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# Pathways From Family Disadvantage via Abusive Parenting and Caregiver Mental Health to Adolescent Health Risks in South Africa

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A B S T R A C T

**Purpose:** Adolescent health is a major concern in low- and middle-income countries, but little is known about its predictors. Family disadvantage and abusive parenting may be important factors associated with adolescent psychological, behavioral, and physical health outcomes. This study, based in South Africa, aimed to develop an empirically based theoretical model of relationships between family factors such as deprivation, illness, parenting, and adolescent health outcomes.
**Methods:** Cross-sectional data were collected in 2009–2010 from 2,477 adolescents (aged 10–17) and their caregivers using stratified random sampling in KwaZulu-Natal, South Africa. Participants reported on sociodemographics, psychological symptoms, parenting, and physical health. Multivariate regressions were conducted, confirmatory factor analysis employed to identify measurement models, and a structural equation model developed.
**Results:** The final model demonstrated that family disadvantage (caregiver AIDS illness and poverty) was associated with increased abusive parenting. Abusive parenting was in turn associated with higher adolescent health risks. Additionally, family disadvantage was directly associated with caregiver mental health distress which increased adolescent health risks. There was no direct effect of family disadvantage on adolescent health risks but indirect effects through caregiver mental health distress and abusive parenting were found.
**Conclusions:** Reducing family disadvantage and abusive parenting is essential in improving adolescent health in South Africa. Combination interventions could include poverty and violence reduction, access to health care, mental health services for caregivers and adolescents, and positive

**IMPLICATIONS AND CONTRIBUTION**

This study examined factors associated with health risks in South African adolescents and associations. The path model showed a double mediation from family disadvantage via abusive parenting or caregiver mental health to adolescent health risk. These findings show the need for combination interventions to support families to improve adolescent health outcomes.

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parenting support. Such combination packages can improve caregiver and child outcomes by reducing disadvantage and mitigating negative pathways from disadvantage among highly vulnerable families.



Each year, 1.4 million adolescents worldwide die due to violence, suicide, and other health complications [1]. Adolescent mental and physical health is a major concern in low- and middle-income countries (LMIC). Country and region-specific research is needed as factors such as unemployment and illness, and in particular, large epidemics such as HIV, malaria, or tuberculosis, may play bigger roles where less comprehensive welfare provisions are available. In sub-Saharan Africa, adolescents are a particular at-risk group with high rates of violence exposure, large gender and health inequalities, and low life expectancy [1]. A growing body of international evidence suggests that family disadvantage such as poverty, interpersonal conflict, disability, and chronic illness drive child abuse victimization [2]. Other evidence suggests that family disadvantage and child abuse are associated with major negative outcomes for adolescents in health, development, and economic capacities [3]. However, research on adolescents in the region has focused primarily on risk behaviors surrounding HIV transmission [4].

In recent years, there has been an upsurge in interest on the importance of parenting and abuse for adolescent outcomes [5], with evidence almost exclusively from high-income countries (HIC). There are many different definitions of child abuse. This paper follows the definition within the South African Children's Act 38 (2005) which defines child abuse as "any form of harm or ill-treatment deliberately inflicted on a child and includes assaulting a child or inflicting any other form of deliberate injury to a child […] exposing or subjecting a child to behavior that may harm the child psychologically or emotionally" [6].

In North American and European studies, associations between abusive parenting and adolescent health disadvantages are well established [7]. In contrast to HIC, evidence remains very limited in LMIC. However, there is emerging high-quality evidence from sub-Saharan Africa that focuses on parenting in infancy and early childhood [8]. These studies find linkages between family disadvantage, poor parenting, and childhood conduct disorders [9], suggesting the importance of testing such associations in adolescence. Research on risk factors for child abuse victimization in adolescent samples in Southern Africa also identified correlations between family disadvantage and child abuse victimization [10]. In fact, family disadvantage may be one of the drivers of violence against children and adolescents.

Evidence from LMIC suggests linkages between family disadvantages and poor caregiver mental health [11]. In turn, caregiver psychological distress such as post-traumatic stress disorder, depression, and anxiety has been shown to affect parenting style and child behavior [12]. However, there is little research on pathways between these, particularly involving adolescents. New research using adolescent samples has identified pathways from household AIDS illness to child abuse victimization mediated by poverty and disability [13]. Such research is rare, and models generally investigate individual relationships between family disadvantage and abusive parenting [14] or abuse and child outcomes [15]. However, in order to understand points of potential intervention, it is essential to develop and test a theoretically and empirically relevant model of individual and family-level pathways to fully understand family dynamics of disadvantage which can be used to inform the design of family-level interventions.

For adequate policy and programming to address the needs of adolescents in Southern Africa, it is imperative to understand whether particular risk factors, such as family disadvantage, may be associated with abusive parenting. It is also important to establish whether abusive parenting is associated with adolescent health risks and to test pathways by which risk factors for abusive parenting may be associated with adolescent health.

Research thus far has been hampered by the limited availability of large scale data on parenting of adolescents in Southern Africa. Although some household surveys examine parenting behaviors, these have used either parents or children in each household, not data from both, and thus have analytical limitations for identifying complex pathways. For example, parents are not reliable reporters of abusive parenting, while adolescents are often less aware of the extent of their caregiver's psychological distress. Consequently, it was essential to develop a model using data from both caregivers and adolescents.

This study aimed to develop a theoretical pathway model investigating hypothesized associations between hypothesized risk factors and outcomes of abusive parenting. It examines potential pathways (1) from family disadvantage to abusive parenting; (2) from abusive parenting to adolescent physical and mental health risks; and (3) from family disadvantage to adolescent health risks via caregiver mental health distress. A pathway model approach was chosen in order to allow for simultaneous analysis of multiple predictors, intervention variables and outcomes [16].

## Methods

### *Participants and procedures*

A total of 2,477 adolescents aged 10–17 (53.9% female) and their primary caregiver (88.8% female) were interviewed in 2009–2010 (refusal rate <.5%) with most refusals by caregivers. Where either part of the dyad refused, the whole dyad was excluded from participation. One urban and one rural health district with high deprivation and poor health outcomes were randomly selected within KwaZulu-Natal province, South Africa. Within each health district, census enumeration areas were randomly sampled until sample size was reached. In each area, every household was visited and included in the study if they had a resident adolescent. One randomly selected adolescent per household and their primary caregiver were interviewed by staff trained in working with vulnerable youth. Questionnaires and