

## CHAPTER 2

### 2. Literature Review

#### 2.1 A Brief History of the Concept of PTSD

Although studies on PTSD seem to have proliferated in the last decades (as reflected also in the establishment of the Journal of Traumatic Stress in 1993), the descriptions of posttraumatic symptoms have been reported in medical journals for over a century (Hersen & Last, 1990; Peterson et al., 1991). Terms such as shell shock, war neurosis, combat fatigue, rape syndrome and others have been used to describe these posttraumatic symptoms. This variety of terms reflected the confusion about the development of symptoms of PTSD.

Initially, the main area of contention was the source of symptom development. The perception was that these symptoms were organic and thought to be internal, i.e. resulting from damage to the brain (Hersen & Last, 1990). This is evident from the use of terminology such as “spinal concussion” and “traumatic neuroses”.

In 1882 a London physician, John Erichsen (cited in Trimble, 1981) published his work titled On the Concussion of the Spine: Nervous Shock and other Obscure Injuries of the Nervous System in their Clinical and Medico-Legal Aspects. His work included cases that were brought to him as a result of numerous railway accidents at the time when railway transportation was expanded to ferry passengers. Erichsen was not the first person to report these symptoms but he documented them in a way that

stimulated vigorous debates as to their actual genesis. He also makes it clear in his journal that while many of these cases were organic some victims exhibited similar symptoms even in the absence of any visible organic abnormalities.

An alternative argument to the debate around the presumed organic origin of the disorder was that the symptoms were a result of psychic trauma (Trimble, 1981). Although psychic trauma can be conceived as being internal, it implies a psychological rather than physical or organic aspect of trauma. It was another London physician, Herbert Page who in his critique of Erichsen's accounts, introduced the term 'functional disorders' to describe cases in which no physical causes could be detected (Trimble, 1981).

Page introduced the term 'fright' as an important factor in understanding the development of these symptoms in individuals who had sustained no visible physical and/or organic injuries. Fright is still considered a significant factor in determining the measurement of exposure necessary to fulfil criterion A of the DSM-IV diagnostic criteria for PTSD. Criterion A implies that, an individual would have been exposed to a traumatic event necessary to elicit negative reactions.

While it was acknowledged that the causative events of traumatic symptoms were external (i.e. train accidents), the debate remained as to whether these symptoms were organic or psychological (Trimble, 1981). As more evidence began to emerge (for instance, the same symptomatology was observed in people who had been exposed to war crimes but sustained no physical injuries), the psychological hypothesis was gradually accepted over the organic hypothesis. Consequently, this gradual

acceptance led to psychological theories being hypothesised to understand how these symptoms developed and were maintained.

An example of one psychological theory originates from Freud's concept of psychoanalysis. At the turn of the century when psychoanalysis was influential, most psychiatric disorders were considered to be the result of psychic conflicts occurring as a result of childhood trauma (Trimble, 1981). Symptoms were thus seen as characterising regression and fixation to earlier stages of development such as the oral or anal stages. As a result the posttraumatic symptoms were also described as a consequence of childhood trauma.

In his original 'seduction theory', Freud made an important observation that emphasised the external factors- viz. the actual sexual abuse (Brett, 1993). Clearly, Freud understood the aetiology of traumatic symptoms and this was the first time that the cause of the symptoms was assigned to external stimuli. However, during the time that Freud was theorising, taboos around sexuality may have caused him to swiftly abandon the theory that locates posttraumatic symptoms to the external factors for one that suggests that intrapsychic mechanisms were internal in nature (Wilson, 1994).

Of all the theoretical explanations, perhaps it is the psychoanalytic models of neurosis and symptom formation that have had a considerable influence in the area of traumatic stress. This has been made particularly possible by the formulations made by Sigmund Freud and Otto Fenichel (Brett, 1993). Freud formulated the theory of stimulus barrier, which he later extended to include the defence technique of repetition compulsion. According to his initial model of stimulus barrier, Freud

suggested trauma to be a stimulus that is so intense that it breaks through the stimulus barrier of the ego thus rendering the ego helpless and overwhelmed (Brett, 1993). The stimulus barrier is seen as a shield that modulates the incoming stimuli. Without this barrier the ego is vulnerable.

While this model explained what trauma is and what is perceived as traumatic it was unfortunately insufficient in explaining the development of symptoms following the exposure to traumatic event. This was particularly in relation to recurrent intrusive memories, flashbacks, dreams and nightmares of the event.

Freud then introduced repetition compulsion as a form of defence against the impulses associated with trauma. He regarded the use of this primitive defence as effort to master the impact made by the traumatic event (Brett, 1993). In this way it is like giving a survivor a second chance to face trauma again, only this time well prepared in order to prevent the ego from being overwhelmed (Brett, 1993).

The other important contribution was made by Fenichel who argued that symptoms form when the infantile conflicts are revived through frustration (Brett, 1993). Like Freud, he perceived these symptoms as defensive techniques. However these techniques according to Fenichel are similar to the ones that were in use in the earlier fixation point.

In addition to these infantile conflicts, Fenichel introduced another factor that is important for symptoms to form. This he argued was that the intensity of current frustration (stressor) should be great (Brett, 1993). He further made an important

observation that these two factors were complementary to one another. For example when the other was too intense, the other need not be. The implication here is that even a minor stressor would be perceived as traumatic provided the individual has greater infantile conflicts. This argument undermines to a greater extent the role the stressor plays in producing posttraumatic symptoms.

When the psychodynamic theories lost their dominance as the behaviourists and cognitive theories provided new and alternative explanations, the external stimuli were again recognised as crucial. A paradigm shift resulted, in which there was a movement from the emphasis on the internal to the external factors. However, the internal mental processes were not entirely abandoned, as they were significant in determining which stressors were to be perceived as traumatic. The internal mental processes also explain how individuals are able to cope with or maintain the symptoms. Since people possessed different mental schemata, it was then believed that they process information differently and thus react differently to stimuli (Peterson et al., 1991).

A major breakthrough came after WWII when the element of adaptation was introduced to complement the internal mechanisms of the mind. It was realised that after the traumatic event occurs, an individual is required to process new information and thus adapt to the new situation (Harrowitz, cited in Joseph et al., 1997). This explanation was developed in an attempt to explain the maintenance of traumatic symptoms. It therefore served as the recognition of the significant role played by the ecological demands of reality (Peterson et al., 1991). Post-traumatic neurosis was as a result seen as failed adaptation (Peterson et al., 1991).

According to Horowitz we all have mental models or schemata that are used to interpret incoming information (Joseph et al., 1997). He makes use of the completion principle, which he argues that we use as a technique to try to make the information compatible with our existing schemata. Traumatic event is a type of information that is not compatible with our schemas. When we receive this information, it becomes important for us to make some major schematic changes. Since this may take some time, he argues that our active memory will repeat the representation of trauma and thus resulting in emotional distress. A person then uses the process of inhibitions and facilitation to prevent this emotional exhaustion (Joseph et al., 1997).

These opposite cognitive actions result in processes of intrusion and denial. It then depends on which of these two actions is stronger. For instance nightmares and flashbacks will occur when the inhibitory controls of denial are not strong enough. When these are very strong we then see the symptoms of denial and avoidance. Since these actions tend to oscillate they thus account for fluctuations of symptoms in the individual. This is very important as it prevents emotional exhaustion and enables the individual to adapt.

Despite these contributions there was still no mention of Posttraumatic Stress Disorder in all of these discussions and certainly in both of the first two DSM publications (Peterson et al., 1991). The DSM I introduced the term 'Gross Stress Reaction' which described post-traumatic neurosis in the same way that Freud did by emphasising the role of prior psychopathology in understanding emotional reactions to trauma (Joseph et al., 1997). It was in the 1970s and 80s that the influence of the

external stressors was beginning to be recognised. Since then it has been widely acknowledged that these stressors impart a huge stress on the individual thus leading to the development of posttraumatic symptoms (Peterson et al., 1991).

It was only in 1980 with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-III; American Psychiatric Association, 1980) that posttraumatic symptoms were organised into a number of diagnostic criteria for Posttraumatic Stress Disorder. The inclusion of PTSD in the DSM III in 1980 provided a stimulus for researchers and clinicians to pay special attention to these syndromes.

It also became much easier for clinicians to make a more informed diagnosis once a structure of PTSD was provided. Many significant findings were as a result reported in various journals. Since then a large amount of data on the aetiology, manifestation and maintenance of traumatic symptoms have been made available.

The International Society for Traumatic Stress Studies and a Journal of Traumatic Stress, spearheaded by Charles Figley were consequently established to focus on these new findings (McNally, 1991) and to report even more findings to better understand the mechanisms of PTSD. These findings led to an improved and modified description of PTSD in the revised edition of the DSM-III. The diagnostic criteria for children were also made in this edition.

The concept of PTSD has also been made familiar to the public through the media and has since become an attractive construct for various reasons (Friedman, 1996). For

instance it has been used frequently as an important mitigating factor in legal cases particularly in civil cases. In 1994 the DSM-IV was published with further improvements and modifications. This is an indication that more findings concerning PTSD are still being made and that less is known regarding PTSD as opposed to other psychiatric disorders (Bracken, 1998).

The introduction of PTSD in the DSM system provided a common language for researchers and clinicians to better understand the effects of trauma on individuals. This is eventuated in more efficient research and better treatment interventions (Joseph et al., 1997) for both adults and children. The following section intends to provide a more detailed discussion of PTSD pertaining specifically to children.

## **2.2 The History of PTSD in Children**

Although it was first suggested by Levy in 1945 that children's traumatic responses were similar to that of adults (Trimble, 1981), this was not enough to sway the researchers' interest in the direction of children and trauma at the time. Studies on children who have experienced emotional distress after surviving disasters were documented but inferences of traumatic stress were not made (Peterson et al., 1991).

Most of the studies of children having experienced trauma were intended either to determine the presence of other psychiatric disorders (such as depression and anxiety) or to describe how children react to disasters. Researchers used certain scales to determine the presence of such psychiatric disorders. Arguably, the assessment scales that were used relied solely on parental reports and this was found to be a major

methodological weakness relating to research in children; for various reasons parents' reports were considered to be unreliable (Yule & Williams, 1990). For instance, Yule and Williams (1990) also observed that parents and teachers reported far less psychological distress in children than children themselves did. They argued that parents were overprotective of their children and were unwilling to admit that their children were suffering (Joseph et al., 1997). A further argument was that perhaps children do not tell their parents about their suffering and that parents are actually unaware of their children's responses and feelings (Petersen et al., 1991).

Available evidence supports the argument that parents tend to report incorrect information about their children's suffering (Burke, Moccia, Borus and Burns, 1986). For instance, in their study, Yule and Williams (1990) observed that parents reported far less psychopathology in their children than the children themselves did. In addition, most scales tend to focus on both the subjective and behavioural aspects of trauma. While this is crucial in the identification of caseness- that the necessary symptoms are present for the diagnosis of PTSD-, it appears that rating the subjective experiences in young children is very difficult as younger children's ability to express themselves verbally is not fully developed (Scheeringa et al., 1995).

Although questioning parents is also not effective in tapping into the subjective world of a child, it became, and still is necessary to include their observations as collateral. This information allows researchers to note the behavioural changes of children as observed by parents after experiencing trauma (Lambert, Knight, Taylor & Achenbach, 1996).

In his argument that children find it difficult to relate their experiences, Scheeringa et al., (1995) were however, referring to children younger than four years of age. It may not be as difficult to rate the subjective experiences of older children, and adolescents. Scheeringa et al., (1995) argue that some developmental factors need to be considered when rating PTSD in children. The level of maturity and ability to verbalise experience are some of these factors. Such factors may influence which events are experienced as traumatic for children and which are not (Scheeringa et al., 1995).

Scheeringa et al., (1995) further argue that there is a need for more behaviourally anchored techniques of rating children's responses to trauma. This presents another weakness as much of the traumatic responses are influenced by the child's subjective world. For instance, the avoidance of traumatic reminders may be motivated by a fear of recurrence. For older children, however, it may be possible for them to verbalise their subjective feelings and thoughts since they have developed verbal maturity necessary for reporting their experiences.

Yule and Williams (1990) believe that studies on children's reactions should be carried out soon after exposure to traumatic events. There are two reasons for this. Firstly, posttraumatic symptoms could be more easily identified in children who have not been provided with psychotherapeutic interventions.

Secondly, since the exposure to traumatic event would have been known, the task of identifying PTS symptoms would be easier thus children's reactions to violence could be more fully understood (Yule & Williams, 1990). For ethical reasons it has proven difficult to prepare adequate studies immediately after the disaster has occurred (Yule

& Williams, 1990) as the main priority is to provide treatment as soon as possible. Providing treatment soon after the incident has the potential to alleviate the symptoms thus affecting the identification of posttraumatic symptoms (Yule & Williams 1990). As a consequence, relatively less knowledge has been acquired on PTSD manifestations in children.

Early writings which contributed to the gradual understanding of PTSD in children include the work of Lenore Terr. In 1979, Terr published a study of a group of school children that were kidnapped in 1976 in a bus and buried alive (Eth, 1990). Heroic efforts were made by the older children to dig themselves out of the hole. Following their survival, these children reacted in a manner that could be classified as posttraumatic. For instance, Terr (1979) reported the initial signs of traumatic disruption, repetitive phenomena, and fears. Follow-ups to this study were made in 1981 and 1983 and a vast amount of data on this subject became available. This also elicited considerable interest among those working with children (Yule & Williams, 1990).

The Chowchilla experience, as reported by Terr (1979), as well as numerous other incidents in the 1980s (Blom, 1986; McFarlane, 1987; Pynoos et al, 1987; Yule, Udwin & Murdock, 1990) that exposed children to life threatening situations, were instrumental in providing the much needed impetus to study children's responses to trauma. Thus, crucial evidence was obtained to support the argument that children do exhibit PTSD symptoms. While previously less attention had been given to children, there has been evidence of an increasing attention to traumatised children (McNally, 1991).

While a relatively large number of studies have been done on younger children across the world, these studies have tended to focus on children who have recently experienced a traumatic incident. These studies include work with children exposed to “The Gulf Crisis” (Hadi & Llabre, 1998), a sniper attack on elementary school children (Nader, Pynoos, Fairbanks & Frederick, 1990), a kidnapped group of school children (Terr, 1985) and children who have been on a sinking ship (Yule & Udwin, 1991).

As with the increase of studies of children’s reaction to trauma the publication of the revised edition of the DSM-III in 1987 also began making a reference to children (Eth, 1990). This was insufficient and appeared as a mere addendum to the general criteria for PTSD as related to children. The implication was that although the DSM-III criteria for PTSD had only been validated for adults, it could also be applied to children (Figley, 1985). It is this universality of PTSD that has been the source of much confusion and frustration as it became clear that children could not be diagnosed using these general criteria (McNally, 1991).

This partial inclusion of the manifestation of PTSD in children, served as an indication of the growing acknowledgement among researchers and clinicians of the impact that traumatic events have on children. It was also during this period that more systematic evidence of PTSD in children started to emerge (Nader et al., 1990; Pynoos et al., 1987; Yule & Udwin, 1991; Yule & Williams, 1990), partly as a result of more data on children being received.

While the publication of the DSM-IV produced improvements on the slight reference to PTSD in children made in the DSM-III-R, further reference to the symptoms of trauma in children in the DSM-IV still seems insufficient, as it does not reflect the additional findings reported in the literature. This can be attributed to a lack of agreement on uniform criteria for PTSD in children among different observers. There are contradictory findings in relation to the manifestation of traumatic symptomatology in children.

Nonetheless, literature on children and posttraumatic stress disorder has remained relatively limited to date. Recent literature shows that there is a wide recognition that children do indeed suffer from PTSD (Nader et al., 1990; Pynoos et al., 1987; Yule & Udwin, 1991; Yule & Williams, 1990). Most of the argument as noted above, has been about the nature of the manifestation of symptoms in children. This results from the way in which the assessment of posttraumatic symptoms in children has been carried out (Yule & Williams, 1990).

It is suggested that these studies, although important, have perhaps also succeeded in creating a misleading impression that children only suffer short-term acute stress disorder. Terr (1979) has indicated that with extended exposure to traumatic events posttraumatic symptoms can persist for several years in children.

### **2.2.1 Current debates on PTSD and children**

Unlike Levy (1945, cited in Trimble, 1981) who believed that children show similar symptoms to adults, it has been reported in many studies that children's manifestation

of posttraumatic symptoms differ to some extent from that of adults (Eth, 1990; Scheeringa et al., 1995). This was due to some realisation that children do suffer from PTSD. That children also suffered from PTSD was not seen as a consideration prior to the 1980s as the children's symptoms were not fully understood.

Some researchers argue that children do not suffer from PTSD. Garnezy and Rutter (cited in Yule and Williams, 1990) for instance, have argued that while children do show signs similar to those of PTSD, these signs dissipate too quickly to warrant them a PTSD diagnosis. They also point to the fact that these children do not show amnesia for events, psychic numbing and flashbacks which are considered to be important symptoms for the diagnosis of PTSD as outlined in the DSM-IV. This is an important indication of the weakness in making a PTSD diagnosis. For example, many children could not be diagnosed with PTSD although they do show symptoms of PTSD (Shannon et al., cited in Tierney, 2000)

This line of argument was further echoed by Monahon (1993) who argued that children do not experience the full-blown flashbacks as observed in adults. However, children do, exhibit signs similar to those exhibited by adults (Eth & Pynoos, 1985; Kaplan & Sadock, 1988). For instance, Yule and Williams (1990) managed to identify symptoms of recurrent distressing dreams, intrusive memories of the event and the re-enactment of the event in children but could not detect psychic numbing.

Frederick (cited in Petersen et al., 1991) on the other hand observed most symptoms necessary for the diagnosis of PTSD in a sample of molested children over the age of six. In this study Frederick (cited in Petersen et al., 1991), found that 77% of children

who were administered the Reaction Index scale were diagnosed as having PTSD. The PTSD Reaction Index scale is a widely used interviewing instrument for the diagnosis of PTSD (Sauter & Franklin, 1998). This scale was originally developed by Frederick in 1985 and was further reworded to be used for the assessment of PTSD in school-aged children.

The PTSD Reaction Index scale is a 20-item scale where children are asked to report their reactions to a recent traumatic event. It has five point likert type scale with the score ranging between 0- 80. PTSD diagnosis is determined by the use of cut off points, for example score of less than 12 is considered as no level of PTSD while a score of more than 60 is regarded as a severe level of PTSD. In his study, Frederick (cited in Petersen et al., 1991) observed that the incidence of PTSD in children was much higher than that in adults because children were more vulnerable to trauma.

Terr (1983) noted that PTSD symptoms are seen in children but differ to adults in six different ways. For example, she observed that children over the age of 3 do not show amnesia, and that they do not experience psychic numbing and flashbacks. Their performance at school usually suffers for only a few months after the event. They tend to re-enact the trauma in the form of play and demonstrate a foreshortening of their view of the future. While there is consensus with regard to most of these findings, some researchers such as Eth and Pynoos (1985) and Petersen et al. (1991) disagree with Terr that children do not experience flashbacks

### **2.3 PTSD in Children: The South African Context**

In South Africa there have been two trends in the studies of trauma. Firstly, Turton, Straker and Moosa (1991) noticed a tendency among researchers to focus on the effects of political violence on the youth at the expense of other forms of violence such as domestic and criminal violence. Secondly, most studies have tended to focus on adults and adolescents and neglected the experiences of younger children (Gibson, 1993; Levett, 1989; Turton et al., 1991).

While clinical data on children with posttraumatic symptoms are manifold (Dawes, 1992; Smith, 1994; Smith & Holford, 1993), there is a dearth of empirical research data. A possible reason for this is related to the observation that children's response to domestic and criminal violence is receiving less attention in South Africa. Therefore we know more about how the effects of trauma manifests in adults and adolescents than we do about how it manifests in younger children.

It has been observed that children in South Africa have for a long time been exposed to disturbing situations (Duncan & Rock, 1994). In a sense these children's basic rights were violated on a daily basis and their physical and psychological well being were placed in constant jeopardy. It was particularly during the transition period preceding the present political order that children were exposed to political violence. Contrary to popular belief, it was not only black children who were affected by the scourge of violence (Duncan & Rock, 1994). Children from other races who were thought to be living in the relatively violence free areas were also indirectly affected by violence (Duncan & Rock, 1994). Studies (Dawes & Finchelescu, 1993 cited in

Duncan & Rock, 1994) have shown that children who are not directly affected by the traumatic events have shown symptoms of distress. Duncan and Rock (1994) refer to a case of a 6 year old who had become obsessed with death and dying. It was discovered that this boy had not been exposed to any trauma but having watched TV with his parents was able to assimilate their fears and concerns regarding the political situation in the country. They had formed a perception that nobody in the country is safe and that death was imminent.

This example shows that children are able to measure the meaning and extent of the traumatic incident by observing those around them, particularly their caretakers. Against this backdrop, it is possible for children to perceive as traumatic a situation based on how their parents or caretakers react to it, with the “countless media reports highlighting the most gruesome acts of public violence with which South African [children] are confronted on virtually a daily basis” (Duncan & Rock, 1994: 1). Mental health professionals around the country were thus called on to determine the effects of public violence on children. A lot of psychological input was provided as a result of this major undertaking (Dawes, 1992; Smith, 1994)

However, these studies were not undertaken to establish the presence of PTSD in these children but rather to look at how children are affected by violence in general. Also, these studies focused almost exclusively on political violence. As mentioned above, there was very little focus on other forms of violence. This becomes understandable when one considers the context within which the studies were undertaken and the nature of public as opposed to domestic or sexual violence. It may be argued that public violence by its very nature as an overt, disruptive, public

domain phenomenon is easier to study and thus quantify. Domestic violence on the other hand is a more hidden form of violence that is not easily accessible to research.

Studies (Smith & Holford, 1993) indicate that domestic violence is currently the most common kind of violence in South Africa. In an inquiry conducted into the effects of public violence on children (Duncan & Rock, 1994), approximately 80% of organisations reported that they admitted on average 33,5% of children suffering from domestic violence induced trauma. In the same study, it was reported that psychological trauma was the most common kind of impact that public violence had on children as opposed to physical injury or death (mean 59.1%). Smith and Holford (1993) also reported that 49% of the children in their sample were victims of domestic violence while only 31% of them were victims of political violence. Criminal violence accounted for 20%. These statistics show that most of the violence that children are exposed to is committed within their homes. Although domestic and sexual violence is less documented than political violence, it is just as important, as Marks and Andersson, (1990, 23) concede:

*“The culture of violence exists at every level; and overt political violence must be located in this wider social context, as but one of the many forms and varieties of endemic violence [and it is] seriously misleading to focus primarily on the more obvious cases of overt and explicitly political violence which constitute only a small part of the overall picture”.*

Having alluded to the fact that children in South Africa, although understudied, are the most vulnerable casualties of traumatic stressors such as violence (public or

private), it is also important to investigate how traumatic stressors affect these children. It would also be beneficial to explore whether children in South Africa react differently in their manifestation of traumatic stress symptoms than children elsewhere, since:

*“[T]here is general concern that South African children are at a significantly greater risk for the development of certain mental disorders than their counterparts in less conflictual and more democratic, stable and predictable societies” (Smith & Holford, 1993: 57).*

Parallel with the development in other countries, some South African researchers have begun to embrace the belief that children do suffer from PTSD (Dawes, 1992; Dawes & Tredoux, 1990; Smith, 1994; Smith & Holford, 1993). In fact, Dawes and Tredoux (1990) reported a lifetime prevalence rate of 9% in children with symptoms ranging from conduct disorder to PTSD. This is a broad quantification and it does not indicate specifically the extent of PTSD. This result would probably have been higher had they looked exclusively at PTSD. Also Dawes and Tredoux (1990) focus was on the effect of public violence and this, as mentioned above, excludes other forms of violence such as those occurring within the homes, viz. domestic and violence of a sexual nature.

Most studies today focus less on the effects of public violence on South African children and the paradigm has shifted towards the effects of trauma generally (that is, irrespective of whether it is categorised as public or private). For instance most studies are increasingly focusing on domestic violence (Smith & Holford, 1993).

It is clear that children in South Africa suffer from psychological distress including Posttraumatic Stress Disorder upon exposure to traumatic stressors. An important question to explore is whether South African children would react differently to traumatic events than children in other countries. It has been established that exposure to traumatic events have negative effects on children and this undermines their optimal development and psychological well-being. Since Duncan and Rock (1994) assert that children frequently present with posttraumatic symptoms sometime after the exposure to incidents of public violence PTSD symptoms may be present but unobservable in children during the interim period between the exposure to the traumatic incident and the actual presentation of the symptoms.

Children need physical and emotional support. Hence the period where symptoms are not visible would make it unlikely that they will receive that support. It could then be argued that the integral factor in the development of traumatic symptoms is time. While some children may experience the interim period before the actual onset of symptoms other children may experience more frequent exposure to violence. There is a concern that children who are exposed to acts of violence more than once tend to begin to perpetrate acts of violence themselves (Dawes and Tredoux 1990). This concern has been confirmed by a number of studies that noted the involvement of children and young adolescents as primary perpetrators in acts of violence (Duncan & Rock, 1994).

Smith & Holford (1993: 58) stated that most South African children “have either been the victims of direct political violence or are the victims of indirect political violence

which manifests in social upheaval, unemployment, criminal violence, domestic violence and acute personal insecurity”. However, Duncan and Rock (1994) warn that South African children, like other children do not exist in a vacuum. In a sense all children rely heavily on the physical and emotional support of others. For example, being separated from their caregivers children suffer a loss of attachment that is important for trauma resolution (Bowlby, 1970).

It is generally assumed that children obtain emotional support from their caregivers and families. There are a large number of children and adolescents being exposed to, and directly involved in brutal acts of violence (Smith and Holford, 1993). A study conducted by the UNICEF and the SA National Children’s Rights Committee (Smith & Holford, 1993) reported that a nationwide assault has been the main cause of deaths in children aged 5 to 14 years. Apart from the deaths, these South African children are presenting with PTSD as a direct consequence of increasing violence (Smith & Holford, 1993). As with children’s exposure to violence in the public domain in some cases the perpetration of violent acts against children occur in their own families.

Considering the above, many researchers and clinicians have attempted to explain why some children are more vulnerable to developing symptoms of trauma than others. In so doing they expand on a number of mediating factors. These factors mediating psychological well-being of children exposed to violence include, the child’s socio-economic situation, age, gender, social support system, the duration of violence, child’s past experience, his or her personality and how violence was perceived.

### **2.3.1 The child's socio-economic status**

The nature of the child's socio-economic status is important in mediating the development of PTSD and the consequent inability to cope with the experience (Duncan & Rock, 1994). Economic, social and political conditions in South Africa are a complex web of factors that render children vulnerable to the development of psychological distress. Suffice it to say that the majority of children in South Africa are living below the poverty level. This is particularly in relation to black children in the South African townships and informal settlements.

Since studies have revealed that low socio-economic status is positively related with the PTS symptoms in children exposed to violence (Butchart, Kruger, Lekoba & Lesebe, 1998) it could be deduced that socio-economic status is an important mediating factor in determining the psychological well being of children who have been exposed to violence in South Africa. It is therefore not surprising to expect children to react negatively to traumatic experiences. Socio-economic status may render South African children more vulnerable to developing PTS symptoms.

### **2.3.2 The child's age**

There has been evidence that children from different age groups are affected differently by violence symptoms (Margolin & Gordis, 2000). Age is related to developmental stages that have been proposed to explain the children's emotional and cognitive development. According to Dawes (1992), children between the ages of 5 and 13 are able to cope well with violence than children falling outside this age group.

While specific reason is not provided for this it appears that children falling within this age group would normally develop PTSD symptoms while older adolescents will tend to develop antisocial behaviour. Younger children on the other hand, it was thought, were too psychologically and emotionally immature to experience the consequences of exposure to traumatic events (Benedek, 1985 cited in Tierney, 2000). That is, it was believed that younger children would not experience PTSD symptoms because they have not developed cognitive and emotional abilities to do so.

Because children's cognitive and emotional development is influenced by the type of education they receive, South African children who have not received equal opportunities may not have been given the chance to develop mechanisms to deal effectively with traumatic symptoms as compared to children from other parts of the world.

### **2.3.3 The child's personality and temperament**

Children who are more extroverted tend to cope well with traumatic experience, as they possess good social skills. A child's extroversion may increase his or her resilience to traumatic experiences (Duncan & Rock, 1994).

### **2.3.4 The child's gender**

There seems to be a relationship between the sex of a child and the development of PTSD. Dawes (1992) indicates that preadolescent boys show more stress symptoms

than girls but that this situation tends to reverse itself during adolescence. In a study by Dawes (1994) it appeared that females tend to show more symptoms than males.

### **2.3.5 The child's availability (or lack) of social support**

There is a common conception that the child's support system is crucial in coping with psychological distress after exposure to violence. The child tends to cope with traumatic experiences if there are sufficient levels of support available. Children get their support from their caregivers (Duncan & Rock, 1994).

In a situation where a child is removed from his or her caregiver it becomes difficult to obtain such support. A child who does not receive sufficient support as a result will develop traumatic symptoms and it would also be difficult to deal with the traumatic experiences. Also with the progression of time the family unit in South Africa (and generally in other developing countries) have begun to disintegrating resulting in the breakdown of support structures. "This pervasive disintegration of the black family has portentous implications for the development and well-being of our children and, indeed, for the future of this country as a whole" (Duncan and Rock, 1994: 5).

Without support from caregivers it become a battle for the child to reconstruct the whole traumatic experience and to make sense of the world. But sometimes caregivers are themselves so overwhelmed by the crisis that they cannot attend to the child. Children interpret the seriousness of the traumatic incidents by the reactions of those around them (Duncan & Rock, 1994). Hence if caregivers react in a way that suggest that they are unable to cope with the situation then the children aren't able to use the

caregivers' support to understand the trauma. It is therefore in many instances "not the incident of political violence per se that impacts negatively on the child's psychological well-being, but the manner in which such trauma is mediated by significant others through the provision of security and emotional support" (Duncan & Rock, 1994: 5).

It is, therefore, imperative that some understanding of factors facilitating the development of PTSD in children is obtained. Few studies have managed to achieve this feat. Perhaps that could be attributed to the lack of knowledge on the degree to which children are exposed to and suffering from PTSD. Whilst the aim of this study is not to investigate the factors facilitating the development of PTSD in children, it is very important in a sense that it provides a step in that direction.

#### **2.4 Research Rationale**

There is no denying the fact that "the legacy of Apartheid has bequeathed to South Africa a 'culture of violence'" (Simpson, 1993: 1). A transitional period from the death of Apartheid to the birth of a new order became a period of great struggle for power. Hence violence (particularly political) was used as a means for both maintaining power and attaining change or resolving conflict (Simpson, 1993). As a result we have seen this type of situation permeating all aspects of South African lives, particularly in the black townships. As the violence took on its own momentum -it is argued that some political interest groups were responsible for 'switching on the violence' and it has become difficult thereafter for any to simply switch it off- the

dividing line between political and criminal violence has become increasingly blurred.

Violence as a means of maintaining power and resolving conflict (this became a legitimised and accepted norm) began to slowly spill over into the social and domestic arenas of our society. Therefore, the country became characterised by a considerable instability over the years. This ranged from political to criminal violence and often a clear distinction became rather difficult to make as most non-political issues were rapidly politicised (Simpson, 1993). A disproportionately high number of children have as a result been exposed (directly or indirectly) to these forms of violence (Turton et al., 1991). Studies (Galante & Foa, 1986) have shown that children are most vulnerable to traumatic stressors and thus susceptible to develop traumatic symptoms.

There is thus a great concern that these children may themselves turn out to be the perpetrators of violence in the future (Gibson, 1993; Levett, 1989), in terms of their psychological development, or could become casualties of the trauma to which they had been exposed (Straker, 1992). Wilson and Keane (1997) emphasise the importance of accurate assessment and effective treatment of childhood trauma as failure to resolve moderate to severe traumatic reactions could result in long-term consequences and thus the perpetuation of ongoing violence. The researcher felt as a result that these children should be detected and offered appropriate interventions in order to avert this situation.

While there is probably an enormous presence of traumatised children in the black townships, an obvious lack of community studies on PTSD and children could mean that many of these individuals are not always noticed. Due to a relative lack of knowledge on how traumatic exposure affects children, many of their behaviours are attributed to the children's naughtiness, lack of discipline (Smith, 1994) or even to what is considered stupidity. Sadly though, these affected children are unfortunately punished or further victimised for showing these symptoms.

It has often occurred to the researcher that there is very little knowledge of traumatic symptomatology in children among the teachers, parents and other caretakers. It is, as a result often impossible that these children would be identified and appropriately afforded the necessary intervention. It will therefore be important to provide training to those who will be working closely with children on how to recognise traumatic symptoms in children once they begin to show.

Seeing that there are fewer studies on traumatised children and even less on community samples throughout the world, there is a need for a change of focus towards community epidemiological studies on children and PTSD. The implication for this is clearly obvious. Presently, there has been an increasing attention in the area of children who have been exposed to traumatic events. Naturally, these studies have tended to focus more on the identification of caseness. That is, whether a diagnosis of PTSD can be made. Very few of these studies have focused on preadolescent children.

The criteria for the diagnosis of PTSD have only just been recently introduced in the scientific manual and the term itself was only introduced into the psychiatric nosology in the last decade. Therefore, it can only be expected that our knowledge of what leads to the manifestation of PTSD is quite limited. Since the 1980s, our understanding of PTSD has grown at an exponential rate, particularly as a result of its inclusion in the DSM-III. This is more so in relation to adults and adolescents. Therefore, greater advances have been made in the understanding of PTSD in adults and adolescents. This has been a universal trend. The opposite trend to this has been the apparent lack of interest in PTSD and children.

The revised edition of DSM-III, published in 1987, was the first to include additional PTSD symptomatology specifically for children. While the diagnosis of PTSD was never made, the children's reaction to traumatic stress has, however, long been discussed in clinical literature. Lenore Terr (1983) was the first to make such diagnosis after observing symptoms similar to adults in children who have been kidnapped and buried in their school bus. She, however, noticed that there were some discrepancies in how these symptoms occurred when compared to adults and this has been the basis for such misunderstanding and lack of PTSD diagnosis in children. That is, while both children and adults showed symptoms of PTSD, these were presented in different pictures.

Attempting to make PTSD diagnosis in children in terms of adult symptomatology is however not advised. Today there is a general agreement among clinicians and researchers that children do show PTSD diagnosable symptoms. While it is clear that this has been established, there is an apparent lack of studies on children who are not

classified as having been exposed to traumatic event. That is, the community prevalence studies on children and PTSD. Clearly there are a lot of children in the black townships whose traumatic exposure status is not known. This study, therefore, hopes to bring to attention that many unnoticed traumatised children are missing out on crucial treatment interventions as a result. The significance of community epidemiological studies is well known.

## **2.5 Aim of the Study**

This research aimed to determine the prevalence of PTSD in a sample of township preadolescent school children. Previous research of this nature has tended to focus mainly on the immediate effects of political violence, specifically, on township youth. There is thus a need to undertake research into the degree to which children are experiencing PTSD as a result of exposure to traumatic events more generally. It is hypothesised that the number of children who have been exposed to different forms of traumatic events in the black townships will be found to be extremely high. Thus the researcher hopes that on completion of the study the researcher would have been able to detect a significant proportion of children who need help and be able to offer some recommendations on how children suffering from PTSD may be helped more efficiently.

The aims of this study is thus to identify the following characteristics:

- i.** The prevalence of PTSD in preadolescent learners in the black township.
- ii.** The gender differences in the exposure to traumatic stressors.
- iii.** The relationship between gender and the severity of PTSD.

iv. The analysis of variance across different schools.

### 2.5.1 Hypotheses

It is hypothesised that:

- i. There will be a high presence of PTSD in a sample of learners in primary schools in a black township.
- ii. The frequency of exposure to stressful events will be much greater for boys than girls.
- iii. The severity of the PTSD is related to gender differences.
- iv. There will not be a significant difference in the frequency of PTSD across different schools.

## 2.6 Conclusion

There has been significant progress made in the understanding of PTSD in children in the last two decades. While the diagnosis of PTSD in children was initially made in terms of adult's understanding of symptom presentation, it gradually became necessary to fully understand these symptoms in relation to children. The introduction of DSM-III-R was instrumental in allowing both researchers and clinicians to generate more data in this area. At first it became clear that children present PTSD symptoms rather differently from adults. There has therefore been a lot of debate around PTSD and children's reaction to trauma. These debates have spurred been the

realisation that children are more vulnerable to developing posttraumatic symptoms than it was previously anticipated. The employment of assessment scales has been regarded to be a major weakness because these instruments relied heavily on parental accounts.

The original debates regarding PTSD in children were around the existence and prevalence of PTSD in children. Since it has been established that PTSD does exist in children the issues no longer centre around the existence of the symptoms but arguably on the manifestation of the symptoms.

An attempt was made in this section to look at how PTSD might manifest differently in South African children. It is clear that these differences are mediated by different factors that are unique to different countries. Factors such as socio-economic status, age, gender, social support, etc are important in that they enable us to understand the individual dynamics in the development of PTSD in children. In South Africa, these factors are linked in a complex and inextricable way.