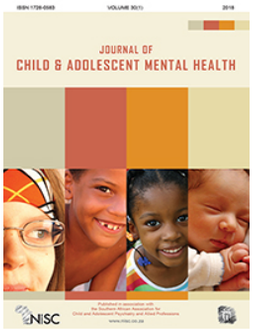

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# Social support, violence exposure and mental health among young South African adolescents

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***Objective:*** **Cumulative violence exposure has been associated with both internalising and externalising difficulties in youth. Therefore, it is important to identify protective factors that may ameliorate both exposure to and the impact of cumulative violence. This study aimed to identify sources of perceived social support amongst early adolescents in a low-income, high-violence community in South Africa, and to examine the association of perceived support with exposure to violence and with the severity of depression, aggression and conduct disorder symptoms.**
***Method:*** **A sample of 615 Grade 7 learners completed measures of perceived social support, different types of violence exposure and symptoms of depression, aggression and conduct disorder.**
***Results:*** **Maternal, paternal and overall family support were weakly associated with a reduced risk of domestic violence, but not with other forms of violence exposure, and were also weakly associated with a reduced risk of mental health difficulties. Peer support was associated with higher symptomatology across all mental health outcomes while teacher support was associated with greater severity of depression.**
***Conclusions:*** **The stress-buffering effects of social support may not be maintained in contexts of high exposure to violence. Implications for interventions to enhance youth safety and resilience in high-violence contexts are considered.**

Violence is a feature of daily life for many children and adolescents in South Africa. High rates of exposure to community, domestic, school, and sexual violence, through witnessing and direct victimisation, have been consistently reported across community-based samples (Cluver, Gardner, & Operario, 2007; Kaminer, du Plessis, Hardy, & Benjamin, 2013) as well as national prevalence studies of South African youth (Burton, 2006). Further, poly-victimisation or experiencing different types of violence simultaneously, appears to be the norm rather than the exception, affecting over 80% of adolescents in community-based samples (Collings, Penning, & Valjee, 2014; Kaminer, du Plessis, Hardy, & Benjamin, 2013). The everyday nature of violence exposure amongst young South Africans does not, however, mean that its impact is psychologically benign. Rather, increasing levels of overall violence exposure and higher levels of poly-victimisation are associated with an increased risk for both internalising and externalising mental health difficulties in both international (Finkelhor, Ormrod, & Turner, 2007; McCart et al., 2007) and South African samples of schoolgoers (Collings et al., 2014; Kaminer et al., 2013). It is therefore important to identify factors that may protect youth against both violence exposure and the associated negative mental health outcomes.

Research from low-income urban samples in the United States suggests that social support may be an important protective factor. Most studies examining the protective role of social support have focused on family support alone. In contexts of high levels of community violence, children and adolescents with greater levels of perceived familial support demonstrate lower levels of violence exposure and internalising and externalising symptoms than their peers who have lower levels of perceived family support (Benhorin & McMahon, 2008; Gorman-Smith, Henry, & Tolan, 2004; Jones, 2007; Kaynak, Lepore, & Kliewer, 2011; Scarpa, Haden, & Hurley, 2006; O'Donnell, Schwab-Stone,

& Muyeed, 2002), suggesting a protective stabilising effect. However, the protective effect of family support has ranged from small to large across studies (Ozer, Lavi, Douglas, & Wolf, 2017), indicating variability in the degree of protection that social support provides, and familial support has seldom been disaggregated across different family members. Several studies have found a protective–reactive pattern whereby the protective effect of supportive family relationships on child and adolescent mental health is present at low to moderate levels of violence exposure but is not sustained at very high levels of exposure (Hammack, Richards, Luo, Edlynn, & Roy, 2004; Salzinger, Feldman, Rosario, & Ng-Mak, 2010). Few international studies have examined whether peer and teacher support offers protection from exposure to violence and its mental health consequences, and findings have been inconsistent (Ozer et al., 2017).

The South African context is characterised by diverse family compositions (such as child-headed households, extended family households and high rates of paternal non-residence) (Meintjies, Hall, Marera, & Boulle, 2010; Posel & Devey, 2006), as well as family systems struggling with multiple adversities that may undermine family support capacities. In this context, understanding the role played by different sources of support in mitigating violence exposure and its effects could inform the development of community-based youth protection and youth resiliency programmes. However, within the limited South African research base on the relationship between social support and levels of violence exposure, findings have not been consistent: one study found that higher levels of overall perceived social support were associated with a reduced risk of community violence exposure and childhood abuse (Bruwer, Emsley, Kidd, Lochner, & Seedat, 2008) while others have found that social support does not reduce the risk of child abuse (Meinck, Cluver, Boyes, & Mhlongo, 2015). Some South African research has found that higher overall levels of social support are associated with a reduced risk of negative mental health outcomes (Bruwer et al., 2008; Cluver, Fincham, & Seedat, 2009; Shields, Nadasen, & Pierce, 2008; Stansfeld et al., 2017) but results were not disaggregated by source of support. In the one study that did report on specific sources of support, school support was associated with reduced levels of depression and conduct problems in Grade 6 learners while parent support had no effect on mental health outcomes (Ward, Martin, Theron, & Distiller, 2007), suggesting possible differential effects across sources of support.

Currently, it is unclear which specific sources of social support are most strongly associated with violence exposure and its effects amongst international and South African youth. Further, gender and developmental patterns in the protective role of social support for youth in high-violence contexts have not been well delineated in previous research.

## Research aims

This study examined the relationship between social support, violence exposure and mental health outcomes amongst young South African adolescents in a low-income, high-violence community. Young adolescents, who straddle the home and community more equally than either younger children or older adolescents, may have developmentally unique experiences of social support. The following questions were examined:

- Which sources (mothers, fathers, nuclear families as a whole, relatives in the extended family, teachers, and peers) are perceived to provide the highest level of social support, and does this differ by participant gender?
- Is there an association between perceived social support from different sources and exposure to different types of violence?
- Is perceived social support from different sources associated with the severity of aggression, depression, and conduct disorder symptoms?

## Method

### *Sample*

A cross-sectional survey was conducted with 616 Grade 7 students attending 9 different schools in a low-income, high-violence community in Cape Town, South Africa in 2012–2013. Only 5.6% ($n = 37$) of all learners at the 9 schools included in the sample declined to participate. Participants'

ages ranged from 12 to 15 years, with a mean age of 12.8 years (SD = 0.74). Female participants comprised 54.7% ($n = 450$) of the sample while 45.3% ($n = 278$) were male. Regarding household composition, just over half of the adolescents (55.4%, $n = 342$) lived with their nuclear families, approximately a quarter (25.3%, $n = 156$) were being raised by a single biological parent, a small proportion (12.6%, $n = 78$) lived in reconstituted families (that is, with a biological parent and a step-parent or partner of the biological parent) and the remainder (6.5%, $n = 40$) stayed in other household compositions. Participants shared a home with an average of 6.17 people (SD = 4.28).

The residential area in which the study was conducted has high levels of gang activity and 58% of its population lives on less than US$270 per household per month (City of Cape Town, 2011). Previously published rates of violence exposure in this sample are high (Kaminer et al., 2013): almost all participants (98.9%) had witnessed community violence, 40.1% had been directly threatened or assaulted in the community, 76.9% had witnessed domestic violence, 58.6% had been directly victimised at home, 75.8% reported direct or indirect exposure to school violence, and 8% reported that they had been sexually abused. Over 93% of participants had experienced more than one type of violence and over half of the sample had experienced four or more types of violence. The association between violence exposure and mental health outcomes has also been previously reported for this sample (du Plessis, Kaminer, Hardy, & Benjamin, 2015). Witnessing violence in the community or at home, direct victimisation in the community or at home, exposure to school violence, and sexual victimisation were all significantly associated with the severity of depression, aggression and conduct disorder.

### *Instruments*

*Demographic questionnaire*

A brief demographic questionnaire was developed specifically for this study and enquired about participants' gender, age, household size and household composition. Although only gender was considered a variable in this study, the other demographic information was collected in order to characterise the sample.

*Social support*

A social support questionnaire was developed specifically for this study in order to target all types and sources of social support likely to be relevant to the sample under study. Three items from the Social Support Scale of the Adolescent Pathways Project (APP) (Seidman & Pedersen, 2003) were combined with two items from the Multidimensional Scale of Perceived Social Support (MSPSS) (Canty-Mitchell & Zimet, 2000) to yield five questions, each addressing a different type of social support: support with personal problem solving (this subscale had an alpha coefficient of $\alpha = 0.75$); monetary support ($\alpha = 0.69$); emotional support ($\alpha = 0.80$); shared free-time activities ($\alpha = 0.74$); and support with decision making ($\alpha = 0.76$). Each of the five questions was answered with regard to each of the following 11 sources of perceived support: mother, father, siblings, grandmother, grandfather, aunt, uncle, cousins, best friends, close group of friends, and teachers, making a total of 55 items. Responses were indicated on a three-point Likert scale with the answering options "never" (0), "sometimes" (1), and "often" (2). For data analysis, sources of social support were grouped into immediate family ($\alpha = 0.85$), relatives ($\alpha = 0.91$), peers ($\alpha = 0.86$), and teachers ($\alpha = 0.68$). Maternal and paternal support were also examined separately.

*Exposure to violence*

An adapted version of the Child Exposure to Community Violence Checklist (CECV) (Amaya-Jackson, 1998) was used to assess participants' level of lifetime violence exposure to six forms of violence: (1) community violence victimisation (this included five forms of direct victimisation in the community, excluding sexual victimisation); (2) community violence witnessing (this included witnessing of nine types of violence in the community); (3) domestic violence victimisation (this included eight forms of direct victimisation in the home, excluding sexual victimisation); (4) domestic violence witnessing (this included witnessing of five forms of violence in the home); (5) exposure to school violence (this included exposure to six forms of direct and witnessed victimisation at school,

excluding sexual victimisation); and (6) sexual victimisation (this included sexual victimisation at home, at school or in the community). Exposure to violence as a perpetrator was not assessed. The list of items for each scale can be found in Kaminer et al. (2013).

The CECV has demonstrated good internal consistency in a previous study with youth exposed to violence in South Africa (Fincham, Altes, Stein, & Seedat, 2009). For this study, some items were added to the CECV to examine violence exposure across different sites, while some items were removed as they do not assess violence exposure but rather the presence of ambient criminal activity. The adapted version used in this study had good internal consistency with a Cronbach's alpha of 0.86.

*Depression*

Symptoms of depression during the past month were measured with the depression subscale of the Social and Health Assessment Scales (SAHA) (Rushkin et al., 2004). The scale's internal consistency of $\alpha = 0.84$ was similar to the internal consistency ($\alpha = 0.80$) of the same scale used in a previous study among a sample of South African adolescents (Ward et al., 2007).

*Aggression*

Three of the four subscales of the Aggression Questionnaire (AQ) (Buss & Perry, 1992) were used to measure the participants' level of aggression in our study. These assessed physical aggression, anger, and hostility. The subscale for verbal aggression was excluded. The internal consistency of the AQ in the current study was $\alpha = 0.84$.

*Conduct disorder*

Eleven items from the delinquency subscale of the Child Behaviour Checklist (CBCL) (Achenbach & Edelbrock, 1983) were used to assess conduct problems, including the frequency of stealing, substance abuse, and truancy. The subscale has shown good internal consistency ($\alpha = 0.89$) in a past study with South African adolescents (Cluver et al., 2007); internal consistency in the present study was $\alpha = 0.70$.

***Data analysis***

Two cases were excluded in gender-specific analyses because participants did not indicate their gender, and one case was excluded because most of the responses were incomplete. For the remaining participants, missing data was addressed using the two-way multiple imputation with error method (Method TW) (Little & Su, 1989; van Ginkel, Sijtsma, van der Ark, & Vermunt, 2010). The software package SPSS 23.0 (IBM Corp., 2014) was used for data analysis.

## Results

***Sources of perceived social support for total sample***

Sources of perceived social support for the sample are presented in Table 1. The mean scale score for each source of social support could reach a value between 0 and 2, representing the Likert scale answering options ("never" = 0, "sometimes" = 1, "always" = 2). Maternal social support was rated highest, followed by collective nuclear family support and then paternal support. Peers were the next most important source of support, and relatives and then teachers were the lowest perceived sources of social support.

***Gender differences in sources of perceived social support***

Using independent-sample *t*-tests, gender differences in mean rates of social support from different sources and overall social support were examined (Table 2). A difference at the $p < 0.05$ level was found for paternal social support, with boys ($M = 1.15$, SD = 0.64) perceiving significantly more social support from their fathers than girls ($M = 1.04$, SD = 0.65). A difference at the $p < 0.001$ level was found for social support provided by peers, with girls perceiving significantly more social support from their peers ($M = 1.10$, SD = 0.48) than boys ($M = 0.95$, SD = 0.47). There were no significant gender differences in other sources of social support, including for overall social support.

**Table 1:** Descriptive statistics for perceived social support by source ($n = 615$)

| Source of perceived social support | *M* | SD |
|---|---|---|
| Family | 1.20 | 0.41 |
| Mother | 1.55 | 0.47 |
| Father | 1.09 | 0.65 |
| Relatives | 0.89 | 0.43 |
| Peers | 1.03 | 0.48 |
| Teachers | 0.74 | 0.44 |
| Overall support | 0.98 | 0.32 |

### *Association of different sources of social support with violence exposure*

Pearson's product–moment correlations were calculated to determine the associations between sources of social support and types of violence exposure. Since correlation coefficients tend to not follow a normal distribution, the Fisher *z*-transformation was applied to the imputed correlation coefficients in order to transform them towards normality. Rubin's rule was applied to the transformed data in order to receive the pooled estimates and these were back-transformed using the Fisher *z*-transformation which are the values reported (Schafer, 1997, cited in van Buuren, 2012). See Table 3 for the correlation coefficients and their significance levels.

Maternal, paternal and overall immediate family support were each significantly negatively associated with domestic violence witnessing and victimisation, indicating that participants who perceived higher levels of support from immediate family members were less likely to experience any form of domestic violence. Support from relatives and from teachers were both significantly positively associated with witnessing community violence, indicating that participants with higher levels of perceived support from these two sources were also more likely to have witnessed community violence. Peer social support was not significantly associated with any form of violence exposure. There were no significant correlations between any source of social support and exposure to community violence victimisation, school violence or sexual abuse.

**Table 2:** Gender differences in perceived social support by source ($n = 614$)

| Source of perceived social support | *t* | df | *p* |
|---|---|---|---|
| Family | 0.88 | 610 | 0.379 |
| Mother | –0.94 | 609 | 0.349 |
| Father | 2.15 | 610 | 0.032 |
| Relatives | 1.73 | 610 | 0.084 |
| Peers | –3.87 | 612 | 0.000 |
| Teachers | –1.83 | 612 | 0.067 |
| Overall support | 0.09 | 612 | 0.93 |

**Table 3:** Pearson's product–moment correlations for associations between sources of perceived social support and violence exposure ($n = 614$)

| Source of perceived social support | Community violence | | Domestic violence | | School violence | Sexual abuse victimisation |
|---|---|---|---|---|---|---|
| | Witnessing | Victimisation | Witnessing | Victimisation | Witnessing or victimisation | |
| Family | –0.02 | 0.02 | –0.10* | –0.17** | 0.00 | –0.04 |
| Mother | –0.01 | –0.07 | –0.11** | –0.24** | –0.08 | –0.02 |
| Father | –0.03 | 0.02 | –0.10* | –0.12** | 0.03 | –0.05 |
| Relatives | 0.08* | 0.04 | –0.02 | –0.07 | 0.03 | 0.01 |
| Peers | 0.06 | 0.07 | 0.04 | 0.05 | –0.01 | 0.01 |

*$p < 0.05$; **$p < 0.001$

The largest strength of correlation was found for the relationship between maternal social support and domestic violence victimisation ($r = -0.24$), with maternal support accounting for 6% of victimisation at home. The strength of this correlation would be categorised as moderate according to Hemphill (2003) but as small according to Cohen (1992). All of the other significant correlations would be categorised as small according to both Cohen (1992) and Hemphill (2003); in each case, the analysed variables accounted for less than 3% of the variance in violence exposure.

***Association of different sources of social support with mental health***

Pearson's product–moment correlations were calculated to determine the association of different sources of social support with depression, aggression and conduct disorder. See Table 4 for the correlation coefficients and their significance levels. Maternal, paternal and overall immediate family support were each negatively associated with all three mental health outcomes, indicating that higher levels of support from all immediate family sources is associated with lower symptoms of both internalising (depression) and externalising (aggression and conduct) symptoms. Peer support was also significantly associated with all three mental health outcomes, but in a positive direction, suggesting that higher levels of perceived support from friends is associated with higher levels of depression, aggression and conduct symptoms. Teacher support was significantly positively associated with depression but had no association with the externalising outcomes, while support from relatives and overall levels of support were not significantly associated with any outcome. The effect sizes of all reported correlations between social support and mental health outcomes were small, according to Cohen (1992).

## Discussion

The young adolescents in this sample on average perceived their immediate families, particularly their mothers, to be their strongest source of social support. This suggests that while younger adolescents are developmentally on the cusp of greater separation and autonomy from their families, the immediate family system remains the most important source of perceived support. Given that a quarter of the sample were being raised in a single parent household in a country where non-residential fathers are common (Posel & Devey, 2006), it is unsurprising that mothers emerged as the most important source of perceived support. As little previous research with younger adolescents has disaggregated support from different family members, comparisons with previous findings cannot be drawn. It is, however, important to note that paternal support was perceived by participants to be higher than support from outside the immediate family. Further, paternal support was perceived to be higher amongst boys than girls, suggesting that fathers may have a particularly salient support role for young adolescent boys in this community. The social support role of fathers for youth in high-violence contexts has seldom been specifically assessed and these findings suggest that this warrants further investigation. Importantly, high rates of paternal non-residence do not necessarily imply that fathers fit the stereotype of the "bad dad" (Miller, 2011) who is absent as a support figure for young adolescents in this community.

**Table 4:** Pearson's product–moment correlations for associations between sources of social support and severity of depression, aggression and conduct disorder symptoms ($n = 614$)

| Source of support | Depression | Aggression | Conduct Disorder |
|---|---|---|---|
| Family | –0.10* | –0.05 | –0.08 |
| Mother | –0.17** | –0.10* | –0.10* |
| Father | –0.11** | –0.06 | –0.09* |
| Relatives | 0.02 | 0.01 | –0.01 |
| Peers | 0.12** | 0.13** | 0.11** |
| Teachers | 0.11** | 0.06 | 0.02 |

*$p < 0.05$; **$p < 0.001$

Outside of the immediate family, peers were the next most important source of perceived support in the sample, and this source of support was more salient for girls than for boys. This gender difference is consistent with findings from other contexts outside South Africa (Bender & Lösel, 1997; Bokhorst, Sumter, & Westenberg, 2010), and may point towards a greater capacity amongst girls to build, maintain and draw on supportive peer relationships. Teachers and extended family relatives were viewed as less supportive than immediate family members and peers, suggesting that there may be scope to enhance the perceived support role played by these sources.

The findings reflect the absence of any strong relationship between perceived social support and violence exposure amongst young adolescents in the sample. Greater perceived social support from mothers, and to a lesser extent fathers and the immediate family as a unit, was significantly though weakly associated with lower exposure to domestic violence. It is to be expected that in families characterised by domestic violence, familial social support may be perceived to be lower, while families that are relatively violence-free are perceived to be better able to support family members. However, it is concerning that familial support showed no relationship with reduced risk of exposure to violence outside the home or to sexual victimisation, possibly reflecting the limited capacity of even supportive families to protect young adolescents from the multiple risks that are pervasive in this community. Similarly, peer social support, while the next most important source of perceived support outside the immediate family, showed no relationship with any form of violence exposure and therefore appears to afford no significant protection. Higher levels of perceived support from extended family members and from teachers were also not significantly associated with levels of violence exposure across most domains, except with a greater likelihood of having witnessed community violence. This was, however, a weak correlation, and may be accounted for by participants seeking out support from teachers and relatives if they have witnessed frequent community violence.

While higher levels of support from all immediate family sources were associated with lower internalising and externalising symptoms, the effect sizes were small and may indicate a lack of practical significance in contexts of high levels of violence. Increased peer support was significantly associated with higher levels of internalising and externalising symptoms. Again, this was a weak association with little practical significance but it may warrant further exploration to establish how higher levels of peer support may be related to a greater severity of mental health difficulties. The type of peer group (pro-social or anti-social) may be a factor in this relationship (Griffin et al., 2003; Halliday-Boykins, & Graham, 2001). Higher levels of teacher support were weakly associated with a greater severity of depressive symptoms. While this could indicate that teacher support somehow makes young adolescents more vulnerable to depression, it may also reflect that participants with obvious depressive symptoms are more likely to seek out or to elicit support from their teachers than those without such difficulties. Support from relatives in the extended family was not associated with either internalising or externalising outcomes.

This study had several limitations and the results should therefore be considered somewhat cautiously. First, the social support scale used was constructed for the study from two existing measures of perceived social support and, while it had good internal consistency, its validity has not been established. Furthermore, in general, perceived social support may not be as valid as more objective measures of social support; it is possible that participants may have over-estimated their levels of social support. It would be beneficial for future research to measure received social support through more objective measures in addition to measuring perceived social support. In addition, the three-point Likert scale format may have created a central tendency in response patterns which do not accurately reflect the range of perceived support across the sample. This lack of variability may have contributed to the failure to find strong significant relationships.

The current study examined the association of perceived social support with several different forms of violence but did not examine its association with the more complex victimisation profiles that have commonly been documented amongst youth globally, including poly-victimisation (Finkelhor et al., 2007) and mixed perpetrator-victim profiles (Weierstall, Hinsberger, Kaminer, Holtzhausen, Madikane, & Elbert, 2013). Furthermore, this study did not examine the ways in which different family compositions (for example, having non-resident fathers or having a non-resident mother or

having a resident grandmother) may have an impact on sources of perceived social support. This could contribute to a more nuanced understanding of how sources of social support are perceived by youth in high violence contexts.

While bearing these limitations in mind, the findings suggest that social support, including support from immediate family members, has, at best, a weak association with any type of violence exposure or with negative mental health outcomes among young adolescents in this high-violence community. This is consistent with some previous findings that social support may no longer be protective when levels of violence exposure are high. In the current study, an amount of support around the middle of the scale was indicated for most sources of support; such moderate levels of perceived social support may not be sufficient to offer protective effects in a context with very high levels of violence across multiple sites. However, the presence of some association between family support and reduced levels of all three mental health outcomes suggests that this source of support, if developed through family strengthening interventions (focusing on, for example, communication, positive time together, positive parenting skills, and emotional support), may be able to play a protective role. Family strengthening interventions in this context should also specifically address ways that families can assist to reduce violence exposure for young adolescents outside the home (such as creating open communication channels for talking about risk and safety, and negotiating young adolescents' strivings for autonomy in a safe way), while providing a physical and emotional safe haven within a dangerous broader context. Further, the absence of any significant stress-buffering role of social support for young adolescents amplifies the urgent need for clear policies and structural changes that effectively reduce levels of violence in South African communities.

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