Section 10. Trauma & Co-Existant Health Challenges

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‘Biosocial degeneration is the consequence of massive trauma. If trauma is not dealt with & in the absence of appropriate mourning processes, the stage is set for a re-enactment of a violent past at some time in the future through the transgenerational transmission of the trauma’ Professor Vamik Volkan

Dr Marjorie Jobson; Crime in Post Apartheid South Africa: Communities under Threat; Khulumani Support Group

“She is in the belly of a fish... the biodiversity of pollen is represented by the bees visiting hundreds, if not thousands of different flowers of different species of plants. The bees gather pollen and nectar in the valleys, up the mountains, in the backyard, down the street, red flowers, blue, purple, white flowers. Where there are flowers you will find bees.”

CC Pollen Co The Importance of Bees http://www.beepollen.com/the-importance-of-bees/

All lines are blurring. Categories can no longer be rigidly classified. Ideas hop from one to the other, shamelessly borrowing from everywhere. Everything is at an intersection with something else. You can be a specialist at what you do, but you better have damn good peripheral vision at the same time.

John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
This section, like all the others is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

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” regretfully 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:

- unrepentant HIV/Aids,
- volatile Substance Abuse,
- desperate Poverty, and
- ubiquitous Violence

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 always finds its dark insidious way into ‘the gang relationships’.

**Terms: Co-Morbid & Co-Occurring**

‘Co-morbid’ and ‘co-occurring’ are essentially one and the same thing. The Mental Health term for is “Co-morbidity”. Behavioural Health (see Section 17), which embraces social constructs, finds the term “co-morbid” to be too limiting. 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”.

Bushra Sabri; Severity of Victimization and Co-Occurring Mental Health Disorders Among Substance Using Adolescents; School of Nursing, Johns Hopkins University, Baltimore, MD, USA; Child Youth Care Forum. 2012 February ; 41(1): 37–55. doi:10.1007/s10566-011-9151-9.

‘The co-occurrence of mental health (MH) disorders among substance-abusing adolescents is often the rule and not the exception (Chan et al. 2008). The co-occurrence of MH disorders or comorbidity is “the presence of more than one diagnosis, whether exclusively psychiatric or both psychiatric and medical (nonpsychiatric)” (Starcevic 2005). “One disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder” (Center for Substance Abuse Treatment 2005). According to the common factor model of comorbidity (Krueger and Markon 2006), a common risk factor can cause symptoms for two different types of disorders. For example, research shows that chronic life stressors, severity of substance misuse and victimization experiences are shared risk factors for internalizing and externalizing problems among adolescents (Berthold 2000; Boney-McCoy and Finkelhor 1995; Chan et al. 2008; Compas et al. 1993; Elze 2002; Kaplan et al. 1998; Menard 2010; Saha et al. 2006; Turner et al. 2010).’
NCBI – The National Center for Biotechnology; Substance Abuse Treatment for Persons with Co-Occurring Disorders. Information http://www.ncbi.nlm.nih.gov/books/NBK64184/

‘Comorbidity: The occurrence of two disorders or illnesses in the same person, either at the same time (co-occurring comorbid conditions) or with a time difference between the initial occurrence of one and the initial occurrence of the other (sequentially comorbid conditions).’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘The term “co-occurring disorders” refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including substance abuse). Co-occurring disorders are common among individuals who have a history of trauma and are seeking help.’

Department of Health; Republic of South Africa; National Mental Health Policy Framework and Strategic Plan 2013-2020;

‘Co-occurring disorders: When an individual has one or more mental disorders as well as one or more substance use disorders (including substance abuse), the term “co-occurring” applies. Although people may have a number of health conditions that co-occur, including physical problems...’

**Mental Health in general**

“In one workshop in Costa Rica with a group of 25 Nicaraguan migrants, we uncovered 60 psychosomatic illnesses.”

Martha Cabrera; Essay: Living and Surviving in a Multiply Wounded Country; http://siyathanda.org.za/index.php/resources2/83-multiply-wounded-country

Department of Health; Republic of South Africa; National Mental Health Policy Framework and Strategic Plan 2013-2020;

‘The burden of mental illness is felt not only through the primary presentations of mental disorders, but through its high co-morbidity with other illnesses. As South Africa is a country with a “quadruple disease burden,” mental ill-health features prominently in its high level of co-morbidity with infectious diseases, such as HIV/AIDS and tuberculosis; its association with the growing burden of non-communicable diseases, such as cardiovascular disease and diabetes mellitus; high levels of violence and injury; and maternal and child illness.’

WHO Department of Mental Health and Substance Dependence, Non-communicable Diseases and Mental Health; Investing in Mental Health; 2003

‘Comorbidity, which signifies the simultaneous occurrence in a person of two or more disorders, is a topic of considerable and growing interest in the context of health care. Research supports the view that a number of mental disorders (e.g. depression, anxiety, substance abuse) occur in people suffering from both non-communicable and communicable diseases more often than would be expected by chance. And people suffering from chronic physical conditions have a greater probability of developing mental disorders such as depression. Rates of suicide are higher among people with physical disorders than among other people. Comorbidity results in lower adherence to medical treatment, an increase in disability and mortality, and higher health costs. However, comorbid mental disorders are often under recognized and not always effectively treated. Increased awareness and understanding, as well as comprehensive integrated management may alleviate the burden caused by comorbid mental disorders on the individual, society and the health services.’

‘Mental and behavioural problems as risk factors for morbidity and mortality It is becoming increasingly clear that mental functioning is fundamentally interconnected with physical and social functioning and health outcomes. For
example, depression is a risk factor for cancer and heart diseases. And mental disorders such as depression, anxiety and substance use disorders in patients who also suffer from physical disorders may result in poor compliance and failure to adhere to their treatment schedules. Furthermore, a number of behaviours such as smoking and sexual activities have been linked to the development of physical disorders such as carcinoma and HIV/AIDS. Among the 10 leading risk factors for the global burden of disease measured in DALYs, as identified in the World Health Report 2002, three were mental/behavioural (unsafe sex, tobacco use, alcohol use) and three others were significantly affected by mental/behavioural factors (overweight, blood pressure and cholesterol).


‘The majority of visits in primary care are related to behavioral health needs but not to identified mental health disorders. Kroenke and Mangelsdorff (1989) reported that fewer than 20% of patient visits to primary care physicians are for symptoms with discoverable organic causes and that 10% are clearly psychological in nature. That leaves the vast majority of patient visits with no discoverable organic pathology found yet occurring because of physical complaints. The 10 most common presenting symptoms are chest pain, fatigue, dizziness, headache, edema, back pain, dyspnea, insomnia, abdominal pain, and numbness. These complaints account for 40% of all visits, and of patients with these complaints, only 10%–15% were determined, after a year of study, to have an organic diagnosis (Kroenke & Mangelsdorff, 1989).’

‘About 75% of patients with depression present physical complaints as the reason they seek health care (Unu’tzer, Schoenbaum, Druss, & Katon, 2006). People who might benefit from behavioral health services to relieve the problems they bring to their physician usually do not think that is what they need when they first come to the doctor. These same people are more likely to come to the doctor’s office. The decision by a patient to go to the doctor is usually not related to how sick he or she is (Berkanovic, Telesky, & Reeder, 1981). A person who has a psychological disorder is much more likely to make a visit to a physician for a physical complaint than a similar person without a psychological disorder.

*American Hospital Association; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes; January 2012*

‘Individuals with behavioral health disorders often have co-occurring physical health conditions. In the past year, 34 million adults—17 percent of American adults had comorbid mental health and medical conditions. Mental health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other.

Individuals with co-occurring physical and mental health conditions present many treatment challenges. A physical condition may exacerbate a mental health condition, while a mental health condition may hinder treatment for a physical ailment. Medical conditions with a significant symptom burden, such as migraine headaches, chronic bronchitis, and back pain are associated with increased incidence of major depression. About one fifth of patients hospitalized for a heart attack suffer from major depression, which roughly triples their risk of dying from a future heart attack or other heart condition. Depressed patients also are three times more likely than non-depressed patients to be noncompliant with treatment recommendations. Moreover, individuals with mental illness more frequently have risk factors, such as smoking and obesity, which contribute to increased likelihood of chronic conditions such as stroke and diabetes.

*California Primary Care Association; Integrated Behavioral Health Care - An Effective and Affordable Model*

‘A study released October 2007 by the Santa Monica think tank the Milken Institute revealed Americans who have common chronic health conditions cost the U.S. economy more than $1.3 trillion a year. While mental disorders rank third in total economic expense, costing the nation an estimated $216.7 billion, the effects of mental illness do not end there. Without mental health care, mental illnesses often remain undiagnosed and other chronic physical illnesses develop, a phenomenon known as “somatization”.

*Somatization disorder* is a psychiatric condition marked by multiple medically unexplained physical symptoms, which interfere significantly with a person’s ability to perform daily activities such as work, school, or family responsibilities. Typical symptoms include: gastrointestinal complaints, sexual dysfunction, headaches, joint and
back pain, as well as neurological conditions such as seizures. Even though the physical chronic illness experienced by a somatic patient is a result of psychological stress, the patient and physician may not be aware of the root cause and simply diagnose the more easily observed condition. Therefore, the true impact of mental disorders likely reaches beyond the estimates given here.

_John D. Weeks, MD, National Council for Behavioral Health; The Business Case For Effective Mental Health Treatment_

‘A new awareness is emerging among those working to improve the U.S. healthcare system – we will be unable to solve the quality and cost problems ($3 trillion per year and counting) until we address the healthcare needs of persons with serious mental health and substance use disorders and the behavioral health needs of all Americans. There are tens of millions of Americans with comorbid chronic health and behavioral health conditions such as mental health disorders. These individuals have higher healthcare costs and generally do not receive the care they require to address these issues. The combination of these factors is creating a major roadblock in our efforts to fix the healthcare system.’

_The Centrality of Trauma_

_Steven M. Southwick, George A. Bonanno, Ann S. Masten, Catherine Panter-Brick and Rachel Yehuda; RESILIENCE AND TRAUMA; Resilience definitions, theory, and challenges: interdisciplinary perspectives; European Journal of Psychotraumatology_

‘When stress exposure is unusually intense, chronic, uncontrollable, and overwhelming, it can give rise to (or exacerbate), burnout, depression, anxiety, and numerous physical conditions, such as inflammatory, cardiovascular, or other medical illnesses.(Karatoreos & McEwen, 2013; Russo, Murrough, Han, Charney, & Nestler, 2012; Southwick & Charney, 2012a, 2012b; Southwick, Litz, Charney, & Friedman, 2011; Southwick, Vythilingam, & Charney, 2005).

_Martha Cabrera; Essay: Living and Surviving in a Multiply Wounded Country; http://siyathanda.org.za/index.php/resources2/83-multiply-wounded-country_

‘At the same time we were inventorying all the traumas and other afflictions and getting a feel for this lack of knowledge, we began to seek tools that would help create some understanding among those working in development. One of the bridges we discovered was to inventory the population’s health conditions parallel to the inventory of psychological wounds. When we met with groups, with communities, we would ask the people to indicate the most important losses they had suffered and also tell us about the state of their personal health. That helped us find more manifestations of the multiple wounds phenomenon, which are social and political as well as personal. We observed that a series of chronic somatic illnesses—gastritis, colitis, migraines, etc.—closely connected to unprocessed traumas were among the most frequent and serious personal manifestations. We also found that the state of our population’s health in the area of psychosomatic illnesses was truly deplorable. Using their health state was a very useful way to get people to open up more, since it is a topic that does not make people feel defensive or threatened. When we began our workshops by doing the health and illness inventory, it tended to surprise people: “What’s this? I come to a workshop on development and political advocacy and the next thing I know you’re asking me about my health.” But while the approach catches them off guard, it works.’

_Heather Pollett; The Connection Between Violence, Trauma and Mental Illness in Women; Canadian Mental Health Association, Newfoundland and Labrador_

‘When the mentally ill are perpetrators of violence, a combination of past trauma, poverty, current living situation and substance abuse all of which are further compounded by marginalization and discrimination can make a person more vulnerable to experiencing violence, and more vulnerable to becoming violent if they are provoked.’
'The relationship between trauma and mental health is a complex one, and a causal relationship is not immediately clear. Not all people who experience abuse, either in childhood or adulthood, inevitably develop mental illness, and not everyone who has been diagnosed with mental illness has experienced abuse. Yet the connection between trauma and mental health is well established. Research has shown that the rate of reported abuse in childhood and/or adulthood among women living with mental illness is alarmingly high: 80% of psychiatric inpatients have been physically or sexually abused (Rajan, 2004).'

'The onset of mental illness in adulthood can be precipitated by trauma but due to differences in individual backgrounds, symptoms of mental illness can manifest themselves differently in each person and this makes it a challenge to pinpoint the exact nature and course of this relationship.'

'One of the issues facing victims of violence is that mental health treatment is currently based on the traditional biomedical model. This model focuses mainly on biological and genetic factors of mental illness and does not adequately take into account the social determinants of mental health such as poverty, housing and stigma (Morrow & Chappell, 1999). Nor does the biomedical model fully consider the extent to which past experiences of violence influence the onset of mental illness in adulthood. All of these factors disproportionately affect women because of gender inequality (Morrow & Chappell).'

'The symptoms of borderline personality disorder are consistent with the emotional and behavioural responses of trauma survivors. Some mental health service providers who treat BPD believe that a diagnosis of complex posttraumatic stress disorder is more fitting than BPD because it takes into account the effects of violence (CMHA, "Violence and Trauma").'

'Whether it is the behaviour itself that makes borderline personality disorder difficult to treat, or the lack of research, training and resources to adequately cope with the disorder, it is possible that women with this diagnosis may find themselves in crisis situations more often and use more health and mental health resources. "Individuals with borderline personality disorder have more frequent hospitalizations, use outpatient psychotherapy more often, and make more visits to emergency rooms than individuals with other personality disorders" (PHAC, 2002). BPD also accounts for 20% of all psychiatric inpatients (APA, 2000). If the symptoms of BPD are not recognized as trauma-related and treated as such, then without effective intervention, these women may be at increased risk for violence or even suicide.'

'Not all mental health issues neatly fit current diagnostic criteria or constitute a significant impairment of normal functioning such that it requires labelling, medication or hospitalization. Trying to fit trauma survivors with mental health issues into the current biomedical model of treatment rather than tailoring services to individual needs negatively affects the provision of appropriate treatment. Often, behaviour is stigmatized, pathologized or criminalized, and symptoms are assessed in isolation without considering the social context of women's lives and without taking into account a history of violence. Even if assessment and treatment are informed by trauma, there are not enough resources to effectively deal with the problem. An inefficient use of health care and law enforcement resources means that the economic burden of inappropriate treatment is carried not only by those who need these services most, but also by society as a whole. Although violence against women may cost over a billion dollars each year, the true cost is much higher, and the magnitude of the suffering is immeasurable.'


'Psychological stress is a major contributor to morbidity, mortality, and health-care costs. Psychiatric disorders directly linked etiologically to stress, including unipolar major depressive disorder (MDD) and posttraumatic stress disorder (PTSD), are among the top causes of disability and disease burden. MDD is ranked as the number one worldwide cause of years lived with disability and is projected to be the second leading cause of global disease burden (combined morbidity and mortality) by the year 2020 (Lopez and Murray, 1998). Less evidence exists on the epidemiology of PTSD, but it is estimated that PTSD may affect as much as 10% of the general population and is among the 20 leading causes of disease burden (Galea et al., 2005, Freed et al., 2010). Furthermore, psychological stress can precipitate or perpetuate other psychiatric disorders, such as schizophrenia, dementia, and addiction (van Winkel et al., 2008, Tsolaki et al., 2009, Sinha et al., 2011), and can negatively affect the course of several non-psychiatric conditions, including cardiovascular disease, cancer, and HIV infection (Cohen et al., 2007, Kaltsas et al.,
2012). Many of these conditions are potentially preventable and/or treatable. Improving the ability to predict which individuals are susceptible to stressors would offer the opportunity for early intervention and could have enormous implications for reducing stress-related disability and health-care costs.’

Alameda County Trauma Informed Care - http://alamedacountytraumainformedcare.org/

‘Trauma has been found to be the central issue for people with mental health problems, substance abuse problems, and co-occurring disorders. Studies conducted over the past decade have consistently highlighted the link between trauma, mental health, and behavioral health. These studies have found:

- Between 34% and 53% of people diagnosed with a severe mental disability report childhood physical or sexual abuse (with some studies reporting figures as high as 51% to 98%);
- As many as 80% of adults (both men and women) in psychiatric hospitals have experienced physical or sexual abuse;
- The majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were abused as children;
- Up to 66% of adults (both men and women) in substance abuse treatment report childhood abuse or neglect;
- 82% of young people in inpatient and residential treatment programs have histories of trauma;
- 93% of psychiatrically hospitalized adolescents had histories of physical, sexual, and/or psychological trauma, and 32% met criteria for PTSD.’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘People who are receiving treatment for severe mental disorders are more likely to have histories of trauma, including childhood physical and sexual abuse, serious accidents, homelessness, involuntary psychiatric hospitalizations, drug overdoses, interpersonal violence, and other forms of violence. Many clients with severe mental disorders meet criteria for PTSD; others with serious mental illness who have histories of trauma present with psychological symptoms or mental disorders that are commonly associated with a history of trauma, including anxiety symptoms and disorders, mood disorders (e.g., major depression, dysthymia, bipolar disorder; Mueser et al., 2004), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters, 2005).

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger & Grabe, 2007). These findings propose that traumatic stress plays a significant role in perpetuating and exacerbating mental illness and suggest that trauma often precedes the development of mental disorders. As with trauma and substance use disorders, there is a bidirectional relationship; mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders.’

‘The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of pre-existing disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.’

our lived experience NEWS: Local study shows link between trauma and physical, mental conditions August 17, 2015; https://ourlivedexperience.wordpress.com/2015/08/17/news-local-study-shows-link-between-trauma-and-physical-mental-conditions/

‘A STUDY by a University of Cape Town (UCT) doctoral graduate has demonstrated a clear link between trauma exposure, chronic physical conditions and other mental disorders — the first time that a scientific study has established this link.

These findings could be useful in designing interventions aimed at reducing the burden of post-traumatic stress disorder (PTSD), chronic physical conditions and other mental disorders, UCT said in a statement on Tuesday. Using the data collected in the South African stress and health study, associate professor Lukoye Atwoli found that there was an association between trauma exposure and chronic physical conditions such as arthritis, cardiovascular disease, respiratory disease and chronic pain.
He also found a link between trauma exposure and other mental disorders, such as mood and anxiety disorder. Trauma exposure also increased the risk of chronic physical conditions such as chronic pain, cardiovascular and respiratory disease and arthritis.

“My research provides information on an important social issue, and for the first time demonstrates a link between trauma exposure and physical health in an African context,” said Atwoli, who is also Dean of the School of Medicine at Moi University in Kenya.

“Going forward, clinicians and other responders to traumatic events will have to take measures to establish baseline physical health, and also take measures to mitigate the risk of occurrence of both mental and physical post traumatic disorders.”

“I hope that my findings will be used in designing interventions for trauma survivors, and for advocacy in addressing the huge burden of trauma exposure not only in South Africa but in most the low and middle-income countries across the globe,” he said.’

The study referred to is:

Lukoye Atwoli, Dan J. Stein, Karestan C. Koenenc, and Katie A. McLaughlin; Epidemiology of posttraumatic stress disorder: prevalence, correlates and consequences; PubMed, 2015 July 01

‘Summary—Recent community studies show that trauma exposure is higher in lower-income countries compared with high-income countries. PTSD prevalence rates are largely similar across countries, however, with the highest rates being found in post-conflict settings. Trauma and PTSD-risk factors are distributed differently in lower-income countries compared with high-income countries, with socio-demographic factors contributing more to this risk in high-income than low-income countries. Apart from PTSD, trauma exposure is also associated with several chronic physical conditions. These findings indicate a high burden of trauma exposure in low-income countries and post-conflict settings, where access to trained mental health professionals is typically low.”

‘Conclusion …Finally, we have reviewed recent data that shows the increasingly important role played by traumatic event exposure in the risk of developing chronic physical conditions. It is clear that addressing the high and rising burden of chronic physical conditions must include interventions mitigating the impact of traumatic event exposure and PTSD on the occurrence of these conditions.’

Department of Social Development/Department of Women, Children and People with Disabilities/ UNICEF; Violence Against Children in South Africa

‘Violence against children is not only a child rights issue but also a major public health concern. Apart from physical injuries, the experience of violence often has severe and lasting consequences for children’s psychological and social development, their behaviour as well as their health outcomes. These consequences can affect them well into adulthood.’

‘Depression, substance abuse, anxiety, suicidal behaviour as well as reproductive health problems such as unwanted pregnancy, sexually transmitted diseases and sexual dysfunction are just some of the consequences associated with exposure to violence. In particular, post-traumatic stress symptoms affect a large number of South African children, with only a small proportion receiving any counselling or professional assistance.80 Traumatic experiences also affect brain development in children and can lead to difficulties in learning and cognitive functioning.’

‘Factors such as age, temperament, previous trauma experiences as well as external factors such as emotional support influence the outcome of exposure to violence for the individual child. The developmental level of the child is also important. For example, younger children who have been exposed to violence are more likely to regress in their developmental milestones by temporarily losing their bowel and bladder control or other recently gained skills. Toddlers and children of pre-school age may become clingy and have tantrums, while children of school-age and adolescents may have difficulty concentrating, and display mood swings and disruptive behaviour at home and at school.'
In terms of intergenerational transmission of violence, there is emerging evidence of the negative impact on developing neurology of being raised in environments characterised by continuous stress (sometimes called toxic stress) from early childhood. Children raised in this situation often have poor self-regulation, are hypervigilant and likely (if boys) to develop aggressive anti-social behaviour patterns.

Brett Moore and Walter Penk: Treating PTSD in Military Personnel – a clinical handbook; Guilford Press, 2011

‘From a clinical perspective, PTSD is rarely the only problem that must be addressed. Indeed, complicate clinical presentations are generally the rule rather than the exception. PTSD is often co-morbid with depression, substance abuse disorders, traumatic brain injury (TBI), insomnia, aggressive behaviours, chronic pain, and other medical and/or surgical complaints.’

“Consequently, too often clinical work is based on clinician preference or prior training, marketing from pharmaceutical companies, and alliances worth specific theoretical “camps” rather than on data from specific studies. In other words, it may not be in the best interest of the patient.’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counsellors should assess all clients for possible trauma-related disorders.’

Malose Langa; The role of childhood trauma and adversity in youth offending in South Africa; The Centre for the Study of Violence and Reconciliation, June 2007

‘The understanding is that some young people who have been exposed to trauma are more likely to become violent later in life. These young people use aggression or violence as a coping mechanism to deal with trauma symptoms such as low self-esteem, shame, guilt, anger, and depression. Some end up committing serious violent crimes and they are now serving long prison sentences. The prevalence rate of trauma amongst youth offenders is estimated to be 24% to 51% (Greenwald, 2005). Currently, despite the high rates of trauma exposure among youth offenders, prison rehabilitation initiatives tend to ignore psychological trauma. Trauma interventions need to be integrated into prisoners’ rehabilitation.’

‘The psychodynamic understanding of violent crime raises a pertinent question, does childhood trauma beget violence or does violence beget trauma? Every child is born innocent, with a sense that the world is a safe place providing experiences of love, care and nurturing. But the world may instead abuse and neglect the child. The child takes in the pain of trauma and releases it later in life in the form of violence. This confirms Pistorious’s (2000) statistics that 90% of perpetrators have a history of child abuse, rejection and neglect. Similarly, Wedge et al. (2000) and Mkondo (2005) found that juvenile offenders had experienced some form of abuse. Thirthysix percent experienced emotional abuse; 16% experienced sexual abuse, and 44% experienced physical abuse (Mkhondo, 2005; Wedge et al. 2000). It seems many young violent offenders are suffering from unresolved childhood trauma. Mkondo’s (2005) work with juvenile offenders also supports the link between early childhood traumatic experiences and violence later in adolescence. In conclusion, it seems we are all responsible for
dealing with causes of violent crime, including preventing all forms of child abuse. Other writers argue that “helping children to grow in safe communities represents an investment in South Africa’s future” (Wedge, et al. 2000, p. 15).’

**HIV/AIDS**


‘South Africa’s leadership in turning the tide against the HIV and AIDS epidemic was acknowledged by United Nations Programme on HIV and AIDS (UNAIDS) in its February 2013 publication. The country has one of the largest antiretroviral (ARV) programmes, with some two million people on treatment.’

‘South African National AIDS Council (Sanac) Trust

‘In February 2013, the new Sanac Trust, which includes members from civil society, business, academia and government, was inducted. Their mandate is to facilitate and manage a multi-sectoral approach to the implementation of the National Strategic Plan (NSP).

The goals of the NSP are to halve the number of new HIV infections; ensure that at least 80% of people who are eligible for treatment for HIV are receiving it; halve the number of new TB infections and deaths from TB; ensure that the rights of people living with HIV are protected; and reduce the stigma related to HIV and TB.’

‘The work that the council undertakes is crucial at a time when South Africa has turned the tide on the response to HIV, but still has a long way to go in addressing the scourge of HIV and AIDS. In April 2013, Sanac welcomed the availability of fixed-dose combination (FDC) ARVs, saying it would encourage patients to stay on treatment and reduce incidents of non-compliance and non-adherence.’


‘Trauma and HIV: What’s the Connection?’

The term "trauma" denotes negative events and circumstances that produce psychological distress and may have adverse effects on the well-being of an individual. Trauma has always been an experience shared by many PLHIV prior to diagnosis. And as the U.S. HIV epidemic has increasingly become a public health crisis disproportionately impacting communities who also face the detrimental effects of systemic racism, homophobia, transphobia, classism, and patriarchy, U.S. PLHIV have become increasingly impacted and burdened by lifetime individual and community-level trauma.

It is well documented that traumatic experiences, including histories of childhood sexual and physical abuse, are far more prevalent among PLHIV than in the general U.S. population. And trauma is all-too-frequently perpetuated by the health care and service delivery system itself, especially for communities of color, sexual minorities and others who suffer from the intentional and unintentional effects of discrimination, prejudice and bias in the very settings entrusted to assure their well-being.

Recent data demonstrates that trauma experienced in adulthood and post-HIV-diagnosis is also significantly higher among PLHIV than among the general population. In part, this may stem from pervasive racism, homophobia, transphobia, classism, patriarchy, and policies that criminalize sex work and drug use, which in and of themselves perpetrate trauma and trauma-related stress, independently of interpersonal violence.’

‘Because of the population overlap between PLHIV and populations in which trauma-informed service delivery has been evaluated, and because of HIV’s strongly collaborative service delivery networks in the U.S., it is logical that
elements of evaluated trauma-informed service delivery may be applicable to HIV outpatient care and service delivery settings.

Resources that may be worth exploring include the Sanctuary Model, a framework for intervening with trauma survivors and for facilitating organizational change originally developed for traumatized adults in inpatient settings and adapted for use in domestic violence settings. Organizations and agencies that seek to become more trauma-informed can look to resources including Creating Trauma-Informed Systems of Care: Facilitating Recovery in Mental Health Services Settings and Developing Trauma-Informed Organizations: A Tool Kit, both designed for use by mental health provider agencies.

The integration of peers (defined, in this case, as trauma survivors and those in trauma recovery) throughout program design and implementation, has been widely acknowledged as key to the success of trauma-informed service delivery.’

Department of Health; Republic of South Africa; NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020

‘In the South African context, the relationship between HIV/AIDS and mental illness is particularly pertinent. Research in South Africa shows that, with high prevalence in both, mental illness and HIV coexist in a complex relationship. Mental health impacts on and is exacerbated by the HIV/AIDS epidemic, both being mutually reinforcing risk factors. Mental health problems are common in HIV disease, cause considerable morbidity, and are often not detected by physicians.’


‘The HIV epidemic is a global public health tragedy. The toll of the epidemic can be measured in premature loss of lives and the concomitant economic burden on resource-constrained countries. It can also be measured in terms of the adverse mental health status of people living with HIV.

HIV stigma not only has detrimental effects on the mental health of people living with the virus, but also adversely affects those people at risk of HIV.33,29 HIV stigma may be a significant threat to the success of educational efforts to prevent HIV infection and legislation designed to enhance HIV testing, treatment seeking, and the adoption of preventative strategies. Worldwide, eradication of HIV stigma remains an important public health goal for effectively combating the HIV epidemic.’

Department of Social Development/Department of Women, Children and People with Disabilities/ UNICEF; Violence Against Children in South Africa

‘The extent of the HIV and AIDS pandemic in South Africa has heightened concern about the particular form of child-headed households. About 90 000 children were found to be living in households with no adult member in the General Household Survey of 2010. However, contrary to common assumptions, 88% of these children had a living parent. Further, only 1% of all orphans lived in child-only households in 2010.

Section 137 of the Children’s Act has a broader definition of child-headed households than a definition that includes only children living in households with no adult member. The Children’s Act defines child-headed households as those in which the parent, guardian or care-giver of the household is terminally ill, has died, or has abandoned the children in the household, and in which a child aged 16 years or older has assumed the role of care-giver in the absence of an adult family member who can play this role. This definition would expand the number of children living in child-headed households. The Act’s provisions in respect of the children highlight the vulnerability of these children and their need for special attention.’

Sr Silke-Andrea Mallmann; Building Resilience in Children Affected by HIV/AIDS; CPS Catholic AIDS; Catholic AIDS Action, Namibia

‘According to the best data we have, in 2001 Namibia, for example, had over 82 000 orphans. Within a generation, that number is expected to triple. The plight of these children will be the single largest impact of the HIV/AIDS pandemic on this nation. The plight is similar in other African countries. One thing we know for sure: Orphans and vulnerable children don’t deserve their fate. There is nothing that any of them did to justify their sorrow, their hardship, and their losses.’
'Studies have shown that girls in our society tend to be more vulnerable than boys. Babies and young children are more vulnerable than older children. Children without a family or a home are vulnerable. Children held in detention are vulnerable. Children lacking education and skills are vulnerable. Children living in poverty are vulnerable. Children who are not involved in taking decisions that affect their own lives are vulnerable. Being exploited, abused, discriminated against or exposed to violence makes children vulnerable. Children who are isolated or withdrawn, who have no access to schools or adequate medical care, are vulnerable. Children whose rights are not upheld are vulnerable.'

'Children who have lost their parents to HIV/AIDS are especially vulnerable. Some children are taken in by their extended families but, as HIV/AIDS affects more and more families, children are often found to be either living on their own or looking after younger brothers and sisters and elderly grandparents. Households headed by children have become common in many parts of Africa. It is clear that orphaned children are highly at risk of exploitation and increasing impoverishment.'

'Children don’t need to be ill or to have HIV/AIDS themselves to be affected by it. It is also very worrying for a child if a member of the family is ill or has HIV/AIDS. One problem leads to another and this creates an enormous burden that is difficult for a child to understand. It makes the child feel overwhelmed and hopeless. Problems that seem to pile up one on top of another are known as “cumulative stressors”. The effect of cumulative stressors on an orphan can be devastating if the child can’t access his or her inner resources and doesn’t receive support from the outside.’

‘Many children feel overwhelmed by the huge responsibility. They nurse their parents without having been taught what to do. They risk being infected themselves because they don’t know what precautions to take when nursing people with HIV/AIDS. In addition to the daily housework, nursing a patient also includes getting up during the night. Nursing a bedridden patient is heavy work – even for an adult. It can be exhausting for a child. Is it surprising that these children have problems concentrating or are “hyperactive” (overactive) in the classroom to prevent themselves from falling asleep? Many children complain about aches and pains that are caused by exhaustion.’

‘Poor housing, poor health, lack of access to health services and a lack of education are common in families affected by HIV/AIDS. Many children turn to prostitution to earn money and child labour is not uncommon. The need to earn money is another major reason for children dropping out of school.’

‘When parents become too weak to fulfil their daily tasks, the family’s income may decrease drastically. Being too sick to work in the fields will reduce the income of a family. Losing a job means losing an income as well. This is a crisis – especially in single income homes. It is often left to older children to earn money and to provide food. Many children suffer from malnutrition, which affects their own health. Children are hungry at school and they can’t concentrate properly. Some schools won’t accept children who can’t pay the school fees or buy the right uniforms and books.’

Robyn Pharoah, AIDS, ORPHANS AND CRIME: Exploring the linkages; Institute for Security Studies;

‘In the hardest hit regions of the world, the HIV/AIDS epidemic is increasing poverty and inequality and reversing decades of improvements in health, education, and life-expectancy. It is also leaving millions of children orphaned and living in situations of acute vulnerability. Yet, even as the international community mobilises in support of these young people, some researchers and practitioners are linking orphaning and crime, suggesting that growing numbers of impoverished orphans may pose a threat to individual and communal security in some countries.’

‘Criminologists acknowledge that pinpointing the ‘causes’ of crime is a difficult undertaking. However, the available literature suggests that there are likely to be strong correlations between the dynamics triggered by the [HIV/Aids] epidemic and crime. Factors like material need, social exclusion, unemployment, poor education, and family breakdown, for instance, lie at the heart of many of the prevailing theories of why individuals commit crime. High levels of inequality are also closely associated with victimisation – and may in fact be more consistently correlated with crime than poverty. Researchers working in South Africa have found that “inequality is highly correlated with both burglary and vehicle theft”, while research in the United States suggests that economic disparities may foster frustration and anger that contributes to violent crime.
This relationship between inequality and crime has been explained using the concept of relative deprivation, which breeds social tensions so that “the poor seek compensation and satisfaction by all means, including committing crimes against both poor and rich”. Less directly, factors such as urbanisation and its correlates – which could be exacerbated by the growing economic hardship associated with the [HIV/AIDS] epidemic – have also been linked to higher levels of criminality the world over.

Figure 1: Problems among children and families affected by HIV/AIDS

![Diagram showing various problems among children and families affected by HIV/AIDS]

Source: J Williams, presentation to the US Council on Foreign Affairs, April 2005

Visual: Robyn Pharoah, AIDS, ORPHANS AND CRIME: Exploring the linkages; Institute for Security Studies;

**HIV/AIDS and Trauma**

Naina Khanna and Suraj Madoori; Untangling the Intersection of HIV & Trauma: Why It Matters and What We Can Do; GMHC Treatment Issues; September 2013

‘Trauma has always been an experience shared by many PLHIV prior to diagnosis. And as the U.S. HIV epidemic has increasingly become a public health crisis disproportionately impacting communities who also face the detrimental effects of systemic racism, homophobia, transphobia, classism, and patriarchy, U.S. PLHIV have become increasingly impacted and burdened by lifetime individual and community-level trauma.’

‘It is well documented that traumatic experiences, including histories of childhood sexual and physical abuse, are far more prevalent among PLHIV than in the general U.S. population. And trauma is all-too-frequently perpetuated by the health care and service delivery system itself, especially for communities of color, sexual minorities and others who suffer from the intentional and unintentional effects of discrimination, prejudice and bias in the very settings entrusted to assure their well-being.

Considering the historical and collective trauma inflicted on communities of color, LGBT communities, and other communities vulnerable to acquiring HIV, minimizing the power imbalance and promoting a trauma-informed response require high levels of cultural competency, which should prioritize employment of peers and leadership by people from disproportionately impacted communities in service delivery.’
'The price of unaddressed trauma is apparent: trauma leads to worse health outcomes and a lower quality of life for PLHIV. Unaddressed trauma complicates public health efforts to stem the HIV epidemic, creates inefficient delivery of services and places additional strain upon scarce public health resources. A system ill-equipped to heal trauma among highly-impacted communities may lose its ability to engage clients in care and thus to perform its very function. For PLHIV accessing services, multidisciplinary care settings including existing Ryan White care models may provide an ideal environment to integrate trauma-informed services for vulnerable populations.'

'Many studies show that a history of trauma, particularly physical and sexual abuse, is common among HIV-positive individuals and exceeds that in the general population.'

'The association between HIV infection and trauma exposure may be causal (for example, childhood sexual abuse has been linked to higher rates of sexual and drug use risk behaviours that increase the risk of HIV) or may reflect of the concentration of HIV infection in socio-economically deprived populations who are at high risk of trauma exposures.12 Traumatic life events, especially multiple traumatic events, are strongly associated with poorer treatment adherence, HIV risk behaviours, a history of alcohol abuse and depression, more hospitalisations, and faster HIV disease progression.'

'Furthermore, there is a dose-response relationship with the odds of non-adherence to antiretroviral therapy (ART) increasing with each additional lifetime traumatic exposure.14 Prior trauma may affect adherence through a variety of pathways, including: (i) PTSD or other mental health problems (as well as substance misuse); (ii) subjective experiences of and trust in the health care system; (iii) individual coping styles and self-efficacy mechanisms; and (iv) the availability of social support.'

'There are essentially three core aspects to consider in the assessment for PTSD in people living with HIV/AIDS (PLWHA):

(i) identification of patients who are predisposed to the disorder (i.e. at risk);
(ii) careful assessment of all traumatic events that a patient has experienced; and
(iii) understanding of the diagnostic criteria for PTSD.

'HIV-infected patients with PTSD can present a special challenge to the primary care physician as they commonly complain of vague somatic symptoms that may be the somatic expression of their disorder, be exacerbated by their PTSD, or be unrelated. Patients with PTSD also suffer from psychiatric co-morbidities such as depression, other anxiety disorders and substance abuse. Many patients use alcohol or drugs in an attempt to self-medicate their PTSD symptoms. In addition, patients with PTSD are at an increased risk of gastro-intestinal, cardiac, respiratory and neurological problems.'

'PLWHA who have PTSD are often fearful and highly sensitive to physical sensations (e.g. a physical examination can remind some patients of their traumatic experience), and in turn may be ambivalent about medical treatment. Being supportive, enhancing a sense of personal safety, and recommending self-care strategies (e.g. an activity that is enjoyable and self-fulfilling) can help patients manage their anxiety and reduce risk-taking and self-destructive behaviours. In clinical practice, the majority of adults with PTSD derive most benefit from a combination of treatment approaches encompassing psychopharmacology and psychotherapy.'

'The present study found that 29.6% of the TB public primary care patients screened positive for PTSD symptoms in South Africa. Similarly, high rates of PTSD or PTSD symptoms have been found in HIV patients in various countries (Olley et al., 2006; Pence, 2009; Klis et al., 2011; Sherr et al., 2011). This study found that the common “worst events” experienced included death of family, partner or friend and being diagnosed with HIV, TB or been diagnosed with HIV/TB co-infection. A study conducted in Tanzania had similar findings. The HIV-positive patients in the Tanzanian study reported the following increased number of “worst events”: Death of relative or friend, witnessed a violent death and having a life-threatening illness other than HIV (Whetten, Whetten, Ostermann, & Itemba, 2008). In addition, TB patients who screened positive for PTSD were more likely to have co-occurring psychological

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**Janine Pingo, Soraya Seedat; THE MANAGEMENT OF TRAUMA AND POSTTRAUMATIC STRESS DISORDER IN HIVINFECTED INDIVIDUALS; The South African Journal of HIV Medicine; Vol 10; No 3; 2009**

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problems such as suicide attempts and psychological distress; Reisner et al., 2009). A minority of those who screened positive for PTSD and anxiety/depression (severe psychological distress) and of those who screened positive for both anxiety/depression and PTSD were using anti-depression medication, as found in a different study (Reisner et al., 2009).’

‘This study found that HIV–TB co-infection was associated with higher rates of PTSD or PTSD symptoms, as in some other studies (Klis et al., 2011; Pence, 2009; Sherr et al., 2011). The HIV–TB co-infected patients have a greater chance of contracting multiple drug-resistant TB (MDR-TB) as well as extra drug-resistant TB which are life-threatening and often lead to death. Being a TB retreatment patient was, in this study, not associated with higher rates of PTSD symptoms than in new TB patients. This finding may indicate that the diagnosis or re-diagnosis of TB may not lead to more PTSD symptoms.’

‘Further, this study found an association between HIV risk behaviour (unprotected sex, alcohol and drug use before sex) and PTSD which is a finding supported by several other studies (Reisner et al., 2009). This calls for intensified HIV broad-based behavioural prevention interventions to address risk-taking behaviour among TB patients. Contrary to other studies (Keuroghlian et al., 2011; Sherr et al., 2011), this study did not find an association between PTSD symptoms and ART and anti-TB drug non-adherence. Vranceanu et al. (2008) also found only a secondary role of PTSD in poor treatment adherence among individuals with HIV, whilst the primary role in poor adherence was depression.’

Ashraf Kagee; THEORETICAL CONCERNS IN APPLYING THE DIAGNOSIS OF PTSD TO PERSONS WITH HIV AND AIDS; http://socialwork.journals.ac.za/; http://dx.doi.org/10.15270/44-3-238

‘It is likely that most patients diagnosed with HIV require psychological and social support as well as assistance in coping with their condition. Some, as pointed out by Freeman, may also require mental health services, especially for conditions such as generalised anxiety disorder or major depressive disorder. Of course, trauma may result from AIDS-related stigma in that discriminatory acts such as violence or abuse that meet criteria A1 and A2 may provoke PTSD-related symptoms. However, such events are qualitatively different from the experience of receiving a diagnosis of HIV or living with AIDS.’

‘Because of the role of poverty, stigma, gender violence, mother-to-child transmission, migrant labour and the controversial nature of treatment access in some countries, it is inappropriate to regard infection with HIV as an example of “bad luck or the ordinary trials of life”. It is no accident that AIDS is much more prevalent in poor countries compared to wealthy nations. However, the argument in this article is that a case for the traumatic nature of AIDS may be misplaced. Persons diagnosed with HIV require help in coping with the psychological distress that ensues following diagnosis, living with their condition, accessing treatment and dealing with social stigma. Considering AIDS a traumatic stressor worthy of precipitating posttraumatic stress disorder may be an inappropriate way in which to frame what is likely to be in most cases non-pathological psychological distress. It is necessary for mental health practitioners, including social workers, psychologists and counsellors to consider the implications of this argument.’


‘The HIV and AIDS epidemic is recognised as one of the major challenges that threatens the development of children and the realisation of children’s rights in South Africa (DSD, 2013). Orphanhood has been tracked since 2002; and in 2012 it was found that the overall level of orphanhood found for those 0–18 years of age is 16.9%. This proportion appears to be similar to the previous survey in 2008, when the rate was 16.8% suggesting that orphanhood has remained stable in the country. The 2008 survey estimated that there were close to three million orphans in South Africa (Shisana, Rehle, Simbayi et al. 2008). The stable figures observed in levels of orphanhood could be due to the availability of ART that has prolonged the lives of HIV-positive parents. Indeed there is evidence of a decline in mortality in South Africa (see Bor, Herbst, Newell & Barnighausen, 2013).’


‘Almost a third of HIV-positive women in the US have recent post-traumatic stress disorder and 55% have experienced intimate partner violence, according to the results of a meta-analysis published in AIDS and Behavior.'
The investigators identified 29 studies examining trauma and post-traumatic stress disorder (PTSD) in women with HIV.

Overall, 33% of women had recent PTSD, some six times the rate seen in the general US population. Almost two-third of women had a lifetime experience of sexual abuse.

“The implications of these findings are highly significant,” comment the authors. “These results...support and inform longtime calls for studies of trauma-prevention and trauma-recovery interventions to reduce the high incidence and relatively poor outcomes of HIV among women.”

‘Women now account for 27% of all new HIV diagnoses in the US and 77% of these infections are in Blacks or Latinos. Despite general improvements in the prognosis of HIV-positive patients, HIV/AIDS is now the leading cause of death among Black women aged 25 to 34.

Trauma is increasingly recognised as contributory factor to the increasing prevalence of HIV in US women and their poorer outcomes. However, studies exploring the prevalence of trauma and PTSD among women with HIV have yielded widely varying results, or cannot be generalised to the general population of HIV-positive women.

Investigators therefore undertook meta-analysis to clarify rates of trauma and PTSD in HIV-positive women. Where possible, the observed prevalence was compared to that recorded in the general population of US women.

The authors searched for studies published between 1990 and 2009. To be included, the research had to examine current or past exposure to at least one traumatic stressor.

A total of 29 studies including 5930 women met the investigators’ criteria and were included in the meta-analysis.

The estimated rate of recent PTSD was 30%.

“This estimate is over five times the rate of recent PTSD reported in a national prevalence sample of women,” write the authors.

Prevalence of intimate partner violence among women with HIV was an estimated 55% - twice the rate reported in US women as a whole.

Rates of adult sexual and physical abuse were 35% and 54% respectively. Estimated prevalence of childhood sexual abuse and childhood physical abuse were 39% and 42%.

“Both of these samples are approximately twice those documented in a national prevalence sample of women,” note the researchers.

They calculated that an estimated 61% of HIV-positive women had a lifetime history of sexual abuse, five times the national US prevalence. The estimated prevalence of lifetime physical abuse was 72%.

“We observed very high rates of all categories of traumatic exposure and PTSD,” write the investigators. “The estimates of the various categories of trauma and recent PTSD in HIV-positive women are mostly between two and five-fold higher.”

Efforts to address trauma and PTSD should be a priority in HIV prevention and care, argue the authors.

“Effectively addressing trauma and PTSD may be an opportunity to make a transformational impact on the HIV epidemic.”

The authors suggest “screening and referrals for recent and past trauma and PTSD should be considered a core component of HIV treatment in this population, along with medication adherence, CD4 cell counts and viral loads.”

‘Previous evidence has suggested that people living with HIV (PLH) are exposed to high levels of traumatic stress (Gore-Felton & Koopman, 2002; Kimerling et al., 1999), and that histories of sexual and physical abuse are particularly prevalent in HIV-positive populations (Kalichman et al., 2002; Martinez, Israeliski, Walker, & Koopman, 2002; Martinez, Hosek, & Carleton, 2009; Welles et al., 2009). Exposure to traumatic events is related to sexual and other risk behavior that may facilitate transmission of HIV (Briere & Runtz, 1987; Cavanaugh & Classen, 2009; Gore-Felton et al., 2006; Gore-Felton & Koopman, 2002; Holmes, 1997; Kalichman et al., 2002; Sachs-Ericsson, Cromer, Hernandez, & Kendall-Tackett, 2009; Welles et al., 2009) and as such is a target for interventions designed to reduce HIV transmission rates. Dissociation, as a specific symptom of trauma, may be related to sexually risky behavior in those exposed to childhood sexual abuse (Zurbriggen & Freyd, 2004).’

‘Dissociative experiences, characterized by lack of awareness of surroundings, emotions, identity and memories, are relatively common in the population at large (Ross, Joshi, & Currie, 1990) and are particularly notable and ubiquitous among populations with psychiatric illness (Putnam et al., 1996). Although dissociative experiences can play a role in pleasant, everyday experiences (Butler & Palesh, 2004), they are most often linked with experiences of traumatic stress, and the impact of childhood abuse on development of later dissociative symptoms has been well-established (Mulder, Beautrais, Joyce, & Fergusson, 1998). There is also evidence that dissociative symptoms are associated with compulsive sexual behavior (Chaney & Chang, 2005), substance abuse (Seedat, Stein, & Forde, 2003), and other risk behaviors such as crossing police barricades to get closer to a firestorm (Koopman, Classen & Spiegel, 1996). Evidence suggests that dissociative symptoms are associated with diagnoses of Post-Traumatic Stress Disorder (PTSD; Ginzburg et al., 2006; Ginzburg, Butler, Saltzman, & Koopman, 2009) as well as with dysregulation of the HPA axis (Koopman et al., 2003).’

**Substance Abuse**


‘Evidence from different disciplines suggests that acute and chronic stress–related mechanisms play an important role in both the development and the chronic, relapsing nature of addiction (Baumeister 2003; Baumeister et al. 1994; Brady and Sinha 2005). Stress is defined as the physiological and psychological process resulting from a challenge to homeostasis by any real or perceived demand on the body (Lazarus and Fokman 1984; McEwen 2000; Selye 1976). Stress often induces multisystem adaptations that occur in the brain and body and affect behavioral and social function. The resulting dynamic condition is a dysregulated physiological state maintained beyond the homeostatic range. This definition and conceptualization of stress was further developed to explain the chronic abuse of substances and comfort foods and has been studied in the context of behavioral addiction (i.e., pathological gambling) (Dallman et al. 2005; Koob and Le Moa 1997; Koob 2003).

Persistent challenges to an organism through chronic substance use may ultimately lead to an altered set point across multiple systems. This hypothesis is consistent with evidence that suggests adaptations in brain reward and stress circuits, and local physiology (e.g., energy balance) can contribute to addictive processes. Cravings or urges, decreases in self-control, and a compulsive engagement in unhealthy behaviors each characterize patients with addiction (Dallman et al. 2005; Kalivas and Volkow 2005; Koob et al. 2004; Sinha 2001). Alternatively, a person’s ability to successfully cope with high stress is reflected in adaptive physiological and psychological responses (Charney 2004; MacQueen et al. 2003).’
WHO Department of Mental Health and Substance Dependence, Non-communicable Diseases and Mental Health; Investing in Mental Health; 2003

- 76.3 million persons are diagnosed with alcohol disorders; • At least 15.3 million persons are affected by disorders related to drug use; • Between 5 and 10 million people currently inject drugs; • 5%–10% of all new HIV infections globally result from injecting drugs; • More than 1.8 million deaths in 2000 were attributed to alcohol-related risks; • 205,000 deaths in 2000 were attributed to illicit drug use (Figure 8); • The government, drug abusers and their families shoulder the main economic burden of drug abuse; and • For every dollar invested in drug treatment, seven dollars are saved in health and social costs.
'Substance abuse services should always be a part of any plan to bring behavioral health services into medical settings, both because of the level of need presenting in medical settings and because of the overlap of substance abuse problems with medical and mental illnesses. The cost offset in treating substance abuse is a result of heading off the dramatic increase in health care costs that occurs as the illness becomes acute (Holder, 1998). When substance abuse services are integrated into primary care, the cost of treatment is about the same as when the services are provided separately for substance-abusing patients who do not have a substance abuse related medical illness. For patients with medical illnesses related to substance abuse, the cost of integrated care is less than half the cost of separated care (Parthasarathy, Mertens, Moore, & Weisner, 2003). A significant percentage of people in treatment for alcohol abuse meet criteria for a diagnosis of major depression, and many people have their first major depressive episode after a period of alcohol or drug use (Lennox, Scott-Lennox, & Bohlig, 1993). People with combined alcohol abuse and depression have significantly higher health care costs than those with only an alcohol abuse diagnosis, but the former are also more likely to seek treatment than the latter.'

Department of Health; Republic of South Africa; NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020

‘Historically, in South Africa substance abuse treatment services have been provided by both the Department of Social Development and the Department of Health. The policy and legislative framework for this area is set out in the Prevention and Treatment of Substance Abuse Act (2008) and the National Drug Master Plan (2006). There are important issues of co-morbidity between substance use and mental disorders, and hence a need to coordinate services. Substance use disorders are to be covered by this policy insofar as there is co-morbidity with mental disorders. The Department of Health committed itself during Parliamentary debate of the Prevention and Treatment of Substance Abuse Act (2008) to provide care, treatment and rehabilitation for those users that present with co-morbid substance use and mental disorders in designated psychiatric hospitals, rather than referring them to the substance abuse treatment centres run by the Department of Social Development. This decision is reflected explicitly in this Mental Health Policy.’

Department of Social Development/Department of Women, Children and People with Disabilities/ UNICEF; Violence Against Children in South Africa

‘Several South African studies have found a link between use of alcohol and drugs and violence and crime. The National Injury Mortality Surveillance System (NIMMS), a mortuary-based reporting system on causes of fatal injuries, found that blood alcohol concentration tested positive in 58% of homicide victims, 52% transport-related accidents and 37% of suicides in 2005. In addition, substance abuse by parents interferes with their ability to care for and monitor their children. According to the Medical Research Council, 15% of children report times in their lives when one or both parents were too drunk to care for them. Furthermore, the poor impulse control and lowered inhibition associated with substance use may result in caregivers reacting in ways that they may not otherwise, and this may end with violence against children.’

‘Children can become victims of violence not only because of use of alcohol and drugs by those within their own home, but also through the use of such substances by individuals within their social environments such as peers. For example, one study found that more than a quarter (27%) of perpetrators of sexual assault against children had been intoxicated at the time of the crime.33 In a vicious cycle, victims often turn to alcohol or drugs to cope with the trauma of their experiences. This ultimately perpetuates violence in society.

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Malose Langa; The role of childhood trauma and adversity in youth offending in South Africa; The Centre for the Study of Violence and Reconciliation, June 2007

‘Drugs and alcohol are easily available for South African youth. In their study, Leoschunt and Burton (2006) found that one in five South African youth knew people in their communities who sell (21%) and buy (28%) drugs. Currently, studies indicate a strong link between substance abuse and crime in South Africa. The Institute for
Security Studies (ISS) and Medical Research Council (in Pluddemann, Parry, Louw & Burton, 2002) found that 58% of youth offenders reported being under the influence of drugs or alcohol at the time they committed their crimes.

Also in the study conducted by Segal, Palmary and Rampa, (1999, p.5) many young offenders said “they relied on drugs to carry out their criminal acts.” It seems drugs give young offenders the courage to commit their crimes. Another study conducted by the South African Police Service (SAPS) revealed the link between alcohol abuse and the prevalence of certain types of violent crime such as assault (Leggett, 2002). According to the National Injury Mortality Surveillance System, 56% of 2,469 arrested suspects tested positive in blood/alcohol tests (Pluddemann, Parry, Louw & Burton, 2002).

Department of Health; Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020

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Substance Abuse and Trauma

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘People with Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders.

1. The “self-medication” hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.

2. The “high-risk” hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.

3. The “susceptibility” hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.’

‘Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person’s ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events.’

Jerome September, Youth Connector at the Citizens Movement; Youth “Woundedness” and the substance abuse crises in South Africa – A contribution towards understanding this “Wicked” Problem! Lead SA

‘In South Africa, 25%–30% of general hospital admissions are directly or indirectly related to alcohol abuse (Albertyn & McCann, 1993), and 60%–75% of admissions in specialized substance abuse treatment centres are for alcohol-related problems and dependence. Almost 80% of all assault patients (both males and females) presenting to an urban trauma unit in Cape Town were either under the influence of alcohol, or injured because of alcohol-related
violence (Steyn, 1996). The majority of victims of train-related accidents, traffic accidents – both pedestrians and drivers – had blood alcohol levels exceeding the legal limits (Van Kralingen et al, 1991). Foetal alcohol syndrome is by far the most common cause of mental disability in the country (Department of Trade and Industry, 1997).

‘In the “woundedness” frame this disjuncture between the promise of a better tomorrow and the near desperate reality of today, and also the search for a new identity amongst our youth is fertile ground for substance abuse with substances often providing an immediate (albeit temporary) escape. Link this to the easy access to substances, both legal and illegal, exposure to public drunkenness, advertising which promotes the use of substances (especially alcohol and smoking) as part of an attractive lifestyle, absent parents and positive role models, peer pressure, boredom and lack of sufficient recreational and sporting facilities, and you have fertile ground for a substance abuse pandemic predicted to be a bigger threat than AIDS to South Africa.

Key to addressing the challenge of substance abuse is thus the need for South Africans to deal with their “woundedness” as this will unlock our agency and sense of self-worth, resulting in us taking full control of our destiny, as citizens. In addressing our “woundedness” it is critical that we give voice to the stories of citizens, and that we provide platforms for citizens to engage in honest conversations. These conversations must be within the framework of positive action towards taking back our streets and declaring our neighbourhoods substance abuse free.’

_Bushra Sabri; Severity of Victimization and Co-Occurring Mental Health Disorders Among Substance Using Adolescents; School of Nursing, Johns Hopkins University, Baltimore, MD, USA; Child Youth Care Forum. 2012 February ; 41(1): 37–55. doi:10.1007/s10566-011-9151-9._

‘Substance using adolescents with co-occurring MH disorders are likely to enter treatment with greater impairment in functioning, less social conformity, more history of engagement in illegal activities, and are less responsive to treatment than are adolescents with either substance use or MH disorder (Beitchman et al. 2001; Hiller et al. 1996). Adolescents with co-occurring disorders, therefore, demand more attention and services compared with adolescents with one type of disorder (Grella et al. 2004). Adolescents are more vulnerable to co-occurring internalizing and externalizing problems due to their challenging and stressful transitional stage of development (Cicchetti and Rogosch 2002). Both internalizing and externalizing problems commonly co-occur with substance use problems.’

‘Research findings assert that victimization experiences can lead to internalizing and externalizing disorder problems among adolescents (Margolin and Gordis 2000). Victimization experiences, considered traumatic, have been associated with internalizing problems, such as depression and anxiety (Taylor and Weems 2009) and externalizing problems, for example, violent (Kimonis et al. 2011), criminal and deviant behaviors (Kerig et al. 2011; Mallie et al. 2011; Riggs Romaine et al. 2011). However, victimization (Margolin and Gordis 2000; Titus et al. 2003) and other adverse experiences (Weems et al. 2010) vary based on severity levels and severity of their impact on adolescents. Adolescents with more severe victimization experiences may be at greater risk for severe or multiple MH problems (such as co-occurrence of ID and EDs), than adolescents with less severe or no victimization experiences.’


‘Studies have further revealed that alcohol and drug abuse are a critical facet of the problem of domestic violence and in South Africa, alcohol and drugs “interact with other internal dispositions and pathologies, such as feelings of low self-worth, the incidence of which is heightened as a result of other factors, such as weaknesses in the family, the legacy of racism, and the context of inequality’.

‘Dealing with Substance Abuse

Successful prevention, reduction and treatment of substance abuse not only relieve poverty, but also reduce other evils, such as crime and violence, that are part and parcel of it. Prevention and reduction of substance abuse also contribute a great deal to the prevention and reduction of interpersonal violence, domestic violence, child abuse and neglect, and unnecessary deaths on the roads caused by driving under the influence of alcohol or drugs.

Furthermore, alcohol and drugs not only act as drivers of crime and violence, but also make victims more vulnerable to such acts and cause people (especially young people) to lose their inhibitions, and engage in all kinds of risky behaviour, including unprotected sex. Alcohol consumption is deeply entrenched in South African society.’
Poverty

“This reflects one of public health’s most difficult dilemmas: unless consciously designed not to, policies and actions that work for populations as a whole often inadvertently entrench inequalities.” Kings Fund (Buck & Frosini, 2012)

Isabella Goldie, Julie Dowds, Chris O’Sullivan; Mental health and inequalities; Mental Health Foundation

Marelise van der Merwe; Psychiatry in distress: How far has South Africa progressed in supporting mental health? 15 July, 2015; Daily Maverick;

‘The Mental Health and Poverty Project (MHaPP), based at the department of psychiatry and mental health at UCT, in turn found that in South Africa, there is a link between poverty and mental disorders. Unfortunately, this means that resources are most constrained where they are needed most. According to a study by Lund et al (2011) 75% of people who live with a mental disorder in South Africa do not receive the care they need.’

WHO Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health; Investing in Mental Health; 2003

‘Talking about mental disorders means talking about poverty: the two are linked in a vicious circle

Since mental disorders generate costs in terms of long-term treatment and lost productivity, it can be argued that such disorders contribute significantly to poverty. At the same time, insecurity, low educational levels, inadequate
housing and malnutrition have all been recognized as contributing to common mental disorders. There is scientific evidence that depression is 1.5 to 2 times more prevalent among the low-income groups of a population. Poverty could therefore be considered a significant contributor to mental disorders, and vice-versa."

_Department of Health; Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020_

‘The relationship between poverty and mental ill-health has been described as a “vicious cycle” people living in poverty are at increased risk of developing mental disorders through the stress of living in poverty, increased obstetric risks, lack of social support, increased exposure to violence and worse physical health. On the other hand, those who live with mental illness are at increased risk of sliding into (or remaining in) poverty, as a result of increased health expenditure, lost income, reduced productivity, lost employment and social exclusion due to stigma.’

**Figure 1. Relationship between poverty and mental ill-health**

_Isabella Goldie, Julie Dowds, Chris O’Sullivan; Mental health and inequalities; Mental Health Foundation_

‘Inequality in mental health means the unequal distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health. Despite investment to address social disadvantage deep inequalities remain in our society with the gap between the rich and poorest increasing (Howell, 2013; Black and O’Sullivan, 2012). Our unequal society and the costs of this to mental health should be a central concern for us all; it leads to an unequal distribution across population groups of mental health problems and illness and in people’s ability to recover and lead fulfilling lives.

If our aim is to create a fairer and more just society and then we need to address the chronic stress and fractures that having less power, status and control brings; and work with people to build strong communities and empowering services. To do this we need to work across all areas of policy to influence the factors that serve as determinants of mental health and enable inequalities and disadvantage to grow.’

‘There is a strong body of evidence that living in poverty brings with it poorer mental health, and that the stresses of living in poverty increases the risk of developing mental health problems. In addition that living with a mental health problem brings with it increased social disadvantage, such as higher levels of unemployment. Across the UK, we
experience mental health inequities, these are inequalities in relation to mental health status that can be described as ‘morally or ethically’ unfair or unjust (Whitehead, 1990). These inequities are often experienced by the same people and accumulate over a lifetime, placing older people who experience poverty at increased risk of poor mental health and of developing mental health problems.

Adverse mental health outcomes are 2 to 2.5 times higher among those experiencing greatest social disadvantage compared to those experiencing least disadvantage (Kessler et al., 1994; Macran et al., 1996; Gilbert & Allan, 1998; Murali & Oyebode, 2004). In addition those living with disability or a mental health problem remain at highest risk of poverty (Parckar, 2008). Socio-economic pressures such as poverty and low levels of education are recognised risks to mental health for individuals and communities. The greater the gap between the rich and the poor, the greater differences are observed in health.

‘Not surprisingly (these) individualistic and (these) universal approaches have not been successful in improving mental health inequalities, which continue to widen. The social gradient that exists in mental health clearly indicates that material advantage has a key role to play in mental health outcomes. We know that poverty is a major determinant of poor mental health, and that universal approaches to mental health improvement may achieve mental health gain across the population but fail to address equity or reduce inequalities.

What will be needed to meet these challenges will be a fundamental change in approach. Some areas to be considered include:

- More integrated approaches to both health and health and social care to respond to increased co-morbidity and multiple morbidity.

- More investment upstream to prevent failure demand.

- Ensuring policy and strategy is linked up and not in silos: that there is an understanding that approaches to improving health and inequality outcomes are integrated.

- Taking an evidence based approach to improving public health with a shift in focus from a dependence on universal approaches and large scale public health social marketing campaigns to a model that takes account of inequalities (see fig 1).

- A proactive and consistent approach to ensuring equality, working alongside equality groups and within communities to co-produce services that respond to their specific needs.’

Department of Social Development/Department of Women, Children and People with Disabilities/ UNICEF; Violence Against Children in South Africa

‘Unemployment and poverty affect children both directly and indirectly. For example, high levels of unemployment and poverty can cause family stress and frustration which, in turn, can result in punitive behaviour towards children as well as abuse. Overcrowding, which is often associated with poverty, can also place children at risk of violence and, in particular, of sexual abuse. South Africa’s history has resulted in poverty being concentrated geographically. In particular, poverty is concentrated in the more rural ex-homeland areas which were the areas to which African people were confined and “removed” during the apartheid era. These areas are disadvantaged both in terms of the socio-economic status of the inhabitants and in the availability and quality of government and private services. Poverty is also concentrated in the informal settlements of urban areas which continue to attract poor people who migrate from rural areas in the hope that they will find employment and services.

‘Poverty and unemployment are widespread in South Africa. Financial stress may increase the likelihood of violence against children in the home. Fathers, in particular, may feel anger and frustration at not being able to provide for their family, as this is seen as part of the traditional masculine role. Meanwhile, economic dependence on men makes it difficult for many women to leave their abusive partners.’
The achievement gap between children from low-income backgrounds and their affluent peers has increased by 40 percent over the last three decades. The impact of this economic disparity can become apparent in children as young as 9 months. By the time children from lower-income backgrounds turn 3, for example, they will have heard 30 million fewer words than those from higher-income families. Such setbacks can hurt young children’s language development and, in turn, curb their achievement from kindergarten to the workforce.

**Poverty and Trauma**

*Max du Preez; A Rumour of Spring; Chap. 1 Multiply wounded, multiply traumatised; 2013; Zebra Press*

‘Mandela and his de facto prime minister, Thabo Mbeki, had little choice but to keep the economy structurally intact.

So once the festivities were over, most people’s lives returned to what they had been before liberation. Most of the poor were still poor. Most black South Africans still lived in townships, squatter camps or neglected rural areas. Most of their children still went to bad township schools. Few had the prospects of a good job and a good life. Millions moved from traditional areas (the former Bantustans) to the cities after 1994, where most of them still live in misery and struggle to cope with the change to life in the city.’

‘…on 26 July 2013, ANC member of Parliament (MP) and leader of the Young Communist League of South Africa, Buti Manamela, said in his Political Report to the Second National Council of the League: ‘As we walk towards twenty years since the democratic breakthrough in 1994, myth making at the expense of the youth has become a national pastime. Everyone will have us believe that those born when Madiba was released are the Born Free generation. Born Frees who supposedly have no memory or inkling of apartheid colonialism. ‘Let me debunk this myth for the ahistorical nonsense that it is. The concept is ideologically fraudulent and is littered with inconsistencies. It essentially suggests that the struggle ended in 1994 whereas we know that the struggle continues....”

‘... now, twenty years after liberation, not having dealt properly with our past, the symptoms of our multiple wounds and traumas still manifest.

*NCTSN; Executive Summary: Understanding the Impact of Trauma and Urban Poverty on Family Systems: Risks, Resilience, and Interventions*

‘Families living in urban poverty often encounter multiple traumas over many years. Further, they are less likely than families living in more affluent communities to have access to the resources that may facilitate the successful negotiation of their traumatic experiences. Thus, many families have difficulty adapting.

Repeated exposures can lead to severe and chronic reactions in multiple family members with effects that ripple throughout the family system and, ultimately, society. Research demonstrates that all levels of the family system are impacted:

- Individual distress can range from transient symptoms to Posttraumatic Stress Disorder (PTSD) to more complex trauma-related disorders, with the potential to disrupt functioning across multiple domains.
- Though some research indicates that supportive adult intimate relationships can be a source of strength in coping with a traumatic experience or dealing with the stress of poverty, the majority focuses on difficulties faced by couples who have experienced trauma, such as problems with communication, difficulty expressing emotion, struggles with sexual intimacy, and high rates of hostility, aggression and interpersonal violence.
- Within the parent-child relationship, compromised attachment and mistrust may stem from parental withdrawal/worry and re-enactment of abandonment/betrayal themes.
- Though trauma may not affect the parenting practices of all parents, the experiences of chronic trauma and the stress associated with urban poverty have been associated with decreased parental effectiveness, less
warmth, limited understanding of child development and needs, increased use of corporal punishment and harsh discipline, high incidents of neglect, and an overall strategy of reactive parenting.

- Sibling relationships may become negative and conflictual depending on the quality of individual parent-child relationships, differential treatment of siblings by parents, parental management of sibling conflict, individual children’s behavior and emotional regulation and coping skills, and family norms regarding aggression and fairness.

- Research on intergenerational trauma and urban poverty has demonstrated that adults with histories of childhood abuse and exposure to family violence have problems with emotional regulation, aggression, social competence, and interpersonal relationships, leading to functional impairments in parenting which transmit to the next generation.

- The family as a whole is also impacted by chronic conditions of high stress and exposure to multiple traumas and families often experience chaotic, disorganized lifestyles, inconsistent and/or conflicted relationships, and crisis-oriented coping.


‘Living within a context of multiple and continuous trauma exposure, with few safe spaces, poses a different set of psychological challenges and requires different intervention approaches to those that have been well-documented for children and adolescents who experience single traumas or those who experience ongoing abuse in only one setting. Furthermore, for many South African children, multiple traumatisation occurs within a broader resource context of poverty, with its attendant burden on family structures and parental coping capacities (Kiser & Black, 2005; Klebanov, Brooks-Gunn & Duncan, 1994), an inadequate educational system (Fiske & Ladd, 2004) and limited mental health services for children (Lund, Boyce, Fliser, Kafaar & Dawes, 2009). These factors may compound the impact of trauma exposure and place constraints on intervention options.’

Portia D. Rawles; The Link between Poverty, the Proliferation of Violence and the Development of Traumatic Stress Among Urban Youth in the United States to School Violence: a Trauma Informed, Social Justice Approach to School Violence; Forum on Public Policy; Norfolk State University

‘There is a substantial body of literature, which clearly demonstrates that children and adolescents living in poor urban areas experience greater incidences of violence, whether as witnesses or victims. (Paxton 2004; Okundaye 2004; Self-Brown 2004; Buka et. al. 2001; Mazza and Reynolds 1999; Duncan 1996; Pastore, Fisher and Friedman 1996). Drug trafficking, vacant and dilapidated structures, unemployment, lack of commitment to learning by youth, substandard housing, chaotic, crowded and noisy households, experiences which routinely occur in urban areas have all been linked to the increased occurrence of shootings, murders, sexual assaults, youth violence, intimate partner violence, school violence and child maltreatment (Carpenter and Nevin 2010; Redwood et. al. 2010; Okundaye 2004; Paxton 2004; Evans and English 2002 Pastore, Fisher and Friedman 1996; Duncan 1996).

According to the Center for Disease Control and Prevention (2010), school violence is a subset of youth violence. School violence involves “harmful behaviors that may start early and continue into young adulthood that occurs on school grounds or on the way to school. It includes bullying, slapping, punching, weapon use and rape.”

‘We now recognize that increased often multifaceted, chronic, and complex exposure to various forms of violence among urban youth is associated with the development of traumatic stress, PTSD and sub-threshold traumatic stress symptomatology (Margolin & Vickerman 2007; Lynch 2003; Margolin and Gordis 2000; Rossman, Hughes and Rosenberg 2000). These multiple and chronic exposures to violence are considered complex traumas (Cook et. al. 2005).’

‘A host of social, political, cultural, and economic factors help to contribute to a generational culture of poverty within many major urban communities in the USA whose devastation manifests itself in excessive community, family, and school violence that poor, urban youth must endure. This increased and chronic exposure to community, family and school violence represents complex trauma. This complex trauma results in the increased manifestation of traumatic stress and PTSD among urban youth.’

‘The role of traumatic stress, in the perpetuation of urban school violence must be considered in this solution, and address by school and city officials, if they hope to effectively resolve this issue. For many, this will require a
significant and possibly uncomfortable paradigm shift. Yet, to ignore this crucial element will be detrimental to the future stability and prosperity of our nation, with the long term consequences being the unfortunate overrepresentation of impoverished and traumatized urban youth that will become; impoverished, traumatized, mentally ill, uneducated and possibly violent adults. Our school systems, neighborhoods, communities, and country will suffer the negative consequences of our continued inattention to this phenomenon and outcome, primarily because persons living in these conditions were unable to escape the unfortunate circumstances of their environment.’

The Centre for Abuse & Trauma Therapy; Poverty and Trauma: How they are Linked and How You can Help; Understanding Therapy; A Series of Educational Articles on Abuse and Trauma Therapy

‘Four years ago the Centre was launched in reaction to the lack of affordable, long term therapy available to men and women in our community. Over the years, we have noted a striking trend in that many members of our community cannot afford the therapy they so desperately need. Almost 50% of our clients pay the lowest fees on the sliding scale.

The low-income cut-off (LICO) rates are often quoted by the media as a measure of poverty however Statistics Canada has stated it is not a poverty measure. The LICO published by Statistics Canada in 2005 was 10.8% (Source: http://en.wikipedia.org/wiki/Poverty_in_Canada ). Unfortunately, individuals who have experienced trauma and abuse can become impoverished as a result of their experiences.

“According to a UN report on modern slavery, the most common form of human trafficking is for prostitution, which is largely fueled by poverty. In Zimbabwe, a number of girls are turning to prostitution for food to survive because of the increasing poverty. In one survey, 67% of children from disadvantaged inner cities said they had witnessed a serious assault, and 33% reported witnessing a homicide. 51% of fifth graders from New Orleans (median income for a household: $27,133) have been found to be victims of violence, compared to 32% in Washington, DC (mean income for a household: $40,127)” Source: http://en.wikipedia.org/wiki/Poverty}