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Exploring the lived experiences of children in relation to trauma and violence exposure in the Vhembe district

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Abstract

Background Violence and trauma exposure among children remain critical public health issues, particularly in under-resourced regions such as the Vhembe district, South Africa. Although much is known about the prevalence of child abuse, limited research explores children's lived experiences and coping mechanisms from their own perspectives.

Objective This study aimed to explore the lived experiences of children exposed to trauma and violence in the Vhembe district, focusing on their emotional responses, coping strategies, and perceived sources of support.

Methods A qualitative research design using Interpretative Phenomenological Analysis (IPA) was adopted. Semi-structured interviews were conducted with fourteen children aged 9–17 years who had experienced trauma or violence and were receiving counselling services at the Thohoyandou Victim Empowerment Programme.

Results Participants reported multiple forms of violence: physical, sexual, emotional, and community-based, often perpetrated by trusted caregivers. Themes included fear, isolation, physical and psychological pain, and reliance on avoidance or social coping strategies.

Conclusion Exposure to violence profoundly shapes children's emotional well-being and coping capacity. These findings emphasize the need for trauma-informed, child-centered mental health services and school-based psychosocial interventions. Future research should expand to explore gender-specific experiences and community-level prevention strategies within rural South African contexts.

Keywords Childhood trauma, Violence exposure, Coping strategies, Interpretative phenomenological analysis, Emotional well-being

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Introduction

According to a secondary data analysis of Indonesia's National Survey on Children and Adolescents' Life Experience, approximately 46.2% of children had experienced some form of violence, including physical, emotional, and sexual abuse [1]. A systematic review indicates that in Africa, Asia, and North America, the prevalence rates of children experiencing violence are at least 50%, which underscores similarly high rates reported across various regions. For instance, in the Balkan countries, lifetime prevalence rates of exposure to physical violence among children range from 50.7% to 76.4%, with past-year victimization rates between 42.4% and 51.0% [2]. In South Africa, although community victimization is less prevalent in early childhood, significant rates of violence exposure emerge as children transition into adolescence [3]. These figures collectively underscore that exposure to violence is a pervasive issue, with some regions reporting even higher statistics compared to global averages.

Child trauma and exposure to violence remains a profound and systemic issue in South Africa, characterized by alarming statistics and a pressing need for comprehensive intervention. The prevalence of violence against children is staggering, with numerous studies revealing that approximately one in three children in South Africa have been victims of sexual violence or physical abuse by the age of 18 [4, 5]. Moreover, 12% of children experience neglect, and 16% report emotional abuse, pointing to a multifaceted landscape of child maltreatment [4, 5].

The ramifications of this violence extend far beyond immediate physical harm; they manifest as significant long-term psychological and social challenges. Evidence suggests that 58% of South African adolescents have encountered physical or emotional violence in their youth, correlating with adverse mental health outcomes, hampered educational achievements, and a diminished quality of life [6]. These statistics are contextualized within a broader scope of endemic violence, where South Africa's child homicide rate is approximately 5.5 per 100,000, more than double the global average, with a considerable fraction of these homicides linked to child abuse and neglect [7].

In the context of socio-economic factors, low-income communities are disproportionately affected, often exacerbated by the intergenerational impacts of poverty and historical injustice [8]. This structural violence contributes to the normalization of aggressive behaviors within these communities, leading to cycles of trauma and victimization that can span generations. Children living in low-income areas are particularly vulnerable to community violence, which further compounds their risk of exposure to domestic violence and abuse within their families [9].

Research conducted in Limpopo shows that women who witnessed Intimate Partner Violence as children are significantly more likely to engage in minor sexual coercion as adults, indicating a learned behavior from exposure to violence [10]. Moreover, nearly 70% of men across various South African contexts have reported experiencing adverse events during childhood, underscoring the intergenerational transmission of violence and trauma [11].

There is little evidence of the lived experiences of children with childhood trauma and exposure to violence in a rural setting, such as the Vhembe district, being explored and described. This study is part of the umbrella study that intended to develop and validate an intervention for children who had been exposed to trauma and violence in Vhembe district, South Africa [12]. It is essential to document the lived experiences of these children and to develop contextually and culturally relevant therapeutic approaches that can provide comprehensive support to them.

Despite growing evidence on the prevalence and consequences of childhood trauma, there remains limited qualitative insight into the lived experiences of children in rural South African settings, particularly in the Vhembe district. Existing studies have focused predominantly on adult survivors or quantitative prevalence data, leaving a gap in understanding the subjective meanings children attach to their trauma experiences. This study addresses this gap by exploring the lived experiences of children exposed to trauma and violence in Vhembe, thereby contributing context-specific knowledge to inform culturally sensitive therapeutic interventions. This study makes a unique contribution by applying Interpretative Phenomenological Analysis (IPA) to children's narratives within a rural South African context, a perspective that is seldom explored in trauma literature. Capturing first-person experiences provides grounded evidence to inform trauma-informed care approaches in under-researched communities.

Methodology

Research design

A phenomenological qualitative research design was used to explore and describe the lived experiences of children who had been exposed to trauma and violence in the Vhembe district. The inquiry design is based on philosophy and psychology, through which researchers describe the lived experiences of persons with the phenomenon as described by the participants [13]. This description captures the essence of multiple participants' encounters with the phenomenon. This design has significant philosophical underpinnings and usually entails conducting interviews.

A phenomenological qualitative research design aims to explore and understand the lived experiences of individuals regarding a specific phenomenon, in this case, the effects of trauma and violence on children and the consequent symptoms of depression and PTSD. This methodological approach is particularly appropriate for studying the psychological impact of trauma on children, as it allows for a deep exploration of their subjective experiences and the meanings they attach to them, providing insights that may be overlooked in quantitative studies.

Study setting

Data was obtained at two specific places where children who had been exposed to trauma and violence are treated. Both selected locations are located in the Vhembe district of Thoyondou. The Vhembe district, located in Limpopo province, is predominantly rural, with communities facing socio-economic hardship, limited access to mental health resources, and high rates of gender-based and community violence.

Study population and sampling

The children recruited for this study ranged in age from 9 years to 17 years, had undergone childhood trauma and violence, and were interviewed at two sites in the Vhembe region of Thohoyandou. A purposive sampling technique was used to select participants who had experienced trauma or violence and were attending therapy at the Thohoyandou Victim Empowerment Programme (TVEP). Fourteen children aged 9–17 participated in this study. Participants included 12 girls and 2 boys, reflecting the predominance of female victims seeking psychosocial support. All participants were currently attending school and receiving services from trauma centres linked to TVEP. Although the initial recruitment aimed for fifteen participants, one withdrew before data collection. Data saturation, the point where no new themes emerged, was reached after the twelfth interview, with two additional interviews confirming thematic redundancy. The sample size aligns with phenomenological research standards, which prioritize depth over breadth, allowing for rich, detailed exploration of lived experiences.

Inclusion and exclusion criteria

Participants were selected based on clear inclusion and exclusion criteria to ensure ethical participation and data quality. Inclusion criteria were as follows:

- Children aged between 9 and 17 years who had experienced trauma or violence, including physical, sexual, or emotional abuse, and who were receiving counselling services at the Thohoyandou Victim Empowerment Programme (TVEP).

- Children who were able to communicate their experiences in Tshivenda or English and demonstrate sufficient emotional and cognitive capacity to participate in an interview.
- Children who had experienced trauma at least one month prior to data collection to minimize acute distress.
- Written informed consent obtained from the child's legal guardian and assent from the child.

Exclusion criteria included:

- Children younger than nine or older than seventeen.
- Children who were experiencing acute psychiatric crises (e.g., active psychosis, suicidal ideation requiring immediate medical intervention) at the time of data collection.
- Children whose guardians did not consent or where the child declined to participate despite guardian consent.

These criteria ensured that participation was voluntary, ethically sound, and appropriate for the sensitive nature of the study.

Ethical safeguards for emotional distress

Given the sensitive nature of the topic and the vulnerability of child participants, a comprehensive protocol was implemented to manage potential emotional distress during and after interviews.

Identification of distress

During interviews, the researcher continuously observed verbal and non-verbal cues (such as crying, agitation, withdrawal) to identify signs of emotional distress. A distress checklist adapted from trauma counselling protocols guided these observations.

Immediate response

When distress was observed, the interview was paused, and participants were offered the option to take a break, discontinue, or continue at a later time.

Evaluation and referral

A registered counsellor stationed at the Thohoyandou Victim Empowerment Programme was responsible for evaluating each participant's emotional state immediately after the session. Children showing signs of acute distress were referred to the district hospital psychologist for further assessment.

Follow-up support

Follow-up appointments were scheduled within one week for referred participants to ensure continuity of

psychological care. Counsellors also provided debriefing sessions for all participants after interviews to help them process the experience safely.

These safeguards align with ethical guidelines for research involving vulnerable populations and ensure that participants' welfare is prioritised at all stages of data collection.

Data collection

Data were collected using in-depth individual interviews at the two sites. The first Author is a qualified clinical psychologist and ensured that the children interviewed were referred following the interviews, and appointment dates were given. The referral was made by the registered counsellor from the centre, who assisted with the list of appointments for children who would be coming for therapy. Interviews were conducted in a private counselling room at the Thohoyandou Victim Empowerment Centre to ensure confidentiality and emotional comfort. A social worker was on standby for support. Younger participants (9–12 years) were engaged through simplified questions and drawing activities, which encouraged expression, while older adolescents participated in open-ended discussions.

The semi-structured interview guide was crafted with insights from trauma research, centering around a key question:

- What are your experiences following trauma and exposure to violence?

To facilitate deeper conversations, the guide included a series of prompts that varied based on participants' responses. These prompts included:

"Can you share a moment when you felt scared or unsafe?"

"Who do you confide in when you feel sad or afraid?"

"What strategies help you feel better when recalling difficult experiences?"

Before its official use, the guide was piloted with two non-participating children to assess clarity and appropriateness. During and after the interviews, detailed field notes were recorded. Additionally, transcripts were shared with participants aged 13 and older for feedback, ensuring accuracy and representation through a process known as member checking.

The researchers had to strike a delicate balance between protecting sensitive information and the potential necessity to disclose it, particularly in cases where there was an ongoing danger of harm. Considering the method of data collection and analysis, which involved semi-structured interviews and IPA, respectively, children were expected

to provide in-depth, personal accounts of their experiences, which could be distressing to them. Measures were taken to address emotional reactions that might develop during the research process. Support mechanisms were in place to help children who became overwhelmed by emotions during and after data collection – they were referred to the local hospital for psychological intervention. Researchers were attentive to ensuring a safe environment in which children could share their experiences without fear of repercussions. Striking this balance is especially challenging in qualitative research settings, as narratives can be intensely personal and potentially traumatic [14].

Data analysis

Data were analysed according to the six phases of the IPA of Smith et al. [13]. The first step of IPA involves reading and rereading data, which researchers do to familiarise themselves with the data. In the second step, researchers wrote notes in the margins of the interview transcriptions to begin exploring the thematic content. In the third step, the researchers developed emerging themes and grouped them into clusters. They then explored connections between the emergent themes and, in the fourth step, integrated the themes. In the fifth stage of analysis, the researchers bracketed the themes to ensure that they remained open-minded as they proceeded to the next participant. The sixth step involved seeking patterns across all the cases to understand the ranking order of qualities and themes. This step took interpretation to a deeper level, leading to a more profound understanding of participants' lived experiences. The themes were confirmed by an independent co-coder who followed the same IPA steps when they analysed the data.

Trustworthiness of the study

To ensure trustworthiness in this study, four key elements were prioritized: credibility, dependability, confirmability, and transferability. Credibility was established through member checking, as three participants confirmed that their transcripts accurately reflected their experiences. Prolonged engagement with participants at the Thohoyandou Victim Empowerment Programme fostered rapport, resulting in detailed narratives. Peer debriefing sessions with co-researchers further validated that themes were grounded in participants' voices. Dependability involved maintaining a detailed audit trail that documented each methodological decision throughout the data collection and analysis process. Independent analysis by a co-coder resulted in 88% inter-coder reliability prior to finalizing themes.

Confirmability was supported by the first author's reflexive journal, which documented assumptions and emotional responses to minimize researcher bias. Peer

Table 1 Themes and Sub-themes

Themes	Sub-themes
Negative experiences regarding childhood trauma and violence exposure	<ul style="list-style-type: none"> • Pain during and after trauma and violence exposure • Children felt anxious after trauma and violence exposure • Social withdrawal from loved ones and previously enjoyed activities • Teenage pregnancy • Decline in academic performance • Suicidal and homicidal ideas
Types of trauma and violence experienced by children	<ul style="list-style-type: none"> • Children experienced kidnapping • Children experienced sexual violence • Children experienced physical abuse • Children experienced bullying
Comprehensive management of childhood trauma and violence	<ul style="list-style-type: none"> • Pharmacologic treatment • Trauma counselling • Use of psychotherapy
Effective coping strategies used by children after childhood trauma and violence	<ul style="list-style-type: none"> • Acceptance of the situation • Avoidance-focused coping • Social coping (support seeking)

debriefing and auditing confirmed that conclusions were based on data rather than preconceptions. Transferability was enhanced by providing rich, contextual descriptions of the Vhembe district and participant characteristics, enabling readers to assess applicability to similar settings.

Reflexivity was integral to the research, with the first author adopting a stance of empathy and openness during interviews. This approach helped create a safe environment for participants, particularly children, ensuring authentic expression and minimizing power dynamics.

Results

The primary objective of this study was to explore and describe the lived experiences of children who had been exposed to trauma and who visited the Thohoyandou Victim Empowerment Centre. Four themes emerged from the data, namely: (1) Negative experiences of childhood trauma and violence exposure; (2) Types of trauma and violence experienced by children; (3) Comprehensive management of childhood trauma and violence; and (4) Effective coping strategies children use after experiencing trauma and violence. Each of these themes had sub-themes, which are discussed below (Table 1).

Negative experiences of childhood trauma and violence exposure

The first theme yielded six subthemes: pain during and after trauma and violence exposure, feeling anxious after trauma and violence exposure, social withdrawal from loved ones and activities they had previously enjoyed, teenage pregnancy, decline in academic performance and suicidal and homicidal ideas.

Pain during and after trauma exposure

The findings reveal that children who had been exposed to stress and violence experienced various types of pain, both during and after the trauma. Some participants described the location of the pain in their bodies, while others did not specify which area of the body was affected by pain, they merely stated that their bodies hurt. The following quotations were used to support this conclusion.

My body is in pain ... My heart is in pain because he beat me without doing anything. (Participant 4)

The study participants reported enduring pain, both psychosomatic and emotional, as a result of the stress they were subjected to due to the traumatic event.

Ever since it happened, I have been feeling so much pain because, in my heart, I cannot stop crying. (Participant 8)

My body was in so much pain during and after sex. (Participant 9)

These quotes demonstrate that participants experienced both physical and emotional pain linked to their traumatic experiences. Across several interviews, children described pain as not only a bodily sensation but also as a manifestation of psychological distress, reinforcing the interconnectedness of emotional and somatic suffering following trauma.

Feeling anxious after trauma and violence exposure

The findings reveal that children who had been exposed to trauma experience excessive feelings of fear, hypervigilance, exaggerated startle responses, an inability to regulate their emotions and apprehension, and they could no longer trust men. Participants explained their feelings as follows:

After the incident, I was scared, and currently, I am still a little bit scared. I cannot walk freely in the streets because I feel like the situation will happen to me again. I am deeply afraid of what will happen to me. (Participant 1)

I feel so scared, I am afraid of people whom I do not know, I get frightened easily and sometimes I struggle to emotionally handle this since it didn't happen long ago. (Participant 2)

At this point, I am afraid and full of hate for men. I don't see them in a good way; to me, they are bad people. (Participant 6)

The quotations above demonstrate persistent fear and perceived threat to safety, and such ongoing apprehension illustrates how trauma disrupted children's sense

of security and mirrors trauma-related hyperawareness described throughout the dataset.

Social withdrawal from loved ones and activities they had previously enjoyed

Participants reported feelings of fear and worry, as well as persistent thoughts of others knowing about them and their trauma experiences.

I am struggling to associate myself with people because I think they know about my situation. (Participant 9)

This reflects internalised stigma and avoidance. Many participants isolated themselves due to shame or fear of judgment, illustrating how trauma undermined interpersonal trust and social engagement. Another participant mentioned feeling nervous and uneasy when they were involved in normal, day-to-day activities.

I am afraid to walk in the streets or play with others. (Participant 11)

A participant indicated that, after their traumatic experience, they avoided going out and activities they used to enjoy.

I had to stop going to extra classes. (Participant 3)

Teenage pregnancy

The study found that participants faced obstacles such as the possibility of pregnancy after their traumatic experiences. In addition to pregnancy, they were confronted by the possibility of humiliation and embarrassment when others learned that they were pregnant.

Honestly speaking, the situation has been worse because my family found out that I am pregnant. (Participant 6)

Another participant reported experiencing anxiety, distress and preoccupied thoughts because of the possibility of being pregnant.

I felt like I could be pregnant. (Participant 8)

Decline in academic performance

Participants mentioned that they suffered from poor attention span at school and excessive fear of and discomfort when they were around older men such as teachers; this is an indication of hyperarousal and hypervigilance, which are trauma symptoms.

I was unable to focus at school and wouldn't want men teachers to come close to me. (Participant 14)

This statement links cognitive distraction with avoidance behaviour. The avoidance of male authority figures indicates how trauma experiences permeated the school environment, reducing concentration and reinforcing anxiety triggers. Among the significant findings of this study are that participants experience depression symptoms. They explained that they experienced crying spells, poor attention and difficulty concentrating, which caused poor performance at school.

Because of this abuse, I am failing at school and I am always crying. (Participant 15)

I was struggling to focus on my schoolwork because I was overthinking a lot. (Participant 11)

Suicidal and homicidal ideas

Participants highlighted that, after the traumatic incidents, they felt extremely sad and had thoughts of suicide. Moreover, the participants explained that they felt like they were not being treated the same as other children.

I cry, and sometimes I think of committing suicide since I am not treated like another pupil. (Participant 16)

This quote captures profound despair and a sense of perceived social exclusion. It contributes by showing how participants' feelings of worthlessness and rejection intensified emotional pain and hopelessness after trauma. Furthermore, the data reveal that participants experienced symptoms of depression, such as crying and suicidal and homicidal thoughts. Suicidal thoughts could be associated with feeling helpless and represent a cry for help.

I almost committed suicide and even if I can see the person, I will kill him. (Participant 9)

The symptoms experienced by the participants were indicative of the challenges they faced, including challenges related to emotional regulation and low frustration tolerance.

She told me that she doesn't have money. I then got angry and left to the river with my friends; that's where I wanted to kill myself. (Participant 5).

Types of trauma and violence experienced by children

The second theme includes four subthemes: kidnapping, sexual violence, physical abuse, and bullying.

Children experienced kidnapping

The trauma experienced by participants caused intense flashbacks, which were evidence of the traumatic events that participants had experienced in their communities.

After that, one guy opened my trousers and did something painful in my butt, or he raped me after that, he took a cloth and wiped me behind. They kidnapped me on Friday, and I was found on Sunday. (Participant 1).

I was going to a local spaza shop to buy bread. I was having R20, and I bought bread for R19, and I was left with R1, which I used to buy chocolate. As I was going back home, cars were passing at the same moment, one car stopped, and some guys grabbed and took me inside the car by force. As I was in the car, they tied my hands, and they took me to a random place. unfortunately, I didn't see anything since I was covered. (Participant 1)

This brief but powerful account reveals the temporal dimension of fear and loss of control during captivity, highlighting the extreme vulnerability of children in unsafe community contexts.

Children experienced sexual violence

According to the information provided by the participants, the perpetrators of the trauma and violence were generally family members or people close to the family, and this familiarity can cause complex trauma. The trusting bond that a child has with their family can easily be disrupted, changing the dynamic.

My mom was going to cook at a funeral, and my stepfather accompanied her when I came back. I went to my room, and my stepfather also went to his room. My stepdad came to my room and asked me to assist him with folding his clothes. I said no; he then said we should play a game on his phone. I said okay. when we were playing, I fell asleep, and he just started touching me and kissing me, then had sex with me after that. (Participant 14)

These quotation illustrates betrayal trauma, where trusted caregivers become perpetrators, reinforcing how familial proximity intensified emotional damage. The findings further revealed that the participants also indicated living in contextual trauma because the most trusted people in their lives and those who caused them to experience trauma were the same people, and they were expected to live with them in the same house.

My aunt asked me to come, and so she went to work and asked my cousin to take care of me when she is

away, so he asked me to take of his clothes and enter into the bathtub with him, I asked him that for what reason he didn't respond after that he took of my clothes and started having sex with me without my consent, I was bleeding after that and he bathed me. He started doing this when I was nine years old and he was 16. (Participant 13)

A unique finding of this study is that participants were being traumatised and directly exposed to trauma by their immediate family members and relatives who have direct access to them; this led participants to experience challenges of contextual and complex trauma.

My uncle then went out for a long time and he came back to and said that he has been asking me to get him a girlfriend but I don't want, in his hand he was holding a knife. He then told me to go at the bedroom with him I denied then he slapped me, I tried to bite him but failed to rescue myself, we went to the bedroom and then he tied my hands and raped me. (Participant 12)

Children experienced physical abuse

The study findings reveal that participants were bullied by their peers. Participants explained that other children made explicit statements about their trauma and criticised their physical appearance. Participants were not only bullied but also socially isolated because other children did not want to befriend them. An example of criticism about physical appearance is the following:

A pupil from school bullied me because of my albinism skin colour ... This is a non-stop, often-situation when I am, and I get harassed and bullied. I do not have friends, no one wants to be associated with me, they laugh at me and treat me badly. (Participant 16)

Negative remarks were also made about the traumas experienced by participants:

During exam time, kids were singing a song for me saying 'I was sexed'; the teachers came and took me to the office and called my mom. The song was started by some girl bullies at school. (Participant 7)

This statement highlights peer humiliation and secondary victimisation, showing how community and school environments perpetuated trauma beyond the original event. The findings further found that exposure to violence occurs in the family environment too, where physical altercations between parental figures are common, and children witness and experience trauma. Poverty and

food security are examples of socioeconomic variables that may contribute to violence in a home.

I was beaten by my father together with my mom; this situation happened at my parents' place; I visited because I was on holiday. The fight started when my mom complained that my dad brought his friends home. He gave them all the food, and we ended up not eating. My dad beat my mom and he beat me as well with a stone; he beat me many times. (Participant 4)

Comprehensive management of childhood trauma and violence

The study's third theme elicited three subthemes: Pharmacological treatment, trauma counselling and psychotherapy use.

Pharmacological treatment

The study revealed that a particular participant was referred for medication and was assisted with HIV and STI testing, and reported for treatment once, but did not follow up or return for further treatment.

I came to the hospital, and I was given medicine, and they also did HIV and STI tests; I only came once for medication. (Participant 1)

The first line of treatment that the participants received was determined by the type of trauma experienced; the study found that participants who had been raped underwent HIV testing and treatment.

The police came and we went to the trauma centre, and I was treated by the doctor. He gave me medication and tested HIV. (Participant 2)

Participants reported that they had to take post-exposure prophylaxis for 28 days; however, it caused side effects such as diarrhoea.

I was tested for HIV and given some recovery pills, some I had to take once a day in bulk, some pills give me a running stomach, and I am under treatment for 28 days. (Participant 12)

Trauma counselling

A participant reported that she was experiencing less emotional pain since she started attending therapy. She explained that, before starting counselling, she used to smoke as a way of forgetting the traumatic incident; she has since stopped smoking because of the counselling.

The situation has been better because I no longer feel the pain, and I am coming for counselling ... Before counselling, I started smoking cigarettes so that I could forget, but now I have stopped because of counselling. (Participant 13)

This quote demonstrates behavioural change facilitated by therapy, and it highlights how counselling provided alternative, healthier outlets for managing emotional pain. Furthermore, A participant revealed that attending counselling sessions could be a way of coping. It provides her with an opportunity to communicate her feelings and express her fears in a safe setting. The participant said that, thus far, counselling has only been her coping mechanism.

Coming for counselling have been my only way of coping so far ... The situation is starting to be better since I have accepted that it happened. And I am also going for counselling. (Participant 9)

A participant explained that talking about what happened with her mother encouraged her to go for counselling at the trauma centre.

My mom talks about it with me, and now I am getting counselling. I am seeing a trauma counsellor at the trauma centre. (Participant 7)

Use of psychotherapy

The findings demonstrate that participants felt pleased and emotionally content after attending psychotherapy treatment.

I feel happy after therapy, and I don't want anything. (Participant 5)

Effective coping strategies children use after childhood trauma and violence

The fourth theme resulted in three subthemes: acceptance of the situation, avoidance-focused coping and social coping (support seeking).

Acceptance of the situation

Acceptance can be associated with grieving. According to the steps of grief, acceptance is the last stage of grief, where a participant learns to live with challenging emotions and thoughts about their trauma. According to one of the participants, acceptance of their trauma made them feel better and experience less intense emotions.

The situation is starting to be better since I have accepted that it happened. And I am also going for counselling. (Participant 9)

The situation is starting to be better since I have accepted that it happened. And I am also going for counselling. (Participant 9)

I accepted ... Acceptance makes me cry less often. (Participant 2)

This illustrates 'acceptance' through an emotional resolution and movement toward recovery, showing how cognitive reframing reduced distress and improved resilience among participants.

Avoidance-focused coping

A significant symptom of trauma that was revealed in the results of the study is that participants avoid thinking about the incident. They experience challenges related to emotions; participants explained their difficulties with emotional regulation, which could also indicate that they experienced depressive symptoms.

I just tend to not think about it, I am trying to avoid thinking about it at all costs. (Participant 3)

This statement illustrates avoidance-focused coping, where participants intentionally suppress trauma-related thoughts to reduce distress. Such cognitive avoidance was common across participants and reflects an attempt to manage overwhelming emotions in the absence of professional or familial support. The study findings also revealed that dealing with unpleasant and deeply felt emotions is another challenge experienced by participants.

I always try not to think about it, but this situation makes me cry a lot. (Participant 7)

Another participant stated that isolation and withdrawal led to overthinking of the terrible events; thus, being around people helps to distract him, and when he is alone, he avoids thinking of the trauma.

I am always with my friend, and it distracts me, and when I am alone, I always try to avoid it. (Participant 1)

Social coping (support seeking)

Behavioural activation, which can also be used in counselling to encourage clients to engage in enjoyable activities and spend time with supportive and encouraging people, was identified in the study results. Participants reported that part of their coping strategy involved relying on the social support of their friends and loved ones.

But thanks to my friends who stopped me, this happened on the 24th of March 2023. My mom found

out because I wrote a letter and left it at home. I always play music or I go play soccer with my friends. (Participant 5)

I am always with loving people around me and also counselling is helping me a lot. (Participant 11)

This quote shows how avoidance can be both behavioural and social. The participant uses distraction through companionship to avoid intrusive memories. This illustrates how children regulate emotions by diverting attention from painful recollections.

Discussion

The current study explored and described the lived experiences of children who had been exposed to trauma and violence in the Vhembe district. The results of the study illustrate that children with childhood trauma and exposure to violence experience negative emotions, body pain during and after the trauma, mental health problems, social withdrawal from their loved ones, an inability to enjoy activities they had previously enjoyed, teenage pregnancy and a decline in academic performance.

The study reveals that children who have been exposed to violence frequently experience considerable psychological suffering. Children in South Africa and the United States reported varying levels of psychological distress in response to their exposure to violence, with chronic exposure possibly leading to the development of coping mechanisms [15]. This shows that, while some children adjust to their surroundings, the underlying emotional suffering persists and could appear as various mental health difficulties later in life.

The study, furthermore, revealed that children could start presenting with behavioural problems. According to one study, children's internalising and externalising behaviour problems act as mediators between early adversity and subsequent encounters with violence. This research highlights a particular pathway through which war trauma and other forms of violence lead to the development of behavioural disorders in children, thereby making them more vulnerable to future victimisation [16]. Similarly, Sriskandarajah et al. found that exposure to mass trauma, such as war and natural disasters, as well as family violence, is independently associated with mental health problems in children [17]. These studies describe the cyclical nature of trauma, in which initial exposure causes behavioural issues that enhance the chance of future victimisation.

Furthermore, the study reveals that children withdraw socially and are isolated after a traumatic event; this finding confirms that of a study that examined genetic predispositions for social withdrawal by children. According to Morneau-Vaillancourt et al., children with a genetic risk for psychiatric disorders tend to prefer solitude; this

preference can be heightened by traumatic experiences [18]. This genetic vulnerability emphasises the complexities of social disengagement by implying that both contextual circumstances, such as exposure to violence, and innate predispositions can influence a child's social behaviour [19].

The results of our study highlight challenges such as diminished interest in pleasurable activities that participants reported experiencing. Post-traumatic stress symptoms can cause functional deficits in children, such as a reluctance to engage in previously valued activities [20]. According to the study by Pereira et al. [21], children who exhibit these symptoms may retreat from social connections and activities they formerly enjoyed because the emotional toll of trauma can create barriers to involvement. This disengagement is often a coping tactic because children could become overwhelmed by reminders of their trauma during these activities.

A study investigated the links between violence and teenage pregnancy and found that, while forced first sexual experiences had no direct correlation with teenage pregnancies, child sexual abuse had a substantial association with first pregnancies [21]. This implies that early trauma might set the stage for future reproductive outcomes, which highlights the importance of tailored interventions for at-risk populations.

A study found that domestic violence had a negative impact on the academic achievement of children and adolescents [22]. The authors discovered that children who were subjected to physical abuse or community violence perform poorly academically, thereby indicating a direct link between violent exposure and education performance [22]. This finding is confirmed by scholars who found socioemotional adjustment to be a mediator in the link between neighbourhood violence exposure and academic achievement of low-income teenagers. They urge implementing school-based mental health interventions to offset these effects and improve children's academic results [23].

Kidnapped children are more likely to acquire post-traumatic stress disorder (PTSD) and complex PTSD as a result of their experiences. Kidnapping was found to be substantially related to the highest conditional prevalence rates of PTSD, which indicates that children who experience such trauma are more likely to acquire serious psychiatric illnesses [24]. The emotional and psychological toll of being forcibly removed from their environment can cause feelings of helplessness, anxiety and depression.

Sexual abuse of children includes a variety of activities, such as inappropriate touching, exploitation and coercion to engage in sexual acts. According to a systematic review, children with mental diseases or physical disabilities are at a higher risk of sexual abuse, which implies

that vulnerability characteristics play a vital role in determining the likelihood of abuse [24]. The review underlines the importance of safeguarding these vulnerable populations through protective measures and increased awareness.

Physical abuse refers to the purposeful use of force against a child and that causes injury or harm [24]. The World Health Organization defines child abuse broadly to encompass physical, emotional and sexual abuse [25]. This type of abuse can result in both acute physical damage and long-term psychological problems, including anxiety and sadness.

It is essential that sexually abused children receive timely medical assistance, particularly those who are at risk of contracting HIV. To lower the risk of HIV infection, HIV post-exposure prophylaxis should be administered within 72 h of sexual assault [26]. This pharmacological intervention is crucial in the immediate aftermath of abuse and should be part of an overall care plan that includes psychological assistance [26].

Trauma counselling is an important way to assist children who have experienced trauma; this was apparent in a comprehensive review that emphasises the need for trauma counselling for children in outpatient and counselling settings [27]. Jeter et al. report that trauma-informed therapies could effectively reduce PTSD symptoms in adolescents, thereby highlighting the need for training and for implementing trauma counselling concepts in therapeutic settings [28]. This approach emphasises the widespread influence of trauma and seeks to establish a safe atmosphere that is conducive to healing. Research indicates that these adverse experiences in childhood can lead to various psychological issues, such as depression, anxiety, aggression and dissociation [29]. Moreover, childhood trauma has been found to have detrimental effects on physical health, educational outcomes and social relationships, and could even increase the risk of criminal behaviour in adulthood [30].

Studies have shown that children who have been exposed to trauma in relationships, whether through direct abuse or through witnessing violence, often exhibit symptoms of traumatic stress [27]. Additionally, young children exposed to family violence and other traumatic events in urban environments are at high risk for developing post-traumatic stress, which can have long-term implications for their health and behaviour [31]. The effects of traumatic experiences, such as witnessing domestic violence or experiencing abuse, can also impact children's academic relationships and expectations [32]. Children exposed to interpersonal trauma, such as witnessing domestic violence or experiencing abuse, may exhibit symptoms of dissociation, which can be influenced by maternal mental health and the number and types of traumatic experiences the child has faced [33].

These findings correspond with emerging international research emphasizing the dual role of schools as both potential stressors and protective environments for children affected by trauma. Recent studies in violence-affected communities underscore that trauma-informed, school-based programs, particularly those integrating counselling, peer-support groups, and teacher training, can reduce anxiety, aggression, and social withdrawal [34, 35]. Trauma-informed care within schools extends beyond counselling to include whole-school frameworks that train educators and nurses to identify distress and respond empathetically [36]. Evidence from psychosocial interventions such as the *KINNECT* model indicates measurable improvement in emotional regulation and classroom engagement among trauma-exposed youth [37]. Similarly, studies of integrated behavioral-health systems show that embedding trauma-responsive practices within school contexts strengthens resilience and academic functioning [38]. Collectively, this evidence reinforces the need for trauma-informed educational strategies in South African rural districts like Vhembe, where schools represent both a risk and a pathway to recovery for violence-affected children.

Recommendations

The study recommends that the relevant government agencies create regulations that are aimed at reducing children's exposure to trauma and violence. Policies that address the need for safe places within communities where children can be cared for are recommended.

These measures will assist in lowering the risk of kidnapping, the consequences of leaving children with people who could potentially harm them and impulsive acts of self-harm, which could be precipitated by feelings of overwhelming emotions. These policies need to include steps to strengthen trauma treatment at trauma centres. Community safety and security are of concern because children are kidnapped from their communities. Support services should be provided for children who are at risk of being exposed to violence and trauma, and positive educational settings should be promoted to curb bullying and violence at home and at school. The study also suggests that relevant government departments provide training to educators at all schools and community stakeholders about the effects of children being exposed to trauma and violence. At the same time, the importance of privacy and confidentiality must be highlighted to foster relationships and identify shared interests. The Department of Education should explore employing registered counsellors to work with children, parents and teachers and to provide trauma-informed care for children who have been exposed to trauma. Doing so will also act as a means of monitoring symptoms and receiving direct

input from teachers and parents to ensure academic performance.

The study also suggests that these departments define roles and responsibilities, recognise capacity limitations and investigate workable solutions for the problems many South African children face. If they are equipped with the knowledge and abilities gained from training, educators, community leaders and other stakeholders will be better equipped to deal with children who have been exposed to trauma and violence, and there will be greater capacity to treat children with trauma.

Limitations

The findings of this study should be interpreted within the context of certain limitations. Firstly, the gender imbalance among participants, predominantly female, may have influenced the results, as experiences and expressions of trauma can vary by gender. The higher number of female participants also coincided with a greater number of reports of sexual violence, potentially shaping the thematic emphasis of the study. Secondly, the research was conducted within the Vhembe district, a rural area with specific cultural, linguistic, and socio-economic characteristics. Therefore, the findings may not be generalizable to other regions or contexts in South Africa. Lastly, the small sample size inherent in qualitative research limits the transferability of results but offers depth and insight into lived experiences.

Conclusions

This study explored the lived experiences of children exposed to trauma and violence in the Vhembe district of South Africa, revealing the complex emotional and social consequences of such exposure. The findings demonstrated that children often experience isolation, withdrawal, and persistent fear following traumatic events, accompanied by symptoms of depression and anxiety. Much of this trauma was perpetrated by caregivers and family members, intensifying emotional distress through the violation of trust within the home environment. Interpreted through the lens of trauma theory and attachment perspectives, these experiences reflect the disruption of emotional security and self-regulation commonly associated with early exposure to violence. Participants' reports of exaggerated startle responses, avoidance of specific people or places, and ongoing feelings of fear align with trauma-related reactions described in existing literature [39, 40]. However, as these reactions were not clinically assessed, they are understood as indicators of heightened emotional sensitivity and perceived threat rather than diagnostic symptoms such as hypervigilance or hyperarousal. The findings underscore the profound impact of trauma on children's emotional well-being and the necessity for community-based, trauma-informed

support systems. Strengthening psychosocial services within schools and local health centres, alongside training for caregivers and educators, can promote early identification and culturally appropriate interventions. Through offering a contextualized understanding of trauma experiences among children in a rural South African setting, this study contributes to the limited qualitative literature on child trauma in under-resourced communities. Future research should expand to include a more gender-balanced sample and explore how socio-economic and cultural factors shape recovery trajectories across different regions.

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Informed consent statement

All participants provided written informed consent for the audio recording of the interviews and the prospective use of their (anonymised) statements.

Authors' contributions

PT conceptualised and designed the study. PT collected and analysed data. LM, AM and NVS supervised the study. PT wrote the manuscript, and all authors reviewed, edited and approved it for submission.

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Data availability

Data for this study will be made accessible upon request.

Declarations

Ethics approval and consent to participate

The University of Venda's Human and Clinical Trial Research Ethics Committee approved and provided ethical clearance for this study (No. SHS/21/PSYCH/08/2411). The study was conducted in accordance with the Declaration of Helsinki.

Competing interests

The authors declare no competing interests.

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