et al., 2011; Richter et al., 2014; Sui et al., 2018). Maladjustment can significantly impact children's psychosocial and academic functioning, relationship attachments and emotional development (Das-Munshi et al., 2016; Fleming & Jacobsen, 2010; Mathews & Benevenuti, 2014). Their health in adulthood is therefore likely to be affected (Richter et al., 2014).

WHO (2018) indicate that about 20% of children experience mental health problems. In South Africa, mental illness affects approximately 41% of adolescents (Das-Munshi et al., 2016; Gevers & Flischer, 2010; Patel, Flisher, Hetrick, & McGorry, 2007). Rates of children receiving mental healthcare are assessed to be high. Available data suggest that community violence is a predictor of elevated rates of mental health symptoms, especially posttraumatic stress, externalized and internalized behaviours (Fowler, Tompsett, Braciszewski, Jacques-Tiura, & Baltes, 2009). The high levels of violence reported however, does not reflect the full extent of the problem (DSD et al., 2012). Examining the effects of violence on children and alleviating the impact of exposure on future mental wellbeing is crucial (Donenberg et al., 2020).

1.2 Problem Statement

International child governing institutions such as the African Charter on the Rights and Welfare of the Child (ACRWC) and the United Nations Convention on the Rights of the Child

(UNCRC) provide fundamental rights of children to be protected from experiencing and witnessing violence. South Africa's constitution, laws and policies have in addition made attempts to address factors that encourage violence, particularly in post-apartheid South Africa. Efforts are made in equalizing and decentralizing protective and mental health services. The gaps however largely remain, and children are left vulnerable (DSD et al., 2012; Save the Children South Africa, 2015).

The development and promotion of mental healthcare services, and the burden of mental illness on children have received minimal attention by policy-makers (DSD et al., 2012; WHO, 2005). Presently, most violence-preventative and early intervention programmes in South Africa are run by a few non-governmental organizations (NGOs) or non-profit organizations (NPOs) and not by the state. All nine provinces rely heavily on NGOs/NPOs to deliver child-focused intervention services (DSD et al., 2012). Existing state mental health services and the education system are inadequately resourced to attend to trauma-related interventions for children (Kaminer & Eagle, 2010; Lund, Boyce, Flisher, Kafaar, & Dawes, 2009). Budgetary limitations largely create serious shortfalls in the allocation of much needed mental health services for children (DSD et al., 2012). Policy guidelines remain unimplemented at provincial level despite the country's adherence to international standards for mental health provision (Eskell-Blokland, 2014; Gregorowski & Seedat, 2013).

Although South Africa has made efforts towards strengthening the mental health care system, such as by reforming the Mental Health Care Act of 2002 and developing a National Mental Health Policy Framework and Strategic Plan 2013–2020, there remains a significant information gap. For instance, the population-based prevalence estimates on the burden of mental disorders date as far back as 2003/2004. This has therefore limited the country's ability to provide a comprehensive national mental healthcare plan that recognizes mental healthcare as an integral part of the healthcare system. There is a need for a system that is aimed at providing quality mental health services that are accessible and equitable more so, for community-based healthcare (Docrat & Lund, 2019). What is then likely to be occurring is that there is inadequate reporting of areas where mental health care services are needed, the kind of care mental health patients are entitled to, identification of the number of healthcare professionals and the amount of resources required to sustain such mental health services (DSD et al., 2012; Docrat & Lund, 2019). This makes accurate budget estimation on mental healthcare requirements challenging, both at national and provincial level.

A recent national-based representative study on the state of mental health spending has revealed that a mere 5% of the total health budget is utilized on mental health services, a much lower amount than the recommended international benchmark. What is even more alarming is the treatment gap, which is estimated at 92% of people with mental health challenges not receiving the required treatment. The study also found disparities in the allocation of mental health resources in the different provinces, mostly affecting uninsured South Africans. Furthermore, the mental healthcare system is focused on prioritizing the treatment of severe mental conditions as opposed to putting in place preventative or early intervention measures. For example, 86% of the mental healthcare budget is spent on inpatient care, 45% is spent on specialized psychiatric hospitals, whilst primary healthcare services are allocated only 7.9%. There are inconsistencies between the national databases of NGOs licensed with the Department of Health. Overall, the study reported a non-compliance culture with the Mental Healthcare Act by most district hospitals, where they are expected to provide 72-hour assessments and subsequent referrals for appropriate treatment and supportive services (Docrat & Lund, 2019).

This picture seems to typically portray the reality observed in other countries, particularly developing countries, where less than 2% of national budgets are allocated to mental healthcare (Gordon, 2013). For example, the Mental Health and Poverty Project [MHaPP] (2010) conducted in four countries, Ghana, South Africa, Uganda and Zambia revealed that none of the four countries have a mental health plan in place. Although South Africa has made progress in decentralizing mental healthcare services, this process remains limited to the managing of psychiatric and psychology-related emergency cases and the on-going psychopharmacological care of mentally stable patients. The de-institutionalization services for patients with serious and chronic mental illnesses remain neglected despite health care featuring significantly in South Africa's Millennium Development Goals (MDG) (The Millennium Goals Report, 2013).

The outcome is that existing intervention services only reach a very small proportion of children rendered more vulnerable to mental illness because of their exposure to a variety of factors (DSD et al., 2012; Flisher et al., 2012). A marginal number of children from deprived, high-violent and under-serviced communities are likely to receive counselling or professional assistance when their psychological wellbeing is severely affected (Kaminer & Eagle, 2010). Undiagnosed and untreated trauma can lead to a broad range of dysfunctions including depression, anxiety, conduct problems, attention deficits, social maladjustment and academic

difficulties, which affect diagnosis, preventing recovery and prolonging suffering (Chaikin & Prout, 2004). Therefore, over time these encumbrances have far-reaching intergenerational consequences, placing a heavy burden on parental and family coping structures (Kiser & Black, 2005), with substantial economic and social costs, particularly in low and middle income countries (LMICs) (Mathews & Benevenuti, 2014). Given the scope and complexity of violence and traumatisation in the country, ensuring children's social and psychological health is therefore a major concern. This is a global tendency but is especially prevalent within economically developing contexts, such as South Africa.

1.3 Rationale and Significance

This study is part of a larger study, investigating the extent and range of violence experienced by children in Mamelodi Township, South Africa. The goal of the larger project is to develop community-based child-trauma focused interventions because there is minimal research conducted on community-based violence prevention and interventions particularly for vulnerable children in LMIC (Skeen et al., 2016; WHO, 2014). This research forms phase one of the larger project, and it seeks to determine current psychological services available in Mamelodi Township for children exposed to and affected by violence and trauma.

A sound body of literature on violence in South Africa is predominantly concerned with understanding the extent of the problem as well as understanding children's vulnerabilities to experience the psychosocial impact of violence and trauma-exposure (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; DSD et al., 2012; Mathews & Benvenuti, 2014). A report published by the Safety and Violence Initiative at the University of Cape Town in 2016 titled "*Towards a more comprehensive understanding of the direct and indirect determinants of violence against women and children in South Africa with a view to enhancing violence prevention*" indicated that most prevalent forms of violence many South African children are exposed to include: physical violence and homicide, corporal punishment, sexual abuse and rape, emotional abuse, neglect, intimate partner violence (IPV), bullying and gang violence. In addition, risk factors for victimization were reported at the individual, relationship, and community level (Mathews et al., 2016). In addition, multiple studies (Andersson et al., 2012; Dawes, de Sas Kropiwnicki, Kafaar, & Richter, 2005; Jewkes & Abrahams, 2002; Leoschut, 2009; UBS Optimus Foundation, 2015; Vetten et al., 2008) on child abuse and violence exposure indicated the scale of maltreatment in South Africa by contributing violence prevalence estimates.

In contrast, literature on child-trauma focused intervention services which are informed by systematic data collection remains limited (Kaminer & Eagle, 2010; Mathews & Benvenuti, 2014). The researcher observed this limitation during practical work as a student psychologist at a community clinic in Mamelodi Township. The lack of evidence in effectively addressing the consequences of violence experienced by children has led the researcher to ask the main research question in this study: "*What psychological services are available for children exposed to and affected by violence and trauma in Mamelodi*?"

1.4 Research Aim and Objectives

1.4.1 Aim of the Study

The aim of the study is to identify and explore existing psychological/therapeutic services provided to children exposed to and affected by violence and trauma in Mamelodi Township, a community close to Pretoria.

1.4.2 Objectives of the Study

The objectives are to:

(i) Describe existing psychological services provided to children affected by violence and trauma in Mamelodi;
(ii) Identify the needs and challenges of the existing service providers as support structures of children affected by violence and trauma in Mamelodi;
(iii) Identify the needs of children exposed to violence and trauma from the perspectives of the service providers in Mamelodi;
(iv) Identify gaps in the existing child-trauma intervention responses and service provision in Mamelodi.

1.5 Overview of Methodology

The researcher identified and explored existing psychological services provided to children exposed to and affected by violence and trauma in Mamelodi Township. A descriptive research methodology guided the current study. Snowball sampling was used to recruit participants or service providers as respondents.The study collected data using a survey with open-ended and

closed questions that provide qualitative and some quantitative data. The questions in the survey were benchmarked from the Trauma System Readiness Tool (TSRT). The obtained data from the survey formed the basis for the findings of this study. Descriptive analysis together with content analysis were done. Quotes were used to highlight the opinions of service providers about existing psychological services for children exposed to and affected by violence and trauma in Mamelodi Township.

1.6 Definition of Key Concepts

For the purpose of this study, the following concepts are defined:

Psychological/Therapeutic Service refers to the provision of mental health interventions that target service beneficiaries (children, youth, families) identified as being exposed to violence, vulnerable or at risk. The nature of these services differs depending on the level of intervention and specific outcomes. The four levels of interventions include preventative, early and secondary interventions, curative and aftercare services, provided for by DSD, other governmental departments, NGOs/NPOs and community-based organization (CBOs) (DSD, 2013).

Violence is defined as the intentional use of physical force or power, threatened or actual that results or is likely to result in injury, death, psychological harm, mal-development and/or deprivation (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). This definition allows for both overt and covert acts against a child by an individual or group which may have direct or indirect consequences to the child's health, survival, development or dignity (Lockhart & Van Niekerk, 2000). "Violence against children" will be used as the umbrella term for all forms of violence or maltreatment encompassing physical, emotional and sexual abuse, neglect, domestic violence, exploitation, school and community-based violence, accidental traumas, suicides, historical/political traumas and other traumatic events.

Trauma is defined as the exposure to external experience(s) or event(s) that generally involves threats to life or bodily integrity, or a close personal encounter with violence and death, creating disruptions in psychological functioning (Herman, 2001).

Children: Any child under the age of 18, as per South Africa's Children's Act 38 of 2005.

1.7 Summary and Outline of the Dissertation

According to literature, child-trauma focused intervention services are limited in South Africa. It was found that interventions are mostly run by NGOs and NPOs. Currently, mental health services are inadequately resourced to attend to trauma-related psychological interventions for affected children. This study sought to identify and explore existing psychological/therapeutic services provided to children exposed to and affected by violence and trauma in Mamelodi Township, using a survey benchmarked on the Trauma System Readiness Tool (TSRT). The results of this study may serve multiple stakeholders such as the Department of Health (National and provincial), NGOs or NPOs, and, most of the health professions working directly or indirectly in child-trauma services.

The dissertation will consist of five chapters. **Chapter One** provided the background information, research context and rationale for the study**. Chapter Two** examines the relevant literature pertaining to violence perpetrated against children in South Africa and interventions available for children exposed to and affected by violence and trauma. **Chapter Three** presents the research methodology utilized to collect and interpret data to answer the study's main research question. **Chapter Four** presents the findings of the study in relation to existing literature on violence against children and child-trauma interventions. **Chapter Five**, the final chapter of the study, provides a discussion of findings. In addition, this chapter highlights the study's limitations and recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

In this chapter the researcher discusses the relevant literature available pertaining to children's exposure and experience of violence and trauma in South Africa, as well as the intervention services available. The review is divided into five sections. The first section is an introduction of the nature of violence against children in South Africa. The second section presents the prevalence rate and types of violence committed against children in South Africa. The third section examines the psychosocial impact of violence and trauma on children's development. The forth section highlights some assessment models and treatment approaches of children exposed to trauma. The final section of the chapter offers a critical review of the need for child-trauma-focused interventions and for adequate research on child-trauma services.

2.1 Introduction

Children's experiences of direct and/or indirect violence, increase their risk for violence perpetration, victimization and/or mental illness (Donenberg et al., 2020; Dube, Gagne, Clement & Chamberland, 2018; Foster & Brooks-Gunn, 2015; Humm et al., 2018; Meinck et al., , 2016). A culture of violence can influence children's responses in resolving conflict and disputes across different settings of their lives (Ward, Dawes, & Matzopoulos, 2012). A number of complex factors have contributed to the economic and social dynamics that escalate violence. A key risk factor is in South Africa's legacy of the apartheid era, contributing to high levels of poverty, unemployment, socio-economic inequalities combined with inadequate housing and education systems (Seedat et al., 2009). South Africa's colonial history, with its weak culture of law enforcement has contributed to normalizing the use of violence as a method of control (Ruane, 2006; Seedat et al., 2009). Chronic environmental poverty and trauma exposure also increases the risk for punitive parenting practices, especially in single-parenting families of unmarried and young mothers (Krenichyn, Saegert, & Evans, 2001; van der Merwe & Dawes, 2007), thus contributing significantly to high rates of violent acts committed against children.

Power imbalances, gender, cultural-based norms, and attitudes that dictate gendered roles and practices heightens the inequalities, powerlessness and disempowerment of women and children. For instance, women are predominantly placed in child-rearing roles, whilst men are

perceived to be the providers, further widening the gap between the father's involvement in his children's lives (Morrell, Jewkes, & Lindegger, 2012). Patriarchal male-centred ideologies of power and control over women and children are compounded by the low status of children. Children are not encouraged to question the authority of parental figures. These social and cultural based norms have contributed to the perception that women and children are 'property', 'objects' or 'possessions' of males (Mathews & Benvenuti, 2014; Ward et al., 2012).

2.2 The Extent of Violence against Children in South Africa

Table 2.1 below provides a picture on the nature, extent and impact of child violence exposure in the country. Different forms of violence are more prevalent at different developmental stages. Infanticide, neglect, abandonement, and physical abuse commonly affects younger children aged 0-4 years. As children venture beyond the family home between the ages of 5-12 years, sexual violence, bullying and corporal punishment becomes prevalent during pre-school and formal schooling years. From 15 years onwards, teenage boys are likely to engage in community violence because of their masculinity roles and use of illegal weapons, with the likeliness of ending up as homicide victims (Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013). Teenage girls are more prone to experiences of intimate partner violence in relationships; this is considered common in intimate relationships nowadays. It is important to note that these forms of violence are not limited to the specified age groups (Mathews & Benvenuti, 2014).

Despite the differences and inconsistencies in identifying prevalence rates of violence against children (Jamieson et al., 2018; Meinck, Cluver, Boyes & Loening-Voysey, 2015; WHO, 2010), recently published studies (see Table 1 below on the scale of violence exposure in South Africa) provided nationally representative data indicating the disproportionally high levels of violence (Donenberg et al., 2020; Hsiao et al., 2018; Humm et al., 2018; Meinck et al., 2015; Richter et al., 2018; Skeen et al., 2016; Stansfeld et al., 2017).

A Birth to Twenty Plus (Bt20+) study was conducted on a cohort of more than 2000 children born around 1990 in Soweto. The children were followed up until they were in their twenties - the largest and longest longitudinal study in Africa. The study found that only 1% of the sampled population had been spared from violence exposure, whilst 99% had been exposed to

different forms of violence. Of the sampled children, 40% had experienced multiple victimization at home, schools and within their communities. Thirty percent of adolescents and young adults had experienced sexual violence, especially amongst boys (44%) aged 13 to 18 years of age. Nearly half of preschool children in the study sample experienced physical punishment by caregivers or parents (Richter et al., 2018).

A retrospective national study on child homicide was carried out on 38 of 123 state-run medico-legal laboratories/mortuaries between the periods of 1 January 2009 to 31 December 2009. The study found that 44.5% from a total of 1018 were child homicide cases; death was a result of child abuse, neglect and abandonment in children aged 0-5 years and more amongst girls (76%) than boys (26.8%). The overall child homicide rate from this sample was nearly double for more boys than girls (Mathews et al., 2013).

A community-based study conducted in two provinces (Mpumalanga and the Western Cape), assessed self-report child abuse from a sample of 3515 children aged 10-17 years. The study revealed high rates of multiple victimization (68.9%), physical abuse (56.3%), emotional abuse (35.5%) and sexual abuse (9%). The study confirms more emotional and lifetime sexual abuse in girls than boys (Meinck et al., 2016).

As it is the case in other parts of the world, violence against children, particularly physical and sexual violence are underreported and inadequately researched (Ravi & Ahluwalia, 2017). Underreporting of child maltreatment is attributed to several factors such as fear of or intimidation from the perpetrator and gift offerings from the perpetrator in exchange for silence. Some cultural practices contribute to the perception of sex as a taboo topic and encourage silence on discussions around family-related matters (Kacker, Varadan, & Kumar, 2007). The child's feelings of shame or guilt about the abuse (Dawes, Richter, & Higson-Smith, 2004) and the slow processing of cases by the police and the legal systems have also been cited as contributing to the increase in low reporting of cases (Artz et al., 2016).

Table 2.1: The Scale of Maltreatment in South Africa

Type of child abuse and violence exposure	Key findings
Sexual Abuse	19.8% of adolescents reported some form of sexual abuse (boys 20%; girls 19%) over their lifetime; 11.7% reported having been forced to have sex (UBS Optimus Foundation, 2015). 38% of females and 17% of males reported sexual assaults prior to age 18 (Eastern Cape survey) (Jewkes & Abrahams, 2002). 84% of child rapes are perpetrated by persons known to the child (studies of Gauteng court cases) (Vetten et al., 2008). 5.9% of adolescents report sexual assault in the past year. Of the assaults, 24% were at home; 21% at another person's home; in 72% of cases, the perpetrator is known to the victim (Leoschut, 2009). 17% of male and 18% of female adolescents aged 11-19 years reported forced sex in the past year (Andersson et al., 2012).
Physical Abuse	34.4% of adolescents reported having been hit, beaten, kicked or physically hurt by an adult who was supposed to be taking care of them over their lifetime; 16.9% reported witnessing violence. 73.8% of child homicides of children under the age of 5 were the result of abuse and neglect (UBS Optimus Foundation, 2015).
Corporal Punishment	57% of parents reported using corporal punishment; 60% confirm beating with a belt or stick. Children under five are more vulnerable than any other age group (Dawes, de Sas Kropiwnicki, Kafaar, & Richter, 2005); 23.8% of adolescents experience corporal punishment at home (Leoschut, 2009).
Emotional/Psychological Abuse.	16% of adolescents reported that over their lifetime, they had become scared or felt really bad because adults called them names, said mean things to them, or said they did not want them (UBS Optimus Foundation, 2015).
Deliberate Neglect	21% of adolescents reported that over their lifetime, they had experienced the forms of neglect examined in the Optimus Study (UBS Optimus Foundation, 2015).

2.3 Violence Exposure and Child Mental Health Outcomes

Whether a child directly experiences abuse during childhood or is indirectly exposed to violence, both forms of exposure are associated with internalizing and externalizing difficulties (see summarized Table 2.2 below). Research suggests that individuals with severely compromised mental health are more likely to witness and perpetrate violence (Foster & Brooks-Gunn, 2015; Ward et al., 2018). The impact of violence exposure and trauma on psychological health are well documented and have implications for the intergenerational transmission of violence (Donenberg et al., 2020; Fulu et al., 2017; Hsiao et al., 2018; Norman et al., 2010; Richter et al., 2018). The psychological and mental health impact is heightened during the adolescent phase of development, a critical phase of psychosocial development associated with increased vulnerability and high risk to the onset of psychopathology. This is because major developmental domains are likely to be interfered (Costello, Erkanli, & Angold, 2006; Kaminer et al., 2013; Margolin, & Gordis, 2000).

Exposure to experiencing or witnessing violence usually of an interpersonal nature during childhood has neurodevelopmental and neuropsychological consequences on later health and behavior outcomes (Lanius, Vermetten, & Pain, 2010; Shonkoff, Richter, van der Gaag & Bhutta, 2012; van der Kolk, 2005). Abuse and neglect in early childhood is associated with brain developmental delays, which could lead to potential cognitive impairment and learning difficulties (Kira, Somers, Lewandowski, & Chiodo, 2012). Repeated exposure to potentially traumatic events can lead to excessive chronic levels of stress and can have negative mental health outcomes (Shonkoff et al., 2012). These health outcomes can range from depression and anxiety to PTSD (Fairbank & Fairbank, 2009; Fowler, Tompsett, Braciszewski, Jacques-Tiura, & Baltes, 2009), alcohol and drug abuse, risky sexual behaviors, HIV/AIDS infections (Bach & Louw, 2010; Jewkes, Dunkle, Nduna, Jama, & Puren, 2010; Shonkoff et al., 2012), poor social functioning (Lanius et al., 2010), physical health consequences (Barker, 2002; Dong et al., 2004) and suicide (Bruwer et al., 2014). Additionally, physical discomfort and distress can cause or exacerbate a number of medical conditions (Barker, 2002; Dong et al., 2004).

Children who experience ongoing toxic stress due to chronic violence exposure or maltreatment may learn to tolerate violence or the excessive stress can result in trauma (Gilbert et al., 2009). This refers to the child experiencing extreme coping difficulties and emotional distress - making them feel unsafe and in constant danger (Van der Kolk, 2005). In the absence

of healthy coping mechanisms, exposed children may develop dissociation and disengagement responses (Ford & Cloitre, 2009; Silvern & Griese, 2012). These children may experience what is characterised as 'defeat reactions' (a longer form of dissociation with lowered blood pressure and heart rate) (Perry & Pollard, 1998) and 'terminal thinking' (belief that a violent death is inevitable) (Garbarino, 1999). These coping strategies develop due to disruptive and insecure parental attachments and it impacts children's ability to regulate their emotions (Cook et al., 2005; van der Kolk, 2005). Thus, dysregulation of affect has important implications for later interpersonal relationships and personality development (Cutajar et al., 2010).

Dissociation, disengagement and defeatism responses are commonly observed in younger children and adolescents, but they are not rigorously researched and well-documented in South Africa's research studies (Kaminer & Eagle, 2010). Although they serve as short-term protective factors, they may compromise children's social, moral and emotional development (Meinck, et al., 2016; Unicef, 2010; van der Kolk, 2005). For instance, the use of such psychic defences prevents the integration of other memories and experiences, thoughts, and feelings (Cook et al., 2005; Gregorowski & Seedat, 2013). Furthermore, continuous violence exposure diminishes children's ability to empathize and show concern for others, thereby increasing their risk for violence perpetration and engagement in antisocial behavior and illegal activities (Fonagy & Target, 2003). In the Bt20+ study, violent behaviour was reported to be high in primary school going children (65%), increasing to 89% in adolescents (Richter et al., 2018).

In response to intense feelings of trauma, somatic complaints (such as consistent headaches, stomach aches and conversion symptoms) may develop (Cook et al., 2005; Ford & Cloitre, 2009). Trauma-exposed children also tend to depict behaviour outside of awareness or control, which communicates their traumatic experiences either by being the abuser or the abused (Cook et al., 2005).

The experiences of violence in childhood are associated with violent and aggressive behaviour in boys later in life (Abrahams & Jewkes, 2005) and in extreme cases of intimate femicide (Jamieson et al., 2018). Witnessing violence causes what is termed as 'bystander trauma', which contributes to violence perpetration and victimization (Abrahams & Jewkes, 2005; Fulu et al., 2017). Unresolved trauma can lead to long-term psychological problems later in life such as repetition compulsion, where the victim would subconsciously choose an abusive partner and exposes him/herself to situations depicting the original trauma (Woollett & Thomson,

2016). The victims are also more likely to practice harsh, neglectful and abusive parenting with their own children (Fulu et al., 2017). Cumulative violence exposure impacts on children's self-concept, their sense of others and the world. Their sense of safety becomes impaired, heightening their feelings of powerlessness (Bowlby, 1980).

To illustrate the link between violence exposure and child mental health outcomes, a cross-sectional family-based study was carried out in the Western Cape Province with 120 primary caregivers/parents and their adolescent children (aged 12-18 years) receiving inpatient and outpatient mental healthcare. The study reveals a direct and strong association between mental health symptoms with witnessing parent, peer and community violence. Boys than girls were significantly exposed to witnessing community violence, with boys describing more externalising symptoms (Donenberg et al., 2020). In Cape Town, a high school-based study confirms the association between high levels of violence exposure with high levels of emotional disorders (depression, anxiety and PTSD) in adolescents with poor social support. In this study, a positive link was also found between violence exposure and self-harm (Stansfeld et al., 2017). Skeen et al., (2016) conducted a community-based study among 989 vulnerable children affected by violence and HIV/AIDS in South Africa and Malawi. The study reveals that interpersonal in the home, community violence, physical and psychological abuse predicted emotional disorders, trauma symptoms, behavioural problems and poorer self-esteem.

Consistent with local research, available data from recent international studies also suggests a positive relationship between violence exposure and child mental health problems. In Quebec Canada for instance, a population-based survey representative of 1400 adolescents (aged 12 and 17 years) reports that adolescent children with exposure to at least one incident of physical community violence presented with psychological difficulties, most especially anger. The study further reveals that the intensity depends on whether the exposure is direct or indirect (Dube et al., 2018).

In a large sample of adolescent children (9-18 year olds) from seven European countries revealed that 76% of adolescent children diagnosed with conduct problems reported at least one incident of community violence exposure in the past year, when compared to 34% of children without the same diagnosis (Kersten et al. 2016). A survey representative of 12–17-

year-old adolescents found that 35.2% of participants also reported experiencing at least one form of community violence in the past year, as a victim or a witness (Dubé et al. 2014).

Table 2.2: Psychiatric Sequelae of Cumulative Childhood Trauma

Mood disorders (Benjet, Borges, & Medina-Mora, 2010; CollinVézina, Coleman, Milne, Sell, & Daigneault, 2011; Lieberman, Chu, van Horn, & Harris, 2011)
Attempted suicide (Lieberman et al, 2011; Wanner, Vitaro, Tremblay, & Turecki, 2012)
Self-injurious behaviour (McReynolds & Wasserman, 2011)
Anxiety disorders (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Cutajar et al. 2010)
Externalizing disorders (intermittent explosive disorder, oppositional defiant disorder, conduct disorder and ADHD) (Shenk, Nolla, Putnamb, & Trickett, 2010; Muller, Vascotto, Konanur, & Rosenkranz, 2013)
Aggression (Silvern & Griese 2012)
Substance use disorders (Tucci, Kerr-Corrêa & Souza-Formigon 2010; Lieberman et al. 2011)
Psychosis (Cutajar et al., 2010)
Personality disorders (most commonly borderline and antisocial personality disorder) (Cutejar et al., 2010)
Alexithymia (Berenbaum 1996)
Dissociation (Collin-Vézina et al. 2011; Silvern and Griese 2012)
Catatonia (Dhossche, Ross & Stoppelbein 2012)
Somatization (Nickel & Egle 2006)
Eating disorders (Jaite et al. 2011)
Body dysmorphic disorder (Didie et al. 2006)
Cognitive difficulties (Majer, Nater, Lin, Capuron, & Reeves, 2010; Kira et al. 2012; Spann et al. 2012)

Exposure to persistent violence has long-term implications for South Africa's future mental health (Norman et al., 2010). Few studies have however examined the association between violence exposure and psychological outcomes for children receiving mental health services (Donenberg et al., 2020; Humm et al., 2018; Stansfeld et al., 2017; Schwartz et al., 2019). Efforts to prevent or address violence against children are therefore hindered by limited evidence (Petersen et al., 2009; WHO, 2014). Nonetheless, findings of high rates of violence exposure calls for targeted and evidence-based preventative (primary prevention) and treatment (secondary) interventions (Chaikin & Prout, 2004; Donenberg et al., 2020).

2.4 Assessment and Treatment Approaches of Children exposed to Traumas

Assessment measures (see Table 2.3) for trauma-exposed children should integrate holistic evaluations of the child's personal and family history. This includes the child's treatment histories, attachment relationships, environmental influences, individual and family strengths, resource, and resilience factors. Methods of assessment should include collateral sources of information (Cook et al., 2005). Treatment should address symptoms and impairment in all affected domains of functioning (i.e. cognition, emotional, behaviour, relational and somatic) (Cook et al., 2005; Ford & Cloitre, 2009).

Table 2.3: Trauma Assessment and Treatment Measures

Modes of Assessments
Child Behaviour Checklist (CBCL) Measures psychological distress in children following abuse (Achenbach (2002 cited in Briere & Spinazzola, 2005)
Trauma Symptom Checklist for Children (TSCC) ages 8-16 years A child self-report questionnaire (Briere (1996 cited in Briere & Spinazzola 2005).
Child Sexual Behaviour Inventory (CSBI) for 2-12-year-old-children (Friedrich (1998 cited in Briere & Spinazzola, 2005).
Treatment Methods
Trauma Focused Cognitive Behavioural Therapy (TF-CBT) Addresses psycho-education and parenting skills; teaches affect modulation and emotional expression; teaches relaxation techniques and coping skills; assists with narrative processing of the trauma; uses desensitisation techniques to reduce traumatic reactions to trauma reminders; and aims to improve the safety of the child (Cohen, 2005; Lieberman et al., 2011).
Child-Parent Psychotherapy (CPP) Combines psychoanalytic attachment and trauma theories with social learning and CBT techniques to restore emotional regulation and positive attachment relationships to the caregiver and to enable the re-telling of the trauma in an integrated life narrative (Lieberman & van Horn, 2008).
Trauma Systems Therapy (TST) Targets the development of self-regulatory capacities in children and reduction of stress and risk in the child's environment (Saxe, Ellis, Fogler, Hansen & Sorkin, 2005).
Attachment, Self-Regulation and Competency (SRC) Model Focuses on the development of skills to overcome trauma related barriers affecting healthy

development (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005)
Skills Training in Affect and Interpersonal Regulation (STAIR) A group treatment model for adolescents, directly targeting affect regulation and interpersonal difficulties before progressing to emotional processing of the trauma through the use of prolonged exposure techniques (Cook et al., 2005).
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) A group treatment model which aims to foster and augment current coping skills through validation and connection. It addresses difficulties with emotional regulation, physical health, attention and information processing, self-perception and sense of meaning (Cook et al., 2005; De Rosa et al., 2006)
Trauma Adaptive Recovery Group Education and Training (TARGET) Teaches adolescents skills for affect and physical self-regulation, information processing, relational problem solving and coping with stress through experiential exercises (Cook et al., 2005; Ford & Russo, 2006).

Treatment guidelines, especially for complex trauma exposure, require an integration of six components. These are: (i) safety; (ii) self-regulation; (iii) self-reflective information processing; (iv) integration of traumatic experience into the life narrative; (v) re-engagement with relationships; and (vi) enhancement of positive affect (Cook et al., 2005).

Treatment plans should be organized around ameliorating distress while simultaneously incorporating the child and caregiver's wishes and goals, and should draw on individual and family strengths, resiliencies and resources (Ford & Cloitre, 2009). For specific treatment models, based on the above treatment principles along with evidence-based treatments of PTSD, see Table 2.3. The following sections outline the recommended guidelines for treating children and adolescents experiencing developmental trauma.

Table 2.3 above summarizes some intervention approaches for trauma treatment. Such interventions largely aim to prevent the development of PTSD as opposed to other trauma-focused symptoms (Resnick, Acierno, Kilpatrick, & Holmes, 2005). Similarly, South African child-trauma intervention have focused on psychiatric symptoms of PTSD, depression and anxiety-related disorders. These interventions often overlook other traumatic stress manifestations in early and middle childhood (Kaminer & Eagle, 2010). Existing interventions

such as psycho-education and school-based services are often provided as a form of psychological first aid or psychological debriefing (Bisson & Cohen, 2006). School-based debriefing interventions are provided to help minimize the impact of the experienced traumatic event and to identify children at risk for developing severe pathology. There are however no outcome-based studies to support their effectiveness (Kaminer & Eagle, 2010).

Beyond the initial containment of acute trauma, effective evidence-based individual approaches are described in the literature such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and trauma-focused play therapy (Agorastos, Marmar, & Otte, 2011; Leibowitz-Levy, 2005). Literature does not document any South African studies that have systematically evaluated TF-CBT with children populations (Kaminer & Eagle, 2010). South African research reviewed by McDermott (2005) and Kekae-Moletsane (2006) highlighted the usefulness and integration of play or art therapeutic approaches, inclusive of cultural symbolism and practices into South Africa's child-trauma treatment. Leibowitz-Levy (2005) further highlights the need for expressive therapies and trauma narrative reconstructions to accommodate the "self in context" of the child.

Additional treatment modalities, commonly used internationally include Eye Movement Desensitization Reprocessing (EMDR) (Ehlers et al., 2010); Exposure Therapy (ET) (Cahill, Rothbaum, Resick, & Follette, 2009); and group psychotherapy. The effectiveness of group therapy has not yet been evaluated for individuals with PTSD or trauma histories (Ford, Fallot, & Harris, 2009). Family therapy is another treatment modality recommended especially for clients with resistant traumatic stress, PTSD or individuals being impacted by prolonged family problems (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009). Psychodynamic approaches are found to be relatively ineffective in treating complex trauma (Kudler, Krupnick, Blank, Herman, & Horowitz, 2009). Pharmacological interventions are found to be effective in reducing traumatic stress symptoms and preventing PTSD (Fletcher, Creamer, & Forbes, 2010; Seedat et al., 2002). The authors caution that pharmacological interventions should not be used as the first line of treatment. International treatment guidelines such as ACPMH (2007) and NICE (2005) have recognized EMDR, ET and pharmacotherapy as effective treatment approaches when used in combination.

2.5 Psychology-Based Mental Healthcare Services

In their review of mental health service delivery in South Africa from the year 2000 to 2010, Petersen and Lund (2011) found that common mental disorders of depression and anxiety-related illnesses are often undetected and/or untreated, and sometimes undocumented. In a paper presented at the first National Mental Health Summit in 2012, Lund et al. (2012) stated that mental disorders rank third to the burden of disease in South Africa, with approximately 1 in 6 South Africans likely to experience a common mental disorder (depression, anxiety or substance use disorder); and 1 in 10 people with a mental health conditions receive treatment (Docrat & Lund, 2019).

In marginalised townships in South Africa, like Mamelodi, there is a serious lack of general mental healthcare services and even less services to assist children with emotionally-focused problems (Eskell-Blokland, 2014). Marginalisation of township life however continues even after twenty five years of democratic government. Township cultural practices typically combines indigenous customs and rituals with modern ways of living. Many township residents have relocated from traditional areas of living to serve as workers in the then white-populated cities. This inevitably resulted in a measure of disconnectedness from traditional ways of life. Many people living in the city centre by day, return to their residing township homes by night. The movement of township residents have also swelled the population of Mamelodi due to the relocation from rural areas and from across South Africa's borders in search for work opportunitities. Many remain undocumented citizens, thereby living under the radar of the already inefficient public healthcare system (Eskell-Blokland, 2014; Ruane, 2006).

In the context of South Africa's apartheid history, the majority of the general healthcare and particulalry mental health services are accessible mostly within and around the inner cities, like Pretoria (Eskell-Blokland, 2014; Pretorius & Pfeiffer, 2010). As a result, Mamelodi residents are required to travel long and costly distances for service accessibility. A few psychological services are available in any general state hospital in South Africa. In this situation of inadequate resources, township residents have established their own ways of handling and resolving life's healthcare challenges, most especially mental health care, relying heavily on indigenous traditional and church-based treatment methods (Eskell-Blokland, 2014).

Living within a context of multiple and prolonged violence and trauma exposure, with few safe spaces, poses a different set of psychological challenges and requires different intervention approaches (Kaminer & Eagle, 2010). The one-on-one psychology-based notions and theories may still be relevant, however the application may need to be different (Eskell-Blokland, 2014). Several authors (see Kaminer & Eagle, 2010; Leibowitz-Levy, 2005; WHO, 2014) propose a modified child-trauma intervention model, highlighting flexibility, eclecticism and multi-dimensional components that consider both the child and the environment as targets of intervention. A multiphasic approach to mental health provision will therefore not only increase access to such services but can ensure that such services meet the needs of beneficiaries as well as empower individuals and community members to have control over their mental health (MHaPP, 2010; Petersen et al., 2009; Skeen et al., 2016; WHO, 2014). Some international authors (Pyari, Kutty, & Sarma, 2012) argue that availability and accessibility to mental health resources is the most effective strategy for preventing and treating traumatic reactions.

Compared to other western countries, the evidence-base to substantiate the efficacy of child-trauma interventions and assessment tools are still very limited within the South African literature (Kaminer & Eagle, 2010; Leibowitz-Levy, 2005). In addition, the majority of South Africa's trauma-exposed assessments rely on self-report symptom scales as opposed to structured psychiatric interviews and collateral data (Kaminer & Eagle, 2010). For example, a small-scale study by Leibowitz-Levy (2005) found that 'the child interview' and 'the Wits Trauma Model' are the most used assessments by key trauma service providers to inform their interventions. Existing research on child-trauma interventions are primarily case study-based (see Kekae-Moletsane, 2006; Leibowitz-Levy, 2005; McDermott, 2005; Pretorius & Pfeiffer, 2010) or observationally-based (see Killian & Brakarsh, 2004). Hence, there is a gap in the scientific literature on the existing psychological services within community-based programmes (i.e. interventions that are culturally appropriate from scarce-resource contexts) in response to children who are exposed to and affected by violence and trauma (Petersen & Lund, 2011; Petersen et al., 2009; Skeen et al., 2016; WHO, 2014).

2.6 Concluding Summary

Violence against children is a global health concern and a culture violence is a potential influencing driver for children's responses in resolving conflict and disputes across different settings of their lives. In South Africa, commonly provided forms of interventions for psychological first aid or psychological debriefing include psycho-education and school-based

services. In addition, assessments of trauma-exposure are based on self-report symptom scales as opposed to structured psychiatric interviews and collateral data. There are currently no outcome-based studies to support the effectiveness of trauma treatment models for children. Research needs to further identify and explore psychological services within community-based programmes in response to children who are exposed to and affected by violence and trauma.

The chapter that follows will provide the methodology employed in the study. The discussion will cover in detail elements such as study design, description of the research site, sample selection, data collection method and data analysis method.

CHAPTER 3

METHODOLOGY

The purpose of the current study is to identify and explore existing psychological/therapeutic services provided for children exposed to and affected by violence and trauma in Mamelodi Township, a community part of Tshwane. The following chapter outlines the methodological approach of the current study, focusing on aspects such as research design, sampling, data collection procedure, data analysis and ethical considerations.

3.1 Research Methodology

A descriptive research methodology guided the current study. Descriptive research is defined as a research methodology used to systematically describe existing phenomena as accurately as possible (Atmowardoyo, 2018). In other words, the main purpose of descriptive research is to describe the state of affairs (i.e. existing psychological services) as they are at present. The researcher has no control over the variables; and can only report on what has happened or what is currently happening (Kothari, 2004). This research is rather concerned with the "what" than "how" or "why" something has happened. It provides a basic understanding of a phenomenon, however it will not necessarily identify variables that explain the occurrence of that phenomenon (Heppner, Kivlighan, & Wampold, 2008). Observation and survey tools are often used to gather data (Nassaji, 2015). Due to the current aim of the study being to identify existing psychological services and furthermore characterize the nature of those services, the descriptive methodology served as an appropriate guide to reach this aim. This type of research serves as a valuable preliminary step in understanding the existing psychological services in Mamelodi (Barker, Pistrang, & Elliot, 2002).

3.1.1 Research Design

A survey design was used in the current study. Survey research is one of the oldest and most widely used research designs in the social sciences (Heppner et al., 2008). The basic aim of survey research is to document the nature or frequency of a particular variable within a certain population. Surveys typically use self-reports to identify facts, opinions, attitudes, and behaviors, as well as the possible relationships among these aspects (Heppner et al., 2008; Saris

& Gallhofer, 2014). The great advantage of self-report is that it gives the researcher the direct point of view of the respondent. It therefore gives access to respondents' perceptions of themselves and their world, which are unobtainable in any other way. The disadvantage of a survey is that there are potential validity problems. Respondents may deceive themselves or others, when responding to the questions posed to them. They may not give a true answer for some or other reason. These limitations of self-report methods are important to bear in mind. However, this does not mean that all self-report data are invalid, only that they cannot be trusted in all cases (Barker et al., 2002; Saris & Gallhofer, 2014).

3.1.2 Description of the Research Site

The research was conducted in the Mamelodi township, a peri-urban settlement located on the far eastern periphery of Pretoria, 20kms east of the Tshwane city centre. Mamelodi township means *Mother of Melodies* (see figure 1). It was a name given to President Paul Kruger (President of the South African Republic from 1883-1900) by black people because of his ability to whistle and imitate birds. Mamelodi Township is one of the five largest townships in South Africa (SA Townships, 2015). The population of Mamelodi is estimated at close to one million inhabitants, generally under priviledged and of low-economic status (Statistics South Africa [Stats SA], 2014). Mamelodi is densely populated, and the housing demand continues to grow as more people migrate to seek for work and opportunities from the rural areas and across South African borders into the city (Mamelodi Trust, 2010). Violent crimes reported to be rife in Mamelodi, are in the form of sexual assaults, contact-related crimes and carjacking (SAPS, 2018).

The general access to healthcare services in Mamelodi township is poor because of the few resources that exist. Mamelodi has a general hopital and a network of primary health care clinics that provide services for routine treatment procedures. Treatment requiring specialist services are referred to major provincial hospitals in Tswane city centre or elsewhere. Psychological services are delivered from a community-based clinic called Itsoseng, functioning from the University of Pretoria (UP) Mamelodi campus. For many years, the Itsoseng Community Clinic continues to provide the only comprehensive psychology-based assessment and treatment service point in Mamelodi. At Itsoseng clinic, the majority of clients are children referred by schools. Social services are delivered from various community-based

NGOs. Satellite branches offering supportive services in the township are often infrequently accessible (Eskell-Blokland, 2014).

Figure 1: A General View of Mamelodi (Pretoria News, 2017)

3.1.3 Sampling

The total sample size of organisations / service providers (participants) was 11. A list of service providers delivering therapeutic services to trauma-exposed children in Mamelodi Township was compiled from the service providers registered on DSS database. The CEO or manager of the organisation was phoned to explain the research and to ask if they were willing to participate in the research. A snowball sampling technique was used to identify other organisations. New organisations were mentioned during the snowball process.

Snowball sampling is sometimes the best way to locate subjects with certain attributes or characteristics necessary in the study. Snowball samples are particularly popular among researchers interested in studying various classes of deviance, sensitive topics, or difficult-to-reach populations (Lune & Berg, 2017). Snowball sampling operates by asking each respondent to name one or two other people who fit the research criteria. Sampling continues up to the point where additional respondents provide little or no extra information (Barker et al., 2002; Creswell, 2014; McMillan & Schumacher, 2014). The possible disadvantages of snowball sampling are that the initial respondents might direct you to other like-minded people

who share their viewpoint, and thus the researcher needs to be aware of possible biases in the achieved sample. However, snowballing was chosen as a method of sampling in this particular study because it allows for an increase in sample size where it is difficult to readily obtain participants (Barker et al., 2002; Lune & Berg, 2017).

3.1.4 Participant Recruitment Strategy

An information letter and consent form explaining the nature of the study was sent to the CEOs or managers of each organisation requesting their participation in the study (See attached Information Letter and Consent Form APPENDIX A). Organisations willing to take part in the study responded to the researcher. Interviews were scheduled and conducted with the therapists, CEOs, or managers of each organisation. At the end of each interview, the interviewed participant was shown the compiled list of service providers to be contacted. The interviewed participant was then asked to identify potential service providers not included on the compiled list. The same procedure was followed in contacting the newly identified service providers. The participants identified were selected upon meeting the following criteria:

- Service providers offering intervention services to violence and trauma-exposed children in Mamelodi (service providers can be NGOs/NPOs, CBOs or government-based service providers);
- Service providers should be registered with the Department of Social Services as providing such services. All the surveyed organisations were not listed on DSS service provider database due to an error in omission and change of the organization address at the time of printing the initial list.
- The language of use for the survey interviews with all the participants was English.

3.1.5 Data Collection Procedure

The method of data collection was a survey with mainly open and closed-ended questions. Surveys are structured and valuable for assessing opinions, perceptions and trends of the given situation using a larger and more representative group (Aldridge & Levine, 2001; Nastasi & Schensul, 2005). After participants agreed to voluntarily take part in the research, the researchers administered the survey in the format of an interview and completed the questionnaire on behalf of the participants. The researchers probed and used follow-up

questions from participants' responses, to facilitate as far as possible a comprehensive understanding of what is being shared (Darlington & Scott, 2002). The survey interviews were conducted in English, by the MA Counselling and Clinical Psychology students. The interviews lasted between one and a half to 2 hours.

3.1.5.1 Data collection instrument

The survey questions were benchmarked from the Trauma System Readiness Tool (TSRT) (Hendricks, Conradie, & Wilson, 2011) developed in San Diego, USA. The TSRT tool aims to understand the ability of an organisation to identify and effectively treat traumatised children. While the TSRT consists mainly of structured questions, the current survey consists of additional open-ended questions to provide more in-depth data. This was done so that service providers can freely describe their practices and challenges. The survey comprises of eight sections (see attached APPENDIX B):

- The demographic data of the clients serviced;
- Type of violence children are exposed to;
- The type of therapy provided to children exposed to violence and trauma and the level of training of the service providers;
- The service providers' perceptions of the needs of children exposed to violence and trauma;
- Available treatment interventions for parents/caregivers of violence and trauma-exposed children;
- Perceived effectiveness of the psychotherapeutic services provided;
- Service coordination with other service providers; and;
- Identified gaps in the provision of trauma services to children exposed to violence.

3.2 Data Analysis

Descriptive studies may involve quantitative analysis or/and qualitative analysis (Atmowardoyo, 2018). In the case of the current study the demographic information of clients as well as the closed ended questions were analysed by means of frequencies in order to summarize the data.

Content analysis was then used to analyse the qualitative answers to the open ended questions. Content analysis is a careful, detailed, systematic examination and interpretation of a particular

body of material in an effort to identify patterns, themes, assumptions, and meanings. The analysis is designed to "code" the content as data in a form that can be used to address research questions (Lune & Berg, 2017).

Lune and Berg (2017) advise that content analysis follows a fairly standard set of analytic activities arranged in a general order of sequence:

(1) Data is collected and made into text or otherwise organized to be "read". In the current study the answers to the open ended questions were in written form on the survey. The researcher typed them out on a separate document in preparation for analysis.
(2) Codes are analytically developed and/or inductively identified in the data and affixed to sets of notes or transcript pages.
(3) Codes are transformed into categorical labels or themes.
(4) The data is sorted by these categories, identifying similar phrases, patterns, relationships, and commonalties or disparities.
(5) The sorted data is examined to isolate meaningful patterns and processes.
(6) Identified patterns are considered in light of previous research and theories, and generalisations are established where applicable.

Since the current study is within a descriptive research framework, the qualitative data obtained was converted into quantitative data by means of obtaining the frequencies (see Appendix C) from the codes generated by means of content analysis. The assumption thereof was to place emphasis on results or codes that were most frequently reported amongst the organizations. This process of quantification allowed for integration of the quantitative and qualitative results.

3.3 Measures to Ensure Trustworthiness

The following criteria are important to consider in pursuit of trustworthiness of research results (Denzin & Lincoln, 2011) (see figure 2).

Credibility or internal validity seeks to ensure that the study focuses on what it intends to investigate. In this study, credibility was achieved through the rapport that the researcher established with the research participants in order to foster honesty in the data they provided. The researcher clarified the voluntary nature of participation and that the study was not in any way an evaluation of the organization's performance. Credibility in the interpretation of the

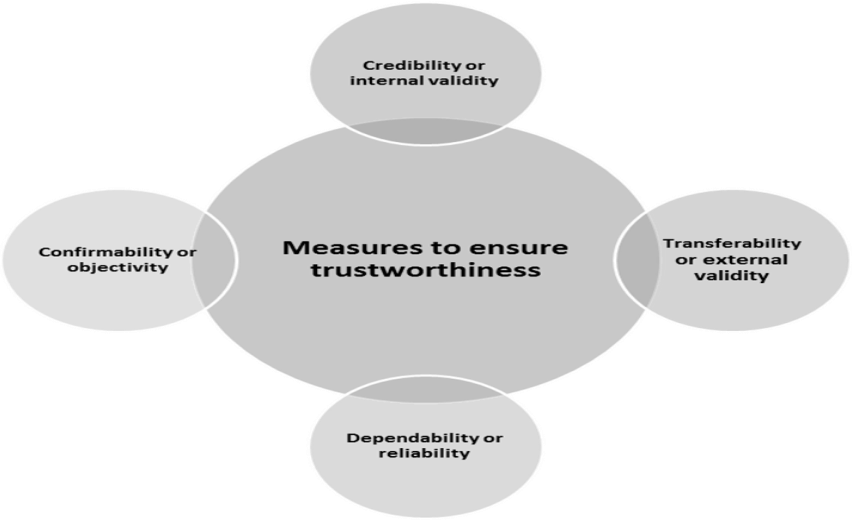
data was assured by making use of a co-coder in order to ensure there are consistencies in the codes generated.

Transferability or external validity refers to the extent to which findings of one study can be applied in similar settings (Merriam, 1998). The researcher will take responsibility to provide sufficient background information of the study's context (Mamelodi Township) and detailed description of the violence phenomenon being studied to allow comparisons with other similar contexts. In addition, the researcher will convey to the reader the boundaries and limitations of the study.

Dependability or reliability enables the yielding of similar results if the study were to be replicated in the same context using the same research sources, methods and participants. In this study, the researcher addressed dependability aspects by detailing the research design and its implementation by describing how it was executed. This is to allow the reader to assess how the research was conducted, enabling them to make decisions about transferability of findings. However, it should be noted that each qualitative study will have unique outcomes due to its unique participants (De Vos, Strydom, Fouche, & Delport, 2005).

Confirmability or objectivity refers to the extent to which the researcher is able to reduce the effect of researcher bias. This was done through the researcher acknowledging her own predispositions concerning the methods used and why, as well as recognition of the weaknesses of the study's methodologies (Braun, Clarke, & Terry, 2014; Miles & Huberman, 1994).

Figure 2: Measures for Trustworthiness in Research Results



3.4 Ethical Considerations

The authority to carry out research comes with the researcher's responsibility to "protect the interests of those being studied" (Neuman, 2003, p. 91). Hence, research principles that ensure voluntary participation, informed consent for participation, and confidentiality were upheld throughout this study (see attached Information Letter and Consent Form APPENDIX A) (McMillan & Schumacher, 2014).

The current study ensured that participants received adequate information about the study and its expected value and benefits (Creswell, 2014). This was done when the researcher met with the participants, explained the consent form and allowed for the participants to ask any clarification questions about the nature of the study before providing consent. Participation in the study was voluntary. Participants were assured of their right to ask questions and/or to withdraw from the study at any time without penalty or disclosing an explanation to the researcher (McMillan & Schumacher, 2014).

The processes of data analysis and results reporting was a monitored process by a co-coder (research psychologist) to ensure quality analysis of the data (Willig, 2013). Participants were also informed that data may be re-used for future research.

Although various institutions were identified by name in the survey for administrative purposes, the data reported in the current study makes use of numbers to safeguard the participants' confidentiality (Polit & Beck, 2004). The researcher also clarified to the participants that the study is not an evaluation of the organisation's performance or lack thereof. All research materials will be securely locked away and password protected at the University of Pretoria in the Department of Psychology for a period of 15 years.

3.5 Conclusion

The current chapter detailed the descriptive methodology that was used in order to identify and explore existing psychological services in response to children exposed to and affected by violence and trauma in Mamelodi Township. A survey design was employed in order to obtain this information. This chapter also detailed the sampling strategy, the recruitment strategy, the analysis, as well as the ethical considerations involved.

The chapter that follows presents the study findings. Description of the service providers' demographic data will be provided. The types of therapeutic interventions available for children exposed to violence and trauma will be highlighted - this includes the level of training of the service providers. Furthermore, service providers' perceptions of the needs of children exposed to violence and trauma will be outlined. The perceived effectiveness of the psychotherapeutic services used will be described. Lastly, the study will identify gaps in the provision of trauma services to children exposed to violence.

CHAPTER 4

RESULTS OF THE STUDY

This chapter presents the analysis of participants' perspectives on psychological resources available for violence and trauma-exposed children in Mamelodi. The first section reports on the structure and sample of organizations who participated in the study. The chapter then highlights participants' perspectives on the effect of violence on children's functioning and the impact thereof. Assessment and treatment options for both exposed children and their caregivers/parents are examined. Subsequent sections of the chapter report on participants' perceived needs as well as barriers to effective child-trauma service provision.

4.1 Contextualizing the Participants

Data was collected from representatives of eleven organizations (n=11). Ten (10) of the eleven organizations are NGO/NPO community-based institutions, whilst one (1) of the organization is a state-owned institution. Six (6) of the NGO/NPO-based organizations provided residential care facilities/place of safety for children removed from their homes due to abuse. These organizations are mandated to deal with different types of cases.

From the eleven (11) participants/representatives of organizations, four (4) were in supervisory roles in their organization; four (4) were fulfilling a social work role in the organization; 1 was a minister/pastor providing religious counselling and two (2) provided no response with regards to their role in the organization. Five (5) of the participants had been employed in the organization for a period of 2 to 5 years; 4 had been employed for a period of 6 to 10 years; and 2 for more than 10 years. The representatives of the organizations are considered experienced in their field.

4.2 Contextualizing the Organizations

4.2.1 Funding

Most of the funding for the organisations was reported to be acquired from national agencies such as the National lottery, universities, South African Police Service (SAPS), Department of Social Development (DSD) and Department of Health (DoH). Further funding is reported to be as a result of the organisations themselves conducting fundraising initiatives in the

communities. The least reported funding source is from international donors such as the United States Agency for International Development (USAID) as indicated by four (4) organisations (see Table 4.1 below)

Insufficient funding was identified by all the participants as a barrier to effective services (n=11), particularly for state dependent child welfare institutions. One participant commented: "*it's a big challenge to have to sustain programs with lack of funds*" (Social Worker/CEO). Another participant acknowledged "*consistent support*" of the provision of infrastructure and human resources from the University of Pretoria (Clinic Manager).

Table 4.1: Source of Funding

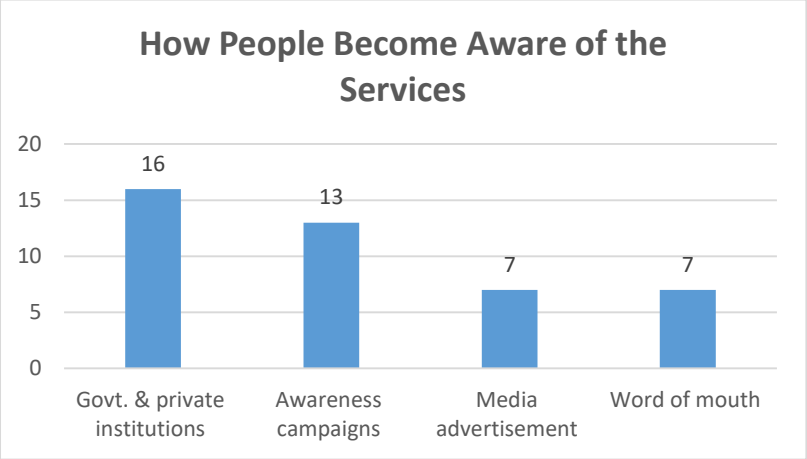
National (n=11)	Internal Fundraising Initiative (n=7)	International (n=4)
DoH	Corporate Institutions (ABSA, FNB, BMW, Ford Motors, National Lottery)	Germany and Canada (Stipend),
DSD	Church Organizations (i.e. The Salvation Army)	PEPFAR,
NPA	Fundraising Campaigns	Soroptimist International (Global Volunteer Movement Advocating for Human Rights and Gender Equality); USAID
SAPS	Individual and Business Donors	

4.2.2 Community Awareness of Services

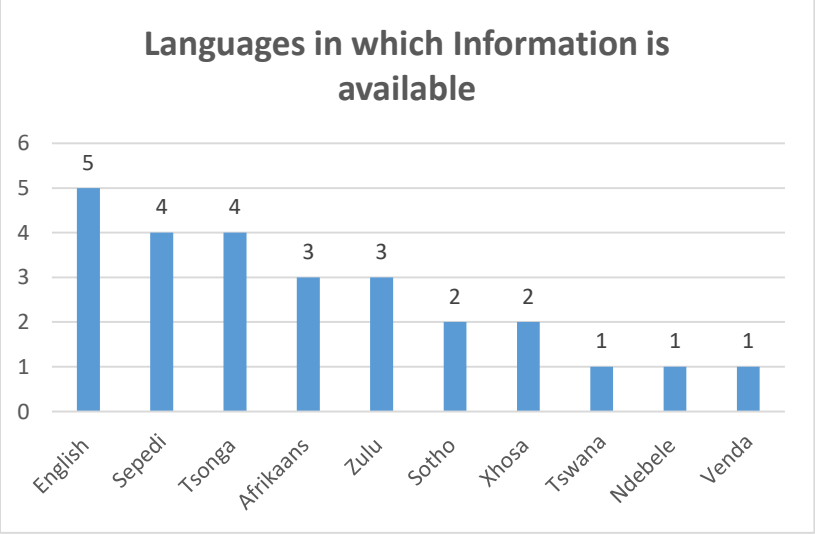
Community members were reported to become aware of the services from the organizations in various ways (see graph 4.1 below) – they could have mentioned several options. The most common way of becoming aware of services is by being referred by government or private institutions. The second common way people are reported to become aware of the services is through the awareness campaigns (n=11) conducted by the organizations in schools, hospitals/clinics, community centers, exhibitions at malls, crisis centers, door-to-door pamphlet distributions and government health community departments such as DSD, DoH, National Prosecuting Authority (NPA), South African National Council on Alcoholism

(SANCA), National Youth Development Outreach (NYDO), Circle of Life. Lastly, media advertisement (n=7) and by word of mouth (n=7) were also reported.

Six (6) of the respondents reported that information regarding their organization is available in different languages, three (3) respondents reported that their organizations only have information in one language, and two (2) respondents provided no response regarding languages. The graph below (graph 4.2) illustrates the number of organizations that stated that their organization has information available in a particular language. English is the most commonly used language of conveying information about the organization. Information is however not readily available in the all the languages spoken by people living in Mamelodi Township.



Graph 4.1: How People Become Aware of Services Provided



Graph 4.2: Languages in which information is available

4.2.3 Age Profile of Clients Consulted by each Organization in the Past Month

Table 4.2 summarizes the particular age group of clients serviced by the organizations in the past month, as indicated by a tick (✓). Below the table is a key for the different age groups. Of the eleven (11) organizations, two (2) indicated to have assisted clients of all age groups in the past month. Two (2) organizations had only assisted a single age group of clients (adolescents and young children). Most of the organizations (n=7) serve children from early childhood to adolescence.

Table 4.2: Client Age Profile in the Past Month

Organisation	A	B	C	D	E	F	G
1				✓			
2		✓	✓				
3		✓					
4	✓	✓	✓	✓	✓	✓	
5	✓	✓	✓	✓	✓	✓	✓
6		✓					
7	✓						
8	✓	✓	✓	✓	✓	✓	✓
9		✓	✓	✓			
10		✓	✓	✓	✓	✓	✓
11	✓		✓	✓			

Note: A= Infants and young children; B = Early childhood; C = Middle childhood; D = Adolescents E = Young adults; F=Adults; G = Elderly

4.2.4 Case Load of Each Organization in any One Month

Table 4.3 below *reflects the number of healthcare professionals and caseloads handled per organization.* The caseload varied from one organization to the next, with a minimum of twelve (12) and a maximum of three hundred and twenty (320) cases in a given month. The average number of cases reported is one hundred and one (101.72).

Table 4.3: Case Load Per Organisation in a Given Month

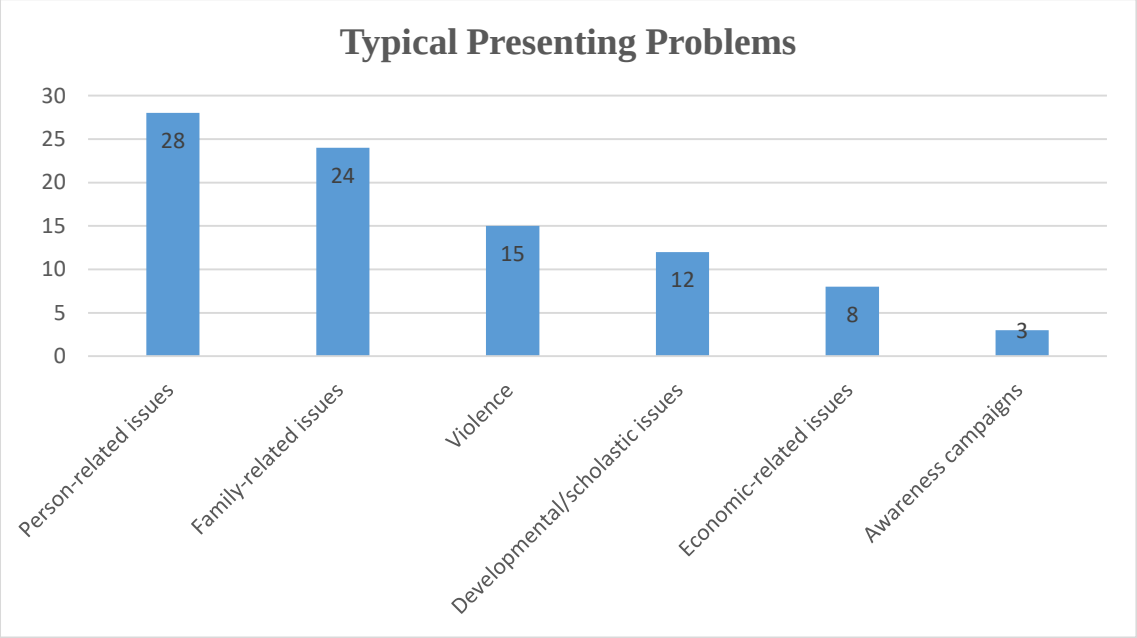
Organisations	Number of Cases	Profile of Organisation Staff
1 (NPO/NGO)	12	Two Lay Counsellors
2 (NGO)	20	One Social Worker and two Auxiliary Social Workers/Housemothers
3 (NPO)	20	Three Social Workers, with one completing Clinical Social Work in Play Therapy; One Forensic Assessment Consultant
4 (State Org.)	28	Manager and two Lay Counsellors
5 (NPO)	30	Seven Therapists and One group leader that volunteers their time and skills (One Psychologist, Two Social Workers, Two Play Therapists, One Occupational Therapist, One Counsellor)
6 (NPO)	45	CEO, Two Social Workers (One at each centre)
7 (NPO/NGO)	80	One Social Worker
8 (NPO)	124	Eight Social Workers
9 (NPO/NGO)	140	Executive Director, Two Care Workers per centre (fifteen Home-based Care Centres with +-twenty eight children per centre; seven After School Care Centres and one Post Matric Youth Centre)
10 (NPO/NGO)	300	One Clinic Manager; M1 and M2 Psychology Students;
11 (NPO)	320	One Social Worker; a Caregiver and Auxiliary Social Worker

Six (6) organizations reported very high caseloads in a given month. Six (6) NPO/NGOs reported to employ mainly social workers to attend to clients, whilst the state organization rely on the use of lay counsellors in providing mental healthcare services. One (1) of the organizations with very high caseloads reported services of masters' psychology students. Most of the organizations with high caseloads have very few professionals to attend to the psychosocial needs of the affected children, reflecting a lack of skilled mental healthcare staff. What is apparent in the findings is that the social workers were the majority of the professionals handling very high caseloads. There were no site-based psychologists and/or psychiatrists reported at any of the sampled organizations. Four (4) NPO/NGO-based organizations for

instance, reported that they work in partnership with individual private mental health institutions, providing psychosocial and mental-health related services. Two (2) other NPO/NGOs stated, that "access to such specialized services is either on voluntary basis (without financial benefits) or on the basis of adequate funding (on payment basis)" (Social Worker/CEO).

4.2.5 Typical Presenting Problems for all Clients

The following graph (4.3) outlines the typical presenting problems identified for all clients listed (i.e. infants and young children; early childhood; middle childhood; adolescents; young adults; adults; and the elderly) across all the organizations.



Graph 4.3: Typical Presenting Problems in Different Organisations

Six themes were identified in terms of the typical presenting problems that clients present with across all 11 organizations. These themes are briefly discussed below:

Personal-Related Issues

Most clients typically present with what we term person-related issues. These can be characterized by personal struggles that the client presents with, that need intervention in order for the client to function better in their family as well as the community. Examples of these

types of problems include aggression, substance abuse, behavioral problems, anxiety, depression, and trauma.

Family-Related Issues

The second most common presenting problem is family-related difficulties. These are characterized by problems that arise within the family system and often need to be addressed by working with multiple members in the family in order to reach a workable solution. Examples of these include child neglect, lack of parental support and supervision, separation/divorce, lack of housing, etc.

Violence

Violence relates to presenting problems in the form of physical harm that the children have experienced. It is important to note that more than half of violence problems was related to some form of sexual assault for preschoolers to adolescents' age-group. Other prominent forms of violence reported were domestic, physical and community violence such as witnessing intimate partner and gang violence, harsh physical beatings as a form of disciplinary practices, etc.

Developmental Challenges

Developmental challenges relate to problems encountered in adjusting to the next phase in life. These range from scholastic difficulties, speech difficulties, fine and gross motor difficulties etc. It is also important to take note that the aspect of inadequate nutrition came up in this theme as a contributing factor.

Economic-Related Issues

For this theme, people presented to these organisations due to unemployment and their need to find jobs or assistance with grants. Some also presented due to their financial dependence on a spouse and the issues that arose due to that.

4.2.6 Child and Adolescent Clients that Present with Trauma due to Violence

The following table (4.4) illustrates the estimated percentage of child and adolescent clients that present to the different organisations because of trauma resulting from violence. The number of clients fitting these criteria is reported to vary from 30% to 100% for the different

organisations. This indicates the prominence of problems related to violence in this community.

Table 4.4: Child and Adolescent Clients that Present with Trauma due to Violence

Organisation	Percentage (%)
1	60-80
2	85
3	90
4	100
5	70
6	80
7	40
8	30
9	No response
10	36
11	80

4.2.7 Types of Traumas

Table 4.5 summarises the types of traumas that referred children have been exposed to reported by each organisation. The most commonly reported forms of violence children are exposed to:

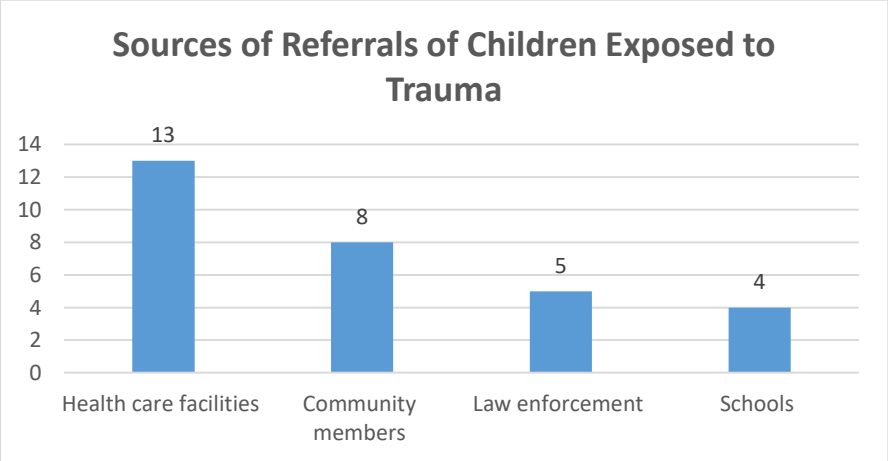
- Sexual and physical abuse (as represented by nine participants);
- Domestic abuse (represented by eight participants);
- Community violence (reported by six participants;
- Emotional abuse, neglect and abandonment (reported by three participants);
- Verbal abuse and corporal punishment (reported by one participant each).
- Four participants further revealed that their organizations also offer psychological interventions to about 20% of the elderly population suffering from violence-related traumas and adjustment difficulties.

Table 4.5: Types of Traumas Children are Referred For

Organisation	Sexual abuse	Physical abuse	Domestic violence	Community violence	Other
1	✓	✓	✓	✓	✓
2	✓	✓	✓		✓
3		✓	✓		✓
4	✓			✓	
5	✓				✓
6	✓	✓	✓	✓	✓
7	✓	✓			
8	✓	✓	✓		✓
9		✓	✓	✓	
10	✓	✓	✓	✓	
11	✓	✓	✓	✓	

4.2.8 Sources of Referrals for Children Exposed to Trauma

It was important to find out what the main referral sources for children who have experienced trauma are (see graph 4.4). The most commonly reported referral source was health care practitioners from health care facilities, followed by community members. Schools were reported to be the least common referral source.

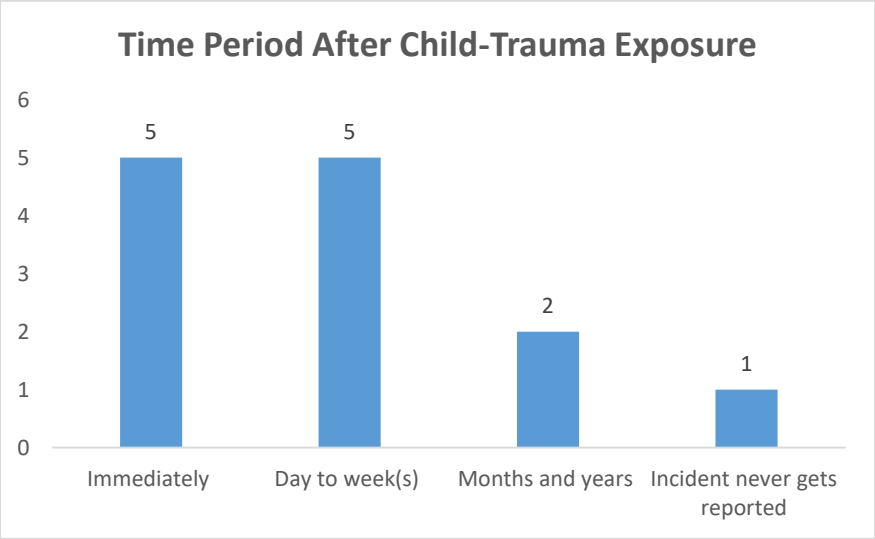


Graph 4.4: Sources of Referrals for Children Exposed to Trauma

4.2.9 Waiting Period Pre-Trauma Intervention

When it comes to the waiting period before trauma intervention (see graph 4.5), half of the organisations reported that this can vary from immediately, to days, and weeks following the incident. Two organisations reported that it can take months to years, while one organisation reported that it is possible that the incident may never get reported. Furthermore, four

organisations reported that they have a waiting list for traumatised children exposed to violence in need of help, while seven organisations reported that they do not have a waiting list. Of the four organisations with waiting lists, two reported that their waiting list is between 2 and 4 weeks, one organisation reported that their waiting list is months long, while the last organisation reported that their waiting list is over a year. This shows that many children have to wait long periods before they can receive trauma intervention after being referred for therapy.



Graph 4.5: Waiting Period Following Trauma

4.3 Participants' Perspectives on Psychological Resources Available for Violence and Trauma-Exposed Children

In terms of screening for trauma, only three organizations reported that they use a trauma screening process to identify children that need trauma counselling or mental health services. Of the three organizations who have a trauma screening process, two reported that they make use of a screening tool developed in-house. Six organizations reported that they do not have a trauma screening process for children. They based their diagnosis of the children on referral information and the assessment of the therapist. Two organizations did not respond to this question.

The process they use to identify children exposed to violence did thus not include standardized scales to assess trauma exposure or the mental health consequences of violence exposure. The respondents did not regard the lack of assessment of trauma exposure as a serious concern, they rather focus on assistance for the child. They felt *"that providing much needed help and support*

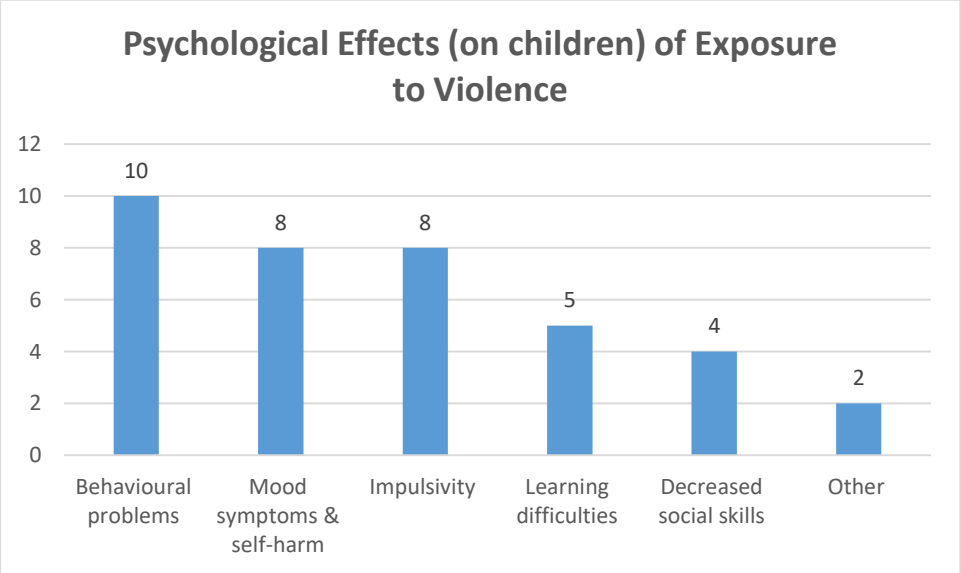
to children in need is better than no assistance" (Auxiliary Social Worker/Housemother). In addition, families and communities are already hesitant to report abuse or seek help. *"Families are not always willing to disclose abuse or neglect. Receiving help becomes challenging for the community as well*" (Clinic Manager). A social worker noted that even with the best of interventions, therapy is costly for the majority of the caregivers'/family members, stating that *"affordability of the services in these disadvantaged communities is a sad reality and they expect a solution to the child's problems*".

Psychological consequences (see graph 4.6) experienced by the affected children post the trauma were reported as mainly behavioral and emotional symptoms, for example conduct problems and somatic complains, frequent mood changes, self-harming tendencies, depression and anxiety amongst others. Other challenges known to be a concern are learning difficulties, impulsivity and decreased social skills. Participant organizations repeatedly expressed concern over the fact that trauma-affected children underperform in school and have poor interpersonal relationship skills.

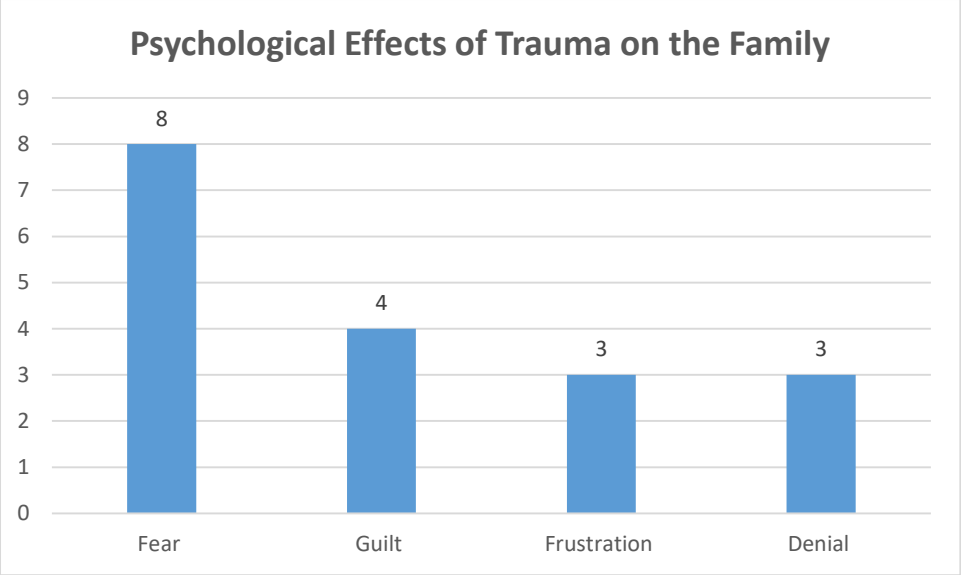
Beyond individual psychological effects, the study also explored the psychological effects of trauma on the family (see graph 4.7). Fear of family disintegration, guilt and frustration of caregivers feeling they have failed the children, as well as denial of the trauma whilst suffering in silence were some of the reported outcomes. Another concern experienced by the participant organizations is the intergenerational cycle of violence and abuse plus the lack of parental involvement in the children's lives. One Social Worker stated, *"Unless there's psychological evaluation and intervention, the child is likely to perpetuate the abuse. The biggest problem is the parents' passive behaviour".* Table 4.6 below gives a detailed description of all forms of symptoms associated with violence and trauma exposure reported by the participants.

Table 4.6: Violence and Trauma Symptoms

Externalising Behaviour: poor interpersonal skills, withdrawn, poor self-esteem and lack of confidence, bedwetting, substance abuse, conduct problems (anger outbursts, aggression, delinquency, theft, lying, bullying, impudent, (destructive), and low frustration tolerance (inability to wait on anything), attention seeking, manipulative, poor hygiene/self-care, lack of consideration/empathy for others, self-serving, pleasing behaviour,
Internalising Behaviour: somatic symptoms i.e. sore tummy, headache
Emotional and Self-Injurious Behaviour: mood changes for no reason, mental health conditions such as depression and anxiety, nightmares/poor sleep, suicidality, cutting, and sexualised behaviour
Learning Difficulties and Impulsivity: low concentration, poor school performance, poor social skills.



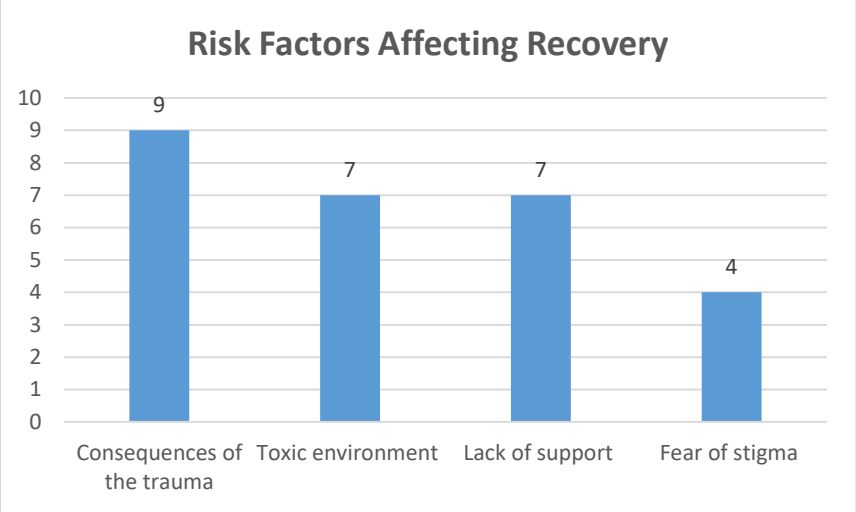
Graph 4.6: Psychological Effects of Exposure to Violence on Children



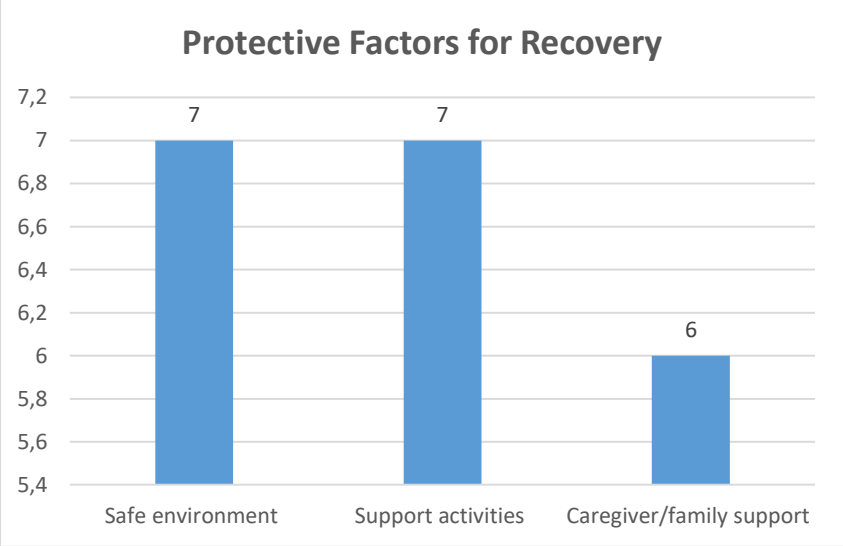
Graph 4.7: Psychological Effects of Trauma on the Family

The study identified risk and protective factors (see graphs 4.8 and 4.9), some of which are located in the family structure. The most commonly reported factor is the consequence of the trauma itself, that of denying the existence of the trauma, particularly sexual abuse and keeping the trauma a secret to protect the perpetrator. This factor is followed by children having to return to a toxic, violent and unsafe home environment, with lack of parental structure and support and a fear of being stigmatized. The participant organizations repeatedly expressed that children do not have trust in their caregivers/adults to protect them and to keep them safe. This in turn affects the children's ability to reach out for help and be able to talk about the trauma. Poverty was also identified as often cultivating the conditions for child abuse to occur. Associated with poverty is the moral decay in societal norms in relation to a violent culture, for instance, violence has become the new normal situation.

Despite the various risk factors mentioned, participant organizations also reported a number of protective factors such as children living in a consistently safe and nurturing environment at home, in the community and in trauma treatment centers; having supportive individual, school and social activities, for example therapeutic activities, life orientation lessons, assertiveness training and informal support groups.



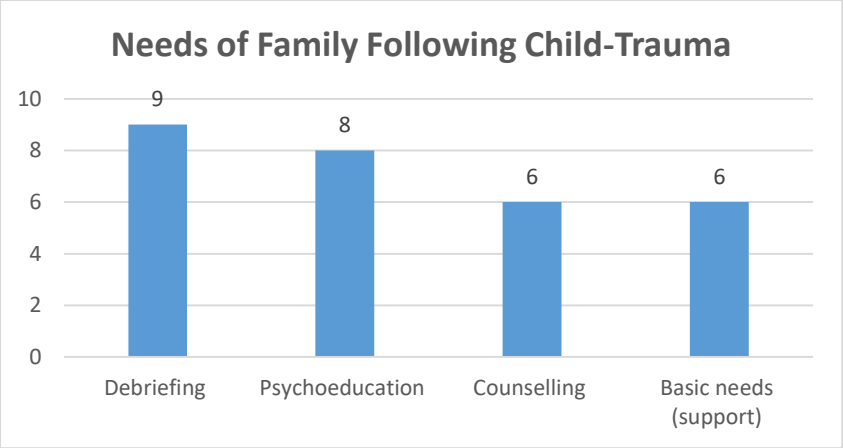
Graph 4.8: Risk Factors Affecting Recovery from Trauma



Graph 4.9: Protective Factors Affecting Recovery from Trauma

It was also important to explore the needs of the children's caregivers, following child-trauma exposure. Several needs were identified by the participants, and this included the lack of adequate debriefing interventions in order for the staff to cope with the nature of their work, considering that some of the staff members have unresolved trauma histories. *"Seldom mothers* (housemothers/staff) *spend time together in meetings or discussions in which they could share their own painful experiences"* (Lay Counsellor/Assistant Supervisor). Failure to deal with previous experiences of trauma exposure can prevent the caregiver/parent from providing the necessary support to affected children as echoed by Fulu et al. (2017). Along with debriefing, majority of the caregivers indicated the need for psychoeducation on how to understand and

deal with children's traumas in order for the service providers to enhance the efficacy of their work. Lack of individual counselling/therapy and resource constraints, particularly, the provision for basic needs and material support such as shelter were also reported by the participants**.** *"Provision of shelter is currently lacking which forces families to remain in abusive relationships, especially in cases of intimate partner violence"* (Manager). In some instances of such material poverty, for example, a caregiver/parent would fail to prioritize parental responsibilities by choosing a partner over her children. Another participant reported that, caregivers are unable to spend quality time with the children at home, as they work long distances from home, leaving their children for extended hours without adult supervision in order to seek better financial opportunities. *"Employers should give the parents time-off from work to develop quality parent-child relationships and promote family restoration".* However, the service providers' support is seen by the participants as *"not recognizing their (*caregivers*) reality"* (Auxiliary Social Worker/Housemother).



Graph 4.10: Needs of the Family Following Child Exposure to Trauma

4.4 Therapeutic Services Offered to Clients

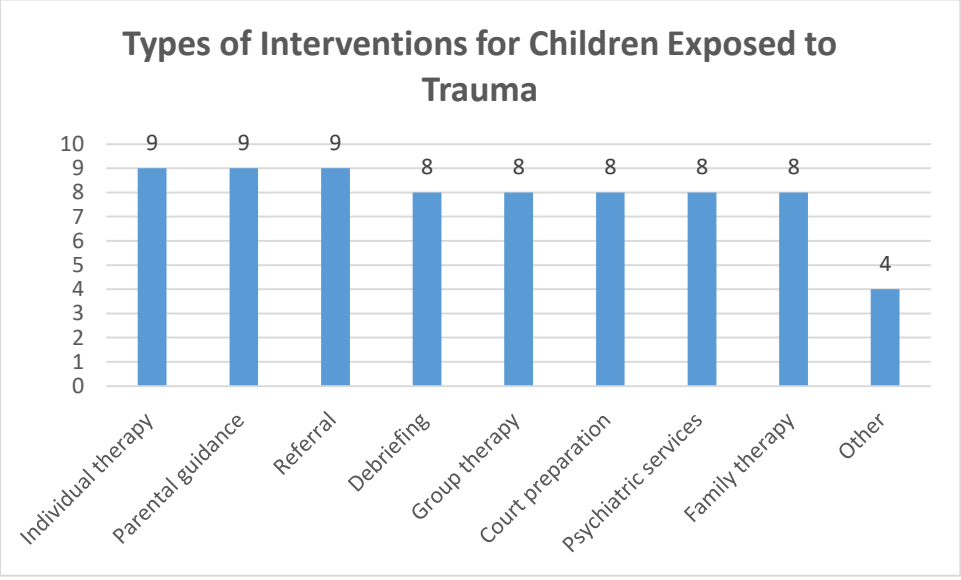
4.4.1 Types of Interventions and Theoretical Frameworks Employed

Graph 4.11 outlines the types of interventions that are most frequently offered by the participating organizations to children exposed to trauma. From the study findings, there were no onsite psychologist and/or psychiatrist. Treatment interventions for trauma-exposed children are limited in disadvantaged communities like Mamelodi. One respondent explained*: "We do not use therapeutic interventions due to lack of professionals. Instead, we make use of*

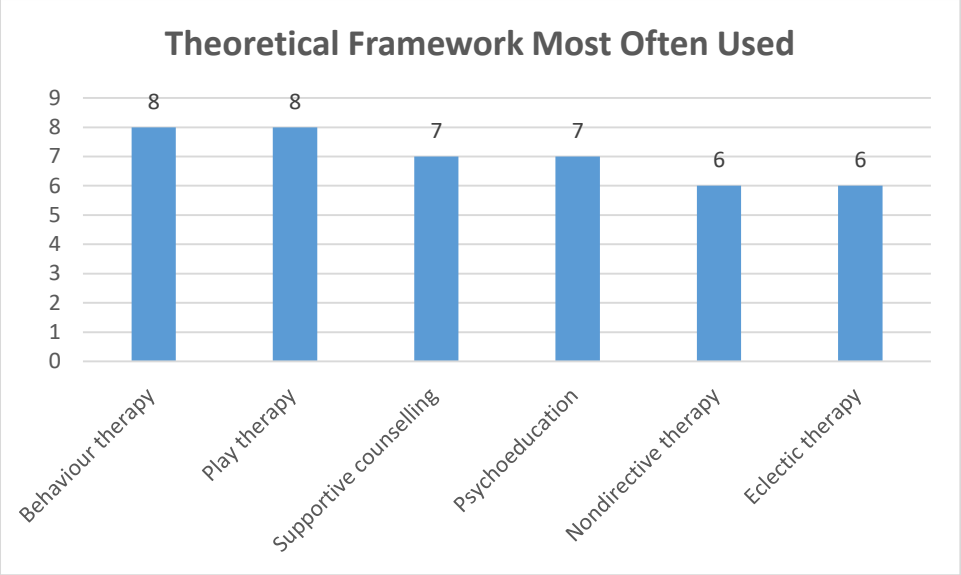
semi-skilled professionals" (Nurse/Executive Director). Only two participants reported offering trauma-focused therapeutic interventions. In cases of spiritual counselling and where the child has no identifiable spiritual connection or association with any church, *"the nearest Salvation Army church is contacted for spiritual counselling"* as stated by a church minister.

The most frequently reported interventions were general individual counselling, parental/caregiver guidance and client referrals for instance to the police, hospital, psychiatrist, etc. Other interventions offered by the organizations included debriefing sessions and court appearance preparations, particularly for sexual abuse cases. In attempts to ease the high caseloads, the organizations also draw on the assistance of semi-skilled volunteers who run non-clinical group activities, where group members get together weekly or bi-weekly to share experiences with one another.

The theoretical framework most often used with these cases, ranged from behaviour modification type of therapy, play therapy, supportive counseling, nondirective therapy, eclectic and psychoeducation (see graph 4.12).



Graph 4.11: Types of Interventions Provided for Children Exposed to Trauma



Graph 4.12: Theoretical Frameworks Employed in the Interventions

In terms of the use of evidenced-based trauma-focused treatment models, only three of the respondents reported that they follow evidence-based therapeutic approaches. Those three respondents mentioned that their treatment centers use cognitive behavioral therapy and play therapy, art therapy, and music therapy. The lack of evidence-based therapy is potentially linked to the lack of training in trauma interventions, hence the use for lay counsellors.

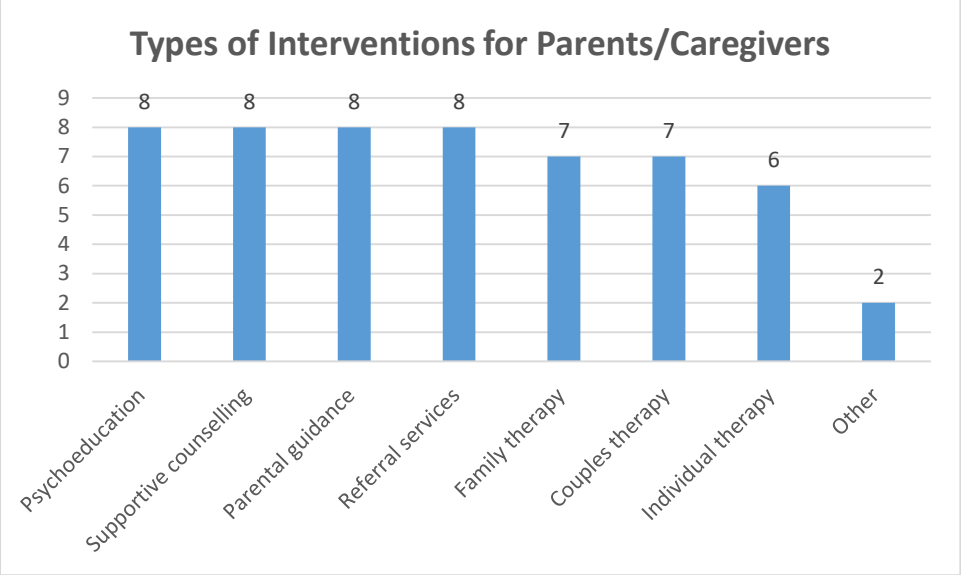
4.4.2 Dropout Rates of Clients

Dropout rates and patterns of clients before proper termination of therapy varied between organizations. About half of the respondents reported high dropout rates of about 80%, where 40% and above is considered high dropout. One Social Worker noted, "*It is very rare for children to complete therapy*". Reasons given by the participants for the dropping out of therapy were a combination of pragmatic concerns such as financial constraints that are for instance impacting on caregivers'/parents' ability to provide adequate food and affecting transportation costs, preventing children from getting to the treatment facilities. Other issues brought up with regard to the drop out of clients is that there is a lack of involvement and commitment from caregivers/parents, there is a fear of separating the family by disclosing the abuse, and possibly, there is a lack of value placed on 'free services'. One participant indicated, *"There is no real (drop-out) pattern. Some children drop out in the beginning, some after a few sessions. We find this baffling, might be due to the services being free"* (Lay Counsellor/Manager). Two other participants explained that, *"some children do not want to be*

helped no matter how and what you try to do for them" (Auxiliary Social Worker/Housemother). Another participant commented*, "Children drop out due to transport issues and lack of food"* (Lay Counsellor/Assistant Supervisor). A Social Worker noted that their organization reported very low dropout rates, stating that "*children love coming*". The social worker alluded this to the caregivers' commitment to the process.

4.4.3 Treatment for Parents/Caregivers

Almost all the participant organizations generally reported that they provided some form of treatment interventions for caregivers/parents and that there is a real need to have specialized types of trauma interventions for caregivers/parents. Interventions offered by the sampled organizations are illustrated in graph 4.13 below. Eight (8) of the organizations reported that they offer supportive counselling to caregivers/parents that have histories of previous trauma. However, only three (3) organizations were reported to assess parents' trauma histories using standardized assessment measures. These services are mostly inaccessible to many of the caregivers/parents. One organization for instance, primarily offers telephonic counselling services to caregivers/parents in order to reduce transportation costs. Walk-in services are per appointment only. A social worker explained that despite the availability of these caregiver/parent interventions, the high caseloads overwhelm the professional staff. They felt that they were unable to offer caregivers/parents the support services they needed. *"Services can be available, however, due to heavy caseloads and not enough trained people, we are unable to help everyone".* A Church Minister also reiterated the lack of treatment interventions for caregivers/parents: *"even where services are accessible, most people* (caregivers/parents) *don't know about them. When unable to help* (offer supportive counselling), *we suggest to them to contact the minister of the church that the person belongs to".*



Graph 4.13: Types of Interventions Provided for Parents/Caregivers

4.4.4 Effectiveness of Therapy

Only three (3) of the respondents reported having some form of standardized or systematic approaches to routinely evaluate the impact of services on children's functioning. These approaches are mostly made up of a formulation of relevant questions. Most of the respondents reported to be using intervention methods that are unscientifically evaluated, for example, informally observing if the behaviour of the child has changed or even just asking how the client feels.

Four (4) of the organizations rated their therapeutic services as very effective, two (2) rated them as effective, four (4) rated them as in between and one (1) organization provided no response to this question. In terms of the changes they observe following the therapeutic services provided, eight (8) respondents from the organizations reported improved physical health, improved schoolwork, improved relationships, emotional and behaviour change. In terms of the effect of the intervention on the family and broader community, some respondents reported a good effect, while others were unsure as this is difficult to determine. Regarding the percentage of clients' return for follow up after their therapy is terminated, this ranged from 0% to 70%.

Respondents were asked to describe a case that they felt exceptionally proud of. Respondents generally described cases where clients could express themselves and thus improved in their communication; where there was a remarkable change in behaviour; where the school marks

improved; and even reconciliation resulted in the family. They also described how the client responded to the therapy by wanting to give back to the community. Respondents' narratives on therapeutic treatment effectiveness and outcomes are illustrated in the following quotes. *"It was a 9-year-old boy, he didn't talk to anyone, not even to his mother. We (lay counsellor and boy) sat with clay and he (boy) made statue-looking like cows continuously. After 4-5 sessions, he made a bigger statue with a penis looking-like object…actually like a sword behind a smaller statue. The big statue ended up being the perpetrator and the boy the smaller animal. It was a case of sexual assault and the art therapy helped him demonstrate what had happened and to eventually talk about it"* (Lay Counsellor/Clinic Manager).

"She was a street child, who was abused by the mother's husband. She was placed with us after she was removed from a previous place of safety. She successfully completed matric with the help of an aftercare program and enrolled into a paramedic course. She wants to help other children and give back to the community" (Social Worker).

"A grade 1 child lost his father a year ago. The school wanted to send him to (psychiatric hospital) because he was preoccupied with rolling sticks. The child blames his mother for his dad's death. The child was also stressed in school. The sticks seemed to be his way of coping with the loss. The mother had a new baby and he (child) felt left out. The death trauma was never properly dealt with. After several weeks of therapy, his school performance improved incredibly" (Social Worker).

"This small child was eating out of bins at railway stations. People took him in and he was sodomized by older boys who are not going to school. A domestic worker took him into the city to care for him but lost him. Child welfare found him sitting in front of a zoo in a terrible condition. He had to undergo three operations because of severe sodomy. Volunteer doctors operated on him. He had terrible nightmares, he was bedwetting and masturbating at age 8. He was taken to (name of psychiatric hospital) for medication. He was later admitted into (name of) community pediatric healthcare centre, nobody was interested in him as no family member looked for him or visited him. A gay couple started visiting him, taking him out for a day and later for weekends. The couple also started horse-riding with him. He (child) was receiving occupational therapy as well. He (child) is still in (the name of) a community pediatric health centre, 19 years old and in grade 10. The court order is extended up until he (child) finishes school at age 21. The couple's interest in the boy made a massive difference in

his (child) *life – they validate him. His school performance and behavior has changed"* (Social Worker).

4.4.5 Challenges Faced by the Service Providers

The graph below illustrates the frequencies of various challenges faced by organizations in providing services to children who are exposed to trauma. The most commonly reported challenges are related to human resource components, such as the lack of staff, inadequate staff training, staff being traumatized by vicarious cases they are presented with and a high staff turnover.

Graph 4.14: Challenges Faced by Organisations Providing Services to Trauma-Exposed Children

Despite the positive therapeutic outcomes listed above, respondents reported several challenging areas scaling up child treatment ineffectiveness. These are briefly outlined below.

In all the eleven survey interviews, respondents repeatedly expressed concern over the serious lack of trained personnel, as a result, contributing to high caseloads and long waiting lists of children awaiting to receive psychological interventions. In the meantime, urgent crises present, further interrupting and delaying services to those already waiting for assistance. *"The waiting period can take months before the children are treated"* (Nurse/Executive Director). *Another respondent commented, "Home violence especially takes even years before it's reported…most times when a woman reaches breaking point"* (Church Minister). A lay counsellor/assistant supervisor highlighted the ineffective record keeping system that negatively impacts on service delivery, *"We need a proper working system to follow through with all pending cases. Otherwise many of the children are never seen".*

When it comes to referrals, these are often poorly integrated and only considered when children present with severe behaviour and emotional difficulties or when there's a sequel of abuse reported and/or suspected. "*Sometimes it's not so clear to all involved what needs to happen when working with children affected by abuse*" (Social Worker). Respondents also faced challenges with the number of available rehabilitation centers, where respondents generally reported that there were limited spaces in rehabilitation centers especially for child victims of abuse and that a real need exists to increase the number of spaces available to violence and trauma affected children.

Another barrier was with the justice system that takes a very long time to resolve cases. This can result in the arising of several issues such as that the client is unable to remember clear details of the incident or the client remaining in an unsafe environment and possibly face re-victimization.

Another challenge felt throughout was the language barrier experienced by most of the health professionals working with children from different cultural backgrounds. This is despite that children can express themselves in different languages during counselling sessions.

Respondents were also asked to narrate challenging cases they had experienced. These cases often resulted in the therapist/counsellor feeling hopelessness as some clients appeared as though they don't recognize their need for help.

"This case is a referral from school. It's a mother with three kids…2 girls and a boy. They live in a one roomed shack. The mother gambles with her children for money, the children are raped continuously and the mother has mental issues. The children are removed but they keep running back to the mother. It was ruled that the kids go back home. The one child fell pregnant, HIV infected and pregnant" (Social Worker).

"This is a pending case of abandonment and neglect. An unemployed mother of three children abandons her children for long hours without any adult supervision. Sometimes they sleep by themselves. The primary school going child is the current care provider for the two preschoolers. The social workers cannot remove the children because the case is not severe enough. The social worker has been working with the mother of the children but there has been no permanent change. Our (name of organization) provides food and support to the children by visiting them once a week" (Social Worker/CEO).

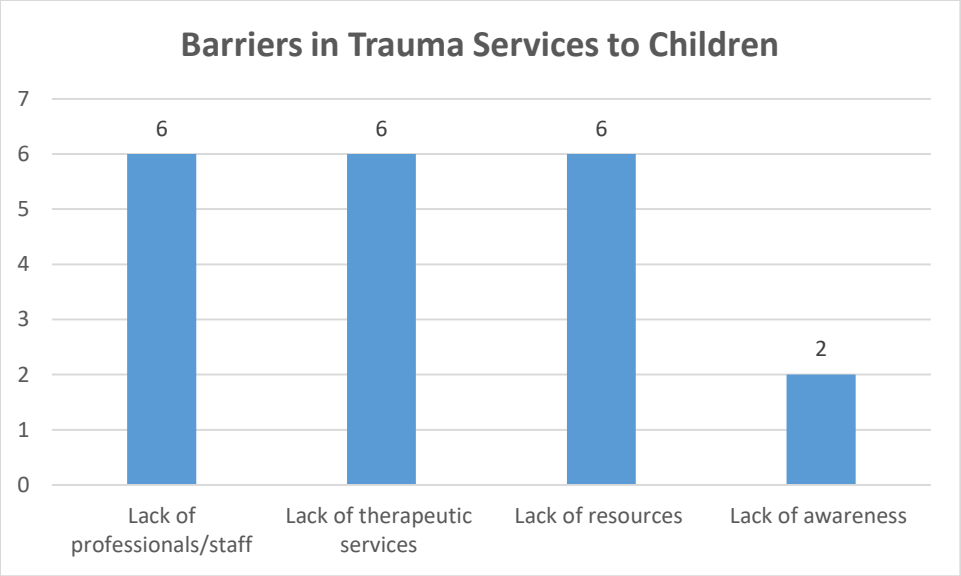
"This child was removed from his parents when he was very young because of physical and emotional abuse. He was placed into (name of a children's home). At age 5, he was noticed by a childless couple who visited him and worked well with him. They (couple) loved him and took care of him. The child later started high school and became part of a small gang. The foster home became a war zone as he (child) also started smoking dagga. The foster mother (with bipolar mood disorder) couldn't take it anymore, the couple felt he (child) was ungrateful" (Social Worker/Village Director).

4.4.6 Staff Capabilities, Support and Service Coordination

Six of the respondents reported that staff members in their organization had specialized training in trauma and trauma interventions. They have routine discussions or in-service training on trauma-related topics. Five respondents reported access to a mental health specialist in childhood trauma. Nine of the respondents reported that there is continuous supervision and ongoing debriefing available to the staff; eight of those respondents reported that the supervision time is used to help staff members understand their own stress reactions. Furthermore, seven respondents reported that there is training and supervision available to reduce the impact of vicarious trauma. Lastly, nine respondents reported that staff development and retention is of importance in their organization. The organizations thus assist the staff to deliver therapeutic services to clients who experience trauma.

Service coordination relates to the external linking of services between organizations in order to provide a better integrated service for the client. With regards to this, eight respondents agreed that their organization encourages the staff to have regular contact with other organizations, working with the same family. Nine respondents agreed that the different service providers work together to provide an integrated service for children and families. Eight respondents reported that their staff participates in joint meetings or case consultation with other service providers.

Respondents were then asked to identify the gaps or barriers in service provision for children exposed to violence and trauma in their community. The most important barriers identified were a lack of personnel, therapeutic services, resources and awareness about the services (see graph 4.15).



Graph 4.15: Barriers in Trauma Services Offered to Children

When asked about the availability of trauma treatment for children in the community, nine respondents reported a lack of availability. Seven respondents reported that families do not have easy access to trauma treatment. When asked how services for children experiencing trauma can be improved, respondents reported that the following aspects need to be addressed: the lack of awareness about trauma services, the skills level of the staff, and financial support.

Respondents were also asked what a successful therapeutic programme for traumatized children would entail. The following themes emerged: (1) a sense of safety and security should be created; (2) effective therapeutic techniques should be employed; (3) and more staff should be available to assist the vast number of cases (see table 4.5).

The last question for respondents was to express their opinions why so many children are exposed to different kinds of violence in this community and what do they think puts children at greatest risk (see table 4.6). The themes that emerged spoke of a (1) societal decay, where there is a decline in morality and a general increase in violence, placing children in dangerous situations. Another theme was that of (2) unemployment and poverty, which results in a 'continuous struggle' or perpetual cycles of children being in vulnerable situations. Another theme relates to (3) poor parenting. Most of the respondents alluded the vulnerability of children to poor parental skills, where parents are unable to guide and support their children effectively to navigate the complex societal demands. (4) Substance abuse was also identified as a major problem affecting the community, in turn putting children at risk of experiencing violence. Lastly, respondents identified (5) an absence of good role models in the community, leading to a small number of people who can guide and assist children effectively so they can be protected.

Although the general feeling of most respondents is that of despondency when it comes to child violence and trauma, they agreed on what may work well and possibly serve as mitigating factors that may enhance the psychological adjustment of trauma-exposed children. Some of the protective factors (see table 4.7) mentioned by the respondents include:

1. *The establishment of a safe and secure environment.* This relates to creating a space where children are encouraged to open up about the traumas. To take it a step further, some measures should be in place to ensure the safety of children around adults. Therefore, care should be taken to work with the family as a unit as opposed to focusing solely on the child.
2. *Individual therapy.* To encourage and enable the expression of emotions and narrative telling. This will also contribute towards fostering a safe and secure environment for the child to process the trauma.
3. *Activities that encourage social support.* There are various activities, particularly in the school context that can aid as a protective factor through fostering social support for the child. These can include informal support groups and participation in extra

mural activities, where children can find a place to build their self-confidence as well as relationships that may assist in building their resilience.

4. *Positive parenting practices.* Parents that create a relationship with their children in which there is warmth, comfort and nurturance foster resilience in their child. Assertive caregivers/parents with healthy boundaries also facilitate the child to develop other healthy relationships.
5. *Changing of social norms in relation to the accepted culture of violence in South Africa.* When caregivers/parents change their attitudes towards domestic/intimate partner violence, in that they no longer view the behaviour as acceptable and take appropriate action, children are also more likely to speak out and ask for help.

While these may serve as resilient factors, a church minister expressed concern over whether *"these children will ever recover because different situations trigger different emotions".*

Table 4.7: Factors that Influence the Outcome of Treatment of Trauma

Risk Factors	Frequency	Protective Factors	Frequency
Poor Parenting Practices: neglect, lack of attention, poor parental supervision, poor attachments, dysfunctional and unstable families, low self-esteem,	11	**Safe and Secure Environment:** encourage children to talk about the traumas, children to be around safe adults, work with the family as a unit and not only the child.	7
Unemployment and Poverty: lack of money, financial pressure, poor education, poor housing (living in informal settlements), dangerous surroundings "*deprivation trap*"	11	**Individual Therapy** to encourage and enable expression of emotions and narrative telling.	7
Societal and Moral Decay: violent culture, apartheid, violence is the new normal, lack of ethical principles, fraud, theft, bribery, human trafficking, opportunistic people taking advantage of vulnerable children, lack of trust in the law enforcement and judiciary systems.	11	**Social Supportive Activities:** creating supportive school environments (i.e. Life Orientation classes); socialisation of same-aged peers; informal support groups and participation in extra-mural activities (children act out roles, build their self-esteem), encourage diary/journal writing.	7
Children's Lack of Trust in Adults to protect and keep them safe	6	**Positive Parenting Practices:** warmth, comfort and nurturance, assertive caregivers/parents (healthy relationships).	6
Substance Abuse Drugs: alcohol and drug abuse (both parents and children), poor school attendance and performance as a result.	5	**Changing social norms:** caregivers/parents change in attitudes towards domestic/intimate partner violence.	5
Absence of Good Role Models: role models behave inappropriately to achieve their goals, parents changing life partners, children mimicking bad behaviour.	4		
Negative attitudes: caregivers/parents display negative attitudes towards exposed children, causing further harm.	4		

4.5 Conclusion

The current study set out to present the analysis of participants' perspectives on psychosocial resources available for violence and trauma-exposed children in Mamelodi. It appears that this area is rife in terms of the forms of violence perpetrated against children. Exposures to and experiences of different forms of violence (physical, sexual, psychological and emotional) are reported to be widespread in the lives of children living in Mamelodi. Many risk factors for violence against disadvantaged township children are prevalent. The consequential effects to violence and trauma exposure is associated with a range of negative mental health outcomes for children and their caregivers/parents. Existing organizations are providing the best service that they can, using interventions that are not evidence-based and the effectiveness is not evaluated scientifically. This study suggests that very few psychology-based mental health services are accessible in any healthcare organization, particularly within community-based institutions. Available interventions are often inadequate and inaccessible. Parents cannot afford transport costs for children to attend sessions. This reinforces the serious lack of mental healthcare services to prevent and/or reduce children's exposure and vulnerability to violence leading to trauma reactions. The findings also allude to the importance of training more specialized and community mental health professionals as a strategy to narrow the intervention treatment gap. Appropriate community-based interventions that are more readily available, accessible, responsive and sensitive to socio-cultural issues may need to be considered.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

In this chapter the results of this situational analysis of participants' perspectives on violence, childhood trauma and the availability of treatment are discussed. First, the discussion focuses on rates and types of violence exposure and abuse and available treatment in the Mamelodi community. These findings are considered in the light of the existing literature on child-trauma interventions. The findings are then considered in terms of the strengths and limitations of the study. The chapter concludes with suggested recommendations for future services for children exposed to trauma.

5.1 Children Exposed to Violence and Trauma

Participants reported a high prevalence of violence exposure in the community of Mamelodi Township, with frequent exposure in sexual and physical abuse and the witnessing of domestic and community violence. Cases of verbal and emotional abuse, neglect and abandonment were also reported. The high levels of violence exposure are comparable to figures reported in studies in South Africa on the magnitude of violence against children in their everyday lives (Mathews & Benvenuti, 2014; Meinck, et al., 2016; Richter et al., 2018; Stansfeld et al., 2017). The high violence-related caseload in this study site might be linked to the fact that the participating service providers serve a population of children from low socio-economic communities, in which the risk for violence exposure may be particularly acute (Richter et al., 2018).

5.2 Presenting Symptoms and Impact of Trauma Exposure on Children and Families

The present study and official reports revealed that violence and trauma exposed children may present with depressive and anxiety symptoms (Jewkes et al., 2010), PTSD symptoms (Fairbank & Fairbank, 2009), suicidality and self-injurious behaviour (Bruwer et al., 2014; McReynolds & Wasserman, 2011), externalizing behaviour problems (Muller et al., 2013), somatization (Nickel & Egle, 2006) and dissociative disorders (Silvern & Griese, 2012). They

are also at greater risk of experiencing attachment problems (Cook et al., 2005; Lanius & Vermetten, 2010) and emotional difficulties (Kaminer & Eagle, 2010).

Data from the study further indicate that some violence-exposed children tend to display poor interpersonal and social functioning skills; they can bully others or behave violently, at times even towards the organization staff members and the caregivers. As demonstrated in other studies, violent behaviour is common during primary school years and the risk of rage and aggression rises in adolescence, especially in children with a history of childhood physical abuse (Richter et al., 2018). Moreover, the study shows that exposed children can become socially withdrawn and non-communicative, over-compliant or defiant, intolerant and manipulative. They can also display poor self-care. These behavioural difficulties were also associated with lying, theft, substance abuse, sexualized behaviour, cutting and suicidality. In some instances, the affected children were reported to be pregnant and suffering from HIV/AIDS infections. The findings further revealed that trauma-related stress levels manifests as abrupt mood changes, frequent sleep disturbances/nightmares, bedwetting and somatic symptoms, i.e. stomach and headaches. These findings seems broadly in line with the literature from other South African studies on violence exposure and mental health of children (Kaminer & Eagle, 2010; Richter et al., 2018; Stansfeld et al., 2017).

Exposed children's resistance to talking about the traumas is supported by several factors. These are:

- The absence and inability of parents to regulate children's fearful emotions;
- Cultural differences in understanding, experiencing and processing of trauma;
- Fear of exposing the perpetrator and the children's lack of trust in people and the world as potentially dangerous and help as unavailable (Bowlby, 1980).

It is worth noting, that untreated trauma can have long-term effects on adult life transitions, roles and taking responsibility of children, becoming neglectful, absent and/or abusive parents (Bowlby, 1980; Mathews & Benvenuti, 2014). This can consequently create an intergenerational cycle of violence and poor mental functioning (McDougall & Vaillancourt, 2015).

Shared effects of violence and trauma on the child and family were reported to include emotional suffering, denial of the violent act and perpetrator anger towards the child. The study data shows that caregivers/parents often lack trust in the social and legal frameworks obligated to protect children even from inside their families (Jamieson et al., 2018). As a result, the caregivers/parents feel that reporting of abuse cases is a futile and time consuming responsibility that often lead to poor outcomes of family separations and relationship break-ups.

5.3 Availability, Accessibility and Effectiveness of Interventions

5.3.1 Sources and Types of Treatment Interventions

The results of this situational study indicate that short-term psychosocial services were the commonly used forms of interventions. The bulk of the early intervention programmes for children and families already affected by trauma and violence were delivered by NGO/NPOs rather than by the state, specifically, social workers, social auxiliary workers and lay counsellors. Social workers are professionals with child trauma and child therapy specializations, often working with high caseloads on inadequate funding resources. None of the participating organizations provided in-house specialist mental health services for violence exposed children. Psychologists and psychiatrists utilized by the organizations are employed on a consultation and/or voluntary basis. This reflects the overall scarcity of mental health specialists in the public health sector (Flisher et al., 2012; Petersen et al., 2009). Child-trauma intervention services are perceived as a component of general mental health services and not a specialized field (Kleintjies, Lund, Swartz, Flisher, & MHaPP, 2010).

From the findings, spiritual counselling was deemed as an accessible avenue of service provision for violence and trauma affected children. Consistent with other findings, spiritual connectedness can serve as a source of comfort, guidance and direction, reinforcing the protective capacity of religion in enabling the development of a solid sense of self (Peres, Moreira-Almeida, Nasello, & Koenig, 2007). This illustrates the usefulness of integrating non-clinical child-focused programmes in other sectors which have a role to play in child and adolescent health and wellbeing (Patel et al., 2008; WHO, 2005).

Moreover, if semi-skilled health workers (such as social auxiliary workers, community health workers and pastors) are afforded the opportunity to be equipped with basic counselling skills, adequate training, support and supervision, they can impact on positive outcomes for children (Jamieson et al., 2018). The idea of using mental health specialists in training and supervisory roles for general health workers has long been proposed by several researchers (Mkhize et al. 2004; Saraceno, Van Ommeren, Batniji, & Cohen, 2007).

5.3.2 Modalities and Assessments Employed in the Treatment of Trauma

In their response to addressing long-term consequences of traumatic exposure, only three NGO/NPOs with assistance of highly trained social workers and psychologists incorporated specialized treatment modalities in their treatment of children. They used specifically trauma-focused CBT (Lieberman et al., 2011), group therapy (Pretorius & Pfeifer, 2010), play, art, and music therapies with children in their early and middle-childhood (Lebowitz-Levy, 2005). Kekae-Moletsane (2006) and McDermont (2005) advocated for the incorporation and integration of traditional play and cultural symbolism and practices to accommodate the 'self' in context of the child. Playing with objects representing the trauma was demonstrated in one of the participants' narratives of a sexual abuse case. The majority of the organizations make use of individual therapy and the referral system that relies on months and sometimes years of children waiting before receiving trauma intervention. In addition, most of the organizations utilize interventions that are not particularly evidence-based but seem to offer relief to the affected children such as non-clinical group activities facilitated by lay counsellors or volunteers.

The majority of the organizations did not incorporate specific assessment measures for trauma identification in children. Without a trauma screening process, many children who experienced trauma may slip through the cracks and not receive the necessary treatment. In addition, there were no standardized scales used to assess treatment effectiveness. Service providers considered that the provision for general treatment of affected children were more critical than trauma assessment and measurement to confirm evidence of treatment efficacy. In this study site, evaluation of service effectiveness, included:

- Feedback from the child;
- Collateral sources of information from treating healthcare professionals and teachers;
- Observation, meetings and case-study discussions with healthcare professionals.

The findings therefore advocate for trauma screening tools that incorporate holistic evaluations of trauma exposure and treatment measures. Moreover, investing in effective psychological resources can foster emotionally supportive environments (Kiser & Black, 2005), but may be a resource-intensive activity.

5.3.3 Treatment Services Addressing the Needs of Caregivers/Parents

Given the historical background and ongoing traumas experienced by many marginalized and poor South Africans living in communities with high levels of violence, there is an urgent need for the provision of services for caregivers/parents. The findings revealed that there are limited counselling opportunities and emotional support groups for caregivers/parents. Parental trauma-related distresses can hinder parents' capacity to parent effectively (Fulu et al., 2017). This was echoed in the study findings that flag poor parenting as a risk factor for poor treatment outcomes for children.

The findings revealed that due to limited knowledge in child-trauma, caregivers/parents find it difficult to deal with children displaying problematic behavior and experiencing emotional difficulties. This reinforces the need for staff training in the recognition and provision of information on child trauma and behaviour management for caregivers/parents. Available material of information on child-trauma management need to be shared with caregivers/parents in a way they can understand and use it.

According to the respondents interviewed caregivers/parents need the provision of basic resources such as adequately equipped shelters for women in abusive relationships, because women and children are often abused in the same household. An efficient transportation system is also suggested for the caregivers/parents to reduce transportation costs for parents to attend therapeutic services. In addition, there is a need for the provision of leave from work for the employed caregivers/parents in order to develop and strengthen attachment relationships between the child and his/her parent. As consistently found in literature, secure attachment relationships and supportive parenting practices are the most important predictors of psychological adjustment after a child's exposure to violence (Pat-Horenczyk et al., 2007).

5.3.4 Factors Affecting Children's Exposure to Violence

According to the current study, risk factors that negatively influence children's exposure to violence and trauma included poor parent-child attachments, poverty and unemployment, moral decay, parental substance abuse, the absence of good role models for the children and negative behaviour of caregivers/parents. The participants indicated that the majority of caregivers/parents do not have a source of income and those employed, often work long hours leaving young children unattended and without adult supervision. Mogotlane, Chauke, van Rensburg, Human, Kganakga, (2010) also reported on the lack of adult support and poverty as exposing children to abuse, sexualized behaviour, increased teenage pregnancy and HIV/AIDS, increased school drop-out rates and in violent/criminal activities.

Findings of the current study further suggest that children's exposure to negative environmental stressors reduces their chances for optimal development while increasing the risk of punitive parenting styles and child maltreatment (Krenichyn et al., 2001); parental mental illness (Patel, Flisher, & McGorry, 2007); and dysfunctional families (Kleintjes et al., 2010; Stansfeld et al., 2017). These findings are in line with those of van Rensburg, Human and Moleki (2013) who reported on the importance of consistent and supportive parenting practices in developing and enhancing appropriate coping skills and resiliency in children in the face of adversity.

5.4 Barriers to Health-Seeking Behaviour

While psychological interventions may be beneficial as revealed in the participants' narratives on treatment outcomes, the need for services however exceed available resources. Consequently, exposed children are placed on long waiting-lists as reported by four organizations, thereby creating a huge backlog of unattended cases.

Referral systems are developed and highly encouraged when connecting children and families to relevant treatment services. Referrals are however only considered in critical situations, for instance, in cases of severe psychological maladjustment either through single or multiple traumatization. In addition, follow-up services are poorly adhered to and the dropping-out of therapy rate is high predominantly amongst children living outside of residential care.

Barriers to service provision were further compounded by limited services and long waiting lists. It would appear that the population experiencing trauma do not know the value of services

and therefore they do not seek help. The perception that a "free" service or infrastructure exist did not mean that the service will be utilized by the community. The underutilization of psychological services, especially amongst the black communities is a consistent finding in literature (Ruane, 2010).

This study finding highlights the need for family, societal and economic investments in early prevention and intervention approaches (Hsiao et al., 2017). Developing and strengthening of trauma identification and referral mechanisms would optimize the use of scarce but relevant health services. It would further facilitate the link between child protection and response interventions such as Family Violence, Child Abuse and Sexual Offences Units, therapeutic and social supportive services (Jamieson et al., 2018).

5.5 Barriers to Effective Trauma Therapeutic Services

5.5.1 Funding

The lack of funding was identified to be a significant factor affecting the provision of effective psychosocial services and general mental health treatment. South Africa's apartheid legacy appears to have contributed to the division between those who are able and unable to afford psychological services (Ruane, 2006). As reflected in findings of this study, the funding of services for child welfare organizations was inadequate and this had an impact on the service delivery by the service providers, who rely heavily on local and international donors. Up-to-date, the state has no mechanisms in place for the provision of full cost of funding for child welfare service providers, whether NGO/NPO or state operated (National Association of Welfare Organizations & Non-Governmental Organizations & Others, 2010).

According to DSD (2011), funding allocations also vary from programme to programme and per province. Lack of funding results in not enough trained professionals employed and high caseloads. Unsustainable funding affected organizations' operational costs including the provision for child care in residential and rehabilitative placements. As a result, some children who were abused would typically be assessed by social workers as "not severe enough" to warrant removal of the child from the threatening home environment. The lack of funding may have further contributed to the high staff turnover. The frequent change of healthcare workers

can prevent children from building rapport, developing and sustaining solid and strong relationships with the service providers.

5.5.2 Lack of Staff Knowledge

The lack of staff knowledge on child-trauma interventions and management was another significant barrier to effective trauma therapeutic services. Despite the fact that training and supervision is offered to individual organizations, non-professionals are still employed due to limited funding. The majority of the participants felt that individual counselling and supervisory services of staff members were not prioritized by most of the service providers and some of the government departments such as DSD/DoH.

5.5.3 Lack of Support

Unresolved, inconclusive and pending court cases of abuse appeared to impede the scaling up and efficient use of mental health resources because very few health centers or hospital conduct clinical examinations. For instance, the study revealed that the speed at which the law enforcement and justice system processes investigations and abuse cases is slow as also reported in literature (Burton, Ward, Artz, & Leoschut, 2016; Dawes et al., 2004). These findings are important as they complicate the under reporting of child maltreatment cases (Dawes et al., 2004) and they under-mine child protection advocacy specialists' efforts in creating safety for children exposed to high rates of violence.

5.5.4 Environmental Factors

Individual and social norms were also considered to play a significant role in contributing to high levels of violence exposure against children. This is in reference specifically to the use of physical punishment against children as a disciplinary practice and men's adoption of power and authority in relationships, within the family and communities (Röhrs, 2017). Results of the study suggests that interventions should therefore target and challenge the transformation of patriarchal norms that condone violent behavior towards children. Due to resource constrained environments, it is therefore essential to use community-based interventions in the shifting of social norms reinforcing violence against children.

5.5 Suggested Interventions for Child-Trauma

When considering the findings of the study, participants expressed their need for interventions targeting structural drivers of poverty and unemployment that underpin violence against children in order to lessen the financial burden on caregivers and families. This finding is supported by Mathews et al. (2016) when they addressed interventions from a family perspective. According to Cowie (2011), families and social systems have a role to play in creating safe and secure environments for children by being the source of protection and provision of practical support in children's lives. In strengthening child-focused interventions, the study findings revealed that human resources and service facilities should be adequately provided for to ensure that there is a sufficient number of onsite specialist mental health professionals for effective service delivery and easy accessibility. Patel et al. (2007) suggested that tertiary-level health care workers, lay counsellors, community social workers, school counsellors and law enforcement workers be included in generalist training for the containment, management and referral of child-trauma treatments. Post-training mentorship and clinical support can therefore improve general healthcare workers' willingness to implement these new skills.

According to the participants, there is a substantial shortfall in the provision of therapeutic and translation services in different languages (Lund et al., 2009; Petersen & Lund, 2011). Moreover, psychological interventions should move beyond the confinement of traditional consulting room and integrate non-clinical/non-mainstream therapeutic interventions that are more practical, movement and fun based such as art, drumming and dancing. Participants further highlight their desire for services that demonstrate love, care and trust. Petersen et al. (2009) has called for the setting up of multi-sectoral forums and collaborative engagements to better coordinate and streamline mental health services between state institutions, non-governmental structures, family and community-based organizations, if low and middle income countries (LMIC)s are to achieve health and wellness developmental goals.

5.6 Conclusion

This situational analysis study has provided information on the status of psychosocial services available for violence and trauma-exposed children from the perspectives of a sample of service providers in Mamelodi Township. The findings suggest that children, at least those living in poor and marginalized communities such as Mamelodi Township are exposed to and

experience multiple forms of on-going violence across different settings despite local and international legislatures governing the protection of children from violence and abuse. The participant organizations/service providers identified symptoms they have observed in trauma-exposed children which agree with the literature.

The consequences of violence exposure and/or experience can be detrimental and the effects can be lasting, affecting individuals negatively with growing familial and societal costs. Existing interventions are not easily accessible in communities nor are they effectively utilised. The evidence base on effective intervention programmes and services is limited, making it difficult to draw conclusions on the suitability of existing services (Kaminer & Eagle, 2010; Mathews & Gould, 2017). There is therefore considerable space for the utilisation of inadequately informed interventions to meet the needs of exposed children and their families (Flisher et al., 2012).

There is a call for integrated approaches that shift social norms and gender relations. Preventing violence and treating potential trauma would therefore require both programmatic and clinical interventions (Jamieson et al., 2018). In the context of limited resources as in this study site, systemic structures and contextual factors such as the promoting of positive parenting, family, community and school support can serve as mitigating factors in the development of emotional and behavioural difficulties (Kaminer & Eagle, 2010, UBS Optimus Foundation, 2015). Thereby, reinforcing the value of social capital in protecting the mental health of children against the effects of violence. The impact of poverty on families and schools may however diminish these protective factors (Kaminer & Eagle, 2010), thus contributing to numerous risk factors as identified in this study. In this study, church organisations appeared to facilitate spiritual connectedness, emotional protection/restoration, moral guidance and community coherence in high-violent prone communities. The value of a church space should therefore not be disregarded.

Parenting programmes to prevent violence in low and middle income countries would need to be cost effective, accessible and culturally appropriate as emphasised in this study and in literature (Skeen et al., 2016; WHO, 2014; Ward et al., 2012). Such interventions could be offered by community-based lay counsellors or health workers (Mejia, Calam, & Sanders, 2012). Parenting and family strengthening programmes and the building of positive relationships are deemed essential for both emotional and physical protection of exposed

children. Relevant institutions should also recognise that caregivers are in need of services and support to address their own traumas.

Access to training on child-trauma, and the provision for supportive and supervisory services for participating staff members and relevant institutions are suggested.

The referral system is poorly implemented and coordinated between state-owned child welfare, judicial, and law enforcement systems, NGOs/NPOs, private specialist health professionals, community-based and religious sectors, as well as families in the advancing of safety measures of lowering childhood violence (Jamieson et al., 2018). The fragmented services and responses might be significant contributing factors to the long-waiting periods following violence and trauma exposure. The gap in the funding of services for children is well documented and it remains a grave concern (Abdoll & Mayet 2017; Cornerstone Economic Research, 2018).

5.7 Significance and Limitations of this Study

Currently there is minimal research addressing mental health services in high violent contexts. A few studies in South Africa and sub-Saharan countries have examined violence exposure and child mental health services and their outcomes (Skeen et al., 2016). Child-trauma intervention research can therefore broaden understanding of relevant service provision, given the scope and complexity of childhood traumatization in the country. This study broadly identifies the needs and challenges of service providers in relation to psycho-social effects of violence and trauma in children in a specific but typical community. An added strength of this study is that it covers a range of childhood and adolescent years through reports from different service providers.

Exploratory studies such as this one can provide ample and relevant information in addressing psycho-social issues pertaining to violence and trauma. It is worth noting that the process of interpreting textual data might be considered subjective, where the researcher is subjected to her own interpretations, ultimately compromising the validity of the data collected (Silverman, 2012). It was therefore important for the researcher to probe for clarifications and to be self-reflective throughout the interpretation process.

In ensuring the credibility of the study findings, the researchers invested time in understanding the phenomenon under study to make sure the study addresses what it intends to investigate. There were no known personal biases which may have influenced the findings. There was a clear demonstration of the information trail to ensure accurate interpretation of information for transparency.

Whilst purposive sampling ascertained that the study was conducted with informants serving a wide range of children in and/or from high violent communities, concerns are acknowledged regarding the generalizability of findings to other broader populations (Silverman, 2012) as the study included a small population of service providers in a specific area. This study focused on the experiences and perceptions of the service providers and not on the experiences of children or the community. It is thus not possible to give accurate prevalence figures or definite causality of child mental health outcomes because of violence exposure. Data obtained in this study was collected by more than one researcher at different times but during the same six months' period. Although standardized questions were used to ensure uniformity and response formats, this study did not assess for the accuracy or correctness of information provided by the participants.

It would also have been helpful if data was obtained from multiple informants or sources from these organizations such as various staff members or members of other settings and from the children themselves to verify the information given by the service providers. Other methods of data gathering could have strengthened the data such as self-report questionnaires from children, behavioral rating scales and formal reports of the organizations. It is possible that the sampled service providers did not capture all the relevant information. Similarly, respondents' understanding of key psycho-social issues of violence and trauma may have been informed and limited by their own experiences. As a result, there may have been some missing data in the surveys.

While the number of black children is markedly more in the sampled population, the sampling strategy used reflected particular type of service provision offered to South Africa's children in an informal settlement of Mamelodi Township. The focus was on Mamelodi, the results can therefore not be generalized. Because Mamelodi can be seen as a typical community, some of the findings may be relevant in other township areas as well. Moreover, there is no comparison group in this study and all participating organizations were serving children living under adverse poverty and social inequalities; children experiencing multiple violence and trauma in

a variety of settings with or without supportive structures (organizations, family, peers, and schools). In terms of the transferability of the qualitative data, the findings suggest that specific conclusions might not necessarily be drawn beyond the sampled population but lessons can be considered for implementation across other similar settings.

For participants in this study for whom English was a second language, proficiency of some respondents was better than others. Some of the participants may not have been able to accurately express their thoughts and experiences due to language barriers. However, this limitation was catered for by the different researchers' abilities to converse in different languages. The questionnaires were also not translated into and administered in the participants' home languages because the questionnaire were administered with participants of diverse language groups.

5.8 Recommendations for Practice

- While there is growing evidence on the extent, causes, social and economic costs of violence against children in South Africa (Hsiao et al., 2018), there is a need for rigorous child-trauma research and intervention studies to establish grounded and sound theory, supplementing existing data. The research should include evidence-based, culturally appropriate and systematically documented information on treatment models (Kaminer & Eagle, 2010; Lund et al., 2012). There is therefore the need to evaluate the effectiveness of existing mental health services.

- The implementation of current knowledge about interventions and accessibility of services are serious concerns. Mental health specialists particularly psychologists should receive training in multicultural issues to broaden their culture-specific knowledge of the mental health and trauma experience of children from diverse backgrounds. Multilingual communication can be addressed to contextualize relevant therapeutic services. These efforts might improve utilization of mental health services in communities with high levels of violence.

- Clinical service provision for child trauma should be expanded through specialized training in trauma intervention for various service providers such as community health workers, lay counsellors, teachers and church pastors. Additional service providers can

contribute to support of parents/caregivers and local child welfare organizations to provide much needed services for children experiencing trauma.

- Semi-skilled or lay counsellors should be trained to provide trauma counselling for children.

- Mental healthcare providers in general and specifically child services should form collaborative networks to improve the referral process. There is a need to streamline and better coordinate the functioning of organizations in the service provision. For instance, public and private sectors can identify and assist families in low-resourced communities through programmatic interventions and support of informal work in order to improve families' quality of life. This may prove beneficial in enhancing family resilience and children's social capital.

- There is also a need to strengthen identification and management of trauma through staff and caregiver training programmes, counselling support and supervision opportunities to promote their capacity for caregiving. Self-help and/or self-care activities for the staff members and caregivers/parents working with violence and trauma-exposed children should as well be harnessed. It is critical for services to respond to the caregivers'/parents' personal traumas because recollection of their own traumas can hinder effective support for trauma-exposed children (Fulu et al., 2017). Investment in both clinical and non-clinical interventions are thus critical in assisting affected children.

- Programmes that promote positive parent-child relationships and good communication should be made widely available and easily accessible.

- Given the various contexts in which violence occurs, intervention initiatives need to be designed in such a way that they work for local settings for maximum effect (Mathews & Benvenuti, 2014) and should be made widely available (Burton et al., 2016). The latter would contribute to the reduction in transportation costs and time caregivers/parents spent on the road seeking psychological and mental health services.

While this study did not focus on violence prevention, it is still imperative that child protection policymakers and service providers invests in evidence-based child abuse prevention programmes. The legal system should support and reinforce legislative regulations on perpetrators of violence against children (Dawes et al., 2004).

- In light of these findings, violence against children should therefore be a high priority to increase financial investment and funding from government for both prevention and intervention purposes (Abdoll & Mayet 2017; Klynveld Peat Marwick Goerdeler [KPMG], 2016). Interventions should therefore move beyond the mere provision of statutory and moral imperatives to the building of healthy future generations.

5.9 Concluding Summary

Considering the forms of violence perpetrated against children of all age groups, childhood trauma interventions are often unavailable and inaccessible to children in low socio-economic communities. Lack of funding has been identified as a major barrier to the utilization of specialized mental health and trauma services. Despite the funding gap, NGOs/NPOs provide the bulk of the existing services. Not attending to childhood trauma can result in serious psycho-social consequences for the individual, families, the community and even inter-generationally. It can effect families, society and the economy. In effectively addressing trauma and enable healing, responsive services should be holistic and well-coordinated in the prevention of violence and trauma treatment. Such interventions should also recognize that service providers, children and their caregivers/families are in need of support.

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APPENDICES

APPENDIX A: Information Letter and Consent Form

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Humanities
Department of Psychology

Tel: +27 (0) 12-420 2549

Dear Service Provider

RE: RESEARCH ON CHILDREN EXPOSED TO AND AFFECTED BY VIOLENCE

The Departments of Psychology and Social Work are engaged in research on children affected by violence. The forms of violence include children exposed to neglect, physical, emotional and sexual violence, as well as domestic, school and community-based violence. The **aim** is to develop community-based interventions. As a first step in the research, we want to conduct a situational analysis to determine the extent of the problem, current services available, and identify any gaps in the service provision. Since you are involved in providing services in the community, we would appreciate your help in this part of the research and invite you to voluntarily participate in the study. Should you agree to participate in this project, please complete the consent form on the last page of this letter. We will negotiate further involvement with you in the next phases of the research.

Title:

"A situational analysis of psychological services provided for children exposed to and affected by violence and trauma in Mamelodi Township".

Procedures:

- This research will involve an interview or group discussion with therapists at your organization that provides help for children exposed to violence. The focus of the interview will be on the need for services, what services are provided and what services are needed in the community. The interviews will be audio recorded and in written format.
- Time required for the interviews may vary, but is estimated to take a 1-2 hours. The interviews will be held at the service provider's office.
- The study is not an evaluation of your organisation's performance.
- Data is expected to be collected and study completed within the year of 2016.

- Please provide your email address below should your organization be interested to receive an electronic copy of the completed dissertation?

  Email address: ……...

Risks: There are no expected risks for your participation in this study. No physical, emotional or psychological harm is foreseen during or after conducting the study.

Benefits: There are no financial gains in participating in the study. However, you will assist in the development of appropriate psychological interventions for prospective victims of violence.

Rights: Participation in this research is completely voluntary. You are free to ask or request for further clarification about any aspect of the research. You may withdraw from participating at any time without any negative consequences for doing so.

Confidentiality: All information will be treated as confidential. Names of participating individuals and organizations will be kept confidential and not disclosed in any reports emerging from the study.

Data: In line with the University of Pretoria data storage policy, all research materials will be securely locked away and password protected at the University of Pretoria in the Department of Psychology for a period of 15 years. Data collected may be re-used for future research and/or training purposes.

Publication: The results of the study will be reported in the form of a dissertation and may be published in an academic article.

For any enquiries or additional information required, do not hesitate to contact myself or the below research leaders on the contact details provided.

…….

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RESEARCH CONSENT

This letter serves as notification that you have read and retained a copy of the letter of information concerning the research titled: "**A situational analysis of psychological services provided for children exposed to and affected by violence and trauma in Mamelodi Township"**

I, …… (**Full Name and Surname of Participant**), of …… (**Organisation Name**) hereby acknowledge that I have read and I understand the research information as provided by the researcher. I had the opportunity to ask questions about the research. I hereby give consent to participate in this first phase of the research process.

……	……	……..
Name & Surname of Participant	**Signature**	**Date**

THANK YOU FOR AGREEING TO BE PART OF THE STUDY

APPENDIX B: Survey for organizations that provide therapeutic services for children exposed to violence

Survey for organizations that provide therapeutic services for children exposed to violence

Name of the organization					
Your position in the organization	volunteer	Social worker	psychologist	manager	Other ……
Time frame you have been working for this organisation	<2 years	2-5 years	6-10 years	10+ years	
Time frame you have been working in child welfare services	< 2 years	2-5 years	6-10 years	10+ years	
Total case load the past month	……				
Total number of cases the past month in the following categories	total	%males	%females	Typical presenting problems	
Infants and young children(<3years)					
Early childhood (4-6 years)					
Middle childhood (7-12 years)					
Adolescents (13-18 years)					
Young adults (19-15 years)					
Adults (25-60 years)					
Elderly (60+ years)					
Who funds the organization?					

How do people become aware of your services?	

This interview mainly focuses on the therapy you provide to children and adolescents experiencing trauma because of exposure to violence				
What percentage of your child and adolescent clients present with trauma related problems due to violence? **……%**				
Demographics of children and adolescents exposed to violence in your organization	Estimate numbers	%males	%females	
Infants and young children(<3years)				
Pre-school children (4-6 years)				
Middle childhood (7-12 years)				
Adolescents (13-18 years)				

Kind of trauma: **Number** of children and adolescents in your organization in the **past month** that was exposed to:	
sexual abuse	
physical abuse	
exposure to domestic violence in families (between adults, between adults and siblings)	
exposure to community violence (shootings, hijacks, street fights)	
exposure to multiple traumas	
other trauma……..	
Who refers children who have experienced trauma to your organisation (i.e. chain of reaction)? ……	
How long after the incident(s) do they get to your organisation?	

……
Do you have a waiting list for traumatised children exposed to violence in need of help? YES NO SOMETIMES
What is the typical waiting time on the waiting list before they receive help? ……

Needs of children exposed to violence

What psychological effects are most commonly experienced by children who have experienced or being exposed to violence? …… ……
What are the psychological effects of childhood trauma on the family? …… ……
Children have different ways of experiencing trauma. What are some difficulties that they may have in overcoming the trauma? (risk factors) …… ……
What helps children to overcome the trauma (protective factors contributing to resilience)? …… ……
What are the needs of the caregivers/family after the child (ren)'s exposed to violence?

……
……

Service provision

Number of therapists employed/doing sessions at the organization	……
Level of training of the therapists	……
What procedure is followed for children who are in danger/at risk? …… ……	
What is the average number of sessions per child/adolescent trauma client?	……
What kind of psychological interventions are most frequently offered for children exposed to violence? …… …… …… ……	

What theoretical framework is used most often for therapy with children exposed to violence? …… ……
Do you use evidenced-based trauma-focused treatment models that are specifically proven to be effective with children and families? YES NO SOMETIMES
If yes, which evidence-based trauma-focused treatment model is implemented? ……
What % clients drop out of therapy before you feel they are ready to terminate? ……%
Is there a specific drop out pattern? Who drops out? When do they drop out? …… ……

Treatment for parents/caregivers

Do you provide assistance for the (non-offending) parents/caregiver(s) of children exposed to violence?	yes	no	sometimes
If yes, what kind of intervention do you provide for caregivers? …… ……			
In your opinion what help do parents/caregivers of children exposed to trauma need?			

…… ……
Are services for parents/caregivers who experience trauma easily accessible in your community? …… ……

Effectiveness of therapy provided

Do you have standardized and systematic approaches to routinely evaluate the impact of services on clients' functioning?	yes	no		
How do you evaluate the effectiveness of services? …… ……				
How effective do you rate the therapy your organization provides?	Very effective	Effective	In between	Not effective
What changes do you observe in children after therapy? Please give examples …… ……				

…… ……
What is the effect of the intervention on the family and broader community? …….. …… …… ……

What percentage of clients return for follow up after their therapy is terminated?	……..%

What challenges do you/your organisation experience in providing services to children exposed to violence/trauma?

Lack of staff	yes	no	Comments:
Insufficient staff training	yes	no	
Vicarious trauma (staff traumatised)	yes	no	
Insufficient supervision	yes	no	
High staff turnover	yes	no	
Lack of access to evidence-based interventions	yes	no	
Lack of caregiver support for therapy	yes	no	
High client dropout	yes	no	
Communication problems (diverse languages)	yes	no	
Pending court procedures	yes	no	

Other ……

……

Could you tell us about a case you feel exceptionally proud of (without mentioning identifying details)?

……

…… ……
Could you tell us about a very challenging case that you have experienced? …… …… ……

Staff support

Do staff members have specialized training in childhood trauma or trauma informed interventions?	yes	no	some
Do you have routine discussions or in-service training about trauma-related topics?	yes	no	sometimes
Do you have access to a mental health specialist in childhood trauma (on staff or consultant)?	yes	no	sometimes
Is there continuous supervision or debriefing available to the staff?	yes	no	sometimes
Is part of supervision time used to help staff members understand their own stress reactions?	yes	no	sometimes
Do you have training and supervision to reduce the impact of vicarious trauma?	yes	no	sometimes
Is staff development and staff retention priorities in the organization?	yes	no	sometimes

Gaps/barriers in trauma services to children exposed to violence

What are the gaps in service provision for children exposed to violence and trauma in this community? …… …… ……				
Is trauma treatment for children widely available in your community?	Absolutely no	no	yes	Widely available
Do families have easy access to trauma treatment?	Absolutely no	no	yes	Widely available

How can services for children experiencing trauma be improved? …… …… ……
Based on your experience, what would a successful therapeutic programme for traumatised children entail? …… …… ……
Why in your opinion are so many children exposed to different kinds of violence in this community? What do you think puts children at greatest risk?

……
……
……

Thank you.

Are there **other organisations** that you know of that work with children exposed to violence that we should contact to help in this research? Please help us:

Organisation: ……

Contact details: ……

……