CHAPTER 5

5. Discussion

The aim of this study was to investigate the presence and prevalence of PTSD in preadolescent school children in a black township. Although this was conducted in one area it was hoped that the results yielded would be an indication of the need to look at the needs of children in the black townships generally. Much of the hypotheses were leaning on the fact that there had been considerable instability in the black townships in the period succeeding the Apartheid era.

While most of the violence in the townships was political, a movement began to emerge where violence became a way of life and generally a way of resolving conflict (Simpson, 1993). This was not confined to the outside arena but also crept into the households of many South Africans. Many children were as a result affected by the growing level of violence that has now been brought closer to them (Duncan & Rock, 1994). It became important therefore to look at how serious this problem was. The present study was therefore borne out of this concern. While data was gathered from the schools it was thought that its results would indicate the level of suffering among children in the townships generally.

5.1 Discussion of the Results

This thesis set out to determine the presence of PTSD in township school children. Related to this is the prevalence of the disorder in children drawn from the

community sample regardless of whether they sought treatment or not. Interesting results were obtained and these will be discussed in detail below. While this study acknowledges the fact that not everyone exposed to an extreme event will develop PTSD, the assumption was that some confounding and salient factors would elevate the prevalence rate in these children.

5.1.1 Hypothesis 1: A higher presence of PTSD in a sample of learners in primary schools in a Black township will be observed

For a diagnosis of PTSD to be made an individual has to have met all the criterion groups as set out in the DSM-IV. Each criterion is made up of a varying number of symptoms of which some have to be present for a criterion to be met. For example, while a particular criterion consists of a certain number of symptoms only an indicated number of those symptoms have to be present for that criterion to be met. Criterion E and F are, however, different in that they do not require the presence of any symptoms. Their inclusion was mainly to determine the duration of the symptoms and the degree of social and occupational dysfunction as a result of the symptoms.

The latter criterions are nevertheless crucial in making the PTSD diagnosis. It became evident in the previous chapter that many of these criterion groups were met by the majority of learners included in the study. While meeting these criterion groups suggests some level of suffering, it does not guarantee the diagnosis of PTSD. For example, results of this thesis show that the majority of learners administered the questionnaire reported very high frequencies of symptoms characteristic of Criterions B, C and D (80.2%, 75.7% &76.5% respectively). The study also showed that the

exposure rate was very high (75.8%). The results of the current study had, therefore, some significant implications for the stated hypotheses.

The first hypothesis stipulated that a higher presence of PTSD in a sample of learners in a black township would be observed. This study confirmed this hypothesis. Of the 797 children administered the WBTH scale, about 114 (or 14.3%) met the definitive diagnosis of PTSD. This is a significantly higher rate and is consistent with other studies on adult populations ranging from a lifetime prevalence of 1% to 12.3% (Cuffe et al. 1998). The prevalence rate in adolescents seemed to be higher with Giaconia et al., (1995) who reported a lifetime prevalence of 6.3%.

A number of clinical studies have been conducted to examine the prevalence rate of PTSD in children and different results have been observed (Sauter & Franklin, 1998). Deblinger (cited in Adam, Everett & O'Neal, 1992) reported a PTSD diagnosis of 6.9% in physically abused children. Hadi and Llabre (1998), on the other hand, reported that 62% of children exposed to the Gulf crisis were given the diagnosis of mild level PTSD. These are the expected figures considering the fact that the children mentioned above comprised a high-risk population. These prevalence rates among different studies in children tend to differ in relation to a number of factors such as the nature of trauma, instruments used in the collection of data, the sample used and the DSM criteria used. It should also be noted that some instruments such as the PTSD Reaction Index use the cut-off point to indicate the level of PTSD while some, like the one used for the present study, rely on meeting all the criterions as stipulated in the DSM-IV criteria.

The high prevalence of PTSD diagnosis and PTSD symptoms in the present study is also consistent with the theory that children are more vulnerable than adults to developing posttraumatic symptoms (Frederick, 1982; Galante & Foa, 1986; Sauter & Franklin, 1998). Therefore, children are to be expected to show higher prevalence rates when exposed to traumatic stressors. There are a number of factors that account for this. With regards to the results on different criterion groups it became apparent that many children were exposed to horrid acts of violence and were showing symptoms characteristic of PTSD.

Criterion A stipulates that an individual has been exposed to extreme stressful event. As PTSD is a disorder that is determined by the exposure to trauma, it is very important to identify the traumatic incident prior to making a diagnosis. About 76% of the children met Criterion A, implying that the majority of children in the township have been exposed to some stressful events. While not everyone who is exposed to traumatic incident would necessarily develop posttraumatic symptoms, it can be expected that such a proportion of exposure to traumatic events undermine the safety and welfare of children. This also implies that children may suffer from posttraumatic symptoms.

About 80% of children in the current study met Criterion B characterised by symptoms of trauma re-experiencing. This manifests in dreams, recollection of the trauma and some images associated with the trauma. This is a significantly high degree of suffering with obvious implications for the psychological need of these children. While this number is so high, it is quite interesting to note that these are the children who receive the least attention. Firstly, there is generally a lack of knowledge

on how children are affected by violence (Yule & Williams, 1990) and this can be expected to be even more in South Africa (Duncan & Rock, 1994). It is as a result that many children in South Africa, especially in the black townships, do not receive the necessary psychological counselling and the social and familial support.

Secondly, Terr (1981) has found in her study of the Chowchilla children that parents may not be able to observe symptoms in their children for up to a year after the traumatic event. Perhaps one can argue that it is probably because parents do not know the symptoms of PTSD in children thus unable to relate them to the traumatic event. This could certainly be assumed to be true for parents in the black townships who are mostly uneducated.

Thirdly, not being able to spend enough time with their children (as most parents in the black townships are) may make this situation even worse. For example, some school principals expressed their concerns that a lot of parents are not actively involved in their children's lives, particularly that related to school. Clearly it can never be easy to notice subtle behavioural changes in a child if parents do not engage closely with their children.

Fourthly, many parents and teachers in the township schools have very little (if any) psychological training. This would be crucial if symptoms of mental health problems, especially PTSD in children were to be recognised. Perhaps it is this lack of knowledge that makes it easier for parents and teachers to look for an easier explanation for their children's behaviours. This makes it convenient for parents to ascribe any visible changes to child's naughtiness (Smith, 1994) or generally place

the blame away from parents (Yule & Williams, 1990). Explanations attributed to the children's behaviours by parents subsequent to trauma may facilitate further punishment in an attempt to "fix" them.

Lastly, because children are not always willing or able to verbally relate their experiences (Scheeringa et al., 1995), it may not always be easy to know if they have been exposed to traumatic events. Since the diagnosis of PTSD is based on the knowledge of exposure to the event (McNally, 1991), it may not be easy for clinicians and researchers to make such a diagnosis even in the presence of clear and obvious symptoms. This is because PTSD symptoms are not easily differentiated from other disorders such as major depressive and anxiety disorders (Friedman, 1996; Joseph at al., 1997). In the case of parents and teachers this presents problems, as the source of behaviour would not be known. This is probably the reason why parents and teachers ascribe different theories to understand the children's problem behaviours and in so doing, miss a clinical diagnosis.

As with the other criteria, most children (75%) in this study indicated the presence of symptoms associated with the avoidance of the trauma stimuli (Criterion C). This involves avoiding the thoughts, feelings, conversations and reminders of the trauma. Some children also fail to remember some important aspects of the trauma. Also noticeable is that these children tend to lose their previously acquired developmental abilities such as toilet training. These are the symptoms that most people look with disdain hence children showing such symptoms are generally considered as lazy, dumb or sick (Smith, 1994). Children are labelled and blamed by their parents, teachers and the communities for showing these symptoms. It is, therefore, unlikely in

most instances that these children would receive the needed support from their parents, teachers and society as a whole. It is likely that while the study shows a high prevalence rate of PTSD diagnosis and PTSD symptoms among these children, their caretakers might not be aware of this situation. This is mainly because children would be unwilling to show or reveal their suffering to those around them for fear of derision. Instead of showing the symptoms, many children might experience somatic complains and other physiological symptoms.

Criterion D was also shown to be high among school children with the prevalence of 76%. Children suffering from these symptoms show an increased level of arousal such as difficulty staying or falling asleep, difficulty concentration, hypervigilance and exaggerated startle responses.

Clearly from the above statistics there are a lot of children who are suffering to a varying degree from posttraumatic symptoms. While these symptoms cannot necessarily be judged as the diagnosis of PTSD, they surely imply that the suffering of many children in black townships cannot be taken at face value. It is very important for the purpose of diagnosis to consider Criterion E and Criterion F in addition to the above four criterion groups. Clinically, meeting any or all of the four criterion groups is an important benchmark for the need of psychological intervention. This is regardless of whether a person is diagnosed with PTSD or not.

It is a common fact that while some children experience severe symptoms subsequent to exposure to traumatic incident some may only show few or no symptoms at all. This explains the reason why despite such high exposure to traumatic incident

relatively few met the definitive diagnosis of PTSD. There are various ways in which children are affected by traumatic events. Some children develop posttraumatic symptoms without being exposed to any event. A number of factors account for these variations. While children are considered more resilient, this can be compromised by a number of variables, for instance, the family cohesion (many children have suffered through the death and traumatisation of family members, neighbours, friends, teachers, etc.), parents' response to trauma, a child's level of development (this is age specific), other undesirable life events, socio-economic status, and child's gender. These variables are discussed below with reference to township population of children in general.

5.1.1.1 ***The child's family cohesion***

In some cases children suffer loss as a result of trauma. This takes different forms. For example, a member of the family dies or they are forced to relocate. In their study, Galante and Foa (1986) discovered that children who have suffered death in the family were not different from those who had not. This compelled them to think that either children were more resilient than was previously thought or community loss was not as traumatising as the individual loss. Community loss happens when someone not related to a child dies in an incident that involved a number of people in the community. An individual loss involves a small-scale population such as family members. However, it transpired from their study that the availability of the children's family support system was very crucial. In many cases trauma occurs in the absence of parents. In such cases, a child is left with no support.

Although about 58.8% of the children in the study came from married parents at the time of study, this does not guarantee the availability of support, however, since Terr (1981) noticed that in many instances parents do not even notice that their children are suffering. It could be assumed in this study that some parents may not be willing to recognise their children's suffering. Suffice it to say that during the time permission was sought by the researcher to administer questionnaires to schoolchildren, face to face interactions with the principals provided some important information. Most principals commented on the need for this kind of research in the township. Many of them also expressed their concerns regarding the parent's lack of interest in their children's work.

It also appeared that many children were not appropriately cared for as they were not properly dressed and did not appear to be clean. This, however, cannot be attributed solely to parent's negligence, as poverty seems to be a major factor in this regard. It became obvious to the researcher during testing that many of the teachers were also naïve when it came to understanding the children's problems. Any deviation from the accepted behaviour by children often elicits harsh reactions from the teachers. For, example, a teacher may verbally reprimand or physically beat the child. It is clear from this that a lot of the children who are exposed to traumatic events often do not receive the necessary support to enable them to cope with their experiences. In fact, the opposite is often true.

It is also a fact that there is a substantial lack of knowledge among parents and teachers of psychological distress and resources to deal with children's problems in the black townships. It is thus not surprising to find parents and the society ascribing a

number of explanations to the children's behaviours. Such explanations involve laziness and stubbornness (Smith, 1994) while some even suspect witchcraft. This is an indication that parents are either unwilling to own responsibility for their children's problems or lack the knowledge of how children react to trauma. Children are, therefore, forced to push their problems away and pretend as if nothing happened. This is often difficult for them, as they tend to exhibit strange behaviours in the eyes of their parents and teachers. Moreover, parents and teachers are often people whom the children have maximum interaction with. It is quite important, therefore, for parents and teachers to be trained on the ways children react to trauma. In this way it would be possible for children to be easily recognised and offered the necessary intervention in time and most importantly the support from their parents.

5.1.1.2 ***A child's level of development***

A child's level of development is very important in determining the possibility of meeting the PTSD diagnosis. Level of development is almost but not always related to the child's age. The level of development as theorised by Piaget and Inhelder (1969) and Erickson (1968) does have influence on how a child would perceive the external stimuli and the way to cope with any traumatic stressor. Therefore, a child operating at Piaget's sensory-motor level of cognition may be overwhelmed by the flood of information that a child at a pre-conventional level might have little problems dealing with.

Piaget and Inhelder (1969) describe the preadolescent stage as that comprising of propositional operations. "This is the age of great ideals and of the beginning of

theories, as well as the time of simple present adaptation to reality" (Piaget & Inhelder, 1969: 130). It is this developmental acquisition that would determine the child's appraisal of the situation. According to Newman (1976, cited in Galante & Foa, 1986) the child's developmental level contribute to their vulnerability.

While this is important for the children to cope with their experiences, there is also the fact that traumatic events can harm the development of the child (Schwarzwald, Weisenberg, Solomon & Waysman, 1994). This presents some confusion as to whether the level of development helps with the child's ability to cope or coping with the experience helps restore the level of development. The children in this study were at the preadolescent stage of development and it was thus assumed that they would have developed the level of maturity to allow them to deal and cope with their experiences.

Garbarino (1992, cited in Schwarzwald et al., 1994), however, stressed in his study that environmental factors affect children's resilience. This can be assumed to be true regardless of the child's level of development, as it is known that this may be severely affected by the trauma. It is thus important to note that most children in the black communities are constantly faced with environmental factors that pose severe strain on their physical and emotional development. While many children may be coming from different locations in the townships, most of them live in very poor areas. Perhaps some parents are overwhelmed by the amount of responsibilities and are thus unable to look after their children. It is almost always the norm in the townships that parents are not involved in their children's education and generally spending quality time with their children. This deprives some children of the opportunity to engage

with their parents or caretakers in ways that could be cognitively and emotionally stimulating. These children's level of emotional and cognitive development is thus compromised very early in their growing up.

5.1.1.3 ***Child's socio-economic status***

Social and economic conditions in South Africa are but one of the factors that mediate the development of and the inability to cope effectively with PTSD among children (Duncan & Rock, 1994). Children from poor areas are more likely to be exposed to traumatic events since crime tends to be more prevalent within poor communities (Duncan & Rock, 1994). Greater exposure would in turn most likely lead to post traumatic reactions. In these cases children are most vulnerable since most of the crime is directed at them.

Results of the present study indicated that about 50.2% of the children came from very poor backgrounds. While this does not guarantee the development of PTSD, it may somehow interfere with the child's ability to cope with traumatic stressor. Children in the present study came from different areas with different characteristics. Because of the unavailability of necessary amenities and conditions for the development of cognitive and emotional maturity, many children from poor background are likely to lack important mechanisms of coping with unfamiliar information and are thus more vulnerable to developing PTSD symptoms.

According to some studies (Duncan & Rock, 1994), low socio-economic status of the child correlates positively with the development and maintenance of posttraumatic

stress symptoms. This could well account for the high rate of PTSD in this study. It is also a fact that children from lower socio-economic conditions are also exposed to other forms of structural violence such as malnutrition and disordered living conditions (Duncan & Rock, 1994). It is, therefore, also possible that these children will be more likely to show more symptoms following the traumatic experience.

5.1.1.4 ***Gender of child***

McNally (1991) suggests that males tend to be more exposed to traumatic events than females. He also states that females are most likely to be exposed to certain types of trauma such as sexual abuse while male are often exposed to violence involving guns and other criminal acts. However, females tend to develop posttraumatic symptoms more than males. This argument can be understood when one considers how differently boys and girls are taught to deal with their emotions. Other factors such as the way in which males and females are socialised does contribute significantly. For example, males are socialised to be strong and brave. In more ways than one, this interferes with their way of coping:

> *"In our society, boys are generally taught to be strong while girls are allowed to be sensitive and show their emotions, even negative emotions such as fear. Since little girls are therefore allowed to give vent to, or display, their fears and rely on adults in their environment for support, it can be expected that they will not be affected as adversely by political violence as boys who are expected to repress—and, consequently, not to deal with—'unmasculine' emotions such as fear and anxiety"* (Duncan & Rock, 1994: 78).

The present study involved about 797 learners, 55.1% of which were females and 44.9% were males. In concert with the above statement more girls showed more symptoms of posttraumatic stress. It will appear in the following section that girls were more frequently exposed to traumatic events than boys. The argument made by McNally (1991) that boys tend to be more exposed to trauma than girl are was not confirmed by these results. However, McNally (1991) did indicate that girls would show more post-traumatic symptoms than boys. Therefore, the results of this study confirmed this and the argument by Duncan and Rock (1994) regarding the way in which girls show their emotions as opposed to boys. This means that in a long run the girls may be able to recover while it may take boys even longer.

5.1.2 Hypothesis 2: The frequency of exposure to stressful events will be much greater for boy than girls

The hypothesis that boys would be found to be more frequently exposed to traumatic events than girls was not confirmed in this study. In fact 46.2% of females were exposed to some form of traumatic incident as opposed to 36.8% for males. About 42% of girls met the criterion A (exposure to traumatic events) of the DSM IV PTSD criteria while only 33.8% were boys. More girls (36.5%) witnessed the events while only 4% reported to be the victims of the events. For boys, only 29.4% were witnesses while 4.5% were the victims.

Clearly from the above results it appears that girls were more vulnerable than boys partly due to the frequency of their exposure to traumatic stressors. Perhaps one

should understand that women especially young girls are the targets of horrible and violent acts. Girls are also exposed to a number of violent acts (such as rape) that are not easily picked up through the interviews as a result of the sensitivity of the incident. Clinical studies are often successful in soliciting this information, but it takes longer for the child to develop a trusting relationship to allow him or her to reveal their experiences.

Most studies (Duncan & Rock, 1994) have revealed that boys are more frequently exposed to traumatic events than girls. This also means that boys would present with more stress related symptoms subsequent to such exposure than their female counterparts. Duncan and Rock (1994) have also observed that while this is the case, this situation is reverse during adolescence. Clearly the results of the present study contradict the above observation. As the findings of the present study indicated above, girls were more vulnerable than boys. Foy, Madvig, Pynoos, and Camilleri (1996) report that findings with respect to gender differences in PTSD have been inconclusive. The present findings are however confirmed by the observation made by Foy et al., (1996). They pointed out that studies that reported significant differences have found higher distress scores among females.

Dawes (1992) sees the reason for male vulnerability as related to differential processes of socialisation. Perhaps one can argue that it is this differential processes that allow girls to effectively deal with their emotions. Since girls are able to show and express their emotion early after the trauma, this enables them to deal with the trauma. Boys on the other hand are encouraged to be *strong* and *masculine* and this

does not allow them to deal with their emotions. It is these repressed emotions that result in later difficulties associated with trauma.

5.1.3 Hypothesis 3: The severity of the PTSD symptoms is related to gender differences

The third hypothesis that the severity of PTSD symptoms was related to gender was also not confirmed in this study, suggesting that gender differences will have no influence on the severity of PTSD symptoms. In this study girls tended to exhibit higher PTSD scores than boys. Perhaps, according to some theories (McNally, 1991), girls are exposed to different incidents than boys. Although more children reported having witnessed incidents involving vehicle accidents, girls were also likely to report rape either as witnessed or experienced. Thus girls by virtue of being females are more vulnerable than boys to incidents of sexual nature.

Boys do experience acts of sexual violence but this occurs less frequently as compared to females. Females, or victims of sexual abuse generally, tend to be either overwhelmed or very inhibited about disclosing their abuse history (Van der Kolk, cited in Adam, Everett & O'Neal., 1992). It is therefore apparent that some traumas are not easily dealt with due to the nature of their sensitiveness.

5.1.4 Hypothesis 4: Significant differences will not be found in the frequency of PTSD across different schools

The hypothesis that different schools will show similar frequency and severity of PTSD was confirmed by this study. It appeared that schools were showing different means in the severity and presence of PTSD. There are a number of reasons one can think of. The most obvious one is that the number of learners administered questionnaires differed quite markedly across schools. This may have influenced the means as projected by different schools. It should also be important to note that the researcher believed that since these schools were coming from the same area (i.e. Sebokeng), children would have been exposed to similar events. Socio-economic variables and nature of discipline in schools are some of the reasons for these variations in means.

However, these schools are placed in different locations that have their own different characteristics. For example, some schools are situated in relatively poor areas while some are in the relatively affluent locations. Some schools were situated nearby the informal settlements and thus children from these places attended some of the schools in the study. Some schools appeared to be quite organised such that one would expect some kind of support for children from their educators. Some of the teachers and principals were also knowledgeable about the psychological services offered in the area and would have previously referred the children for these services. The scale used for this study did not provide the opportunity to investigate this possibility. Due to the nature of schools selection, which was random, the study could be said to be representative of the sample from the township. One would therefore expect to find these characteristics across different areas from which schools were sampled.

Clearly, this is a confluence of factors that were discussed above. It is important to note that children in the black townships are exposed to a complex interlink of the above factors. As most of these children come from very poor families—many of these families are disorganised—one would expect a relatively high degree of exposure and prevalence.