Exposure to violence in children referred for psychiatric evaluation

R. J. Nichol, G. Joubert, C. A. Gagiano

One hundred consecutive patients referred to the Child Mental Health Section of Oranje Hospital in Bloemfontein for psychiatric evaluation were included in the study. Seventy-four per cent of children in the study reported exposure to some form of violence in the past: 32% reported exposure to domestic violence, 9% disciplinary violence, 15% violent crime, 2% political violence, 24% sexual violence and 25% other forms of violence. Political violence did not feature prominently in the study.

S Afr Med J 1995; **85:** 584-586.

In South Africa, violence and the effects of violence feature prominently in the media. D. Lewis[1] has described violence as prevalent in every group of people, regardless of ethnicity, race or religion. M. Lewis[2] defined violence as 'behaviour by one person intended to cause pain, damage or destruction to another'.[2]

Within the South African context very little medical information on the effects of violence on children is available. Single studies have been published describing work done in certain communities.[3,4] Butchart and co-workers[5] feature a few children in their study on non-fatal injuries caused by interpersonal violence in Johannesburg-Soweto. Most of the findings, however, are dominated by adult statistics. Parry and Yach[6] quote 1988 mortality statistics for South Africa (excluding the TBVC states) which indicate that violence and trauma cause the most deaths in South Africa. These deaths must have a profound effect on the families (including children) of the victims.

The present study was undertaken to establish the nature and effects of violence within the local context by studying a group of children referred for psychiatric evaluation.

Method

The Child Mental Care Centre of Oranje Hospital in Bloemfontein is a tertiary referral unit that serves the whole Orange Free State region. Children and families have access to psychiatric care at peripheral clinics and hospitals in the region. Initially, patients are referred to the unit or peripheral clinics by general practitioners. In this study, consecutive children referred to the Centre for psychiatric evaluation

Department of Psychiatry and Division of Biostatistics, University of the Orange Free State, Bloemfontein

R. J. Nichol, M.B. CH.B., D.P.H., M.MED. (PSYCH.)

G. Joubert, B.A., B.SC. HONS

C. A. Gagiano, M.B. CH.B., M.MED. (PSYCH.), M.D.

were considered for inclusion in the study. The children and/or guardians were interviewed about the type(s) of violence they had been exposed to. The categories included: (*i*) *domestic violence* committed by family members, excluding disciplinary action and sexual molestation; (*ii*) *disciplinary violence,* i.e. physical violence administered to children as punishment; (*iii*) *criminal violence* considered contrary to the law, excluding violence with sexual, political or punitive connotations, but including street fighting; (*iv*) *political violence* or acts of terror relating to political unrest; (*v*) *sexual violence* ranging from fondling of the victim's genitals to forced prostitution, rape and sodomy.

The interview was carried out by a psychiatrist and/or psychiatric nurse by means of a structured questionnaire. Siblings were also included in the study, if available, where psychopathology was suspected. Some children could not be included in the study because of lack of parental consent and four black children with a severe degree of mental retardation could not be included as their parents were not available to give consent or the information needed. One hundred children were included in the study. The study took place between mid-April 1993 and mid-July 1993. The patients and/or guardians were asked to relate which type or types of violence the patient had been exposed to. They were asked whether or not the patients had behaved violently. A *DSM-III-R* multi-axial diagnosis was made after each evaluation.

Results

Of the 100 children included in the study, 45 were boys and 55 girls, and their ages ranged from 2,4 years to 18,8 years. The median age of boys was 9,8 and of girls 10,8 years. The language spoken at home was Afrikaans in 82 cases, English in 3, Sotho in 7, and other languages (including Zulu and Tswana) in 8. The racial composition according to the traditional South African classification was white 79, coloured 6, black 14 and Asian 1.

Of the children interviewed, 61% lived in urban areas of the Orange Free State or adjacent regions and 39% in rural areas. Socio-economic status was rated according to where the patient lived and the joint income of the family. Nine per cent came from the upper-income group, 62% from the middle-income group and 29% from the lower-income group. Seventy-four per cent of children (95% CI 64 - 82%) reported having been exposed to some form of violence in the past. Table I outlines the types of violence.

Table I. Types of violence to which children were exposed

Type of violence	All children (%) (*N* = 100)	Boys (%) (*N* = 45)	Girls (%) (*N* = 55)
Any violence	74	80	69
Domestic	32	38	27
Disciplinary	9	4	13
Crime	15	11	18
Political	2	0	4
Sexual	24	7	38
Other	25	49	5

Some children were exposed to more than one kind of violence.

Boys and girls had similar age and race distributions. Girls were significantly more likely to report sexual violence than boys (relative risk 5,7; 95% CI 1,8 - 17,9). Boys were significantly more likely to report 'other' violence (relative risk 9,0; 95% CI 2,9 - 28).

Thirty-nine per cent of children gave a history of aggressive behaviour. Boys who had experienced violence were 1,7 times more likely to behave violently than boys who had not (95% CI 0,65 - 4,2), whereas girls who had experienced violence were 2,8 times more likely to behave violently than those who had not (95% CI 0,70 - 10,7). In only 3 cases could no axis I or axis II diagnosis be made. Approximately one-third of patients had a mood disorder and one-third anxiety disorders; the remaining third was a miscellaneous group which included children with attention-deficit hyperactivity disorder and conduct disorders.

Discussion

Although the province has access to psychiatric clinics scattered throughout the region, these statistics probably reflect under-utilisation of these facilities. Many children do not seek help or are not referred to the clinics by general practitioners. That nearly 40% of children interviewed were from rural areas representing most parts of the province is encouraging. The predominance of Afrikaans-speaking children can be understood within the context of the Orange Free State. The *DSM-III-R* diagnoses indicate that most referrals were appropriate.

Exposure to violence

Twenty-six per cent of the children interviewed stated that they had never been exposed to any form of violence. Despite the continuing political unrest in South Africa, only 2% of patients reported experiencing political violence.

This may be a result of the over-representation of white children in the study and the fact that a large part of the political unrest has occurred within black townships or been directed at elderly, isolated farmers, or that children use denial as a defence mechanism when exposed to ongoing political violence.[7] The high prevalence of domestic and sexual abuse, often left unreported and untreated for long periods of time, is alarming. Physicians and other therapists working with children and families should investigate the role and implications of violence in the life of the patient being treated. Individual and family therapy can play a vital role in helping the victims of violence within the family and help to prevent further abuse.

REFERENCES

1. Lewis D. From abuse to violence: psycho-physiological consequences of maltreatment. *J Am Acad Child Adolesc Psychiatry* 1992; **31:** 383-391.
2. Lewis M. *Child and Adolescent Psychiatry: A Comprehensive Textbook.* 1st ed. Baltimore: Williams & Wilkins, 1991: 331.
3. Pillay Y, Magwaza A, Petersen I. Civil conflict in Mpululanga: some mental health sequelae in a sample of children and their primary caregivers. *S Afr Child Adolesc Psychiatry* 1992; **4**(2): 42-45.
4. Abdool Karim S S, Andelman R. Impact of the political violence in Natal on emergency surgical services of a tertiary hospital. *S Afr Med J* 1991; **88:** 134-138.
5. Butchart A, Brown D. Non-fatal injuries due to interpersonal violence in Johannesburg-Soweto: incidence, determinants and consequences. *Forensic Sci Int* 1991; **52:** 35-51.
6. Parry CDH, Yach D. Public health in South Africa: need for greater input from psychologists. *J Comp Health* 1993; **4**(2): 58-62.
7. Dawes A, Donald D. *Childhood and Adversity: Psychological Perspectives from South African Research.* Cape Town: David Philip (in press).

Accepted 6 Oct 1994.