Section 12. Trauma & Social Trust 1

“Bees fly to flowers, and inside this incredible environment, they search for their food, pollen and nectar.”

“Cultures are dynamic, not static, and therefore some of these attitudes need to change.”

Way before a thought can evolve into something we believe in, it floats in the primitive soup of instinct.


John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
Notes:
1. 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.

2. The concepts of Historical Trauma and Intergenerational Trauma are inseparable and are most often used interchangeably. This proposal has tended to use the term Intergenerational most often in the context of transference of Trauma from one individual to another; and the term Historical Trauma to represent the intergenerational transmission of Trauma in a community or group sense. This is for convenience only. (Please see Intergenerational Trauma under Section 5 Impact of Trauma).

The evidence of trauma in the social context as a primary driver of co-existent Health Care problems like HIV/Aids, Poverty, Violence and Substance Abuse – linked at almost every level by Trauma, has long been on the table. It is remarkable that South Africa’s Mental Health industry, save for the Research sector, has simply ignored any form of solution building mechanics. Going negligently hand in hand with this oversight is the failure to address the cultural challenges of Mental Health. It is extraordinary that countries like Canada and New Zealand can make such great strides with minority interests when South Africa has a majority issue with the same challenges. This inertia is a direct contribution to our countries psycho-social and socio-economic ills. This degree of irresponsibility from the Psych sector as well as the Social Sciences shows a lack of patriotism and a lack of leadership in these sectors.

Social Capital


‘What is social capital?’
Social capital describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit.

Definitions of social capital vary, but the main aspects include citizenship, 'neighbourliness', social networks and civic participation. The definition used by ONS, taken from the Office for Economic Co-operation and Development (OECD), is 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups'.

‘Why does social capital matter?’
Research has shown that higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates. In other words, those with extensive networks are more likely to be ‘housed, healthy, hired and happy’. All of these areas are of concern to both policy-makers and community members alike.

‘What are networks?’
Formal and informal networks are central to the concept of social capital. They are defined as the personal relationships which are accumulated when people interact with each other in families, workplaces, neighbourhoods, local associations and a range of informal and formal meeting places.

Different types of social capital can be described in terms of different types of networks:

- **bonding social capital** – describes closer connections between people and is characterised by strong bonds, for example, among family members or among members of the same ethnic group; it is good for ‘getting by’ in life

- **bridging social capital** – describes more distant connections between people and is characterised by weaker, but more cross-cutting ties, for example, with business associates, acquaintances, friends from different ethnic groups, friends of friends, etc; it is good for ‘getting ahead’ in life

- **linking social capital** – describes connections with people in positions of power and is characterised by relations between those within a hierarchy where there are differing levels of power; it is good for accessing
support from formal institutions. It is different from bonding and bridging in that it is concerned with relations between people who are not on an equal footing. An example would be a social services agency dealing with an individual, for example, job searching at the Benefits Agency.’


‘Social capital includes connections among individual social networks and the norms of reciprocity and trustworthiness that arise from them, as well as standards for behavior that are socially dictated. These standards, or behavioral and gender norms, strongly influence behavioral choices about alcohol consumption, tobacco use, and sexual activity. Further, elements of social capital are associated with significant increases in mental health and lower rates of homicide, suicide, and alcohol and drug abuse.’

‘When people come together for the common good, communities have marshalled their resources and efforts to reduce levels of violence and improve food access. Social capital factors include trust and cohesion; willingness to take action for the community’s benefit; community engagement, such as voting or volunteering; behavior norms; and gender norms.’

Social Trust

Unite for sight; Social Capital; http://www.uniteforsight.org/community-development/course3/module1

“Trust is the expectation that arises within a community of regular, honest, and cooperative behavior, based on commonly shared norms, on the part of other members of that community ... Social capital is a capability that arises from the prevalence of trust in a society or in certain parts of it. It can be embodied in the smallest and most basic social group, the family, as well as the largest of all groups, the nation, and in all the other groups in between. Social capital differs from other forms of human capital insofar as it is usually created and transmitted through cultural mechanisms like religion, tradition, or historical habit.” Francis Fukuyama

‘Social capital is not something that can be easily incubated by outside agencies. As Fukuyama describes, it is born of historical and inherently cultural tendencies and values to associate and cooperate. Institution-building, a vital aspect of development, requires social capital. Accordingly, institution-building is greatly contingent on the cultural personality of the target community. The characteristic inflexibility of culture to manipulation makes development in a society lacking trust and social capital difficult. Fukuyama vehemently asserts that since it is impossible for governments or external agencies to “mitigate the cultural dimensions of the problem,” the single thing that can be done to build social capital is “strengthen the rule of law and the basic political institutions on which it rests.” This would involve an increase in “the radius of trust” among inward-looking, familial societies, like those of Latin America and some Asian countries.’

Ronnie Mmotlane, Jarè Struwig & Ben Roberts; Social Trust in South Africa: The Glue That Binds or Divides; South African Social Attitudes Survey; HSRC

‘Social trust acts as a foundation for cooperation, contributes to social integration and harmony among people, leads to life satisfaction and ultimately to democratic stability and development. Social trust is therefore at the centre of issues pertaining to practical, daily life, including happiness, optimism, well-being, health, economic prosperity, education, welfare, and participation in community and civil society. South Africa’s history of segregation and apartheid produced multiple divisions, inequalities and injustices. Given the emphasis placed on national reconciliation since 1994 and the benefits of trust for society and democracy, the importance of monitoring and understanding the dynamics and determinants of social trust in our society assumes particular importance. When compared to citizens in European countries by directly comparing the 2008 SASAS (South African Social Attitudes Survey) results with those derived from the most recent round of the European Social Survey, conducted in the same year (Fig. 2), the analysis reaffirms our position as a country with relatively low interpersonal trust. With its mean trust score of 3.82, South Africa ranked 25th out of the 29 countries listed...

Over the last two decades, trust in the country appears to have fluctuated within a narrow band. Levels of trust were found to be inversely related with socioeconomic status, with those least believing in the trustworthiness of our society being in general the more marginalised and materially deprived. There are also interesting signs of an emerging generational change, with today’s youth typically more trusting than older cohorts.’
Social Justice

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

'The high levels of violence in South Africa can be explained variously, including its roots in the country’s history. Apartheid left South Africa with a deeply embedded “culture of violence”. The apartheid society was one in which violence was used by those in power as a legitimate means of achieving their goals. The use of violence to solve problems was thus socially sanctioned from the top. The decades of apartheid, with its attendant political violence and state sponsored oppression, alongside widespread gang and other forms of criminal violence within communities, contributed to a scenario where, for many people in the country, violence was – and continues to be – used as a strategy for conflict resolution.’

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

'Social Justice in the most simplistic terms is defined as the concept of justice on a social scale. According to Rawls (1971), within the social justice framework, injustice represents situations in which an individual’s freedom or ability to be equal is violated or where fairness is lacking (Coates 2007). Thus, the idea of social justice has evolved to include the ideas of: economic egalitarianism, human rights, and equality of opportunity and outcome. Yet, despite the concept’s rich legacy of development and expansion by scholars and politicians, for many in society it continues to be an illusion.’

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

‘The South African Story”: A story of more of less organised brutality and disastrous social divisions from the time of the hunting down of the San & Khoikhoi to the time of the creation of the ‘homelands’ & the establishment of patterns of forced migration with at least one parent being away from the family home for extended periods of time. (Craig Higson-Smith)

Brian-Vincent IKEJIAKU; The Relationship between Poverty, Conflict and Development; Journal of Sustainable Development; Volume 2, No. 1 March 2009.

‘Contrary to the expectations and dreams nourished by many people that the end of the ‘Trio-Crisis Initiators’ in Africa: Colonialism (1960s) Cold War (1998) and Apartheid (1994), will bring stability and succour to the continent, however, the new era could as well be perceived as a turbulent period.

In summation, my argument is that corruption, particularly political corruption directly undermines democracy and governance by destroying the trust relationship between the people and the state. An indispensable obligation of the state is to provide the basic needs of its people and also to ensure the safety of its citizens. When the state fails to fulfil this obligation, or provides for some groups, but not for others, or worse when the leaders are corrupt, the people effectively reclaim their right to use force (conflict) in the resolution of disputes, often with disastrous consequences, such as a rise in crime and stunted development. Thus, my argument is that ‘Political Corruption (POL C) causes or worsens Poverty (POV), which leads to an increase in Conflict (C), which in turn leads to the stunting of Development (DVP). That is POL C → POV → C → DVP. In conclusion, though, there are no doubt, additional explanatory variables and theories for the relationship between poverty, peace and development in Africa, as discussed; it is my argument that political corruption is the major and most persuasive causal factor and the human needs theory most relevant for this paper.’

Phuong N. Pham, Harvey M. Weinstein, Timothy Longman; Trauma and PTSD Symptoms in Rwanda- Implications for Attitudes Toward Justice and Reconciliation

‘An important finding was the significantly greater support for gacaca (desire to reconcile) trials compared with other judicial responses. There are 2 possible interrelated explanations for this finding. People may have a more positive attitude toward gacaca because they may feel more informed and involved with the process. Social learning theorists such as Bandura have proposed that self-efficacy is a critical dimension of well-being and behaviour change. When people feel as though they have more control of the outcome, they are more likely to support the
process. Since gacaca is community-based and trials are held publicly within the community, people may be more involved and committed.’

‘There was more support for interdependence and social justice. However, there was less support for community and nonviolence. Interdependence was measured by such questions as whether respondents had shared a drink with a member of another group or attended a funeral. It may be that respondents are willing to develop relationships at an individual level but that these relationships do not yet constitute a shared sense of community.’

Social Capital and Psychology

Douglas D. Perkins, Joseph Hughey & Paul W. Speer; Community Psychology Perspectives on Social Capital Theory and Community Development Practice; Journal of the Community Development Society; Volume 33, Issue 1, 2002; DOI: 10.1080/15575330209490141

‘Concepts and research from community psychology can inform community development practice by reframing social capital theory. Social capital (SC) is generally defined and measured at the interpersonal, community, institutional, or societal levels in terms of networks (bridging) and norms of reciprocity and trust (bonding) within those networks. SC should be analyzed in a multi-level ecological framework in terms of both individual psychological and behavioral conceptions (sense of community, collective efficacy—or empowerment, neighboring, and citizen participation) and institutional and community network-level conceptions. Excessive concern for social cohesion undermines the ability to confront or engage in necessary conflict, and thus, it dis-empowers the community. Instead of emphasizing social cohesion, “network-bridging” opportunities to increase power, access, and learning should be emphasized. Institutional and community network analysis shows how SC operates at those levels and where to target service resources and develop mediating structures. Psychological and behavioral factors point to factors that motivate individuals to engage in building SC and methods to maintain and improve that engagement.’

Padraig O’Malley; Consequences of Gross Violations of Human Rights; the Nelson Mandela Centre of Memory.
https://www.nelsonmandela.org/omalley/index.php/site/q/03lv02167/04lv02264/05lv02335/06lv02357/07lv02398/08lv02402.htm

‘It must also be remembered that human rights violations affect many more people than simply their direct victims. Family members, communities and societies themselves were all adversely affected. Moreover, the South African conflict had affects far beyond those who were activists or agents of the state; many victims who approached the Commission were simply going about their daily business when they were caught in the crossfire. Human rights violations can also trigger a cascade of psychological, physical and interpersonal problems for victims, influence the functioning of the surrounding social system’

Social Capital/Trust and Trauma

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

‘When one has a lot of accumulated pain, one loses the capacity to communicate with others. The ability to communicate, to be flexible and tolerant is enormously reduced among people who have a number of unresolved personal traumas. The characteristics vital to a person’s ability to function adequately become affected. The loss of solidarity that we lament in today’s Nicaragua has to do with loss of trust between people. An incredible amount of money has been spent in this country on programs to build and strengthen institutional capacity, not just in state institutions but also in nongovernmental and local grassroots organizations. But the strengthening of an institution is based on mutual trust and that is one of the things that’s lost when there is an accumulation of pain and misplaced intolerance and inflexibility.’


‘This study found that higher cognitive social capital is independently associated with lower prevalence of chronic PTSD among survivors of the 2007 Earthquake residing in Pisco, Peru, even 48 months after the disaster occurred. Participants with high cognitive social capital had a prevalence of chronic PTSD nearly twice as low as those with low cognitive social capital, even after adjusting for key confounders. No association was found between the structural dimension of social capital and chronic PTSD.’
involved in several community groups, receive support from multiple individuals and/or participate in citizenship activities (high structural social capital) yet not feel connected or trusting of his or her community (low cognitive social capital).’

‘To summarize, empirical research on social capital has stimulated a vigorous debate regarding its conceptualization and definition. A fundamental point of contention is whether social capital ought to be considered as an individual or as a group attribute. Our tentative answer to this question is that it is both. Although the social cohesion approach to social capital conceptualizes it as a group attribute, the network-based definition embraces both the individual (ego-centered) and group (sociometric) levels of analysis. A second fundamental point of contention is whether social capital ought to be conceptualized as social cohesion or as resources embedded in networks. Again, our tentative answer is yes to both.’

Regardless of whether one subscribes to the social cohesion school of social capital or the network school, consensus now exists about the importance of distinguishing between bonding and bridging social capital (Gittell & Vidal, 1998; Kawachi, 2006; Szreter & Woolcock, 2004). Bonding capital refers to resources that are accessed within social groups whose members are alike (“homophilous”) in terms of their social identity, such as class or race. By contrast, bridging capital refers to the resources accessed by individuals and groups through connections that cross class, race/ethnicity, and other boundaries of social identity.3 Although few empirical studies so far have actually measured both bonding and bridging capital, growing evidence suggests that distinguishing between these types will help us to understand how social capital promotes – or harms – the health of individuals.’


The key manifestation of the veterans’ psychological injuries in the treatment setting is destruction of the capacity for social trust. How the veterans’ incapacity for trust plays out in the family, workplace, government office, commercial establishment, has been well described elsewhere (Lifton, 1973; Shatan, 1985; Mason, 1990; Matsakis, 1996). In the clinic, social trust is the readiness to repose trust in:

- Professional credentials
- Institutional position
- The value pattern of the professional

‘How stable character is, depends largely on the ecology of social power, upon the good enough fulfilment of the culture’s moral order by those who hold power. The normal adult’s cloak of safety and guarantor of narcissistic, hence characterologic, stability is the normative structure of the society, its implementation by power holders, and the concrete social support of a face-to-face community. Good-enough realization in the world of these commitments is the foundation of ordinary self-respect and of the sense of self-worth that we expect in the normal adult. Sudden, undreamed of fulfilment in any of these three realms, will usually make a healthy adult euphoric. And serious, high-stakes destruction in any of these three realms—especially when the threat originates in betrayal of the moral order by power-holders or in abandonment by those to whom one is attached and socially affiliated—is the basis of the damaging changes to character which are the principle subject of this chapter. We do not offer character stability as a goal or good in itself—the post-traumatic changes in character we attempt to reverse are sometimes horrifyingly robust—and it is only the continuing fluidity of adult character that provides an opportunity for treatment.’

‘When “basic trust” is destroyed, what replaces it is perpetual mobilization to fend off attack and to figure out other people’s trickery. In the world of Homer’s warriors, the world was seen primarily in two dimensions, biê, might, and métis, cunning; Achilles embodied the former and Odysseus the latter. Our patients construct the world similarly. Civil society, founded in a third dimension of trust and trustworthy restraints, seems to them a deceptive veneer to hide a violent and exploitative reality (Munroe, 1991). Alertness and suspicion anticipate attack and deception.’

‘Probably the most frequent “boundaries” that combat veterans openly or subtly demand we cross—as a test of trust—is the boundaries of functional specificity, professional specialization, division of labor. Masters level counseling psychologists are importuned for advice on medication; psychiatrists are pressured to locate Section 8
housing, and so on. No wonder well-socialized mental health professionals see these patients as demanding and narcissistic. However, the engine behind these demands is fear, not vanity.'

_Ime Kerlee; Cultural Trauma - Understanding and treating your whole client; PDX Trauma Free_

‘This study demonstrates that traumatic exposure, PTSD symptoms, and other factors are associated with attitudes toward justice and reconciliation. Societal interventions following mass violence should consider the effects of trauma if reconciliation is to be realized.’

**Historical Trauma**

"Essentially, the devastating trauma of genocide, loss of culture, and forcible removal from family and communities are all unresolved and become a sort of 'psychological baggage... continuously being acted out and recreated in contemporary Aboriginal culture'."


B. HUDNALL STAMM, HENRY E. STAMM, AMY C. HUDNALL, CRAIG HIGSON-SMITH; CONSIDERING A THEORY OF CULTURAL TRAUMA AND LOSS; Journal of Loss and Trauma, 9: 89-111 Copyright # Taylor & Francis Inc. ISSN:1532-5024 print=1532-5032 online DOI:10.1080/15325020490255412

‘Taking the broad cultural perspective we suggest requires viewing trauma and loss across time and place. Two methods that use this perspective are multigenerational legacies of trauma (Danieli, 1998) and historical trauma (Duran & Duran, 1995). This cross-time-place perspective sees events and their resulting trauma and loss not as PTSD per se, but as events sufficiently strong that their legacy may retain salience across generations.

Danieli views multigenerational legacies as the transmission across generations of the legacies of a traumatic event. She includes cultural, political, economic, and other dimensions to understand life before, during, and after the event. This perspective may include, but does not require, cultural clash; events transmitted generation to generation can be perpetrated from within, across, or between individuals or cultures. While a parent’s traumatic stress may carry forward to the next generation through the parent’s impaired ability to parent, it may also be transmitted through a shared belief system that is held by the parent, the family, or even the culture. Historical trauma, as defined by Duran and Duran (1995), is more properly referred to as postcolonial psychology. In order to exist, colonialism must have occurred and there may be a continuing aspect to the colonial trauma.’

The manifestations of historical trauma include
(a) communal feelings of familial and social disruption,
(b) existential depression based on communal disruption,
(c) confusion toward owning the ancestral pain accompanied by the temptation to adopt colonial values,
(d) chronic existential grief and angst manifested in destructive behaviors,
(e) daily re-experiencing of the colonial trauma through racism and stereotyping, and
(f) lack of resolution of the existential, communal pain.’


‘According to Brave Heart (2003), the current realities facing Aboriginal groups today are a remnant of the trauma experienced directly by whole generations, then unintentionally passed on to later generations. More specifically, what we are seeing today is a cumulative emotional and psychological wounding which has occurred over the lifespan and across generations, emanating from massive group trauma experiences. This process as a whole has been labeled intergenerational trauma, or historical trauma (HT). Brave Heart (2003) further notes that this
historically transmitted trauma continues to affect today’s populations of Aboriginal people and has led to a historical trauma response (HTR). HTR represents a behavioural manifestation of transmitted trauma in that it is defined as a cluster of features that develop as a response. Typical examples include mental health concerns (posttraumatic stress, depression and anxiety), low self-esteem, suicidal ideation, violence and abuse (emotional, physical and sexual), loss of child-rearing skills, and substance use (Watson et al, 2002; Brave Heart, 2003)."

‘Wesley-Esquimaux and Smolewski (2004) highlight the strong effects of () Residential Schools within the context of forced assimilation and transmission of trauma from one generation to the next. As such, they note the profound impact of HT on women of childbearing age who have mothers, grandmothers and/or other family members who have experienced the Residential Schools. With these past losses combined with modern losses of unemployment, poverty, poor housing, social and geographical isolation and poor health/high morbidity rates, is it any wonder that trauma responses such as mental health and substance use are so prevalent within this population?

‘The results of this study indicate that the modern generation of American Indian adults possess frequent thoughts around historical losses and that these thoughts are associated with negative feelings. This is particularly noted around the aspect of substance use, as the highest percentage of daily thoughts of perceived loss revolved around effects of alcoholism in this group. Almost one half of participants (45.9%) thought of alcohol-associated losses at least once a day or more, and two thirds (63.5%) thought of it at least weekly. These findings support the presence of HT in this group, particularly in relation to the on-going issue of substance use.’

Aaron R. Denham; Rethinking Historical Trauma: Narratives of Resilience; Transcultural Psychiatry

‘There is significant variation in how people experience, emplot, and intergenerationally transmit trauma experiences. Despite this variation, the literature rarely illustrates alternative manifestations or resilient responses to the construct of historical trauma. Based upon person-centered ethnographic research, this paper highlights how a four-generation American Indian family contextualizes historical trauma and, specifically, how they frame their traumatic past into an ethic that functions in the transmission of resilience strategies, family identity, and as a framework for narrative emplotment. In conclusion, the author clarifies the distinction between historical trauma—the precipitating conditions or experiences—and the historical trauma response—the pattern of diverse responses that may result from exposure to historical trauma.’

‘Much of the literature regarding historical trauma privileges psychological or psychiatric models and explanations that center around the pathological. Indeed, such empirical literature is necessary; however, it often results in shortcomings, such as reification or reductionist tendencies, unchecked cross-cultural assumptions resulting in limited consideration of ethnic or religious factors and their variability in the transmission process, or perspectives constrained to the immediate family rather than the socio-cultural and historical context (Gottschalk, 2003). Thus, due to the tremendous variation within and between ethnic group experiences and responses, and the paucity of literature addressing the previously listed themes, it is difficult to characterize or operationalize a definition or mechanism that can embrace the diversity of contexts and meanings attributed to this form of human experience. In other words, I question our readiness for a diagnostic category concerning historical trauma and the validity of the concept as narrow categorization. I am not rejecting the concept of historical trauma altogether; rather, I believe that attempts to reduce and reify the concept to a narrow biomedical construct may further remove it from local understandings and modes of healing.’

‘Most frequently, historical trauma is regarded as both the history or experience of trauma and the resultant impact or constellation of behaviors. A more accurate conceptualization or definition of historical trauma would refer only to the conditions, experiences, and events that have the potential to contribute to or trigger a response, rather than referring to both the events and the response. Accordingly, the subsequent manifestation of or reaction to historical trauma, which, I posit, varies from expressions of suffering to expressions of resilience and resistance, are appropriately recognized as the historical trauma response.’

‘Therefore, returning to the question at hand, I believe a pathological or dysphoric historical trauma response should not be a requirement to validate the presence or impact of historical trauma. Future definitions and discussions regarding the historical trauma complex should consider the potential for alternative and potentially resilient expressions. Increasing critical exploration and challenge of the historical trauma complex will not likely weaken it as
a construct; rather, it will widen our understandings of and the practical efforts towards culturally appropriate responses to individual and collective trauma experiences.'

**National Trauma**

*Wikipedia; National Trauma; https://en.wikipedia.org/wiki/National_trem*  

‘A **national trauma** is a crisis or a tragic experience which affects the spirit of a nation or an ethnicity, sometimes for generations to come. Large-scale disasters like war or genocide inevitably have this effect, but in an otherwise stable and prosperous country even a specific event (like an assassination of the leader or a transport disaster) can be traumatic.’

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

‘The question is not whether we have democratic organizations, but whether we can have them. We’ve discovered that it’s very difficult to build democracy when a country’s personal history still hurts.

This is an extremely complex challenge, because from 1990 forward, we Nicaraguans have not been able to acquire a critical distance from the history we have lived through. Even the textbooks have been changed twice and they now have such an ideological slant that they don’t allow the new generations the necessary distance either. These books polarize us; they continue reproducing the same two political bands. In response to this problem, we’ve also made an effort to prepare new texts that might help us see history more critically.’

‘The social and political manifestations, (), are not as immediate, not as easy to access. When a person does not or cannot work through a trauma right away, its social consequences, the most frequent of which are apathy, isolation and aggressiveness, are only revealed over time. We understood that there’s a close connection between so many accumulated wounds and traumas and the behavior that can be seen today in the large number of Nicaraguans who insist they “don’t want to know any more about politics,” or “don’t want to get involved in anything.” Unprocessed traumas and other wounds and grief explain much of the current lack of mobilization.’

*Galia Plotkin Amrami; Genealogy of 'national trauma', looping effect and different circles of recognition of new professional category; National Trauma Discourse in Israel; ethics.tau.ac.il/en/wp-content/uploads/.../national-trauma-gp.docx*

‘Over the last decade the use of term “national trauma” has become ubiquitous following the acts of mass terrorism perceived as threatening to destabilize collective identities of entire populations... The category of "national trauma" is not simply a rhetorical tool for politicians and policymakers. Surprisingly, mental health practitioners, whose conventional object of intervention is an individual psyche rather than national collective, embraced this new category.... Mental health practitioners began investing institutional, research, and clinical resources in order to both detect the effects of "national trauma" and provide professional aid to its victims.

From the perspective of layperson, the expansion of trauma to the level of the national collective can be seen as a direct result of the emergence of new types of stressful events – mass terrorist acts that caused traumatic effects on a broad scale. However, if one adopts the sociological-historical perception of "trauma" as a cultural and historically situated idiom of illness (Young, 1995, Anze and Lambek, 1996, Alexander at al, 2004, Kleinman, Das and Lock 1997), the current development may be explained by social, cultural and political factors. Some scholars indeed connect an expansion of trauma discourse with the democratization of vulnerability and the expansion of democratic ethos (Brunner 2004)¹. Others explain the rapid distribution of PTSD into the global arena by the development of humanitarian institutions as the response to political violence (Breslau 2004). The growing usage of trauma concept may be also indicative of the emergence of a powerful new language for expressing political suffering (Fassin 2008). "Nationalization" of trauma could be seen as a new stage in the history of trauma discourse.’

‘The translation from collective to national trauma stems from the inner logic of the principle of proximity (or identification) that explains non-direct wide traumatization in therapeutic theory. Expressions such as "that person who was wounded, was Israeli exactly like me, the same age, he spent at the same places I spent..." (sited in Tal and Perl 2006)², and more generally, the conceptualization of circles of vulnerability, which include "anyone who felt
under threat because of the proximity to the injured person, both physical proximity, and the proximity, based on identity" (ibid), allow defining collective traumatization through the images of national identity.

**Community Trauma**

*Klinic Community Health Centre – Canada; Trauma-informed - The Trauma Toolkit Second Edition, 2013*

‘The cumulative impact of traumatic events and experiences needs to be acknowledged and measured, rather than having each event or manifestation treated separately. Consequences for physical and mental health should always be considered simultaneously.’

*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*

‘The varying impact of socio-demographic factors on the risk of traumatic event exposure may reflect differences in social and political contexts, but is more likely associated with overall levels of traumatic event exposure in the community.’

*Substance Abuse and Mental Health Services Administration. SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.*

‘Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighbourhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.’
Trauma issues and trauma treatment have become topical in Africa as a result of the political, social and economic instabilities that are common in the region. From a pastoral care perspective there is need to review and raise the philosophical argument about the relevance of humanitarian intervention, specifically in regard to the approach and treatment used. The Western medical and psychiatry fields view a person on the basis of an egocentric approach, but their African counterparts do so from a socio-centric perspective. A worldview is defined as how different people view their reality and therefore it is critical to accept that the Western worldview is different from the African one. The definition of trauma and the associated post-traumatic stress disorder (PTSD) diagnosis are at the centre of this debate. Do these represent the African perspective and if not what should be used in their place?

Africans view a person from a socio-centric perspective because a person is part of the bigger whole. An individual is an individual because he or she belongs to others in the community. The African view thus understands trauma to be a problem that affects the whole person and the whole community. Western philosophy, on the other hand, says a person is simply composed of soul and body and that trauma is a thing of the mind. Therefore, redefining trauma in light of this African viewpoint is critical and will enhance our caring of the many traumatised millions who desperately need help on this continent.

Most of the world’s population outside of the West holds onto a more socio-centric conception of the self, where individuals exist within networks of social relationships. It is from this relationship that they derive self-worth, self-fulfilment and self-control. In this context and model, reciprocal and interpersonal privileges or obligations are more important than the rights of individuals (Losi 2000). This is critical in the sense that the way in which we define trauma is influenced by how we perceive reality.

The concept of ‘mundu’ in Kiswahili or ‘ubuntu’ in Ndebele is central to what Mbiti is explaining, in that whatever happens to the individual happens to the whole group. The individual can only say, ‘I am because we are and since we are, therefore I am’ (Mbiti 1969:11). Thus, the African view of an individual is one which is intertwined with the whole tribe and community and cannot be understood in isolation. Often, the Western view misses this perspective because it does not realise that issues of guilt and shame exist in a sense of collective responsibility. Indeed, Shorter (1998:43) alludes that within the African worldview, the individual appears as the passive object of an external agency which becomes the diffused image of selfhood.

Therefore pain and stress in Africa is perceived by the people as a problem affecting the community and not just individuals. This is true especially if society fails to provide answers and support to the people who are helpless and desperate. Psychology will not be able to bring about the necessary community comfort and restoration that is required to meet the traditional African expectations.

Of great interest to this research is the comment made by psychologist Michael Wessels (cited in Bloomfield, Barnes & Huyse 2003:69), as he reflected on his experiences of working in sub-Saharan Africa. He observed that spirituality and community are at the centre of life in the region. An Angolan boy, whose parents were killed in political violence, may not need to talk about his personal experience of loss but, rather, the major stressor of the spiritual discord and lack of means to provide decent burial for his parents (Mbiti 1969). Interestingly, our primary context – that of Zimbabwe – is also mentioned by Wessels. Commenting on the massacres that occurred in Matabeleland, he said that:

Zimbabwean survivors of the Matabeleland massacre consider the corruption of community values and lack of cohesiveness as more offensive and disturbing than any other aspect of the conflict. It is the loss that is still being mourned years after the massacres of the 1982 to 1987. (Wessels, cited in Bloomfield, Barnes & Huyse 2003:78)

The reactions depend on a personal pre-traumatic personality structure, temperament and the extended community support structure. The pre-traumatic period and the personality structure of the individual have a role to play in the lives of those who find themselves face to face with these experiences.
Community Trauma & Violence

Lane Benjamin and Sarah Crawford Brown (South Africa); The psychological impact of continuous traumatic stress -- limitations of existing diagnostic frameworks

‘Community violence has been defined as interpersonal violence that occurs in public places such as neighbourhoods and schools (Potter, 1999 cited in Overstreet & Mazza, 2003)....

...It is clear that the associated features and dissociative effects of trauma on individuals also influence those around individuals, as well as the communities in which they live (Kasiram & Khosa, 2008). In order to locate the processes of the impact of trauma and dissociation within a community context, we need to understand community violence. All these processes have an impact on community and have an escalating, cyclical, cause and effect dynamic.’

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

‘Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighbourhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe.’

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

‘Community violence includes predatory violence (robbery, for example) and violence that comes from personal conflicts between people who are not family members. It may include brutal acts such as shootings, rapes, stabbings, and beatings. Community violence can be traumatic if you are the focus of or a bystander to a specific violent act. However, community violence can also traumatize a person (or a community) by merely living in what feels like a dangerous situation day-to-day.’


‘Among the many topics of interest to researchers, clinicians, and policymakers concerned with political violence, is the question of whether violent societies produce aggressive and delinquent youth. Across multiple contexts including the United States, Croatia, and Israel and Palestine there is evidence that youth exposed to violence are at a great risk for a range of negative behaviors including aggression, and delinquent behaviors, such as stealing, carrying a weapon, and destroying property (Fowler, Tompsett, Braciszewski, Jacques-Tiura & Baltes, 2009; Gorman-Smith & Tolan, 1998; Kerestes, 2006; Lynch & Cicchetti, 1998; Qouta, Punämaki, Miller, & El-Sarraj, 2008). The development of aggressive and delinquent tendencies stem from a range of individual and environmental factors including parent expressions of and responses to conflict (Cummings, Goeke-Morey, & Papp, 2004; Patterson, Dishion, & Bank, 1988), cultural mores regarding the use of aggression (Henry et al, 2000; Nipedal, Nedsdale, & Killen, 2010), genetics (Caspi et al., 2002), and physiological and biological markers of reactivity (Gordis, Granger, Susman, & Trickett, 2006), among other factors.’

‘There is no simple relationship between violence exposure and youth outcomes, thus, researchers must identify culturally-relevant factors that may increase or decrease the likelihood that growing up in a violent society will result in the development of aggression, delinquency, or the perpetration of violence.’

‘Social identity theory (Tajfel & Turner, 1979) and self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987), postulate the interplay between the social context and an individual’s psychological needs that motivate the development of in-group and out-group attitudes and behaviors.’

‘Not only is their silence shaped by a more pervasive communal discourse of silence, it is also informed by a gender discourse that prescribes that women specifically should be passive and silent in order to protect men and the community. As such, they become the carriers of painful feelings, such as shame. Furthermore, shame by its very nature is difficult to articulate and can be isolating, alienating individuals from their families and communities. Disclosure in unsafe spaces can potentially bring more shame and more disconnection for a woman who has already experienced the psychological, physical and emotional damage of being sexually violated. This may, in turn, lead to increased feelings of helplessness and a lack of agency which further entrench feelings of shame.’


‘It would also be erroneous to see conflict or violence as always resulting in complete breakdown of social, community and psychological functioning. Some communities and individuals can become extremely good at coping with adversity. Local and indigenous coping strategies, patterns of social resilience and ways of dealing with vulnerability may need to be identified and worked with rather than introducing foreign concepts of coping (Boyden, 1994).’


‘Many analysts have concluded that violence in the South African society has become normative and a widely accepted means of resolving conflict. Researchers have argued that in communities characterised by widespread poverty and unemployment, as is the case in South Africa, there is likely to be a multitude of causes of friction between people on an interpersonal level.”

‘The National School Violence Study shows that the primary drivers of violence within schools are firmly rooted in the generally violent environments in which children live outside the school. Victims and perpetrators of violence at schools report high levels of violence within their homes and communities, as well as easy access to drugs, guns and knives within their communities. Learners who have been exposed to some form of family violence are twice as likely to be victimised at school as those who have not been exposed to such violence.’

‘Impact of prisoner re-entry on communities: There is increasing evidence that certain communities, and indeed certain families, contribute disproportionately to the prison population and that high incarceration communities are destabilised in a variety of ways (Clear 2007). These communities suffer from unstable power relations, high teenage pregnancy rates and above-normal STI rates. The net effect is large numbers of predominantly young men circulating through the prison system on a continuous basis from these communities.’

‘Impact of prisoner re-entry on families: Returning parents may have to resume or start assuming the role of parent in a family set-up that often faces significant challenges. Families may, in themselves, be experiencing deep-seated problems and, therefore, have great difficulty accepting a family member or parent that has been in prison. The incarceration of a parent or close family member remains an important indicator for future delinquency among children.’

‘Community Mobilisation and Development

Community mobilisation is a capacity and community development process through which local groups or organisations identify needs, develop an outline of an action plan and then implement it (Caine 2008). Expected outcomes are usually improvement in community well-being, access to services, improved safety and better schooling, among others. Community development is important, not just for preventing negative incidents, but also for promoting positive outcomes in the community to encourage harmony, wellness and healing on all levels: physical, mental, spiritual, cultural, social, economic and political.

The community development approach moves away from the usual approach to crime prevention, which involves addressing the results of crime through rehabilitation, community service orders, victim empowerment and substance…”
The ISCPS should focus on promoting social cohesion, youth, families and groups at risk, as well as the implementation of socio-economic interventions to undercut the causes of crime. The promotion of social cohesion most likely refers to conflict resolution, reconciliation and rebuilding the social fabric of our society by promoting institutions that are sources of “social capital”. Interventions aimed at preventing youth crime and victimisation are seen as vital to effective social crime prevention. Social crime prevention should focus on economic upliftment and social development. The provision of more secure employment would affect crime (Ingrid, 2001: np).


Community violence is recognized as a major public health problem (WHO, World Report on Violence and Health, 2002) that Americans increasingly understand has adverse implications beyond inner-cities. However, the majority of research on chronic community violence exposure focuses on ethnic minority, impoverished, and/or crime-ridden communities while treatment and prevention focuses on the perpetrators of the violence, not on the youth who are its direct or indirect victims. School-based treatment and preventive interventions are needed for children at elevated risk for exposure to community violence.

It is possible that older youth who are chronically and repeatedly exposed to violent events habituate or become desensitized (Fitzpatrick and Boldizar 1993). For example, signs of danger (e.g., police and ambulance sirens, gun shots) may occur with such frequency that youth eventually learn not to react with a “fight or flight” response and habituate to fear. In contrast, younger or infrequently exposed youth escape/avoid the anxiety-producing stimuli, a pattern that functions to increase or sustain the intensity of the fear response (Turner et al. 1997). The habituation or extinction model of fear is supported by a considerable body of literature noting that prolonged contact with fear producing stimuli results in increased physiological reactivity and subjective distress.

Prevention and intervention programs typically have minimal impact in producing sustained deterrents to youth violence (Tolan and Guerra 1994) and its concomitants, although there may be more promise for the victims of community violence. It is critical, however, to fully appreciate the multiple influences that compromise urban children’s lives (e.g., un-/under-employment, quality of education and housing, family dysfunction (Reese et al. 2001). For example, it is problematic to teach urban youth conflict management skills without addressing the effects of witnessing violence (Jenkins and Bell 1994). Human ecology theory emphasizes the importance of understanding children in context, a critical component in designing effective treatment and preventive interventions (e.g., Bronfenbrenner 1979; Lerner 1995; Lewis et al. 1998).


Deborah Daro and Kenneth Dodge observe that efforts to prevent child abuse have historically focused on directly improving the skills of parents who are at risk for or engaged in maltreatment. But, as experts increasingly recognize that negative forces within a community can overwhelm even well-intentioned parents, attention is shifting toward creating environments that facilitate a parent’s ability to do the right thing. The most sophisticated and widely used community prevention programs, say Daro and Dodge, emphasize the reciprocal interplay between individual family behavior and broader neighborhood, community, and cultural contexts.’

The current evidence base for community child abuse prevention, observe Daro and Dodge, offers both encouragement and reason for caution. Although theory and empirical research suggest that intervention at the neighborhood level is likely to prevent child maltreatment, designing and implementing a high-quality, multifaceted community prevention initiative is expensive. Policy makers must consider the trade-offs in investing in strategies to alter community context and those that expand services for known high-risk individuals. The authors conclude that if the concept of community prevention is to move beyond the isolated examples examined in their article, additional conceptual and empirical work is needed to garner support from public institutions, community-based stakeholders, and local residents.”
Cultural Trauma

“Honey bees are social insects, which means that they live together in large, well organised family groups. Social insects are highly evolved insects that engage in a variety of complex tasks not practiced by the multitude of solitary insects. Communication, complex nest construction, environmental control, defence and division of the labour are just some of the behaviours that honey bees have developed to exist in social colonies.”

Mid Atlantic Agricultural Research and Extension Consortium

“Nicolas and McIntosh suggest that such histories are like infected wounds, ‘where individuals, families, and nations carry unresolved trauma from their past. It shows ... in the whole web of social dysfunctions -alcoholism, drugs, and even institutional corruption. It shows wherever human dignity has been compromised’” (p.18).”

B. HUDNALL STAMM, et al; CONSIDERING A THEORY OF CULTURAL TRAUMA AND LOSS; Journal of Loss and Trauma, 9: 89^111 Copyright # Taylor & Francis Inc. ISSN:1532-5024 print=1532-5032 online DOI:10.1080/15325020490255412

Dan J Stein, Soraya Seedat, Amy Iversen, Simon Wessely Post-traumatic stress disorder: medicine and politics ‘Cultural and social factors can be important determinants of susceptibility to the disorder by shaping ideas of what constitutes a trauma and what constitutes abnormal responses to trauma, and by affecting known vulnerability factors such as early childhood experiences, co-morbidity (eg, alcohol abuse), and social resources for responding to trauma. Post-traumatic stress disorder, like all psychiatric disorders, is bound by culture.’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014 ‘Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.”

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behaviour, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behaviour and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.’

B. HUDNALL STAMM, HENRY E. STAMM, AMYC. HUDNALL, CRAIG HIGSON-SMITH; CONSIDERING A THEORY OF CULTURAL TRAUMA AND LOSS; Journal of Loss and Trauma, 9: 89^111 Copyright # Taylor & Francis Inc. ISSN:1532-5024 print=1532-5032 online DOI:10.1080/15325020490255412

‘One of the differentiations from multigenerational or historical trauma is that in our understanding of cultural trauma, the event does not have to be in the past; it may be under way.’

‘It is our collective concern that if we do not address these situations in which cultural loss and cultural trauma are taking place, the losses of access to communal infrastructures will be so pervasive that it will be impossible for a community to rebuild itself. If we concentrate only on the rebuilding of the physical infrastructure, and not the human infrastructure, we address only part of the task. If the rebuilding is focused on the people in a way that
ignores their cultural heritage, we believe the results will not stand the test of time or support the people’s needs. We believe it is through the preservation of a culture’s strengths and the flexibility and adaptability of its people that a new middle ground will emerge that incorporates the strengths of the past, the lessons of the struggle, and hope for the future.’

‘Speaking of culture writ large inevitably leads to overgeneralizations. There is variation in seemingly homogenous groups. A theory of cultural trauma, at best, is nonspecific and helps contextualize human interchange across cultures with differences in economic, social, and technological organization.’

‘By the early to mid-1990s, researchers and field workers realized that wholesale applications of PTSD, and its individual and group treatment protocols, did not necessarily offer effective relief across cultures. PTSD and its treatment are largely derived from a Euro-American epistemology, and as Stamm and Friedman noted (2000), identifying PTSD within a group does not always speak to its goodness of fit for the expression of posttraumatic distress. The lack of fit was most conspicuous when treatments emerged from a culture substantially different from the culture being “treated.” Traumatic events and loss may have universal components, but responses to events and even the definition of symptoms are expressed within specific cultural contexts that may or may not fit with expected symptoms or psychotherapies that have been validated for treatment of PTSD (Stamm & Friedman, 2000).

‘Defining trauma and loss seems simple until one tries to identify terms that work cross culturally and across time. In the traumatic stress literature, loss may refer to the removal of a value, belief, or material item, but it is most commonly associated with the loss of a person who has died. Similarly, trauma refers to a terrifying death or threatened death. Yet, not every death is associated with terror, nor does every loss come from death. Across cultures, there are differences in what constitutes trauma or loss and in how the culture interprets and manages it. Hence, the definitions of trauma must be adapted to the culture from which it arises.’

‘Defining culture is difficult, even though there is a rapidly growing literature on the topic in relation to traumatic stress and loss (cf. Bracken & Petty, 1998; Caruth, 1996; Danielli, 1998; Higson-Smith, 2002a, 2002b, Lacapra, 2000; Marsella et al., 1996; Stamm & Friedman, 2000; Stamm, Higson-Smith, & Hudnall, in press; Weine, 1999). Marsella, Friedman, and Spain (1996) suggest there are three dimensions that should be considered:
(a) universal dimensions that apply to almost anyone,
(b) cultural aspects that are associated with particular cultures, and
(c) personal uniqueness experienced by individuals. Marsella (1988) defines culture as “shared learned behavior . . . transmitted from one generation to another to promote individual and group adjustment and adaptation. Culture is presented externally as artifacts, roles, and institutions, and is represented internally as values, beliefs, attitudes, cognitive styles, epistemologies, and consciousness patterns” (p.10).’


‘Any discussion of cultural competence must be rooted in a clear understanding of the concept of “culture.” What is culture? How unique or consistent are cultural beliefs, attitudes, and practices? Where does one culture begin and another end? Unfortunately, these questions have no easy answers, in large part because of the difficulty of pinning down what we mean by “culture,” exactly. According to the classic anthropological view, expressed by Edward Burnett Tylor in his Primitive Culture, in 1871: “Culture ... is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.”

‘This definition was widely adopted in the 19th and early 20th centuries and supported by anthropological “discoveries” of new, exotic, and “primitive” cultures around the world. However, anthropologists in the 20th century began questioning the definition and meaning of culture, in part as a result of modernization, progress, and rapid cultural contact. In the 1960s, predictions of “culture loss” and Marshall McLuhan’s vision of a “global village” amounted to a rejection of the idea that cultures were unique, distinctive, and easily told apart. Globalization added fuel to the fire. The creation of new and lucrative global markets for goods such as Coca Cola and McDonalds, popular television shows such as Dallas and Dynasty, and other Western cultural artifacts led scholars to theorize the emergence of a global marketplace in which cultural differences and boundaries were fast eroding and disappearing altogether.'
Not all scholars agreed, however. Tamar Liebes, for example, questioned the idea of “Western cultural imperialism” sweeping the world and blotting out other cultures.

‘Efforts to understand culture grew more nuanced as a result of this debate. At the end of the 1980s, Herbert Schiller, once a staunch believer in the idea that cultures were being wiped out by Western influences, wrote: The transfer of cultural values is a complex matter. It is not a one-shot hypodermic inoculation of individual plots and character representations. It involves the much more difficult to measure acceptance of deep-structured meanings that may not even be explicitly stated. Can the transfer, for example, of acquisitive or consumerist perspectives be simply quantified? Recent efforts to understand what culture is and how cultural change occurs have led to the idea that culture is not a concrete, objective phenomenon, but something that is collectively imagined, socially constructed, and constantly reshaped and renegotiated.’


‘The developing world, and Africa in particular, is unique in that inter-dependency of community and family ties are often stronger than in the developed world. People from traditional cultures are more likely to perceive themselves as part of a larger whole and trauma and illness are viewed as being externally caused and ongoing, which is linked to the larger society.’

‘Culture provides the community with a system of values, lifestyles and knowledge. The disruption of these aspects will have a disastrous effect on its members. Culture is powerful and resilient to the stress of the environment and is therefore often resistant to change. And herein lies the biggest challenge. Normally, cultural change comes through necessity, youthfulness and interaction. However, in many of our African cultures, family and community resources become primary sources of rehabilitation and necessary healing. This is even more so when one recognises that skilled medical personnel are unavailable across much of the continent. But even when they are, this rehabilitation demands comprehensive understanding and skill of interpersonal, family and community variables (ed. Basoglu 1992:491). The argument here is that there is a danger that responses to trauma may be underestimated by limiting them only to psychological trauma, which eventually results a diagnosis of PTSD. Trauma impacts body, mind and spirit and when it is experienced at the level of a community, the whole immediate society is affected. This is especially the case in an African context where life is based on interdependence rather than individual self-reliance.

‘Family is the first line of defence against trauma and, with this, culture is the identity provider in the community. If family and culture fail to provide the safety net, other ‘ugly’ models of identity formation and social group formation take their place. The roles and status that had previously organised the system may have no further meaning. When cultural protection and security fail, the individual’s problems are proportional to the cultural disintegration. The avenues of vulnerability resulting from trauma follow the routes vacated by culture. Normally, the situation is compounded by the problem that, in most areas of the world, the population is often physically depleted and fatigued in times of cultural disintegration as well. For example, Van der Kolk et al. (2007) wrote extensively about the people of Bosnia, Somalia and Rwanda, relating how they were physically and psychologically traumatised as a result of the protracted wars they had been fighting.’

‘Through this article, we seek to highlight the traditional cultural impact of gender and sexual violence on survivors as a result of cultural beliefs and attitudes in primary cultures of the world. The insensitivity, chauvinism and patronisation of men towards women in Africa needs to be confronted in order to address some of these cultural injustices. Cultures are dynamic, not static, and therefore some of these attitudes need to change. It is not only historians of culture who note that people are yearning to integrate all their past into a meaningful unity (Volf 2006). A good deal of trauma literature echoes the same idea. Van der Kolk et al. (2007) suggest that because survivors of trauma cannot, like anybody else, change their past, they must place traumatic memories in the proper context and reconstruct them in a personal and meaningful way – ‘Giving meaning is a central goal of therapy’ (Volf 2006:184). Similarly, Janoff-Bulman and Frieze (cited in Kleber & Brown 1992:144) suggest that when dealing with traumatic experiences, the world of certainties disappears and ‘the assumptive world’ must be reconstructed.’


‘In this study from the therapists’ perspective, the cultural beliefs regarding the aetiology of disease and disability impacted negatively on the utilisation of rehabilitation services. This finding provides valuable insight into the
perceptions of the therapists working in this rural community. Their perceptions on how cultural beliefs affect the utilisation of their services can also assist to inform education and health promotion programmes specifically in a rural South African context.

It is the responsibility of all health care providers to ensure that they become culturally aware, knowledgeable and competent in order to provide the best possible services that meet the needs of the intended community.’

‘Cultural beliefs define who people are, how they interact with the world and how they behave in certain situations, and can be considered a combination of religious beliefs, socially accepted norms and traditions (Bailey, Erwin & Belin 2000; Omu & Reynolds 2012; Maart et al. 2007). Culture plays a central role in health related behaviours (Carroll et al. 2007; Omu & Reynolds 2012). The importance of cultural beliefs regarding health and health seeking behaviour has been well-documented (Bailey et al. 2000; Carroll et al. 2007; Legg & Penn 2013; Maart et al. 2007).’

‘Different cultural groups have vastly different perceptions of the causes of disability and disease and these perceptions influence their health seeking behaviour (Bailey et al. 2000; Legg & Penn 2013; Pronyk et al. 2001). According to the South African Department of Health’s Disability Survey, 3% of the population stated ‘bewitchment’ as the cause of their disability (DOH 2002). In a rural South African study the belief that ‘bewitchment’ caused tuberculosis resulted in a delay in seeking Western health care (Pronyk et al. 2001). Omu and Reynolds (2012) conducted a similar study into health seeking behaviours in Kuwait, and although persons with disabilities believed that their disability had a divine origin it did not stop them from utilising rehabilitation services. It is thus imperative to understand how a specific cultural group’s beliefs influence their health seeking behaviour.’

‘Cultural beliefs regarding the causes of disability do not only affect the health seeking behaviour of patients living in rural areas, but also their conviction about the effectiveness of therapy services. Therapists reported that if patients believed that their disability was caused by an ancestral curse, the patients would not comply with doing exercises because they would not be able to rationalise how it could remove the curse in order to heal them.’

‘Therapists also reported that patients usually deteriorated at home once they were discharged from the hospital. They attributed the patient’s deterioration to the cultural belief that a person with a disability could not contribute to the household and was not worthy of care and limited financial resources. This finding directly contradicts recent disability literature which states that persons with disabilities are valued as a result of their potential to qualify for disability grants of approximately R1200 per month (Leclerec-Madlala 2006; Penn 2014). The fact that the therapists discussed this issue could either indicate that not all rural families are aware of disability grants, or possibly cannot access it due to problems with the system or lack of personal identification documents (ID) (Penn 2014; Social Assistance Act 2004). The fact that the therapists discussed this issue could either indicate that not all rural families are aware of disability grants, or possibly cannot access it due to problems with the system or lack of personal identification documents (ID) (Penn 2014; Social Assistance Act 2004).’

Aaron R. Denham; Rethinking Historical Trauma: Narratives of Resilience; Transcultural Psychiatry

‘There is a tendency for researchers and professionals to use the Jewish Holocaust as a standard for which all other forms of collective traumatic experience are measured (Waldram, 2004). It is difficult to correlate the experience of second-generation Holocaust survivors with that of the experiences of Aboriginal people of North America (Weiss & Weiss, 2000; Daniell, 1981). Even assuming homogeneity among culturally similar persons experiencing a common traumatic event is irresponsible; to do so is to place individual experiences of suffering into the same category. Furthermore, one would think that it is unnecessary to emphasize the fact that we cannot draw conclusions based on people’s appearances (Daniell, 1998). Yet, the history of research with American Indian communities has proven that “researchers are prepared to assume that Aboriginal peoples are dysfunctional” (Waldram, 2004, p. 166). Falling back on a diagnosis like PTSD, or the construct of historical trauma, does little to improve the health or social difficulties that American Indian people continue to experience. Additionally, such designations fail to communicate the diversity of individual and family experiences.’
Cultural Competence

“Understanding the cultures of the youth we serve requires more than words and good intentions. The journey toward cultural competence requires the willingness to experience, learn from those experiences, and act.”
Jerome H. Hanley


‘There is much that we as educators and practitioners have chosen not to learn about those whom we serve, even though understanding the culture and history of Asian, African, Latino, and Native American people is essential to helping them. One of the most valuable skills we can have is cultural competence—the ability to work effectively across cultures in a way that acknowledges and respects the culture of the person or organization being served.

Dr. Carter G. Woodson may have introduced the concept of cultural competence in 1927 when he put his life on the line to create the Society for the Study of Negro Culture and Life and instituted Negro History Week (Goggin, 1993), the precursor of Black History Month. Though these special events have been recognized commercially, few people today understand their origin, significance, or the broad social changes they were intended to achieve.

Dr. Woodson was only the second person of African descent to receive a doctorate from Harvard University, and he was the first Harvard graduate to have been born to enslaved parents. He understood that the country was in danger of splitting apart along racial, regional, and cultural lines. As a historian, Dr. Woodson believed that if a people understood their history and contributions to the society in which they lived, then (1) they would feel better about themselves, (2) other groups of people would feel better about the oppressed group and be more accepting of them, and (3) there would be greater acceptance between and within groups of people, reducing the level of racism in society. Although Dr. Woodson was right about the first and second effects, knowledge alone cannot lead to the third effect. The third effect can only be achieved when all groups in society have achieved cultural competence.’

Perhaps the most salient document to date on cultural competence is Toward a Culturally competent System of care, Volume I, by Cross, Bazron, Dennis, and Isaacs (1989) and Volume II by Isaacs and Benjamin (1991). In this two-volume monograph, culture is defined as the integrated pattern of human behavior that includes thoughts, communication, action, customs, beliefs, values, and instructions of a racial, ethnic, religious, or social group.

Gary Weaver (1986) uses the image of an iceberg to explain these many layers of culture (see figure below). Like an iceberg, part of a culture is "above the water" in that it is visible and easy to identify and know. This part includes surface culture and elements of folk culture—the arts, folk dancing, dress, cooking, etc. But just as nine tenths of an iceberg is out of sight below the water, Paige explains, nine tenths of a culture is also "hidden" from view. This out-of-awareness part of culture has been termed "deep culture," although it does include some elements of folk culture. Deep culture includes elements such as the definition of sin, concept of justice, work ethic, eye behavior, definition of insanity, approaches to problem solving, fiscal expression, and approach to interpersonal relationships. Ogbu (1988) presents this essential idea most clearly when he states that "cultural tasks vary from culture to culture because different populations have worked out different solutions to common problems in life, such as how to make a living, reproduce, maintain order within their border, defend themselves against outsiders, and so on" (p. 13).

‘Cultural competence acknowledges and validates biculturality, a concept understood and practiced by people of color since 1619 in the United States. Biculturality is the ability of people in a minority culture to understand and work within the dominant culture in order to improve their economic and/or physical well-being when they interact with that culture. At the same time, these people are able to retain the knowledge and behaviors of their own indigenous culture, thereby ensuring inclusion and physical, emotional, and spiritual survival within that culture.’

NIH: Cultural Competency; http://www.nih.gov/clearcommunication/culturalcompetency.htm

‘Culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems
surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.’


‘Racial/ethnic disparities in health have been well described, with data showing that members of minority groups suffer disproportionately from cardiovascular disease, diabetes, asthma, and cancer, among other conditions. The causes of these disparities are multifactorial, and perhaps the largest contributors are those related to social determinants of health external to the health care delivery system.

As a result of these observations, the field of “cultural competence” in health care has emerged. A “culturally competent” health care system has been defined as one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.’


‘Cultural competence may be viewed as a continuum on which, through learning, the provider increases his or her understanding and effectiveness with different ethnic groups. Various researchers have described the markers on this continuum (Castro et al. 1999; Cross 1988; Kim et al. 1992). The continuum moves from cultural destructiveness, in which an individual regards other cultures as inferior to the dominant culture, through cultural incapacity and blindness to the more positive attitudes and greater levels of skill described below:

- **Cultural sensitivity** is being “open to working with issues of culture and diversity” (Castro et al. 1999, p. 505). Viewed as a point on the continuum, however, a culturally sensitive individual has limited cultural knowledge and may still think in terms of stereotypes.

- **Cultural competence**, when viewed as the next stage on this continuum, includes an ability to “examine and understand nuances” and exercise “full cultural empathy.” This enables the counsellor to “understand the client from the client’s own cultural perspective” (Castro et al. 1999, p. 505).

- **Cultural proficiency** is the highest level of cultural capacity. In addition to understanding nuances of culture in even greater depth, the culturally proficient counsellor also is working to advance the field through leadership, research, and outreach (Castro et al. 1999, p. 505).

It is important to remember that clients, not counsellors, define what is culturally relevant to them. It is possible to damage the relationship with a client by making assumptions, however well intentioned, about the client’s cultural identity.”

The National Center for Biotechnology Information

J de Beer PhD; J Chipps PhD; A survey of cultural competence of critical care nurses in KwaZulu-Natal; S Afr J Crit Care 2014;30(2):xx-xx. DOI:10.7196/SAJCC.188

‘The growing interest in culture and healthcare dates back to the days of Florence Nightingale, who touched on the concept of transcultural nursing in the 19th century when advising British nurses working in India to take into the account the cultural background of their patients. In the 1950s, transcultural nursing was introduced as a formal area of study and practice for nurses striving towards providing optimal and culturally appropriate care for patients.’
Table 1. Component of culturally competent care

<table>
<thead>
<tr>
<th>Cultural construct</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Cultural desire</td>
<td>The nurse must be motivated to become involved in the process of becoming culturally competent.</td>
</tr>
<tr>
<td>Cultural awareness</td>
<td>The nurse becomes sensitive to the values, beliefs, lifestyles and practices of the patient and identifies his/her own values, biases and prejudices.</td>
</tr>
<tr>
<td>Cultural knowledge</td>
<td>The nurse seeks information about other cultures and different worldviews, and how these views impact a patient's health.</td>
</tr>
<tr>
<td>Cultural skills</td>
<td>The nurse collects relevant cultural data regarding the patient's presenting problem and accurately performs a culturally based physical assessment.</td>
</tr>
<tr>
<td>Cultural encounters</td>
<td>The nurse is involved in face-to-face encounters with patients from diverse cultures. Directly interacting with clients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and will prevent possible stereotyping that may have occurred.</td>
</tr>
</tbody>
</table>


‘Culturally competent agencies and individuals accept and respect cultural differences, continue self-assessment of cultural awareness, pay careful attention to the dynamics of cultural differences, continually expand their cultural knowledge and resources, and adopt culturally relevant service models in order to better meet the needs of minority populations. Examples include:

- Developing a cultural resources library.
- Diversifying the professional staff.
- Involving the community in the development of services and in planning and decision-making activities.
- Bringing in representatives of the community served to conduct workshops for the professionals who will serve them. (In children’s services, parents are now asked to conduct these workshops.)

*Cultural Safety*

NCBI – The National Center for Biotechnology Information  
Substance Abuse Treatment for Persons with Co-Occurring Disorders: http://www.ncbi.nlm.nih.gov/books/NBK64184/

‘Cultural Safety’ - Cultural safety involves health professionals’ recognition that they bring their own culture and attitudes to the relationship with the patient and need to be respectful of the patient’s nationality, culture, age, sex, political and religious beliefs, and sexual orientation. In order to achieve cultural safety, health professionals must learn to move beyond the concept of cultural awareness — being aware that a difference exists — to analysing power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to health care.”

“(Devon) Hinton is part of a group that has catalogued more enigmatic sources of distress; they have even succeeded in having them included in the DSM-V. The manual includes nine culturally specific presentations of mental disorders; one is Cambodian, others are Latino, Japanese, and Chinese.’

*New Zealand Psychologists Board; Guidelines for Cultural Safety; The Treaty of Waitangi and Maori Health and Wellbeing in Education and Psychological Practice*

‘The New Zealand Psychologists Board governs the practice of registered psychologists by setting and monitoring standards and competencies for registration and practice, which ensures safe and competent care for the public of New Zealand. The Board’s policy acknowledges that the training and practice of psychologists in Aotearoa/New Zealand reflects paradigms and worldviews of both partners to te Tiriti o Waitangi /the Treaty of Waitangi.

The Code of Ethics for Psychologists Working in Aotearoa/New Zealand1 in its preamble and guiding principles refers to the centrality of the Treaty of Waitangi, and the importance of respecting the dignity of “people and peoples”. The Code of Ethics thus explicitly recognises factors relating to the Treaty relationship between Maori and the Crown and its agents, and between ethnically and culturally distinct peoples in New Zealand, as central to safe and competent psychological education and practice.’
‘Origins and Background

- The term “cultural safety” was developed in the 1980s in New Zealand in response to the indigenous Maori people’s discontent with nursing care. Maori nursing students and Maori national organizations supported the theory of “cultural safety,” which upheld political ideas of self-determination and de-colonization of Maori people.

- Cultural safety was controversial when first introduced to public health and academic communities in the late 1980s and early 1990s. Criticisms voiced in the media claimed that nursing schools, by adopting mandatory cultural safety curriculum, were “force-feeding culture” and “indoctrinating nursing students” with specific political views.

- In 1990, the Nursing Council of New Zealand incorporated cultural safety in its curriculum assessment processes, and nursing school examinations began testing student comprehension of the concept. Cultural safety is based within a framework of dual cultures and is congruent with the tenets of Aotearoa/New Zealand’s founding document, the Treaty of Waitangi.

- “Transcultural nursing” is the most common theoretical approach to cultural skills education in Canadian nursing schools. It differs in a number of ways, including in origin, from the newer concept of cultural safety. Transcultural nursing was developed from the perspective of the dominant (European, white) culture, whereas cultural safety was developed by non-dominant Maori peoples reacting to negative experiences in the health and nursing system.

Simon Brascoupé, Catherine Waters; Cultural Safety Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness.

‘The concept of cultural safety evolved as Aboriginal people and organizations adopted the term to define new approaches to healthcare and community healing. Much of the literature confirms that a definition of cultural safety should include a strategic and intensely practical plan to change the way healthcare is delivered to Aboriginal people. In particular, the concept is used to express an approach to healthcare that recognizes the contemporary conditions of Aboriginal people which result from their post-contact history.’

‘The differences between the concept of cultural safety versus cultural competence and transcultural practice are profound, but they could be used to imply different angles of the same exchange. Cultural competence and transcultural practice, like cultural safety, are both based on an assumption of respect for Aboriginal people, their culture and knowledge, and the building of trust between the professional and the client. Cultural competence and transcultural practice are both defined in terms of the non-Aboriginal professional’s knowledge and understanding of the culture of their Aboriginal client.

Cultural competence (and the linked concepts of cultural sensitivity and transcultural practice) is based on the process of building an effective service delivery interaction with Aboriginal clients, rather than the outcome of the success of the interaction. However knowledgeable or sensitive the professional is, this does not in itself ensure the effectiveness of the interaction.

Cultural safety relies rather on the expectation on the parts of the non-Aboriginal professional and the Aboriginal client that it is the client who has the power to make decisions regarding their health (or other matters) and also the power to judge if the interaction has been culturally safe. Unlike training to acquire knowledge of Aboriginal culture, training under cultural safety focuses on the nature of cultural safety itself (respect, trust, sharing) and on the history of Aboriginal people that contributes to the contemporary conditions of many Aboriginal People (colonization, residential schools, etc.).

‘The concept of cultural safety has extended beyond its origins in the literature concerning nursing in New Zealand. It resonates with Indigenous peoples around the world, and has been explored in academic literature, government reports and professional studies in relation to the health of Indigenous people, particularly in New Zealand, Australia and Canada. Similarly, it relates usefully to other subjects where Indigenous people are disproportionately disadvantaged in social policy areas, such as education, economic opportunity and criminal justice. However, it remains confined largely to academic studies and government reports, and little hard evidence appears to have been applied to professional practice. It seems that the practicalities of cultural safety as an outcome rather than a concept have yet to be realized.’
‘Until now, much of the discussion on cultural safety has focused on individual health care professionals; in other words, we consider the power relations between two individuals – the nurse and the patient – when we consider cultural implications. However, key to this section is the recognition that it is institutions – government departments, hospitals, clinics, schools, etc. – that must demonstrate cultural safety and cultural competence in order to effect cultural change in the design and delivery of policy. This implies that the culturally safe behaviour and knowledge and the power transfer must be institutionalized.’