
Exploring the mental health needs of children

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Background

- CSA has been the subject of much research, yet limited work has been conducted in developing countries.
- The long-term negative health impact of CSA is well documented
- It has been associated with long-term physical and psychological consequences
- Review of literature from developed countries suggests that PTSD is one of the most common psychological responses
- However very little is known about children's psycho-social needs post sexual assault in South Africa

Aim

To develop an understanding of the mental health needs of children post rape and to what extent existing services meet these needs.



Study Design

- Longitudinal follow-up study
- Combining both qualitative and quantitative approaches
- A purposive sample of 33 cases of CSA (child & caregiver) were recruited at 2 sexual assault centres in the WC
- Girl children between the ages of 8-17years of age
- Psychological distress was assessed through self report in the children's interview
- Screening tools were used to assess children's psychological symptomatology

Data Collection

- 3 repeated interviews with children and caregiver with 4-6 weeks interval in between interviews
- Repeated interviews allowed for an assessment of social and psychological adjustment over time
- Interviews with children were worksheet based as the children are familiar with this concept
- All tools were translated into the 3 major language groups of the region and interviews were conducted in the language of choice
- The instruments used had been validated for use in SA (Seedat et al 2004, Flisher et al 2006 and Cluver et al 2007)

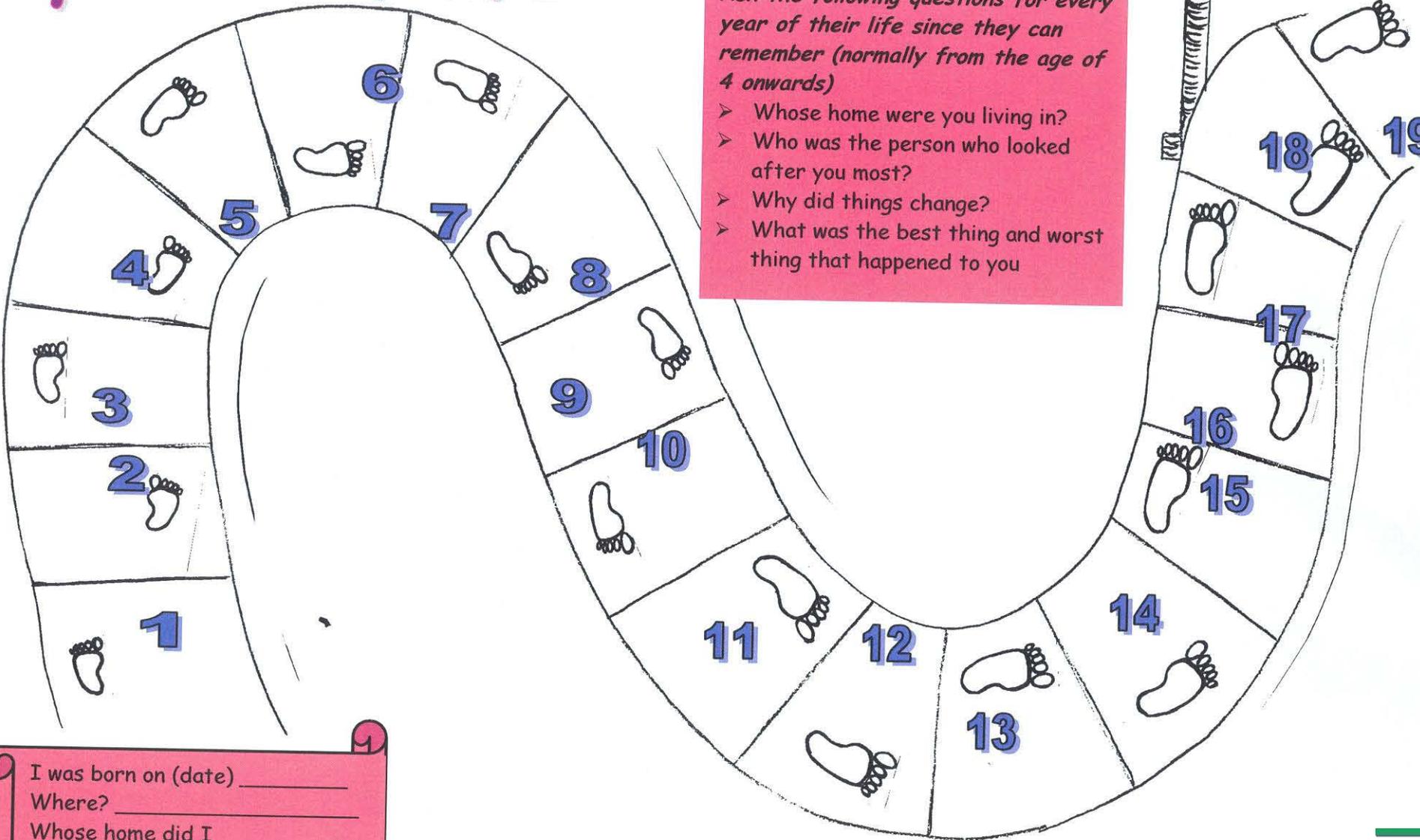
Child PTSD Checklist: Amaya-Jackson (1996) adapted by Seedat et al 2004

		not	some	most	all
	Do you get nightmares or bad dreams about what happened?				
Do you get upset when you think about what happened?					

- Depression was measured using the Child Depression Inventory (CDI short form) Kovacs 1992
- Validated for use in SA by Flisher et al 2006

My road of life

Section Four



Ask the following questions for every year of their life since they can remember (normally from the age of 4 onwards)

- Whose home were you living in?
- Who was the person who looked after you most?
- Why did things change?
- What was the best thing and worst thing that happened to you

1

I was born on (date) _____
Where? _____
Whose home did I live in? _____
Who looked after me most?

Data Analysis

- Qualitative Analysis

- Thematic content analysis
- Interviews were analysed inductively through a process of coding and sub-coding

- Quantitative Analysis

- Stata 10
- Univariate analysis – descriptive analysis of demographic data
- T-test for matched data to determine differences in PTSD scores

So what did we find?

Demographics

	n(%)
Age	
<12	6 (19.4)
12-14	14 (45.1)
15-17	11 (35.5)
Primary Caregiver	
Mother	9 (29.0)
Father	1 (3.2)
Both Parents	15 (48.5)
Other Relative	6 (19.3)

Self Reported Mental Health Assessment of Children

	4 weeks Post present (N=31)	8 - 12weeks Post present (N=30)	13 –16weeks Post present (N=30)
Depression Inventory			
<8	20 (64.5%)	26 (86.7%)	26 (86.7%)
≥8	11 (35.5%)	4 (13.3%)	4 (13.3%)
PTSD Mean Symptom Scores:			
- Re-experiencing (5)	3	2.6	1.7
- Avoidance (7)	3.7	3.7	3.1
- Hyper-arousal (5)	2.7	2.2	1.6
Full-symptom PTSD (n)	21 (67.7%)	14 (46.7%)	13 (43.3%)

Disclosure of CSA

- Disclosure of sexual assault is a difficult process for children leading to heightened anxiety
- A few presented with severe psychosomatic symptoms i.e. nightmares; headaches; tummy aches ... before disclosure
- Children expressed fear of their parents response with most expecting to be blamed
- Most children therefore do not disclose to parents but someone they think they can trust i.e. friend, teacher, relative

'This girl is actually questioning her own sanity because she's acting normal like nothing happened but she gets flashes all the time,... and I asked her that happened to you hey? She said no mommy!the very next day she went to the social worker and her what happened.'
(15 year old)

Children's mental health responses

- Children's responses are influenced by their caregivers ability to "cope" with the sexual assault
- Most children withdrew from normal activities such as mixing with friends, stayed indoors, and slept more in the immediate period post disclosure
- Children expressed continued feelings of fear
- Older girls displayed acting out – becoming aggressive and moody, mixing with the wrong friends, sleeping out, missing school
- Complexities in managing adolescents have been highlighted
- Teenagers are not treated as children and often blamed for the rape by both parents and services influencing their access to support services

Impact of CSA on caregivers

- The post rape period is a distressing and stressful period for caregivers
- Caregivers describe feels of “shock” and “anger”
- Many caregivers struggle to cope psychologically and they internalise their emotional pain
- Caregivers are unable to articulate their feelings, but describe it as felling “*sick*” or “*ill*”.
- Emotional distress is affected by their own exposure to trauma such as rape and intimate partner violence
- These impact on their ability to support the child in their recovery post rape

Mental health of caregivers

- For many secrecy about the rape is maintained
- Some maintain secrecy is also kept for fear of stigma
- This is linked to their feelings of shame and fear of blame
- Many avoid counselling as they find it too painful to talk about it
- For some “talking” about the rape is viewed as “taking them back”
- Carers avoid speaking about it and internalise feelings with some displaying physical symptoms

*“This thing really worried me very much, even if I am sitting alone it does not go away, it comes sometimes that I have visions, that I am the one seeing that thing”
(mother of a 12 year old)*

Psycho-social support

- Most children and carers did not access support services
- For those who attempted to access support this was fraught with bureaucratic obstacles such as waiting lists
- Accessing support was not prioritised by carers as this as competed with work demands
- Carers expressed disillusionment and frustration with services

“ I did not feel right at all, I did not like it, it felt like there was no help at all”.

Conclusions

- Psychological distress in children 4 -6 months post rape have been shown to remain high
- Responding appropriately to the needs of the child and caregiver is critical as this will facilitate post rape recovery
- Developing appropriate services have to take into account both the needs of the child and their carer
- Importantly our understanding of what constitutes an effective service in SA is limited and requires further investigation given our context