“It’s hard to overestimate the importance of pollinators.” Lori Ann Burd

Solutions to South Africa’s Psycho-Social Challenges
Trauma and Resilience-Informed Capability

The Challenge - Minister of Health Aaron Motsoaledi, the 2012 National Health Summit

Primary Health, Mental Health, Poverty, Violence, Substance Abuse, HIV/Aids and Customer Centricity

“At the 2012 National Health Summit, Health Minister Aaron Motsoaledi called for greater awareness, better planning and a move away from a “Hospicentric approach” to the treatment of Mental Illness. He described South Africa’s Mental Health Services as fragmented, unfairly distributed and inadequately resourced. “We know that there continues to be over-reliance on Psychiatric Hospitals as the mode to care, treatment and rehabilitation” Motsoaledi said. South Africa has continued to follow the colonial, “Hospicentric approach”, and in doing so have neglected critical aspects of Primary Health Care. He said that it is an offence against human rights and the country’s constitution to neglect the worse off in society.

Minister Motsoaledi voiced the need to scale up investment in South Africa’s Community-Based Mental Health services and reverse the trend of institutionalised care: “We must examine how Mental Health can be integrated into General Health Care and particularly into Primary Health Care”. “Because of their condition, Mental Health Care users are often ‘voiceless’, and it is critical that we both give this group the space to voice their needs and then respond appropriately through including Mental Health in all health plans and programmes” he stated.”

SA Federation for Mental Health Making Mental Health A South African Priority - July 2015 Awareness Campaign

Regrettably the Minister’s challenge cannot be met by South Africa’s Mental Health resources alone. An analysis of the historic and present academic and organisational capabilities in South Africa shows that they are probably too inwardly focused (too siloed) and too independent, to make an urgent collective impact on a solution to these expressed national needs alone.

“We need to replenish our imagination.
We have to reimagine the desirable society we wanted, before it is too late.”

Prof Kopano Ratele

Prof Kopano Ratele Why I am against ‘transformation’; Sunday Tribune, September 21, 2014
Section 1. Introducing TRISI

This is one of 24 sections that make up the proposal to form TRISI. The other sections can be found at: 
http://www.ptgrr.com/contents/get-involved/trisi-content

Reference: Brian Rogers. Trauma & Resilience-Informed Solutions Institute of Southern Africa – Proposal of a Trauma-Activist; PTG-RR; Sep 2015/1

This proposal is a living discussion platform. The answers do not lie in one person’s mind. Its objective is to attract enabling-capital which includes intellectual contribution and financial support. Should you wish to participate, please visit the TRISI web page. Furthermore, it is not in any way intended to presume scientific validity. The style, or method, is argumentative and documentary. It lacks academic skills which include the traditional representation of sources.

Full acknowledgement is given at the point of disclosure so that the reader can identify the source and seek its original in order to explore further.

Section 1. Introducing TRISI

1. The Purpose
2. The Objective
3. The Method
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5. The Trauma & Resilience-Informed lens
6. Resilience – not the antidote for Trauma
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11. Trauma and the “Health Gang”
12. The Customer – we need more

“A tidal wave of goodness is still a tidal wave. It needs to be organised”.
European refugee aid worker, September 5th, 2015. SkyNews

1. The Purpose of this proposal is to present TRISI (the Trauma & Resilience-Informed Solution Institute) as an efficient and cost effective response to the Minister’s challenge.

TRISI will apply both a Trauma-Informed and a Resilience-Informed lens to customer health solutions - in the co-existent environment of Primary Health, Mental Health, Poverty, Violence, Substance Abuse and HIV/Aids.

TRISI will be capable of positively impacting diverse customers’ needs such as: Individual Consumers, Home Care Givers, Primary Health, Communities, Educators, Businesses, the Criminal Justice System, Institutions, NPO’s and Government.

TRISI will embrace, not replace, existing Health Care skills sets, whilst incorporating others such as Resilience, Trauma-Informed Care, Consumerism, Social Science, Innovation & Entrepreneurism, Communication, Systems, Impact Finance, and Human Resource Deployment.

TRISI’s efficiencies will come from networks and partnerships with international organisations already advanced in the fields of Resilience and Health Care.

TRISI will be an educator and a learner, ‘hubbed’ (but not necessarily always confined) in an appropriate academic institution.

TRISI will be skilled at providing efficient solutions to South Africa’s psycho-social problems which, in turn, will positively impact on the socio-economic future of our country.
“We cannot know what bees are really thinking, but it is safe to say that they are trying to create the maximum amount of space with a minimal amount of material”.

Hiroto Fujiyoshi Yamada Bee Farm Why is the Beehive Hexagonal? http://www.3838.com/english/mitsubachi_park/frombeefarm/from05_rokkaku/

2. The Objective of the proposal is to raise “enabling-capital” to make this solution a reality.

   - Intellectual enabling-capital;
   - Network enabling-capital;
   - Business Expertise enabling-capital;
   - Financial enabling-capital.
   - Political-will enabling-capital;
   - Partnership enabling-capital

3. The method – The proposal is argumentative and not scientific. However, the entire document consists of 24 sections of which 18 take an in-depth look at the literature and social comment of recent times, in a ‘documentary’ style; allowing the reader full insight into leading Health Care scientific, academic and social thinkers. Relevant, global and local, Human Rights and Health Care legislative themes are also covered. This body of knowledge advised and shaped the proposal, however these are only the ‘starting blocks’ of a living document, which others are most welcome to enhance. All the information is open to any interested reader at no cost.

   “Your work is very important. I have argued many times that untreated or unaddressed trauma is a serious cause of violence and aggression both here and in the Middle East”

   Prof Steven Friedman, Political Scientist;
   Personal correspondence; LinkedIn; May 1st 2015
## 4. The Customer

### Individuals
- Violence, Abuse, Grief, Tragedy
  - Children
  - Adults
  - Quadriplegic
  - Paraplegic
  - Mobility impaired
  - Hearing impaired
  - Visually impaired
  - Cerebral Palsy
  - Multiple Sclerosis
  - Other Chronic
- Physical disability (Inc. Children)
  - Heart & Vital
  - Organs
  - Cancer
  - HIV/AIDS
  - Substance Abuse
  - Obesity
  - Bulimia & Anorexia

### Organisations
- Trauma
- Peer Support
- Primary Care
- Chronic Health
- Human Basic Needs
- Religious groups
- Substance Abuse
- Sex/other Abusive behaviour
- HIV/AIDS

### GO’s / NGO’s
- Physicians
- Occupational Health
- Nursing
- Physiotherapy
- Home/Family Care
- Community Care
- Psyche/social

### Health Care
- Police
- Prisons
- Judiciary
- Legal representation
- Courts management

### Criminal Justice System
- Hospitals & Clinics
- Mental Health
- Physical Disability
- Child Welfare
- Old Age
- Substance Abuse

### Institutions & Facilities (GO / NGO)
- Emergency Medical
- Fire
- Sea & Mountain Rescue
- Disaster Management teams
- CPF & Neighb’rhood Watch
- Security Services
- Military

### Communities
- Geographic
- Cultural
- Beliefs
- Refugees
- Child Trafficking

### Inter-relational
- Pre-Primary
- Primary
- Secondary
- Tertiary

### Education
- Corporate Wellness
- High Risk Industry
  - Mining
  - Hazardous mat’s
  - Farming
  - Transport

### Business
5. Appreciating the Trauma-Informed and the Resilience-Informed lens

The earth, and the humans who inhabit it, face an ever increasing traumatic-risk as the populations expand and the resources diminish.

Resilience-Informed and Trauma-Informed are both appropriate Health Care constructs. They are active, human resource, solution paradigms. They are not, as is often presumed, just a toolbox for other professions. They are high density skills in their own right. South Africa needs such expertise - and the investment is affordable.

Globally there is a conspicuous energy, an excitement, a vast network of sharing and collaboration going on across both fields of Resilience and TIC. Solutions to human and ecological problems are being tabled and implemented on a daily basis. These insightful disciplines currently attract enabling expertise and thinking from way beyond their narrow starting blocks of ecology and biological science respectively. We are witnessing the greatest pooled deployment of the human mind in history. Intellectual, analytical and creative mind-sets are, generating a new global ecological, social and biological future. Humans are inspiring humans - with the welfare of our planet at stake.

Harnessing Resilience-Informed and Trauma-Informed expertise in a single customer-focused, solution-generating entity, focused on the Health Care domain, is the foundation of this proposal.

Applying the Resilience-Informed and Trauma-Informed lens to solution building

Focus and clarity are required to turn challenges and problems into solutions. Using sight as a metaphor and binoculars as a vehicle; ecological, biological and social issues can best be examined by using both eyes, magnified independently by Resilience and Trauma lenses. However, Trauma and Resilience are both messy concepts, never really being black or white. They are dynamic, changing constantly with environmental forces. So sometimes overlaying an additional Resilience-Informed lens, over the Trauma-Informed lens, is appropriate for solution based focus; and sometimes an additional Trauma-Informed lens enhancing the Resilience-Informed perspective, will expose the true problem and generate the appropriate solution based thinking.

Are Resilience and Trauma measurable? Yes. However what you measure today is not what you will measure tomorrow if any variables are changed; and change they do. Adaptive forces are equally impactful. Are you measuring the moth or the chrysalis? In Mental Health there is not always a sequential progressive relationship between the moth and the chrysalis.

Trauma-Informed and Resilience-Informed are not two sides of the same coin. They are different coins. They may even be different currencies! However, they are undeniably the most effective lenses through which solutions of ecological, biological or social upheaval can be studied – even when the currency exchange rate is objectionable.
6. Resilience – not the antidote for Trauma

Mark this down! Resilience is not necessarily positive. Somehow everyone wants Resilience to be the human and ecological opposite of Trauma; the Knight in Shining Armour that saves the world. In the human case at least, this is a fundamental misconception - the rosy coloured “plastic flower” that our metaphorical honey bee will disregard.

Most of us have had a resilient head cold that won’t go away. Criminal entities and gangs trouble law enforcement most because they practice the networking, risk and adaptive qualities of resilient systems more efficiently than their adversaries. Finding the cure for TB (Tuberculosis) is proving most difficult because it carries Resilience traits that are not yet understood. They appear unique.

The popular euphemism ‘to bend and not break’ mostly leads adventurous specialists in fields other than Resilience, to jump to the conclusion that ‘if it’s not broken its resilient’. This oversimplification of Resilience is misinformed, often wasteful in research, time and effort and, sometimes even treacherous. Yes, a traumatised ‘anything’ can be Resilient. An ecological subset, exposed to unrelenting hardship and devastated in its initial primary form, can re-emerge stronger or even evolve into a different existence, with a different purpose. However, it does not necessarily mean the Trauma is no longer present. Resilient systems and entities can remain traumatised. The original consequences of Trauma may lie dormant and emerge when a certain environmental mix of variables emerges.

Is the opposite true? Undoubtedly! Just ask long term caregivers about the Resilience of Mental Health patients. Challenged by frustrating personal internal upheaval and societal rejection and exploitation - (very traumatising constructs) - many afflicted by poor Mental Health show remarkable Resilience, thrive and exhibit great happiness; but regrettably not always. Top PTSD (Post-traumatic Stress Disorder) Psychiatrists are adamant many of their patients are exceedingly Resilient; but regrettably not always.

The question then is, if the individual with Mental Health challenges is not showing typical signs of Resilience, is it possible to empower them with Resilience? Many positive strides have been made in identifying the personal Resilience factors that one can build – Optimism, Cognitive & Emotional flexibility, Physical fitness, Diet, Brain fitness etc. etc. Scientific neuro-biology (the 21st century science break-through Special Forces) is enthusiastic and ‘neuro-plasticity’ and ‘mirror-neurons’ hold much promise for biological solutions. Perhaps artificially enlarging the hypothalamus, (or dietary changes with the same affect), may ensure our personal ‘library’ of data is not under resourced; or ‘stroking’ the twins – the amygdala – in a specific way will bring calm to our instinctive fear-response child? They are not all the way there yet, but progress is rapid.

Eliminating Risk is often the first - and only - solution applied in managing systems. What is defined as “risk” is often the ecological, biological or social glue that holds the system together in the first place. Anti-fire measures originally applied to Cape Town’s famous Table Mountain nearly destroyed the eco-system. Well-meaning Town Planners deduced that by preventing fires not only would they preserve the beauty of the sacred mountain, but bordering residents would be protected from the hazards of fire. Eventually it had to be acknowledged that Fynbos requires fire in order to thrive. Human intrusion had to pay its own protective price.

When SA Breweries felt the time was right to respond to rising female consumer demand for beer, they replaced the long standing, rather squat Dumpy – the one that looked like a rugby front-row forward with no neck – with a more elegant neckline. There were many grumbles from the male market. It was indeed symbolically male. Yet that organisation was able to assess these grumbles as sustainable and overcome-able. The risk of growing the beer drinking market by more attractive packaging for female customers was negated by increased sales and a number of replacement behaviors, including beer driven inter-gender sociability. It helped though that they controlled the beer ecology with a virtual monopoly at the time!

However, another global beverage giant made a classic risk elimination error. They fundamentally misunderstood the resilience of the Coke brand when they launched sweeter ‘New’ Coke as a replacement for the iconic Coca-Cola. Pepsi was gaining market share on home US soil and endless consumer research had told them Coke was not sweet enough. The consumer reaction was swift, furious and costly. New Coke had to go! They wanted real Coke!

Another important challenge in Health Care is defining Resilience in the absence of a system. 99% of resilience theory and practice assumes the analysis of some form of system as part and parcel of solution based thinking. Yet, Resilience persists in the absence of a system too. An “idea” has no system. Yes, it’s perfectly feasible to establish
systems to generate ideas, and systems may result from the idea. But an idea itself has no system and can be very, very Resilient. What about emotions – anger, love, grief, sadness, happiness, joy, hate? Today the biological paths can probably all be identified by systems; and even the expression of the emotion can be defined systematically. Yet the emotion itself has no system and can be most Resilient. **Love is systemic not systematic.**

The most pressing issue, in all forms of Mental Health, is the **Trauma of Stigma**. Stigma prevents individuals coming forward to seek help, causes societal rejection, and identifies the individual with Mental Health issues as a target – everything from bullying and shunning to violence and sexual assault. Stigma also has no identifiable system. From a Mental Health point of view, this provides a completely different perspective on Behavioral Health; especially Health Care diagnostics, signs and symptoms. **Resilience, in the absence of a system, is critical issue for TRISI to address.**

### 7. Resilience and Trauma-Informed Care development

Resilience and Trauma-Informed theory are ripe for cross pollination convergence, collectively producing solutions to seemingly overwhelming challenges for individuals, societies and the planet as a whole. Both actually have their early history grounded in the 19th century. Yet both slipped into the shadows as more popular and more time-appropriate fields were explored. In the modern world, both had their early beginnings in the 1970’s.

Modern Resilience theory was founded in the broad minded thinking of global ecology. C.S. Holling defined Resilience as “a measure of the persistence of systems and of their ability to absorb change and disturbance and still maintain the same relationships between populations or state variables”. The first to use humans in real life situations was Eugene Bleuer, who studied individuals afflicted with schizophrenia. Resilience rapidly captured the imagination of diverse fields that saw the potential to apply resilience-thinking to systems of all types, smaller habitats, clusters and even individuals. It was probably Norm Garmezy who really kick-started the Resilience movement. His early writings on Resilience were among the first to stress the importance of investigating protective factors in “at-risk” populations. Disliking the focus at the time on vulnerability and invulnerability he believed in an efficient process for specific situations – with the looming uncertainty that they might not work every time for every situation.

Trauma theory re-emerged from the biological and behavioral studies of the individual. The early focus of Psychiatrists such as Frank Ochberg, Jonathan Shay and a young Bessel van der Kolk, who were working with US military veterans of Vietnam in the late 70’s and early ‘80’s, brought the diagnostic term Post-traumatic Stress Disorder (PTSD) to the world’s attention. Trauma was seen primarily as a biological construct (PTSD) that affected individuals Mental Health, and their subsequent behavior, until the late 1990’s. A new lobby group, (van der Kolk included), then emerged and pointed out the societal impacts of Trauma went way beyond the biological appreciation of the individual. Trauma, they clearly showed, also had a family origin and that childhood adversity had significant consequences for the sustainability of individuals and communities alike. Some communities were locked in traumatic negative intergenerational cycles of poverty, violence, substance abuse and other co-existent hazards such as HIV/AIDS.

Trauma-Informed Care was conceived during a Woodstock like symbol of change. The limitations of Mental Health, dominated by Psychiatry and overwhelmingly influenced by The American Psychiatric Association (ASA), failed to solve societies ever increasing Mental Health challenges; which are overwhelming Public Health services around the world. Customers – individuals, communities, cultures and social workers required freedom from the narrow conscripts of biological science in order to seek and find satisfaction.
Simultaneously, another innovative revolutionary emerged: neuro-science. A new breed of scientist who were only too willing to connect their findings to the needs of these customers and sit down with the front line “social worker” forces, compare notes and help build collective solutions.

Globally, the cry went up for Integrated Health Care services toward the end of the last century. The concept of Behavioral Health emerged to build the necessary bridge, in rapid time.

Mythology might one day say that Trauma-Informed Care was the freedom child of Neuro-Science and Behavioral Health Care during the mind-altering Health Care revolution; 1995-2015. Indeed it is the love-child of those caregivers, seeking freedom from scientific restraint on the one hand and proficient, practical solutions to the human suffering they daily observed, on the other: the Social Worker – volunteer and professional; lay, qualified, psychologist, psychiatrist and neuro-scientist alike.

Trauma-Informed Care was almost adolescent before it was granted its official national birth certificates - in 2012 both Australia (ACSA) and Canada (CMHC) committed to a Behavioral Health Trauma-Informed Care way forward; with the USA, an equal primary driver of the change, publishing their comprehensive Trauma-Informed Protocols (TIP) in 2014 (SAMHSA).

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8. Behavioral Health Care

Throughout the world, Primary Health and Mental Health are co-existent. Their relationship is sometimes independent, mostly interactive and often bio-directionally causative. The burden of Mental Health services is increasingly carried by Primary Health caregivers. This is a global challenge, not limited to South Africa. Elsewhere, Integrated Health Care is rapidly being deployed as the means to create more efficient customer service.

In the United States a distinctive health care system has emerged which they call Behavioral Health. In a matter of 15 years Behavioral Health has become the driving force behind US solution based thinking in Integrated Health Care.

Behavioral Health (individual and social health) has superseded the traditional, Mental (biological) Health authority and nomenclature in the United States. Noticeably, biological Mental Health is a component part of Behavioral Health solutions. Following an intensive and time efficient process and significant political will saw the establishment of central customer service organisations such as SAMHSA (Substance Abuse and Mental Health Services Administration).
The comparison of Mental Health and Behavioral Health services

Behavioral Health remarkably has no official status, signified by any kind of ‘board’ or controlling body. Yet it permeates the entire US Health infrastructure and directly impacts Education, the Criminal Justice System, the Military, Disaster Management and Homeland Security. All bodies of government (national and state customers) were seeking solutions that the limited traditional Mental Health system could not provide. Behavioral Health stepped up to the USA plate!

The graphic below is a visual impression of the existing hierarchy of relationships that have evolved.

A conceptual graphic of emerging inter-disciplinary Integrated Health Care services
A similar wave of change has swept the Canadian system and, thanks to an independent Australian NPO called ASCA (Adults Surviving Child Abuse), the Antipodeans in general. Australia and Canada are foundation thinkers in Behavioral Health centred, impact solutions, for Integrated Health Care.

Note: An extremely important component of Behavioral Health style solutions thinking, from a South African point of view, is its cultural sensitivity. Both Canada and Australia have contributed significantly to this progress.

However, South Africa is not the United States, Australia or Canada. We don’t have the organisational customer infrastructure, the organisational customer edification, the trained human resources or the education system to turn our massive integrated health potential around affordably, or quickly enough.

The individual and team skill sets to make that impact in South Africa do exist. Naturally! This is South Africa, a global leader in impactful, innovative solutions across many diverse fields. In Health Care terms those skill sets are currently dispersed in independent pockets of goodwill, each striving heroically to make a difference in their own right. They exist in government, quasi-government, academic, non-profit and commercial institutions.

There is no shortage of social entrepreneurism either – another national trait we should be so proud of. Current lack of visible intellectual co-ordination and leadership leaves the collective impact of these individuals, teams and organisations short of customer-required, nationally-efficient service delivery. There lacks a ‘gestalt’ impact.

We have pockets of exceptional skills in South Africa and we have indomitable social entrepreneurial spirit. These are assets that cannot be dispensed with. How best to harness them then? Through an institution that treats these human skills-sets as customers, in partnership with solution building; a customer-centric solution institute - called TRISI.

Financial resources are always going to be under pressure. Affordable solutions, harmonising these skills-assets, must therefore be able to make a micro and a macro impact over an extended period of time. Enhancing local skill-sets will require integrative co-operation with leading organisations and individuals around the world. This is not a barrier in the slightest. In fact it’s an enticement to success.

What sets modern professional Resilience and Behavioral Health practitioners apart from the existing skills-sets in Public Health, is their willingness and ability to share. Ego is not centred on “ownership” in the disciplines. They were both founded in societal orphanages where they seemingly belonged to no parent discipline. In order to survive and thrive they grew up on a diet of sharing, comparing and communicating. Like the humble bee they thrive on pollinating for sustainability. They have created intellectual and practical solution eco-systems. Their communication is modern and swift, using open-membership, participatory websites and social media to spread ‘the news’ quickly and efficiently.

In South Africa, appropriately endorsed, TRISI will find no lack of willing authoritative and effective partners from around the globe in either discipline. Suitably structured and staffed with the skills-sets that are available - particularly in a restless younger generation, eager to make this country flourish – TRISI will become a new leading contributor to Health Care solutions in Africa and the World.

Globally, Poverty, Violence, Substance Abuse and HIV/Aids are the social companions of Primary and Mental Health Care. This detail is fundamental to Behavioral Health Care solutions. In South Africa we have more than our fair dose of these resilient “health gang” members! Interactive network cycles within this “health gang” regrettably ensure their sustainability and resilience. Collectively the influence they have on the ability of the nation to find its traction and thrive is prohibitive. They impact on our children, our schooling, our criminal justice system; our employment ratio’s our business profitability and future investments at public and commercial levels.

The South Africa “health gang” consists of:

- a creaking, overloaded Primary Health system,
- institutionalised and/or disparate Mental Health services,
- desperate Poverty,
- ubiquitous Violence,
- volatile Substance Abuse, and the
- unrepentant HIV/Aids,

The Health Care industry may not appreciate being included as part of the “health gang”, but in networking theory, you don’t have to be an instigator, nor a willing participant, to be a component part of a gang. You’re in it – sometimes even unknowingly! You can’t find a way out of it, so you survive as best you can within the gang.

Mental Health is in the “health gang” network trap whether it likes it or not. The way out of the trap is by applying a Trauma & Resilience-Informed lens to solutions. This cannot be ad hoc. It’s a major challenge. It requires sustainable and adaptable strategy over time. It requires dedicated innovative people, appropriate systems, useful measurement tools and an attuned appreciation of the building blocks of risk. It will take specific skills, drawn from a wide variety of fields, with a common purpose and dynamic leadership to free Mental Health from the “health gang”. This is the TRISI mission.

When a nation goes to war, sooner or later it forms specialist thought-teams to supplement its specialist execution-teams. In South Africa we have a war on our hands – the war against the “health gang”. We need a special combat thought-team to design solutions that can be implemented by special combat execution-teams (existing and evolutionary). We need efficient solutions that are designed in spite of our economic and time constraints, whilst remaining morally and ethically accountable to international Human Rights law.

The formation of TRISI will play a crucial role liberating Mental Health (and consequently Primary Health) from the “health gang”.

10. The South African overlord of the “Health Gang”… is Trauma.

(Note: Trauma is used throughout this proposal in the psychological sense unless otherwise specifically indicated.)

Trauma, in South Africa, operates from the shadows, playing one “health gang” member off against another, tying individuals, communities, cultures and the nation in a powerful resilient grip of intergenerational social and economic harm.

Trauma, for some inexplicable reason, went underground in South Africa around 1997. Social commentary just stopped talking of “this traumatised nation”. Perhaps we committed our future hopes to the example of Nelson Mandela, the morality of The Good Bishop, Desmond Tutu, The Rainbow Nation and the Truth and Reconciliation Commission and went into denial? The scientific biological Mental Health field admittedly held their Trauma ground. Yet, in our higher education systems, Trauma is a semester or two of effort unless you go to a specialised college. Too few do.
Trauma has become such a media shut door that in South African Mental Health month, July 2015, a vigilant scan of the media found not a single mention of Trauma – and only one passing mention of the diagnosis Post-traumatic Stress Disorder. What is so strange is that over the last twenty years, around the world, the irascibility of Trauma was being studied, defined and linked to the “health gang” in a social context.

Their premise is simple. We are social animals. If we cannot connect with our fellow human beings, our lives are miserable, even terminable. We would rather join a destructive gang than be seen as social outcasts. This very human trait is simply Resilience-in-Action.

What has been clearly demonstrated in psycho-social studies is that the traumatised individual affects the community; but even more importantly cultures, communities and even nations can become collectively traumatised in their own right. The absence of public discourse in South Africa amounts to a denial. Perhaps this is because facets of social trauma themselves, (Betrayal Trauma, Moral Injury, Stigma and Victim Mentality), have taken a Resilient hold on our national psyche.

Resilience-In-Action applies to Victim Mentality (VM) too. VM is the agent provocateur of the “health gang”. VM seems to pervade every facet of our South African lives. ‘Race’, of course, is a primary VM presentation in South Africa. The recent re-emergence of race hate-speech is disturbing; with incidents of race-VM coming from many sectors expressing some form of current or previous disadvantage that holds “them” back. But it’s not by any means the only VM on the South African block.

VM is an insidious form of behavior that clusters groups of individuals together, under one cathartic “victim-banner”; which assumes some form of threatened martyrdom. Unfortunately it’s also a mask for simmering aggression that can burst out suddenly, and in an unexpected direction. This is not just a case of bad behavior. There are substantial Trauma-Informed factors that underpin the characteristics of VM. A root societal cause is Betrayal Trauma and Moral Injury. So too are Adverse Childhood Experiences (ACEs) and the compounding effects of Intergenerational Trauma that bedevil generations the world over - and are so ominously present in our own country.

VM is very much in the psyche of many of the ‘nations’ that make up the Rainbow. For 150 years this country has experienced just such a Machiavellian Trauma underworld trick. The iron fist of Apartheid not only characterises the most recent Moral Betrayal, but by keeping such a tight lid on 150 years of festering traumatic effects, it took the great statesmanship of Mandela to prevent ubiquitous bloodshed. Unfortunately this “health gang” supporter is highly resilient and adaptable and re-inserted itself in petty and organised crime. VM walks hand in hand with “health gang” member, Violence, on every corner of every street in the country. VM may hide in the Poverty neighbourhood but it rears its ugly head in the wealthiest localities. In the absence of a strategy to deal with the consequences of ACEs the compounding effects on this current generation of youth are staggering.

This is not only a Criminal Justice System (CJS) responsibility; it’s a Behavioral Health responsibility and demands a Trauma-Informed Care response. In fact our CJS displays many symptoms of unresolved Trauma itself. Our CJS needs TRISI TIC TLC (tender loving care) too!

The South African Trauma overlord needs to be apprehended! TRISI is the means do so.
11. Trauma and the “Health Gang” relationship

Trauma is the pivotal individual and societal link to all the other “health gang” members. The starting point in “Operation Trauma Overthrow” is a collective need for all potential contributors to TRISI (e.g. Social Anthropology, Political Science, Law, Human Sciences, and the broadest possible definition of the Health Care industry) to take a huge Trauma-Informed leap forward. We can only do that if we unlock the gates of diagnostics, definitions, signs and symptoms that are guarded so closely by Psychiatry.

Trauma always finds its dark insidious way into ‘the gang relationships’. For example, any Primary Health condition can be traumatising. It may be as simple as the fear of the health symbol of this proposal, the indispensable bee. (A risk understood, in its inclusion!) A bee sting can kill some people - rapidly. Others might derive serious health consequences of a bee sting and some, probably the large majority, might just be annoyed at the prick of pain. The psychological consequences are scaled – but not always in approximation to the severity of the primary significance. Just as the potential of perishing at the whim of a bee might not invoke great traumatic stress in an individual, the mere fear of a bee sting may be quite seriously traumatic in another. In more prominent Primary Health Care scenarios, the loss of mobility, cancer, heart attack and other chronic disease, Trauma will have similar disparate scales of impact.

In the social context Trauma plays an even bigger role. Communities and cultures are also vulnerable to what defines individual PTSD - ‘experience’, ‘intrusion into psyche’, ‘avoidance’ and ‘mood’. Unfortunately, diagnosing traumatic experiences in a social context has not yet been an outcome of the Behavioral Health initiative. TRISI needs to urgently address this in order to identify key “health gang” territory.

The relationship between Trauma and Substance Abuse (and other Trauma ‘masking agents’ like gambling, sex, co-dependency) has been well documented. Trauma inspires some very unusual personal choices of therapy that inevitably lead to worsening of the individuals overall health - and the health of whatever family or society he or she interacts with. Using a ‘masking agent’ as a “therapy” will not always be as a result of Trauma. Sometimes there are other drivers. However, the trauma of being locked in an addiction remains absolute. Similar relationship constructs are being identified between Trauma and HIV/AIDS.

The “health gang” is a network in which Trauma thrives. Strategically, networks are hard to bust – unless you can interrupt relationships that link network participants.

The Mental Health term for such linkage is “Co-morbidity”. “Co-morbidity” is tricky all round. What may appear as a Bi-polar condition might also be the adult expressions of childhood ADHD; what is diagnosed as schizophrenia may be co-morbid with many other Mental Health problems. Understanding co-morbidity is high on the agenda in biological science. Correctly identifying co-morbidity has crucial implications for Mental Health resolution and caregiving. There appears little doubt that Trauma, and its lurking cousins - stress, depression and anxiety - have a distinctive co-morbid relationship with other Mental Health challenges.

PTSD (Post-traumatic Stress Disorder) was thought at one time thought to be an Anxiety and Depression disorder. It was marketed as such to the world in 1994, in the fourth version of the DSM (Diagnosics and Statistical Manual). Many suffering from PTSD were pharmacologically treated for Anxiety and Depression to their detriment. PTSD is sometimes co-morbid with Depression and Anxiety and not a result of either. Unfortunately most caregivers in South African Primary Health care have limited Trauma-Informed education - (and no one de-marketed the error to them after DSM5 made the change in 2013!) - So they fail to apply that all important Trauma lens to Depression and Anxiety.

This is a challenge to Psychiatry. Their diagnostic capability and their appreciation of “co-morbidity” (and their ability to express it in consumable language) affects Primary Health Care substantially. In low income, low resource environments particularly. It is Primary Health Care that bears the brunt of unravelling Mental Health signs, symptoms and diagnostics. It’s unlikely they will solve their definition problem in the modern world without a broad minded understanding of the “customer”. Today’s customers want to understand and appreciate – not be told in strange terms or patronisingly dictated to.
The biological links between the “health gang” members - called ‘Substance Abuse’ & ‘HIV/AIDS’ - and other mental health problems, is very much on the Psychiatric analysis table at the moment. But are they co-morbid? The current debate, more often than not, gets confounded by technicalities.

Behavioural Health, which embraces social constructs, finds the term “co-morbid” to be too limiting. It also considers it another ethnographic foundation of Mental Health Stigma. Behavioural Health furthermore recognises the other “health gang” member, Poverty, as a crucial component of the “health gang” network. They use the term “Co-occurring” to describe health network relationships. Whilst the psychiatric term of “co-morbidity” might be rather parochial and instructive, “co-occurring” may be equally limiting. In an attempt to find a gentler, kinder solution the term “co-occurring” lacks the necessary associative linkage “co-morbidity” has. And linked our “health gang” members most certainly are!

For those reasons, this proposal prefers to use a more generalised term - “Co-existent”. Sometimes people or even groups of people can be inflicted with “co-morbidity” as a consequence of one affliction upon another, but not always. Sometimes the term “co-occurring”, with its time based foundations, is appropriate, but not always. Those differences are important. Shoe horning everything into one slipper has potentially limiting, hazardous and costly ramifications in the midnight world of the “health gang”.

Diagnostics, definitions, signs and symptoms of individual and social Mental Health, and in particular Trauma, will be a key component of the TRISI output. They would be expressed in such a way that customers can make the most use of them.

(Note: Perhaps researching this proposal has missed an amendment somewhere, but it does appear our South African Mental Health Act has left a diagnostic legal loophole. There appears to be no definition of a “diagnosis”, nor any emphasis on the reliance on any system of “diagnosis”. There appears to be no expressed need to utilise the American commercial DSM (which seems to be a South African tradition rather than a consensus), or the free World Health Organisation ICD – International Classification of Diseases. The DSM and ICD appear not even to be mentioned. The way the Act could be interpreted is that if any legally standing Mental Health practitioner made a diagnosis outside of these two guides, then that would suffice, subject to peer scrutiny. What is troubling is that our Act expresses consequences to the defiance of official ‘diagnoses’.)

12. The Customer – We Need More

“Beyond any other investigative appreciation of the Mental Health Care customer, we must remember to ‘think global and act local’. Human beings are human beings – the world over. The same respect and moralities apply to understanding the soldier, the nurse; the rape victim, the child; the homeless and the multi-home oligarch; cultures, communities and institutes. It is a narrative of humankind that can only be suitably considered and optimised with Resilience & Trauma-Informed solutions, tailored to the specific needs of the individual or society. To be considered and treated as equal, yet unique, is a fundamental Human Right. Never forget that.” Brian Rogers

In South Africa our cup runneth over with Health Care customer needs – individuals, communities and organisations.

First of all, how do we, appreciate these needs? The current methods of Psychiatry and Psychology fall well short of acceptable customer-centric practice.

Individual Psychiatric biological definitions (diagnostics) are a top down approach – we define you as ‘X’, so you will be categorised as ‘X’. This methodology is currently undergoing an ‘ Authenticity’ challenge on many levels.

On the other hand, while Primary Health and Political Science routinely report confidence levels and sample size effects, Psychology tends to publish results based on the means of the study sample - which signifies that the results
of a particular sample are known, but the accuracy of these results, for a larger or different population, are left to hypothesis.

Social study after social study shows a lack of appreciation for the true dynamics of customer research. Perhaps the problem is that often it is designed to find out the difference between being right or wrong. “Here is my hypothesis, does it hold true for this sample or not?”

In qualitative research into social behavior there often seem to be two extremes – one that is so methodology obsessed that it actually filters out meaningful response data for interpretation; and at the other extreme, methods that are so lackadaisical in their purpose, simply anything can be presented as a result, and identified as a consequence for solution building.

The Health World needs lessons from the Business World. Oh, make no mistake the above criticisms apply in that environment as well! However, much of consumer research in the business world is about listening to what the customer has to say, in a participative environment. This may be staged or real. Formal, or informal.

For example, effective commercial organisations will have a communication system that thrives on unsolicited feedback. When the salesman is talking to the shop keeper, he listens not only to the opinion of the shopkeeper, but to the foundations of that opinion - the consumer’s feedback to the shopkeeper. This is not evidential it’s suppositional, but if the system is sensitive enough it will begin to identify large enough clusters that need investigating more closely. In some cases the rate of growth of the cluster is so fast that emergency action is the only thing to save the entity.

A national Health Care, Trauma & Resilience-Informed, Customer-Needs Information System is urgently required. TRISI is the organisation to evolve such a system. We need to centralise the information flow, collecting information from all studies and sources, and design further specific studies that become national customer information treasures from which customers can draw - and contribute to retrospectively. Simply, we need to build a customer-information sharing system that can correlate the incoming information - turning hunches and possibilities into realistic decision making platforms.

A huge body of social psychology information and knowledge exists! This system should be designed to educate the public and caregivers of all descriptions in meaningful ways that make a difference to day-to-day self-health management.

Not everything can be researched simultaneously, it’s expensive and it’s cumbersome to do that. The system must target certain primary needs of both consumers and caregivers. And those needs are not expensive to ascertain. It’s a simple response to a simple question – what can we change today that makes your life easier, that allows you to cope better and to function as near to optimally as you require?

Undoubtedly ‘resources’ will be part of the mix in the customer feedback. Instead of adopting a ‘well we knew that already’ hegemony, armed with the customer’s interpretation of what those resources might be, TRISI can set about building solutions. That’s where innovation and entrepreneurship must be incentivised as part of the TRISI equation. A solution focused institution does not give what is wanted; it invents and provides what is needed, through an efficient delivery system. This is a core component of Resilience-Innovation theory and progress.

Additionally the system must be approachable so that customers of all types can share their needs and, in turn, be given service - or directed to appropriate services. Individual consumer’s, home caregivers and social workers need to have a constructive forum in order to articulate their thoughts and ideas on how their needs can be met. Organisations (commercial, governmental and NPO’s) of all descriptions should be able to approach TRISI through defined customer service channels and request assistance and service – not only for mahala (free). Business should be done at TRISI too!

Communities probably need a different customer service system. One that is defined by the component parts of the service industry in that community. (Municipal, NPO, Health Care, Education etc.). Education should command its own team of customer service experts as our children are our most precious asset.