CHAPTER 1

1. Introduction

Although studies on posttraumatic stress disorder (PTSD) seem relatively recent, the symptoms of the disorder have been recorded in both clinical and medical literature from as early as the 19th century (Sauter & Franklin, 1998; Terr, 1981). The disorder as a phenomenon itself has been in existence since time immemorial (Trimble, 1981). It was only in the latter part of the 20th century that crucial information about the disorder was beginning to emerge. It was mainly due to lack of knowledge about the source of posttraumatic symptoms that no apparent interest in PTSD was evident.

The clinical symptoms of PTSD have been described for ages long before their aetiology and maintenance were to be clearly understood. As these followed particular traumatic incidents they resulted in a lot of debate as to whether the nature of these symptoms were psychological or physiological. As increasing findings surfaced to the effect that the symptoms followed exposure to a traumatic event and that they resulted from emotional scars following the stressor, the psychological hypothesis was accepted as an appropriate explanation.

At the onset the symptoms of PTSD were hypothesised to have resulted from the organic damage due to head injuries (Trimble, 1981). Trimble (1981) documented a history of PTSD beginning with the advent of railway transportation in the early 1800s as a means of carrying passengers. Physicians were, as a result of a number of railway accidents at the time, faced with a number of casualties with brain damages.

Many of these people were showing signs such as regression and memory loss among others (Erichsen, 1882 cited in Trimble, 1981). These symptoms were subsequently termed the ‘spinal concussion’ since damage to the spine was believed to have been responsible for their manifestation.

With more people being admitted as a result of the accidents, different sets of evidence began to emerge. Erichsen was finding it hard to explain the same symptoms in people who sustained no apparent physical or organic injuries (Trimble, 1981). Debates around the actual origin of posttraumatic symptoms began to predominate. Two opposing views concerning the aetiology of traumatic symptoms emerged out of these debates. One view emphasised the internal organic damage as the source of traumatic symptoms while the other hypothesised the more functional symptoms as a result of fright (Trimble, 1981). The latter hypothesis was, therefore, arguing that external factors were responsible for the manifestation of posttraumatic symptoms.

In keeping with these debates various terms were used to explain the disorder. These included terms such as "shell shock", "traumatic neurosis", "combat fatigue", "rape syndrome", etc. There were also some suggestions that these people were malingering (Trimble, 1981). This occurred after the introduction of the compensation law that allowed victims of train accidents to be compensated for their injuries (Trimble, 1981). For example, Ross (cited in Trimble, 1981) believed that trauma did not lead to neurosis unless some advantage was to be gained. However, as malingering was seen as a conscious, deliberate attempt to gain compensation, the psychoanalyst theorists regarded this as the expression of the unconscious dynamics to fulfil one’s needs (Trimble, 1981).

Psychoanalytic theory also considered the expectation of secondary gain as a motivation. This is considered as the unconsciously suppressed desire for sympathy, attention, revenge, and even masochistic longing (Trimble, 1981). Ferenczi and Abraham (cited in Trimble, 1981), for example, reported that posttraumatic neuroses were never observed in prisoners of war (POW) because they had no advantage to gain. Moreover, since PTSD places responsibility for people's suffering on factors outside of themselves, i.e. factors that they have no control over, it becomes an attractive explanatory model for individuals (Friedman, 1996) by placing responsibility for the symptoms on external factors.

With Freud's original work on 'seduction theory' revisited, these symptoms began to make sense. It became possible to understand the impact of the external stressor on a human psyche. The internal conflicts were nevertheless still considered of primary importance. Therefore, the individual's psychic life was to be considered for traumatic symptoms to be explained. Further theories however, hypothesised the importance of the external stressor. It was through bringing these two extremes together that these symptoms were clearly understood.

Most arguments have, therefore, centred on the aetiology of PTSD as opposed to any other area of it. Numerous hypotheses as to the aetiology of PTSD have ranged from organicity to hysteria and ultimately to exposure to traumatic events (Trimble, 1981). Some of the hypotheses even considered malingering as the explanation while some even suspected the atmospheric pressure from the excess carbon dioxide as a result of battles (Petersen, Prout and Schwarz, 1991). The theoretical explanations of onset and

maintenance of PTSD is very crucial in the understanding of PTSD diagnosis. These help to answer questions as to why trauma survivors manifest different symptoms, why some are affected more than the others and why even more suffer longer than the others (Joseph, Williams & Yule, 1997).

Publication of the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (APA, 1980) marks a turning point in the understanding of PTSD and subsequent treatment of it. This enabled both researchers and clinicians to collect more data regarding the disorder thus allowing even more understanding of the disorder (Wilson & Keane, 1997). Margolin and Gordis (2000: 461) defined PTSD as "a disorder in response to a recognisable, serious stressor that is characterised by specific behaviour falling into the categories of reexperiencing the event, avoidance and psychic numbing, and increased arousal".

It was, therefore, in the DSM-III that the symptoms of PTSD were arranged into three separate categories according to their common characteristics. The three categories were; (1) reexperiencing the event (Criterion B). The victim experiences recurrent and repetitive distressing recollection of the traumatic event, flashbacks (dissociative states in which the person acts or feels as if the traumatic events were recurring) and internal distress on or physiological response to cues. (2) Avoidance of the traumatic memories and psychic numbing (Criterion C). This represents the coping mechanisms the person uses to deal with the above symptoms. (3) Increased arousal, such as difficulty falling or staying asleep, difficulty concentrating and exaggerated startle responses (Criterion D).

Meeting these categories does not, however, guarantee the diagnosis of PTSD. This is mainly because PTSD is defined by the occurrence of the external traumatic event (Bracken, 1998; Joseph et al., 1997; Wilson, 1994). Therefore, in addition to fulfilling the three criteria above, one has to have been exposed to the traumatic event (Criterion A). According to the DSM-III the traumatic event is generally outside the normal range of human experience (APA, 1980). Therefore, the traumatic event will be unusual and unexpected such as an earthquake.

It also emerged from the data collected that not everyone exposed to a traumatic event would eventually develop PTSD (Sauter & Franklin, 1998). There are a number of factors that facilitate the development of PTSD. Factors such as the severity of the traumatic event, number of events experienced, proximity to the scene of violence, whether trauma was natural or man made, etc. are vital in determining the individual's vulnerability or resilience (Wilson, 1994).

Bearing this in mind two more criteria were added to determine the duration of the symptoms (Criterion E) and to measure the level of occupational and social dysfunction as a result of the event (Criterion F). In sum, for an individual to be diagnosed with PTSD, six criterion groups (Criterion A to F) have to be met.

While the psychiatric community celebrated the inclusion of PTSD in the DSM nomenclature, another area was being ignored. It became evident, with more information becoming available, that children were also affected by the traumatic events. Symptoms of PTSD were then seen as universal and present in both adults and children (Bracken, 1998). It also became clear that while children were equally

affected by trauma as adults are, they tended to exhibit different symptoms (Terr, 1979). A lot of information on children's reaction to trauma was available albeit not a subject of interest particularly among researchers.

The publication of DSM-III-R seven years later made an attempt at integrating the children-specific symptoms into the PTSD diagnosis (APA, 1987). However, despite the amount of data available on children's response to trauma very little was included in the manual for the diagnosis of PTSD. Current literature concurs that children react negatively to traumatic events and are more vulnerable to developing posttraumatic symptoms than adults are (Margolin & Gordis, 2000).

Bearing in mind that many children, particularly in the black townships in South Africa, are almost on a daily bases faced with situations that are life-threatening, it is very important to examine the degree to which children may be suffering as a result of exposure to traumatic events. This thesis, therefore, attempts to understand the seriousness of PTSD in township children. This is made possible by looking at the rate of the disorder in the township children. The current thesis also attempts to understand how children in the township react to violence and other traumatic events that they are exposed to on a daily basis.

Generally, the thesis looks at the problems related to research in children and PTSD, the diagnostic difficulties and other methodological problems. Understanding these problems would lead to a much more informed discussion and treatment of PTSD, particularly in children.

Furthermore, the results of this study are discussed in terms of available literature on children's reaction to traumatic events. This is significant in that it would allow most children access to available services such as counselling and other forms of intervention that they have been deprived of as a result of lack of knowledge of their suffering. It is hoped that the results of this paper will add to available knowledge another dimension to the description of PTSD symptoms among traumatised children, especially in the black townships.

1.1 The Description of Post Traumatic Stress Disorder (PTSD)

Following a protracted period in which some people developed a constellation of symptoms resulting from an exposure to life-threatening events, researchers and clinicians noted some similarities in these symptoms thus agreed to classify these symptoms into different categories to formulate the diagnostic criteria for PTSD. It was thought that classifying them into a number of criteria would make it easy to make an accurate diagnosis of the disorder (Joseph et al. 1997).

The American Psychiatric Association belatedly included these criteria in the DSM-III. PTSD was classified under the Anxiety Disorders and was divided into four independent clusters (Criterion A to Criterion D). As with many other psychiatric disorders in the DSM system, symptoms were grouped according to their common characters into clusters and referred to as criteria. For PTSD to be diagnosed therefore, an individual needs to meet all the prescribed criteria.

While this clustering was made in an effort to make diagnosis simple and accurate, Yule et al. (1990) argue that the DSM encourages the making of multiple diagnosis which may increase the amount of co-morbidity. PTSD co-morbidity is thus a main concern prior to making a diagnosis. This will be discussed further elsewhere in this thesis. It is, however, important to provide guidance for the diagnosis of PTSD and the advances that have been made hitherto as far as the diagnosis of PTSD is concerned

Table 1.1: DSM-IV Criteria for PTSD

A. The person has been exposed to a traumatic event in which both the following were present:
   (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to physical integrity of self or others.
   (2) The person's response involved fear, helplessness, or horror. ***Note:*** **In children, this may be expressed instead by disorganised or agitated behaviour**.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. ***Note:*** **In young children, repetitive play may occur in which themes or aspects of the trauma are expressed**.
   (2) Recurrent distressing dreams of the event. ***Note:*** **In children, there may be frightening dreams without recognisable content**.
   (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). ***Note:*** **In young children, trauma specific re-enactment may occur**.
   (4) Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
   (5) Physiological reactivity on exposure to internal or external cues that symbolise an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
   (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.
   (3) Inability to recall an important aspect of the trauma.
   (4) Markedly diminished interest or participation in significant activities.
   (5) Feelings of detachment or estrangement from others.
   (6) Restricted range of affect (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:
   (1) Difficulty falling or staying asleep.
   (2) Irritability or outbursts of anger.
   (3) Difficulty concentration.
   (4) Hypervigilance.
   (5) Exaggerated startle response.

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than one month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than three months.
Chronic: if duration of symptoms is three months or more.

Specify if:
With delayed onset: if onset of symptoms is at least six months after the stressor.

1.2 Trends in the Development of PTSD

The concept of PTSD was primarily derived from studies on traumatised adults (Eth & Pynoos, 1985b). The interest in PTSD was given impetus by the observation of the psychological effects of war on war veterans especially Vietnam veterans and survivors of World War II (Keane, Newman & Orsillo, 1997). It was mainly developed as an attempt to understand apparently strange behaviours exhibited by many veterans when confronted with trauma-linked stimuli (i.e. cues associated with war). Much of the initial emphasis in PTSD research was consequently on combat related stress. This emphasis on combat related studies in relation to PTSD research, therefore, seems to be expected given that the traumatic effects of combat have been documented in the clinical literature for centuries (Hersen & Last, 1990).

It was only in the latter half of the 20th century that the concept of PTSD was formally extended to civilian populations, after similar symptoms were observed in patients who were not war veterans. For example, symptoms of posttraumatic stress were described in victims of natural disasters such as earthquakes (Peterson et al., 1991).

At the same time, the focus of these studies grew to encompass other high-risk groups such as individuals experiencing rape, domestic violence, torture in politically repressive contexts and violent crimes (Cuffe et al., 1998). However, not much research in PTSD was conducted on other groups such as non-clinical samples and children.

Since the formal classification of PTSD symptoms in the DSM-III (APA, 1980) the scientific, clinical and social interest in PTSD has increased dramatically. The interest spread across all areas of trauma and included the effects of trauma on children (Nader, Pynoos, Fairbanks, Al-Ajed and Al-Asfour, 1993).

Consequently, Yule and Williams (1990), Eth and Pynoos (1985a) and Terr (1983), emphasised that children react to extreme trauma as much as adults do. However, there seems to be a consensus within the area of traumatic stress that children do not show the full range of symptoms of PTSD as adults do. Because of the differences in symptom presentation, some writers such as Garmezy and Rutter (cited in Yule & Williams, 1990) argue that the DSM-III-R category of PTSD in its current form cannot be applied to children.

A possible reason for the findings that while children react to extreme trauma to the same extent as adults but present with different symptoms may be due to methodological weaknesses in previous research. One such weakness could be that the scales used to measure PTSD failed to account for developmental factors in young children (Scheeringa, Zeanah, Drell and Larrieu, 1995).

Great thinkers such as Freud (1955), Erickson (1968) and Piaget (1953) theorised different stages of development that people go through as they grow up. While these theorists differ in terms of when these stages begin and end (that is, at what age?) or what behaviour and thought processes constitute each stage, it is important to note that each stage is characterised by behaviours and thought processes that are different from the previous stages.

The later stages are often characterised by behaviour and thought processes that are more advanced than the previous stages. This implies that as the individual moves from one stage to another he/she develops better emotional and cognitive abilities to deal more effectively with the demands of the world around him/her. It further implies that the individual at a higher developmental stage is more capable of coping with and perceiving threat of danger or traumatic incidents.

This may mean that while adults are able to express their subjective experiences due to their more developed cognitive abilities, children find it difficult to do so (Scheeringa et al., 1995). For example, a scale might request that an informant state whether he or she has experienced recurrent disturbing memories of the incident. In this case young children may not have developed sufficient abstract reasoning and thinking to comment on a subjective experience of this nature.

There has, therefore, been a suggestion that alternative criteria should be developed specifically for the diagnosis of PTSD in children (Scheeringa et al., 1995). These criteria should include the use of scales that are behaviour oriented thus focusing less on subjective feelings. These scales would focus on regressive behaviours that are associated with the exposure to traumatic events. This would include for, example, separation and stranger anxiety and the re-enactment of the traumatic event among other symptoms. This takes into consideration that children may not always be able or willing to verbalise their experience. This would in turn make the scale developmentally sensitive and more able to detect PTSD in children (Scheeringa et al., 1995).

Another weakness is that most studies tended to rely on interviews with parents and other caretakers for information on the symptoms of childhood trauma (UNICEF, 1997; Yule & Williams, 1990). Yule and Williams (1990) argue that parents' reports are unreliable as parents may be unwilling to accept that their children are suffering. Accepting this seems to have undesirable implications as it could mean that they have failed to protect their children. Consequently, it has been suggested that interviewing should not rely solely on parents but that children should also be interviewed (Fletcher, 1996; Yule & Williams, 1990). Information obtained from both could therefore be complementary.

Despite these weaknesses, there seems to be encouraging progress in the study of PTSD in general. Data that have been generated from both children and adults responses to trauma have helped professionals to understand the development and maintenance of posttraumatic symptoms more fully (McNally 1991). This understanding has in turn led to even more interest in PTSD research. It has also been made easier to provide a better and more accurate diagnosis of PTSD. This has a significant implication in as far as treatment of PTSD symptoms is concerned.

1.3 Diagnosis and Differential Diagnosis of PTSD

PTSD is one of the most difficult disorders to accurately diagnose for a number of reasons. Firstly, the propensity for PTSD symptoms to co-exist with other disorders (Friedman, 1996). Secondly, the formulation of Criterion A (exposure to traumatic stressor) of the diagnostic criteria of PTSD has been continuously revised in the DSM

system (APA, 1980; APA, 1987; APA, 1994). This indicates the level of frustration imposed by the difficulty in determining what trauma is and the type of trauma leading to the development of PTSD. Thirdly, the presence of traumatic stressor leading to symptoms is not always easy to determine.

Finally, less has been documented on the manifestation of PTSD in children, meaning that their reaction to trauma is not fully understood. It is therefore even more difficult to provide an accurate diagnosis of PTSD in children than in adults. These are discussed in detail below. Although these problems still persist, significant inroads have been made since the classification of PTSD in 1980 with the publication of the DSM-III.

1.3.1 Diagnostic criteria for PTSD

Since the publication of the third edition of the DSM, it has become possible for clinicians to make a better diagnosis of PTSD. This has helped a great deal in enabling clinician to get a better understanding of the disorder and thus providing more efficient treatment. Despite different theoretical hypotheses, the understanding of PTSD has been greatly improved and there seems to be an accord among clinicians and researchers concerning the criteria suggested for the diagnosis of PTSD. This, however, does not mean that there are no problems associated with the diagnosis of PTSD.

Two problem areas are the determination of Criterion A and the inclusion of children-specific symptomatology. The problem with the determination of Criterion A lies

partly with the difficulty in defining trauma. These are discussed further under differential diagnosis. The diagnosis of PTSD is dependent on these two areas. In addition to these two areas, PTSD symptoms are classified into different criteria that must be met for the diagnosis to be made.

Horowitz's (cited in Joseph et al., 1997) two-factor model was very instrumental in the grouping of symptoms into two main clusters: intrusions and denial. Horowitz's information processing approach is based on the hypothesis that individuals possess mental models or schemata of their world and themselves from which they interpret incoming information. "The symptoms observed during stress responses, … involving denials and intrusion, occur as a result of opposite actions of a control system that regulates the incoming information to tolerable doses" (Horowitz cited in Joseph et al. 1997: 73-74).

To date these groupings are still influential in determining the Criteria for B (intrusion) and C (avoidance and numbing). The former stipulates that one should experience either a recurrent and intrusive recollection of the traumatic event, recurrent distressing dreams of the event, feeling of reliving the experience, or psychological and/or physiological distress and reaction upon exposure to trauma linked cues (APA, 1994). The Criterion C indicates that an individual should make efforts to avoid or be unable to recall some information or places associated with the traumatic event (APA, 1994). It appears therefore, that Criterion C symptoms follow as responses to or avoidance of Criterion B symptoms.

With further evidence becoming available, it was noted that some biophysiological reactions also followed the traumatic incident (Perry, Pollard, Blakley, Baker & Vigilante, 1996). These are included in Criterion D. Criterion D states that the individual should experience persistent symptoms of increased arousal. For example, difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and exaggerated startle responses.

Criterion E was also included as a separate Criterion to differentiate PTSD from Acute Stress Disorder. This differentiation is mainly based on 'time frame' with PTSD indicated to be longer lasting (i.e. at least a month). This is an attempt to avoid the possibility of misdiagnosis as these disorders share similar symptom presentation thus allowing clinicians to make a better differentiation. Since PTSD symptoms also cause clinically significant impairment in social, occupational and in other areas of functioning Criterion F was introduced to assess this. It should be noted that for an individual to be diagnosed with PTSD, he or she has to meet all the above Criteria (i.e. Criterion A to D). Criteria E and F should also be considered when making a diagnosis.

1.3.2 Differential diagnosis

Probably one of the greatest obstacles in making a confident and accurate diagnosis of PTSD is co-morbidity. It is reported that 80% of the time these symptoms are accompanied by other psychiatric disorders (Friedman, 1996; Joseph et al., 1997). Such disorders as Major Depression (such as trouble sleeping and trouble concentration), Anxiety (such as fear of recurrence, jumpy/nervous/startles easily,

being upset when thinking of the event and being afraid when thinking of the event) can mask the real PTSD symptoms. In children, one should look at oppositional disorder and so-called school refusal (such symptoms as separation and stranger anxiety) as possible co-morbid disorders. It is therefore imperative for clinicians to differentiate these disorders prior to making a PTSD diagnosis. Friedman (1996) further argues that a protracted sexual abuse may present with personality disorders that could also make a PTSD diagnosis difficult. One of the ways to differentiate PTSD from other disorders is to consider the origin of the disorder.

Unlike other classified psychiatric disorders in the DSM system, the diagnosis of PTSD is dependent on the identification of an etiological event (McNally, 1991). Therefore, for a diagnosis to have been made an individual has to have been exposed to a traumatic event (stressor). In some cases the traumatic event is often difficult to identify thus complicating the diagnosis of PTSD in situations where the stressor is not salient or not reported (such as incest).

A major contention regarding Criterion A has therefore been the definition of what constitutes a traumatic stressor. This is evident in the constant redefinition of the Criterion A in all the DSM publications. The DSM-III (APA, 1980) Criterion A was defined as “a recognisable stressor that would evoke significant symptoms of distress in almost everyone”. This definition was problematic in that it did not take into account the fact that there is a “stress-threshold continuum and [that] a recognisable stressor to one person may not be so to another” (Wilson, 1994: 693). The traumatic stressor may, therefore, not lead to traumatic responses in other people. It, therefore,

became necessary for Criterion A to include a reference to subjective factors since it is how the event is perceived that is important (Joseph et al., 1997).

The development of DSM-III-R made possible this clarification by specifying that stressors associated with the onset of PTSD were external events outside the usual range of human experience (Wilson, 1994). This definition implies that the event should be unfamiliar to the individual experiencing it. It includes experiences such as exposure to combat situations, natural disasters and other man-made acts. Because of this unfamiliarity with the event, an individual's response would be that of helplessness (Freud, 1928 cited in Maclean 1977). The problem with this differentiation was that during the latter half of the 20th century these "unusual" events proliferated with an unprecedented frequency such that it becomes cynical to regard them as unusual or outside the realm of daily hassles.

The DSM-IV subsequently omitted the word unusual contained in the DSM-III-R. This meant that the trauma is not necessarily unusual aspect of human experience (Friedman, 1996). It was further differentiated in both the DSM-III-R and DSM-IV that the person would have been exposed to an event that was physically and psychologically threatening.

Consequently, an individual's response would include fear, helplessness and horror. The stressors associated with the onset of PTSD are, therefore, generally at the extreme end of the stress continuum and that the severity of the event would have a higher probability of producing PTSD or other forms of psychopathology (Wilson, 1994). This raises the problem of identifying which stressor would be more likely to

be perceived as traumatic thus leading to the development of PTSD. This would be made possible by providing the definition of trauma.

While Monahon (1993: 1) simply defines trauma as the "occurrence of the unthinkable", Freud defined it as the extensive breach to the protective layer of the ego against the stimuli. The nature of the traumatic event should be sudden, unpredictable, and life threatening and should involve exposure to grotesque death, personal injury, or injury to others (March, cited in McNally, 1991).

The description of criterion A of PTSD in the DSM-IV states that a person should have been exposed to a traumatic event in which he or she experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or threat to physical integrity of self or others. Furthermore, his or her response to the event would involve fear, helplessness or horror. McNally (cited in Davidson & Foa, 1993) compared different studies with different stressors and observed that in some stressors such as natural disasters and sexual abuse, PTSD as a diagnosis was scarcely made or not made at all. This could mean that the stressor may not have been consistent with criterion A. This implies that the stressors may not have been as sudden, unpredictable, life threatening, etc as they should have been. Or a person may not have reacted helplessly to the traumatic event.

It became evident that some types of stressors were mostly associated with the development of stress disorders than others (Brett, 1993). In addition to the inclusion of the children-specific symptoms in the DSM-III-R, it became necessary for the definition of traumatic stressor to be refined. The important question concerned the

identification of stressors that led to PTSD in children and how the posttraumatic symptoms manifest in children. The DSM-IV (APA, 1994) states that while adults may react with fear, helplessness and horror, children may on the other hand express their reaction by disorganised and agitated behaviour. Instead of having recurrent and intrusive behaviour as adults would, children would re-enact the event in which themes and aspects of the trauma are portrayed through a repetitive play. Children also tend to have frightening dreams without recognisable content.

Since children tend to exhibit PTSD symptoms that are different to that of adults, it is not always easy to make a PTSD diagnosis. The major difficulties in detecting PTSD symptoms in children can be attributed to a lack of knowledge about how symptoms manifest in children (Yule & Williams, 1990). Comparing this problem, many earlier studies had major methodological weaknesses in the identification of PTSD. For example, some studies used screening inventories completed by teachers and parents to identify PTSD and these were not sufficiently sensitive to identifying emotional problems in children (Yule & Udwin, 1991).

Further, the assessment of PTSD in children was limited by the heavy reliance on parental reports (McNally, 1991; Pynoos et al., 1987). Yule and Williams (1990) argue that teachers and parents report far less psychopathology in children than children themselves experience. Parents are also unwilling to acknowledge their children's symptoms due to fear and embarrassment, as parents felt that they had failed to protect their children from harm. They also tended to misinterpret children's numbed silence as fortitude (McNally, 1991).

As PTSD research grew, more understanding of children's reaction to trauma helped to facilitate the recognition of the children's suffering subsequent to exposure to traumatic events. This also facilitated the recognition that children are more vulnerable to traumatic exposure than it was previously accepted (Wilson, 1994). As mentioned previously, in order for the diagnosis of PTSD to be made an individual would have to have been exposed to a traumatic event (Cuffe, et al. 1998). Therefore, it is clear that the traumatic stressor is a crucial aetiological factor in the diagnosis of PTSD.

Since it is crucial to identify a traumatic event for the diagnosis of PTSD, many studies (Dawes, 1992; Hadi & Llabre, 1998; McFarlane, Policansky & Irwin, 1987; Smith & Holford, 1993; Terr, 1979; Yule & Williams, 1990) have focused specifically on individuals who have been exposed to a specific traumatic event. Research on PTSD may be enhanced and further refined by conducting studies in a community sample where a large number of children may have been exposed to specific traumatic events but who may not have reported it. Wilson and Keane (1997) defines a community sample as consisting of people regardless of whether they have sought treatment or not. They further argue that the selection of individuals for this purpose is not based on their exposure status. The present study focuses on a community sample of children as this has been largely neglected.

The focus is on a particular black township in the Vaal Triangle area. There are two reasons for the choice of this area. Firstly, the Vaal Triangle is one of the townships that were badly affected by the spate of violence in the late eighties (1980s). These violent acts included looting of stores, arson, vigilante killings, military and/or police

occupation and detentions. High levels of violence in Sebokeng have caused a considerable disorganisation in the area. A lot of families were significantly affected by this violence and this has been ongoing. The Vaal Triangle has been described as one of the most violent townships in the country (Statistics SA, 1998). Secondly, the researcher is quite familiar with the area as he is a resident there. It was thought that this would facilitate easy access to the targeted sample and would also be cost effective.

1.4 Demographic characteristics of Sebokeng Township

The township of Sebokeng is situated in the Vaal Triangle area a little over 40 kilometres south of Johannesburg. It has a population size of at least 420 000 (Personal communication) (data available from the Metropolitan council is for 1994). The neighbouring townships are Sharpeville, Bophelong and Boipatong. These areas are known for their exposure to extreme political violence that started in the late 1980s. The Vaal Triangle a highly industrialised area surrounded by three big industrial firms. These are Sasol (oil producer), Iscor (steel producer) and Lethaba (electricity producer). As a result of these and many other firms, the area is also known for its high degree of air pollution (Koch, Cooper & Coetzee, 1990). These firms employ most of the people in Sebokeng and the neighbouring areas.

Sebokeng Township is itself surrounded by several newly built townships, the government RDP housing projects and the informal settlements (e.g. Eatonside and Johandeo). Children from these areas (especially in both the government housing sectors and the informal settlements) attend schools in the nearby Sebokeng and

Evaton areas (Stevens, Marshal & Bega, 2000). Sebokeng is divided into different zones that in themselves possess different characteristics. For example some zones are occupied by relatively affluent people while others are characteristically poor. Each zone is very big, probably comprising more than 2000 households. There are on average 5-8 schools in each zone (these include primary and secondary schools). Evaton is one of the older areas in the township and is included as part of the Sebokeng administration. It is therefore included in the study. It is also one of the poor areas in Sebokeng with most of the people living in shacks and mud houses.