Section 5. The Impact of Trauma

The Impact of Trauma

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“The “night sea journey” is the journey into the parts of ourselves that are split off, disavowed, unknown, unwanted, cast out, and exiled to the various subterranean worlds of consciousness.... The goal of this journey is to reunite ourselves. Such a homecoming can be surprisingly painful, even brutal. In order to undertake it, we must first agree to exile nothing.”

Stephen Cope

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

“Bees create royal jelly from their own bodies.... It (Royal Jelly) is the only demonstrable substance known in nature that actually extends life, in this case, the life of the bee. Bees not fed royal jelly, workers and drones, live much shorter lives...”

Wikipedia

“Not knowing in advance exactly how the call will be answered, shouldn’t halt the journey. The fact that we start out not sure of where we’re going is what makes the quest so noble. There’s a little Don Quixote in all original ideas.

It’s just those windmills in our minds and we should never be scared of them.”

John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
“Unresolved trauma is the fuel for the cycle of violence in our country” Brian Rogers

Note: 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.

If this section is as emotional to read as it was to prepare, then the reader should ensure that a post study de-stress is planned before attempting it.

Despite the lack of empirical South African confirmation, the evidence that “unresolved trauma is the fuel for the cycle of violence in our country” is so strong we barely have to corroborate it locally. For over 150 years we have been building to this point. Apartheid and its predecessor, British Colonialism (and the war like tendencies of some of the African nations), played their part in building an intergenerational nightmare cycle of violence. This proposal contends that we urgently need to place Trauma at the forefront of our minds when assessing the psycho-social, criminal justice and socio-economic landscape in our country.

For some strange reason, Trauma has been expunged from our public discourse on Mental Health. The last unconfined acknowledgements of the effects of Trauma on our nation came from the Social Sciences (and not our Mental Health guardians, Psychology and Psychiatry), in the late 1990’s. This banishment has reached such an extreme that in July of 2015, Mental Health Month, a very thorough screening of the media found not a single mention of Trauma and only one example Post-traumatic Stress Disorder, made almost in passing. Perhaps we, as a country, believed that the Truth and Reconciliation Commission, the benevolence of Nelson Mandela and the morality of Bishop Tutu, would be some kind of magic wand that blew the intergenerational effects of Trauma away.

What is really strange about this – shall we call it denial? – is that the rest of the world, over exactly the same period, were placing Trauma at the forefront of solving dilemmas in Public Health, Behavioral Health and co-existent human frailties like Substance Abuse and Poverty. There probably are a number of reasons that make up the total patchwork blanket that has been thrown over Trauma here. To argue them will distract from the proposal. TRISI is designed to create a bridge so the many divisions of professional expertise can join intellectual forces - make a difference, interrupt the intergenerational cycles, rescue today’s children and provide for future generations.

We have to join the international wagon train as soon as feasibly possible. For instance, connecting with the Adverse Childhood Experiences field of expertise brings not only causative knowledge that can be adapted for local research, it brings a myriad of access points to the latest solutions that are being trialled and spread as they succeed.

This document is desperately short of LGBT material and submissions will be gratefully accepted.

The Impact of Trauma

Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D. July, 2009; Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol

Over the past fifteen years, there has been growing acknowledgement of several interrelated facts concerning the prevalence and impact of trauma in the lives of people in contact with various human service systems. We advocate for trauma-informed service approaches for a number of reasons.

Trauma is pervasive. National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes. The experience of trauma is not the rare exception we once considered it. It is part and parcel of our social reality.

The impact of trauma is very broad and touches many life domains. Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma thus touches many areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.
The impact of trauma is often deep and life-shaping. Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become central realities around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous place. Trauma may shape a person’s way of being in the world; it can deflate the spirit and trample the soul.

Violent trauma is often self-perpetuating. Individuals who are victims of violence are at increased risk of becoming perpetrators themselves. The intergenerational transmission of violence is well documented. Community violence is often built around cycles of retaliation. Community Connections/Version 2.2/ 7-09

Many of our institutions—criminal justice settings, certainly, but also schools and churches and hospitals—are too frequently places where violent trauma is perpetuated rather than eliminated.

Trauma is insidious and preys particularly on the more vulnerable among us. People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities—all of these groups are at increased risk of violent victimization.

Trauma affects the way people approach potentially helpful relationships. Not surprisingly, those individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many human services. Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for survivors to feel the safety and trust necessary to helpful relationships.

Trauma has often occurred in the service context itself. Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still too common in our centres of help and care.

Trauma affects staff members as well as consumers in human services programs. Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is “secondary” or “vicarious” traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do “more and more with less and less” becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.

Adverse Childhood Experiences

“How do you turn a new born baby with all its promise and infinite capacities into a thirty-year-old homeless drunk?”

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

It is unusual for this proposal to feature Wikipedia information so prominently, however the way this article is structured, it provides an excellent introduction to this very important subject.

Wikipedia Adverse Childhood Experiences Study https://en.wikipedia.org/wiki/Adverse_Childhood_Experiences_Study

‘The Adverse Childhood Experiences Study (ACE Study) is a research study conducted by Kaiser Permanente health maintenance organization and the Centers for Disease Control and Prevention (CDC). Participants were recruited to the study between 1995 and 1997 and have been in long-term follow up for health outcomes. The study has demonstrated an association of adverse childhood experiences (ACEs) with health and social problems as an adult. The study has been analyzed extensively, is frequently cited as a notable landmark in epidemiological research, has produced more than 50 scientific articles and more than 100 conference and workshop presentations that look at the prevalence and consequences of ACEs.’

‘Impact - The ACE Study has produced more than 50 articles that look at the prevalence and consequences of ACEs. It has been influential in several areas. Subsequent studies have confirmed the high frequency of adverse childhood
experiences, or found even higher incidences in urban or youth populations. The original study questions have been used to develop screening tools that evaluate adverse childhood experience scores. Cognitive and neuroscience researchers have examined possible mechanisms that might explain the negative consequences of adverse childhood experiences on adult health. The ACEs Study and related data has an influence on public policy.

‘Subsequent Surveys’ - The original study questions have been used to develop a 10 item screening questionnaire. Numerous subsequent surveys have confirmed that adverse childhood experiences are frequent.

The CDC runs the Behavioral Risk Factor Surveillance System (BRFSS), an annual survey conducted by individual state health departments in all 50 states. An expanded survey instrument in several states found each state to be similar. Some states have collected additional local data. Adverse childhood experiences were even more frequent in studies in urban Philadelphia and in a survey of young mothers (mostly younger than 19).

Internationally, an ACE International Questionnaire (ACE-IQ) is undergoing validation testing. Surveys of adverse childhood experiences have been conducted in Romania, the Czech Republic, the Republic of Macedonia, Norway, the Philippines, the United Kingdom, Canada, China and Jordan. Child Trends used data from the 2011/12 National Survey of Children’s Health (NSCH) to analyze ACEs prevalence in children nationally, and by state. The NSCH’s list of “adverse family experiences” includes a measure of economic hardship and shows that this is the most common ACE reported nationally.

‘Consequences’ - Cognitive and neuroscience researchers have examined possible mechanisms that might explain the negative consequences of adverse childhood experiences on adult health. Adverse childhood experiences can alter the structural development of neural networks and the biochemistry of neuroendocrine systems and may have long-term effects on the body, including speeding up the processes of disease and aging and compromising immune systems.

Additionally, epigenetic transmission may occur due to stress during pregnancy or during interactions between mother and newborns. Maternal stress, depression, and exposure to partner violence have all been shown to have epigenetic effects on infants.

‘Implementing practices’

As knowledge about the prevalence and consequences of adverse childhood experiences increases, trauma-informed and resilience-building practices based on the research is being implemented in communities, education, public health departments, social services, faith-based organizations and criminal justice. A few states are considering legislation.

‘Communities’

As knowledge about the prevalence and consequences of ACEs increases, more communities seek to integrate trauma-informed and resilience-building practices into their agencies and systems. Tarpon Springs, Florida, became the first trauma-informed community in 2011. Trauma-informed initiatives in Tarpon Springs include trauma-awareness training for the local housing authority, changes in programs for ex-offenders, and new approaches to educating students with learning difficulties.

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

The first time I heard Robert Anda present the results of the ACE study, he could not hold back his tears...when the ACE study data started to appear on his computer screen, he realized that he had stumbled upon the gravest and most costly public health issue in the United States: child abuse. He had calculated that its overall costs exceeded those of cancer or heart disease and that eradicating child abuse in America would reduce the overall rate of depression by more than half, alcoholism by two thirds and suicide, drug use and domestic violence by three quarters.

Mental Health Coordinating Council (MHCC), Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, 2013

The Damaging Consequences of Violence and Trauma and the Adverse Childhood Experiences (ACE) Study Chart - The chart...shows the sequence of events related to unaddressed childhood abuse and other early traumatic experiences. Without interventions to interrupt the cycle, intergenerational transmission will perpetuate ACEs.
Childhood trauma is associated with medical and physical health consequences in two primary ways: 1) as a direct physical consequence of the abuse or trauma, and 2) as a longer-term influence on coping, adaptation, and habits and routines that may increase the eventual risk of undesired medical and physical health consequences. Thus, some of the medical and physical health consequences occur immediately (or shortly after) the trauma, while others represent longer-term outcomes.

The Adverse Childhood Experiences Study (Centres for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

Most studies will show the prevalence of outcomes in a manner such as the one below done in Minnesota. The causative factors do vary in their levels of impact.
Given the latest analysis of the South African Stress and Health Survey (SASH) (Section 6.), it is most probable that witnessing violence will have a much higher incidence. Perhaps a South African study should add Witnessing of Violence in a non-domestic situation as many of our children are exposed to the gang violence in our communities.

The higher the ACEs score the greater the probability of adverse Behavioral Health. Example...

**Table: Probability of Outcomes**

<table>
<thead>
<tr>
<th>ACE Score</th>
<th>Groups</th>
<th>Outcome 1</th>
<th>Outcome 2</th>
<th>Outcome 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 ACEs</td>
<td>16</td>
<td>1 in 69 are alcoholic</td>
<td>1 in 480 uses IV drugs</td>
<td>1 in 96 attempts suicide</td>
</tr>
<tr>
<td>1-3 ACEs</td>
<td>51</td>
<td>1 in 9 are alcoholic</td>
<td>1 in 43 uses IV drugs</td>
<td>1 in 10 attempts suicide</td>
</tr>
<tr>
<td>4-8 ACEs</td>
<td>16</td>
<td>1 in 6 are alcoholic</td>
<td>1 in 30 use IV drugs</td>
<td>1 in 5 attempts suicide</td>
</tr>
</tbody>
</table>

Visual from ACEs-Too-High; [http://acestoohigh.com/got-your-ace-score/](http://acestoohigh.com/got-your-ace-score/)

Another example...

**Graph: Childhood Experiences Underlie Later Being Raped**

Visual from ACEs-Too-High; [http://acestoohigh.com/got-your-ace-score/](http://acestoohigh.com/got-your-ace-score/)
The higher the ACEs score the greater the probability of impaired brain development.

*Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014*

“Research on the effects of early maltreatment tells a different story: that early maltreatment has enduring effects on brain development. Our brains are sculpted by our earlier experiences. Maltreatment is a chisel that shapes a brain to contend with strife, but at the cost of deep enduring wounds.

Children abuse isn’t something you “get over”. It is an evil that we must acknowledged and confront if we aim to do anything about the unchecked cycle of violence in this country”

*Martin Telcher, MD, PhD, Scientific American.*
The higher the ACEs score the greater the effect on our economy. Example...

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Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘That many adult problems might be ‘the logical consequences of childhood maltreatment’ is not difficult to grasp at one level. Yet notwithstanding its logic and well established empirical support, recognition of this connection – as distinct from acknowledgement of the existence of child abuse – is not widespread. The contention that ‘much (if not most) of what we think of as adult psychopathology actually reflects long-term reactions to child abuse’ suggests some of the reasons for this. Child abuse is challenging in ways that affect the extent to which its prevalence and many effects are fully countenanced even as the evidence base is solid and continues to expand.

Ambivalence about the extent and ongoing effects of child abuse is present throughout many levels of society, and is as much a reality as the abuse which elicits it. This needs to be borne in mind and confronted in any attempt to address its many and ongoing effects. For example, in her introduction to Briere’s 1992 text, Berliner remarks that it is ‘curious’ that ‘major texts in psychopathology have so seldom identified child abuse as the source of adult difficulties’. It is not, she says, ‘that childhood maltreatment is not implicated, but that it is not explicitly the focus of the various explanatory models’.

A further insidious effect of the ‘re-badging’ of symptoms and conditions associated with childhood trauma is upholding of the ‘culture of silence’ that continues to surround child abuse. This further compounds the already endemic myopia which seriously distorts both perceptions and current treatment of those whose underlying trauma is not recognised.’

THRIVE; Maine’s Trauma-informed System of Care; Final Evaluation Report; Prepared by Hornby Zeller Associates, Inc.

‘…children and youth who experience trauma are not likely to receive a formal PTSD diagnosis; instead they often manifest that exposure to trauma in other ways. Among adults, the risk for a number of health and well-being problems over the lifespan increases in direct relation to the number of childhood trauma exposures. The following sections explore these concepts for participants in THRIVE’s Family Partnering Program.'
Youth Trauma Symptoms, Behaviors and Strengths

Children and youth who reported more trauma experiences in their lives displayed a higher likelihood of experiencing clinical symptoms of trauma when they first enrolled in THRIVE’s Family Partnering Program. For example, as Figure 2-5 shows, children and youth with extensive trauma histories were significantly more likely to exhibit symptoms of anxiety (25% compared to 7%) and post-traumatic stress (40% and 9%), both of which were statistically significant at the .05 level. Other observed differences were not statistically significant.

![Figure 2-5. Child/Youth Trauma Symptoms, By Number of Trauma Experiences](image)

'These results are not overly surprising, as children with a trauma background exhibit higher rates of trauma symptoms. However, the effects of youth trauma experiences were observed in other measures as well. For example, those with a higher level of trauma experiences were more likely to exhibit challenging behaviors and less likely to exhibit strengths. This is demonstrated in Figure 2-6, which shows the percentage of children and youth whose reported behaviors placed them within the clinical range on indicators captured by the Child Behavior Checklist (CBCL). For example, compared to children and youth reporting fewer trauma experiences, those reporting a higher incidence of trauma were much more likely to present social problems (52% compared to 28%), withdrawn or depressive behaviors (41% compared to 17%), somatic complaints (38% versus 14%) and aggressive behaviors (67% compared to 44%). These were all statistically significant differences.'

![Figure 2-6. Child/Youth Challenging Behaviors, By Number of Trauma Experiences](image)
The costs of ACE’s are enormous....

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘Total estimated cost of child abuse and neglect in the United States (2012) including costs across all aspects of mental and physical health care, social care and law enforcement totalled over between $US80 billion and $US124 billion across numerous studies in the US.

The ACE Study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at $161 billion in 2000. The human costs are incalculable to the victims and their children, family and community.’

‘In correlating decisive links between adverse childhood experience and subsequent adult health problems, the epidemiological results of the ACE study are authoritative in their magnitude. The study also elicited health information which had not previously been sought, and which, in the words of its key convenor, is generally ‘well protected by social convention and taboo’.

‘Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early years shapes brain and psychological development, sets up vulnerability to stress and to the range of mental health problems’.

‘The many constraints which still militate against open discussion of child abuse compound recognition and addressing of violations the scale and magnitude of which, were they to be acknowledged and confronted, would both raise questions of complicity and comprise grounds for deep national shame.’

‘Adverse Childhood Experiences and Health and Well-Being Over the Lifespan This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACES) result in long-term disease, disability, chronic social problems and early death. 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission that perpetuates ACES will continue without implementation of interventions to interrupt the cycle.’

‘The findings of the ACE study also raise urgent and disturbing questions about the construction and operation of health service provision: If the origins of so much dysfunction are to be found in the adverse experiences of childhood that a majority...apparently experience... then what exactly is the role of the mental health professional, the substance abuse counsellor, the domestic violence advocate? What should social service institutions focus their efforts upon? Can we stay comfortably settled in our offices or is advocacy for fundamental change a moral necessity? What exactly do all the diagnostic categories mean when someone diagnosed with posttraumatic stress disorder is six times more likely to be diagnosed with three or more psychiatric disorders?’

‘In fact the prevalence of unrecognised and untreated underlying trauma raises disturbing questions not only about health systems. It has disturbing implications for the full spectrum of service delivery, and raises critical questions about societal organisation per se.’

‘The challenges posed by trauma relating to child abuse are not, then, solely ‘clinical’, ‘personal’, ‘psychological’ or the preserve of ‘the helping professions’. They are social, national and political in the broadest sense. Both because of its prevalence and ongoing effects, child abuse in its various forms comprises a major public health problem, and widespread recognition of this by policy-makers, as well as by the public, comprises one of the major challenges that needs to be met. The corresponding corollary is the need both for specific services to survivors of child abuse and the many affected by it, and advocacy around a topic the reality and dimensions of which are still not widely apprehended and understood. Acknowledgment of the need for both these priorities is prerequisite to comprehensive addressing of what is at stake.’
## Adverse Childhood Experiences

**Abuse of Child**
- Psychological abuse
- Physical abuse
- Sexual abuse

**Trauma in Child's Household Environment**
- Substance abuse
- Parental separation and/or divorce
- Mentally ill or suicidal household member
- Violence to mother
- Imprisoned household member

**Neglect of Child**
- Abandonment
- Child's basic physical and/or emotional needs unmet

## Impact of Trauma and Adoption of Health Risk Behaviours to Ease Pain of Trauma

**Neurobiologic Effects of Trauma**
- Disrupted neurodevelopment
- Difficulty controlling anger – rage
- Hallucinations
- Depression
- Panic reactions
- Anxiety
- Multiple (5+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

**Health Risk Behaviours**
- Smoking
- Severe obesity
- Physical inactivity
- Suicide attempts
- Alcoholism
- Drug abuse
- 50+ sex partners
- Reputation of original trauma
- Self-injury
- Eating disorders
- Perpetrate interpersonal violence

## Long-Term Consequences of Unaddressed Trauma

**Disease and Disability**
- Ischemic heart disease
- Cancer
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Skeletal fractures
- Poor self rated health
- Sexually transmitted disease
- HIV/AIDS

**Social Problems**
- Homelessness
- Prostitution
- Delinquency, violence and criminal behaviour
- Inability to sustain employment – welfare recipient
- Re-victimisation: rape; domestic violence
- Inability to parent
- Inter-generational transmission of abuse
- Long-term use of health, behavioural health, correctional, and social services

Data supporting the above model can be found in the Adverse Childhood Experience Study (Center for Disease Control and Kaiser Permanente, see www.ACEstudy.org) and The Damaging Consequences of Violence and Trauma (see www.NASMHPD.ORG). Chart created by Ann Jennings, PhD. www.anafoundation.org
Most mental health disorders have their roots in childhood, with 50% of affected adults manifesting disorders by age 14 and 75% by age 24 (HHS, 1999; Kessler, Chiu, Demier, & Walters, 2005; Institute of Medicine and National Research Council, 2009). These disorders affect children of all ages, every socio-economic status, and every racial and ethnic background. Mental health conditions in children are typically complex, involving multiple problems, multiple diagnoses, and co-occurring disorders. They impact children in different ways throughout their development, from infancy through school years and the transition to adulthood, and affect their functioning at home, in school, and in their communities. Devastating consequences, including poor academic achievement, dropping out of school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, and suicide, often result from serious mental health conditions (Huang et al., 2005; Clark et al., 2008; Cocozza, Skowyra, Burrell, Dollard, & Scales, 2008; Epstein, Nelson, Trout, & Mooney, 2005; National Alliance on Mental Illness [NAMI], 2010; Pullmann et al., 2006; Wagner & Cameto, 2004). Although these problems have been characterized as a public health crisis, approximately 65% to 80% of children with behavioral health disorders do not receive the specialty services and supports they need (President’s New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000).'

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

‘The costs of childhood disorders can be both large and largely hidden (Knapp et al., 1999). Early onset of mental disorders disrupts education and early careers (Kessler et al., 1995). The consequences in adulthood can be enormous if effective treatment is not provided (Maughan & Rutter, 1998). Knapp shows in figure 4 that children with conduct disorders generate substantial additional costs from ages 10 to 27 years. These are not mainly related to health, as one would expect, but to education and criminal justice, creating a serious challenge for the social capital as a whole.’

‘Mental health problems in childhood generate additional costs in adulthood’

Copied from: WHO Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health; Investing in Mental Health; 2003
It is estimated that three million children and adolescents in the United States are exposed to serious traumatic events each year. Nearly one out of three adolescents was found to be physically or sexually assaulted by the age of sixteen (Boney-McCoy & Finkelhor, 1995) and violent crime victimization among youth was twice as high as the rate for adults (Hashima & Finkelhor, 1999). High rates (50-70%) of PostTraumatic Stress Disorder (PTSD) were found among child, adolescent and adult public service users, while PTSD rates among Medicaid enrollees were highest among children ages five to twelve, at 609.5 per 1,000 (Macy, 2002; Kessler, 2000; Switzer, et al., 1999). Child and adolescent trauma survivors had higher rates of mental health service use and were more likely to use acute mental health treatment services, including: inpatient hospitalization, crisis services, and residential treatment services at higher cost (Frothingham, et al. 2000; Macy, 2002; Newmann, et al., 1998; NTAC, 2003).

Adult survivors of physical and sexual abuse frequently complain of a host of illnesses and psychosomatic problems during their adult lives. The most common generalized effects include stomach problems, difficulty in breathing, muscular tension and pain, migraine headaches, incontinence and heightened susceptibility to illness and infection. In addition, skin disorders, back pain ulcers and asthma are common ailments that are stress-related and may signify unresolved childhood abuse issues. In cases of sexual abuse, the breasts, buttocks, anus and genitals may be the site of discomfort, chronic pain and otherwise unsubstantiated sensations. If the survivor was forced to have oral sex, s/he may experience episodes of nausea, vomiting and choking that are unrelated to a physical or systemic cause. Incontinence has been found in survivors who have been sodomized. Again, we remind you that any or all of these problems may be caused by non-abuse-related factors or conditions as well.

In particular, sexual abuse has been linked with gastrointestinal functioning, while leftover feelings of anger may be related to migraine headaches. Some research indicates that eating disorders such as anorexia and bulimia are more frequently found in women who have survived prolonged sexual abuse. The bingeing and purging behavior that characterizes eating disorders offers survivors a sense of control over their bodies when they lack such control over their feelings. Phobias, such as claustrophobia, although not technically physical symptoms, may be directly related to the circumstances of the abuse, as in the case of a child being locked in a closet for hours on end. Sudden weight
gain and obesity can also be related to childhood abuse, and are sometimes related to the survivor's need to feel more insulated from his/her body or to present a safer, non-sexual appearance to the world.

Depending on one's childhood experience and type of personality, illness can have different meanings for the survivor. Being sick can offer an opportunity to be taken care of either by yourself or someone else. For some survivors, the best care they ever received from their parents may have been when they were sick. Being sick may be one of the few instances in which survivors will care for themselves. In many cases, however, illness may be the body's message that all is not well emotionally. When strong feelings are repressed, the unexpressed psychic energy can cross the mind/body threshold and establish its presence in the form of bodily symptoms and illness.’

Gordon R. Hodas MD Statewide Child Psychiatric Consultant, Pennsylvania Office of Mental Health and Substance Abuse Services; RESPONDING TO CHILDHOOD TRAUMA: THE PROMISE AND PRACTICE OF TRAUMA INFORMED CARE; February 2006

‘An important variable involves the age of the child. In contrast to earlier belief that early trauma had little impact on the child, it is now recognized that early trauma has the greatest potential impact, by altering fundamental neurochemical processes, which in turn can affect the growth, structure, and functioning of the brain (Schwartz and Perry, 1994). Whereas trauma during adulthood tends to be more circumscribed (although still significant) and is activated by exposure to cues associated with the traumatic event, early childhood trauma tends to have more global and pervasive consequences for the child, affecting the basic template for development (Perry, 2004).’

‘The chronicity of traumatic exposure is regarded as extremely significant, in terms of its impact on the child over time. Since the brain adapts to the requirements of the environment, the child’s metabolism and blood flow, and subsequent brain development and functioning, can be significantly altered in response to ongoing trauma (NIMH, 2001). In like manner, the child’s behavioral patterns are influenced by the need to maintain safety and survival. The child’s development in effect becomes skewed by a state of chronic helplessness and hyperarousal, with the resultant development of what is referred to as “malignant memories” (Schwartz and Perry, 1994), which predispose the child to re-experiencing and other symptoms of PTSD.’

‘We have seen that children subjected to a discrete traumatic episode, when offered appropriate early intervention and support, typically respond favorably and return to their baseline state within several weeks.’

‘Children subjected to severe, chronic maltreatment may experience multiple symptoms as well as alterations in neurobiology that affect their developmental process. Many, but not all, of these children eventually meet the criteria for PTSD, yet even when this is not the case, their impairments are significant.’

‘Not unexpectedly, children who have experienced trauma with subsequent maladaptation and disruption of typical development are at increased risk of behaviors that may lead to legal problems, with increased entry into the juvenile and criminal justice systems.’

William Steele, PsyD and Caelan Kuban, LMSW; Advancing Trauma-Informed Practices Bringing trauma-informed, resilience-focused care to children, adolescents, families, schools and communities. The National Institute for Trauma and Loss in Children.

‘An Internet search for trauma-informed care yields more than seven million references. It is safe to say that a great deal of information exists about the prevalence of trauma experienced by children and what constitutes trauma-informed care. The majority of articles regarding trauma consistently cite violence as the primary cause of trauma. There is no doubt that violence does induce severe trauma in children. Most would agree that at least 50% of the children in child welfare and 60-70% of youth in the juvenile justice system experience trauma (Hodas, 2006 a). However, research began to emerge as early as the 1990s indicating that trauma can also be induced by such disasters as fires (McFarlane, 1994), hurricanes (Lonnigan et. al., 1991), boating accidents (Yule, 1992), burns and medical procedures such as bone marrow transplants (Stubner et. al., 1991). Three million people yearly are involved in car accidents; up to 45% of those injured suffer posttraumatic stress disorder (PTSD) (PTSD Support Services, 2011). In fact, divorce can also induce trauma when the conditions of that experience leave children vulnerable (PTSD Causes and History, 2011).

Often trauma is not screened for in children exposed to situations like house fires, car fatalities, critical injuries, terminal illnesses, divorce, even as victims of bullying and cyberbullying. Secondly, we must conclude that if both violent and non-violent situations can induce trauma, then perhaps it is not the situation that induces trauma but how that situation is being experienced that leaves children and youth vulnerable to trauma. If this is true, then it
follows that we must first know how children are experiencing what they are exposed to if we want to determine what might be the most helpful and appropriate trauma-informed response.’

Jeannie Campbell, Executive Vice President, National Council for Community Behavioral Healthcare; “ACEing Trauma-informed Care; Breaking the Silence Trauma-informed Behavioral Healthcare

‘What can behavioral health organizations do to improve care? ACE Study findings strongly suggest a shift in the paradigm of behavioral health and medical care from a focus solely on biological to a true biopsychosocial approach. All consumers of medical and behavioral health services should be asked early in the assessment process about childhood stressors and traumatic experiences, which, if necessary, must then be addressed through prevention or trauma-informed treatment and systems of care.’

The response to childhood abuse in South Africa comes in the form of the Early Childhood Development (ECD) initiative. The following is an extract from the Department of Social Development Integrated Crime Prevention Strategy (ISCPS)


‘Through providing stimulation, nutrition, protection and care, and health services to our children during the critical stages of their development, we make significant contributions to a safe society. Interventions such as the provision of ECD programmes increase primary school enrolments, enhance school performance, lower repetition and drop-out rates, and reduce child offences.’

‘ECD is a broad concept (Biersteker 2008). “Early Childhood Development encompasses an ideological and political struggle towards the creation of a society founded on human rights, which acknowledges the centrality of childhood in human and social development and children as individuals and citizens. It emerged out of the broader democratic struggle against apartheid, with the goal of addressing the lack of a nurturing, educative and supportive environment for the vast majority of South Africa’s disenfranchised children. “Providing appropriate stimulation, nutrition, care and health services during this critical development period results in: increased primary school enrolment, enhanced school performance, lower repetition and drop-out rates, reductions in juvenile crime rates, reduced remedial medical and welfare costs, and improved economic and social productivity indicators.” (Department of Education 2001).’

‘Literature identifies six different types of child abuse: physical, sexual, emotional, structural, neglect and child labour. All are identified because of the deliberate harm caused to children and the specific negative consequences for children (Frank & Wesley 2008).’

We need to hurry. TRISI must join the global ACEs fraternity, learn from them, access their resources and contribute in kind.
Intergenerational Trauma

“A drowsiness hanged over him; a kind of paralyzing spell.
As so many times before, he found himself again in the Ghetto,
being chased by soldiers and looking for a hiding place.
The nightmares were vivid and emotionally draining and he yearned for peace and relief.
He tried to put shape and give meaning to the frightening images that kept haunting him,
but he found nothing of the sort.
Just a life-long struggle with a past terror that was not his own, with a tragedy that he, himself,
had not survived and with a conviction that catastrophe would surely strike again.
How long would it go on?”

Natan P.F. Kellermann; Epigenetic Transmission of Holocaust Trauma: Can Nightmares Be Inherited? AMCHA, the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, Jerusalem, Israel

From the UK...


‘(Prof Marcus Pembrey, from University College London )commented: “It is high time public health researchers took human transgenerational responses seriously. "I suspect we will not understand the rise in neuropsychiatric disorders or obesity, diabetes and metabolic disruptions generally without taking a multigenerational approach.”’

Psychotherapeutic Work with Intergenerational Trauma - Confer – Seminars, conferences and online resources for psychotherapists; http://www.confer.uk.com/module-intergenerational.html

‘Dr Clara Mucci: “Past generations, trauma, loss and the modes of psychic transmission - asserts, "We don't just get a patient. We get someone who is the last part of a chain of family heritage."’

‘Dr Françoise Davoine The "stoppage of time" due to intergenerational trauma- suggests that the hiding of abuse and crimes when the truth has been impossible to accept (for example, an experience of a war atrocity), requires the defence of delusion within the family. We see how the secreting of trauma by a parent or grandparent can leave an unconscious impression of those events in the mind of a child or grandchild which later re-emerges in the imagery of a psychotic episode.’

‘Prof. Franz Ruppert Multigenerational psycho-traumatology: Symbiotic trauma and entanglements across generations - explores both the nature of trauma and its intergenerational transmission. Experiences of trauma, he suggests, lead to splits in the human psyche by which the intolerable feelings are suppressed in a range of survival strategies. In the process of bonding it is impossible for a mother or father to avoid passing on something of their own traumatic experiences to their children. Even when parents try to hide and neglect their own traumas, their children will sense these, primarily due to a lack of safe emotional contact. This normally results in the children experiencing vicarious or "symbiotic trauma" in which the child suffers from and identifies with the split-off traumatised feelings of their parents.’

‘Dr Estela Welldon: The intergenerational traumatic roots of perversion - discusses clinical cases where intergenerational trauma has been a primary cause of extreme or hazardous behaviour. Referring principally to psychodynamic theory she discusses how unconscious permeation of (bad) objects penetrates and overwhelsms the ego, forcing the patient to seek relief from deep sexual tensions that originate in childhood relationships. Sometimes, this search for relief may lead to dangerous and illegal acts of abuse.’

‘Dr Isha Mckenzie-Mavinga: Black rage and internalised oppression: the impact of intergenerational racism - illustrates how racism continues to cause and compound trauma and depression. It is often forgotten that slavery was damaging for both the perpetrators and the enslaved.’
From Nicaragua

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

‘Multiply wounded societies run the risk of becoming societies with inter-generational traumas. It is virtually a law that one treats others the way one treats oneself. Anywhere that large population groups are traumatized, the trauma is transferred to the next generation. Working with the multiple wound phenomenon means accepting that the wounds are collective as well as personal.’

From Australia …

Naomi Ralph; Kathy Hamaguchi; Marie Cox; Transgenerational Trauma, Suicide and Healing from Sexual Abuse in the Kimberley Region, Australia - The Kimberley Aboriginal Medical Services Council Inc.

‘As Milroy (2005: xxi) stated -Given that the traumas of separation, social control and exclusion have been sustained over several generations and that almost the entire Aboriginal population was affected, the ability of individuals to psychologically integrate and for families and communities to collectively resolve these experiences in the face of ongoing denial of history is extraordinarily difficult.’

Australia, with the influence no less of South America …

Judy Atkinson, Jeff Nelson and Caroline Atkinson Trauma, Transgenerational Transfer and Effects on Community Wellbeing;

‘The intergenerational transmission of trauma Blanco (in Levine & Kline, 2007) developed a five-generation account of the effects of violence on subsequent generations in South America that can be mapped onto the history of Indigenous Australia:

1st Generation: Conquered males were killed, imprisoned, enslaved or in some way deprived of the ability to provide for their families.

2nd Generation: Many men overused alcohol and/or drugs to cope with their resultant loss of cultural identity and diminished sense of self-worth.

3rd Generation: The intergenerational effects of violence manifest in the increased prevalence of spousal abuse and other forms of domestic violence

4th Generation: Trauma begins to be re-enacted and directed at the spouse and the child; signifying a serious challenge to family unit and societal norms of accepted behaviour.

5th Generation: In this generation, the cycle of violence is repeated and compounded, as trauma begets violence, with trauma enacted through increasingly severe violence and increasing societal distress.’

Canada …

Urban Society for Aboriginal Youth, YMCA Calgary and University of Calgary; Intervention to Address Intergenerational Trauma: Overcoming, Resisting and Preventing Structural Violence.

‘Intergenerational trauma is the transmission of historical oppression and its negative consequences across generations. There is evidence of the impact of intergenerational trauma on the health and well-being and on the health and social disparities facing Aboriginal peoples in Canada and other countries.

… A definition of intergenerational trauma can be found in Evans---Campbell (2008): “A collective complex trauma inflicted on a group of people who share a specific group identity or affiliation—ethnicity, nationality, and religious affiliation. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events.’
‘To further understand the prevalence of trauma within the families served by THRIVE’s Family Partnering Program, the evaluation explored intergenerational trauma, that is, the incidence of child and youth trauma in conjunction with the prevalence of caregiver trauma during their own childhood years ago. Evaluators were seeking to determine whether there were statistically valid correlations between a parent having experienced trauma in his or her own childhood and the children’s traumatic experiences as well as mental health symptoms. The first step was to calculate the proportion of families where both the caregiver and the child independently reported significant trauma histories. The family member would have had to report trauma incidents in childhood. Again the standard of three or more traumatic events was used.

Figure 2-4 shows that 42 percent of the families presented intergenerational trauma, while 19 percent reported a trauma history for only the child or youth. Interestingly, 22 percent of families had a parent with a childhood trauma history, but the child/youth was not presenting a trauma history. Chi-square analysis suggests that there is a relationship between parental history of trauma and child’s history of trauma although, due to small sample size, it is not statistically significant.’

‘Although there is existing research that demonstrates the effects of trauma on children and the effects of childhood trauma on adults, there is little research that explores how the trauma combined experiences of youth and primary caregivers affect families, that is, that tests the compounding effects of intergenerational trauma on trauma survivors within a family. To explore this more fully, the evaluation study created an additional comparative layer that compared the symptoms and behaviors of youth with a trauma histories by whether their primary caregiver also reported a significant history of trauma.’

Figure 2-8 below shows the proportion of children/youth scoring in the clinical range for trauma symptoms among those who had experienced three or more trauma experiences. It is comparing two groups: those where both the children/youth and the caregiver had experienced three of more trauma events and those where only the youth had experienced three or more trauma events.’
Judith Shulewitz. Senior Editor New Republic. ‘The Science of Suffering - Kids are inheriting their parents’ trauma. Can science stop it?’ With Rachel Yehuda (Director of the Mental Health Patient Care Clinic at the Peters Medical Center, and a professor of psychiatry and neuroscience at the Icahn School of Medicine at Mount Sinai Hospital.) Nov 16 2014;

‘American Indians suffer shockingly worse health than other Americans. Native Americans and native Alaskans die in greater proportions than other racial or ethnic groups in the country, from homicide, suicide, accidents, cirrhosis of the liver, pneumonia, and tuberculosis. Public health officials point to a slew of socioeconomic factors to explain these disparities: poverty, unemployment, lack of health insurance, cultural barriers, discrimination, living far from decent grocery stores. Sociologists cite the disintegration of families, the culture of poverty, perpetual conflict with mainstream culture, and, of course, alcoholism. The research on multigenerational trauma, however, offers a new set of possible causes.’

Daniel McLaughlin, Elisabeth Wickeri; SPECIAL REPORT Mental Health and Human Rights in Cambodia; Leitner Center for International Law and Justice

‘The psychological impact of the Khmer Rouge extends to the generation of Cambodians born after the fall of the regime. Drawing upon studies of children of World War II Holocaust survivors,139 mental health professionals believe that trauma in Cambodia was transmitted intergenerationally on account of both the Khmer Rouge period’s impact on the parenting styles of the regime’s survivors and its broader devastation of the Cambodian infrastructure.140 Indeed, studies have also found elevated rates of PTSD among the general Cambodian population, which may reflect a wider transmission of Khmer Rouge-associated trauma.’

Lukoye Atwoli, Matthew K Nock, David R Williams and Dan J Stein; Association between Parental Psychopathology and Suicidal Behaviour among Adult Offspring: results from the cross-sectional South African Stress and Health Survey; BMC Psychiatry 2014, 14:65

“Abstract - Conclusions: Parental psychopathology increases the odds of suicidal behaviour among their adult offspring in the South African context, replicating results found in other regions. Specific parental disorders predicted the onset and persistence of suicidal ideation or attempts in their offspring. Further research into these associations is recommended in order to determine the mechanisms through which parent psychopathology increases the odds of suicidal behaviour among offspring.”
**Of DNA and Genes**

“Depictions of humans collecting honey from wild bees date to 15,000 years ago; efforts to domesticate them are shown in Egyptian art around 4,500 years ago. Simple hives and smoke were used and honey was stored in jars, some of which were found in the tombs of pharaohs such as Tutankhamun.” Wikipedia

*Brent Bambury interview with Amy Bombay (assistant professor of psychiatry at Dalhousie University)* Can trauma have genetic effects across generations? CBC Radio, Friday June 05, 2015

“The Truth and Reconciliation Commission’s report on residential schools in Canada laid out the neglect and abuse aboriginal children and youth were put through. Studies have shown that trauma might have an affect not only the person experiencing the trauma, but also subsequent generations via their DNA.

“We're all born with our DNA and we used to think that wasn't changeable and it's not. But what we know now is that experience can make certain kinds of these DNA "tags", which is the unscientific way to talk about it that can tag onto our DNA. Those little tags can basically turn the gene on or off. And so while the same gene is still there, it could be not functioning or functioning differently and therefore the functional aspects and roles of that DNA are different.’

“The development of new methodologies will cause the cost of DNA extraction, genotyping, and expression in humans to decline further over the next decade. Such methodological innovations will allow trauma and violence researchers to routinely collect and analyse genetic data. Rather than being in conflict, trauma and violence researchers and behaviour geneticists will have the opportunity to collaborate in the larger goal of understanding the complex interplay between trauma and violence and genetic variation in the development of adverse outcomes. This research will contribute to our understanding of the mechanisms by which exposure to trauma and violence exerts their adverse effects, aid in identifying individuals who are at risk, and facilitate the prevention of adverse effects in these individuals.’


‘(N)ew Australian research points to DNA as a potential factor in determining who will suffer depression later on. Scientists say they've spotted a gene variant that appears to raise the odds of depression in adults who suffered childhood abuse.

There's a twist, however: People with the same gene variant who never suffered abuse actually tend to be happier than similar people without the gene, the researchers found.’

‘The study included more than 300 middle-aged Australians of northern and western European ancestry who underwent genetic testing. The participants also had their symptoms of depression recorded over five years. (W) hile "you can't change your [genetic makeup] or go back and change your childhood... you can take steps to modify your current environment," (Dr. Chad) Bousman said.’

"A person’s genes alone are not enough to determine how they might experience depression," he explained. "This research tells us that what may be considered a risk gene in one context, may actually be beneficial in another. So this directly opposes the notion of genetic determinism, the idea that your genes define your fate.”

*Denise A. Hines Kimberly J. Saudino; Boston University Intergenerational Transmission of Intimate Partner Violence A Behavioral Genetic Perspective.*

“A Behavioral Genetic Approach

The social learning theory account of the intergenerational transmission of intimate partner violence assumes that familial patterns of violence are entirely due to environmental factors. However, the pattern of familial resemblance reported in the literature could also be due to shared genes.” *Denise A. Hines; Kimberly J. Saudino*
Epigenetics

“More than two centuries ago, the founder of evolution, Jean-Baptiste Lamarck, suggested that acquired characteristics may be transmitted from one generation to another.”

Natan P.F. Kellermann

Nataly Woollett Curbing the intergenerational transmission of trauma: outcomes of an intervention for child witnesses of domestic violence and their mothers SVRI Conference - Bangkok October 20

“It wasn’t until the 18th century that European understanding of the colonies and biology of bees allowed the construction of the moveable comb hive so that honey could be harvested without destroying the entire colony.” Wikipedia


‘Epigenetic modifications, such as DNA methylation, can occur in response to environmental influences to alter the functional expression of genes in an enduring and potentially, intergenerationally transmissible manner. As such, they may explain inter-individual variation, as well as the long-lasting effects of trauma exposure. While there are currently no findings that suggest epigenetic modifications that are specific to PTSD or PTSD risk, many recent observations are compatible with epigenetic explanations. These include recent findings of stress-related gene expression, in utero contributions to infant biology, the association of PTSD risk with maternal PTSD, and the relevance of childhood adversity to the development of PTSD.’

‘An epigenetic modification refers to a change in the DNA produced by an environmental perturbation that alters the function, but not the structure, of a gene. Epigenetic changes are stable and long-lasting, and can, in some cases, be transmitted intergenerationally (Meaney & Szyf, 2005). Epigenetic modifications that alter gene expression explain how environmental exposures produce transformational change. When this change occurs during a critical developmental window, it may serve to recalibrate biological systems to influence the response to a subsequent traumatic exposure.’

‘The recognition of individual differences in the response to trauma has led to the search for genetic markers (polymorphisms) associated with PTSD risk (Broekman, Olff, & Boer, 2007). The identification of susceptibility genes and gene by environment (GxE) interactions in PTSD has been prompted not only by the limited prevalence of PTSD following exposure, but by demonstrations that PTSD runs in families (Nugent, Amstadter, & Koenen, 2008). A greater prevalence of PTSD has been reported among trauma survivors who also had a twin with PTSD (Koenen, Nugent, & Amstadter, 2008) and among first-degree relatives of persons with PTSD, including children of trauma survivors with PTSD (Yehuda, Bell, Bierer, & Schmeidler, 2008). Even after controlling for the familial clustering that contributes to risk for exposure, genetic factors continue to account for approximately one-third of the variance in PTSD (True et al., 1993).’

‘The application of epigenetic methods to the field of PTSD represents an exciting frontier because of their ability to account for individual differences in response to trauma based on environmental exposures that permanently alter gene function. Integrating epigenetics into a model that permits prior experience to have a central role in determining individual differences is also consistent with a developmental perspective of PTSD vulnerability. Importantly, an appreciation of the mechanisms through which experience may alter the expression of genes regulating biological substrates critical to PTSD pathophysiology may help establish relevant biological subtypes of the disorder.’

Natan P.F. Kellermann; Epigenetic Transmission of Holocaust Trauma: Can Nightmares Be Inherited? AMCHA, the National Israeli Center for Psychosocial Support of Survivors of the Holocaust and the Second Generation, Jerusalem, Israel

‘Epigenetics is typically defined as the study of heritable changes in gene expression that are not due to changes in the underlying DNA sequence. Such heritable changes in gene expression often occur as a result of environmental stress or major emotional trauma and would then leave certain marks on the chemical coating, or methylation, of the chromosomes The coating becomes a sort of “memory” of the cell and since all cells in our body carry this kind of memory, it becomes a constant physical reminder of past events, our own and those of our parents, grandparents and beyond. “The body keeps the score”, not only in the first generation of trauma survivors, but possibly also in subsequent ones.’
‘Apparently, not only children of Holocaust survivors, but offspring of other PTSD parents are also vulnerable to such a burdensome legacy, including descendants of war veterans survivors of war trauma and childhood sexual abuse, refugees, torture victims and many others. Moreover, the transmission may continue beyond the second generation and also include the grandchildren, great grandchildren and perhaps others as well. This process of transgenerational transmission of trauma (TTT) has been repeatedly described in the academic literature for more than half a century.’

‘Previous research assumed that such transmission was caused by environmental factors, such as the parents’ childrearing behaviour. New research, however, indicates that these transgenerational effects may have been also (epi) genetically transmitted to their children. Integrating both hereditary and environmental factors, epigenetics adds a new and more comprehensive psychobiological dimension to the explanation of transgenerational transmission of trauma. Specifically, epigenetics may explain why latent transmission becomes manifest under stress.’

‘A recent overview of such research (Kellermann, 2011) concluded that the contrasting forces of vulnerability and resilience were both present in many Holocaust survivors and their children.

But how did the first generation of survivors achieve so much, and how can their children function so well? And how can we understand that offspring who came to psychotherapy complained so much from various kinds of secondary traumatization effects, while epidemiological studies repeatedly failed to show that they were any different from comparable populations? Clinical observations and controlled research were consistently divided in their assessment of this population for many decades.

With the added use of epigenetics, however, this dispute has become much more reconcilable. Epigenetic transmission models make the discrepant findings regarding the presence or absence of specific psychopathology as well as the simultaneous presence of both frailty and hardness in this population much more explicable. Because from the point of view of epigenetics, any inherited (genetic) dispositions can be either turned on or off, and thus activate either overwhelming anxiety or sufficient coping in the same person at different times, according to certain aggravating and mitigating (environmental) factors (Kellermann, 2009). As emphasized by Yehuda & Bierer (2009), “integrating epigenetics into a model that permits prior experience to have a central role in determining individual differences is also consistent with a developmental perspective of PTSD vulnerability.”

Gender

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

‘Together with the study of emotions and psychology, about which there is little generalized understanding in Nicaragua, the gender perspective gave us another piece that helped us put the puzzle together better. It has been documented in Nicaragua, for example, that after the war of the eighties ended, there was increase in domestic violence in households where the men had participated in the war. These men had lived through very tough situations on the battlefield without being able to process them or express any emotion about them because of the learned masculinity model. On top of that, they went from being soldiers and officers defending their country or
values to being jobless and ignored by an inhumane system. The only way they found to express their pain was through violence and aggressiveness, because that’s the only way men have learned to express their emotions and shake off their traumas.’


‘Mental health problems and illnesses affect men and women differently and at different stages in life. For example, women are more likely than men to experience anxiety and depression, including depression following the birth of a child.215 Men are more likely to develop schizophrenia at a younger age. Girls and women attempt suicide at higher rates, but men and boys (particularly older men) die by suicide more often.

The different ways that gender makes a person vulnerable to mental health problems and illnesses mean that the impact of gender needs to be considered in prevention and early intervention efforts. Key risk factors for women are often interrelated: women have more caregiving responsibilities, higher rates of poverty, and are more likely to suffer domestic violence and abuse.218 Childhood sexual abuse is linked to mental health problems and illnesses later in life for both girls and boys, but girls are more likely to be abused. Factors that threaten their sense of success and achievement, such as job loss, have a particular impact on men. Men may be less likely to recognize that they have an emotional problem, may feel that they should handle it alone, and may delay seeking help. In addition, men do not always present signs and symptoms in ways that are easily recognized by service providers.’

**Women**

*British Columbia Centre of Excellence for Women’s Health; Trauma-informed Approaches in Addictions Treatment, Gendering the National Framework; 2009*

‘The implications of (these) interconnections are significant, relating not only to emotional health and well-being, but all areas of women’s lives, including physical health and mothering. Experiences of trauma are linked to central nervous system changes, sleep disorders, cardio vascular problems, gastrointestinal and genito-urinary problems, reproductive and sexual problems. Physical health may also be affected by self-harming behaviours as attempts to cope with emotional pain. Women are in a unique position when it comes to pregnancy and mothering, yet little attention has been directed to the needs of mothers in the context of co-occurring mental illness, substance use problems and experience of trauma. Women may experience the trauma of having a child removed, or threats by a partner to report her to child welfare authorities. The stigma attached to violence and substance use in relation to pregnant and parenting women can prevent or delay help seeking. This can be magnified for women who find themselves even further in marginalised positions (e.g. poverty, colonization).’


‘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.’


‘The literature over the past decade has emphasized the centrality of the experience of interpersonal victimization including childhood abuse, sexual abuse, and intimate partner violence for women with mental health problems and addictions. Women are at greater risk than men for interpersonal victimization, and a recent meta-analysis found women to be twice as likely to develop PTSD after a traumatic event and the chronicity of symptoms for women to persist up to 4 times longer than for men.’

‘This study examined associations between trauma and physical health, as well as changes in physical health over time, in women with co-occurring disorders and histories of violence who received either integrated trauma-informed services or usual care. Results revealed that women who had experienced more severe trauma also
suffered worse physical health and were more likely to engage in poor health behaviours. Receiving behavioral health care services was associated with improved physical health and health behaviours. Predictors of physical health improvements included reduced interpersonal abuse, reduced severity of posttraumatic symptoms, improved health behaviours, and adequate access to medical care.’

‘Regarding secondary prevention, our findings suggest that providing behavioral health services could cause a domino effect by positively affecting several variables that lead to improved physical health, including interpersonal abuse, PTSD symptoms, and drug use. Behavioral health services may further improve physical health if they include programs in stress management, weight control, physical exercise, and smoking cessation (Kilpatrick et al., 1997).’

‘Conclusion: Our data revealed several connections among trauma, poor physical health, poor health behaviours, and alcohol and drug use with a positive correlation between the severity of the trauma and the severity of the health and health behaviour problems. Our findings suggest that behavioral interventions not only reduce substance use and improve mental health (Cocozza et al., 2005; Morrissey et al., 2005) but may also improve health behaviours and physical health. The number of interrelationships between trauma and health make a case for a multifaceted approach that decreases the impact of trauma on physical health and reduces the associated social and economic costs to the individual and to society, as well as trauma’s personal costs to the survivor.’

**Women and Interpersonal Violence (IPV)**


Abuse remains an important public health concern and, in women, it may be a stronger predictor of poor physical health than poverty (Sutherland, Bybee, & Sullivan, 2002). Various authors have reported that women with histories of trauma and co-occurring disorders have multiple complex needs that are poorly served by the existing fragmented service system.

*Pat Bracken; Towards a hermeneutic shift in psychiatry;* World Psychiatry 13:3 - October 2014

The context of motherhood is usually rich with love and hope; the suffering of childbirth has a positive meaning and can be integrated into the mother’s life. This is seldom the case for those who endure torture. The context of their suffering is very different, despite the fact that in both cases the physical pain will have been mediated through similar centres in the brain and similar neurotransmitters will have been released. Even the most sophisticated neuroscience will not help us to understand the meaning of pain in the life of any particular person. And it is the meaning of the experience that will determine the longer-term outcome.

*Susan Omilian; The Thriver Workbook: Journey from Victim to Survivor to Thriver!* http://thriverzone.com/thriver-collection/the-thriver-workbook/

‘Many IPV (Intimate Partner Violence) survivors are still under threat of ongoing abuse or stalking, which not only directly impacts their physical and psychological safety but impacts treatment options, as well. Little is known about the extent to which existing evidence-based trauma treatment modalities are applicable to, or require modification for, IPV survivors.’

‘Intimate Partner violence (IPV) is a widespread and devastating phenomenon, with millions of women being assaulted by intimate partners and ex-partners across their lifespan (Black et al., 2011). Ongoing abuse and violence can induce feelings of shock, disbelief, confusion, terror, isolation, and despair, and can undermine a person’s sense of self. These, in turn, can manifest as psychiatric symptoms (e.g., reliving the traumatic event, hyperarousal, avoiding reminders of the trauma, depression, anxiety, and sleep disruption).’

‘They may have little time and insufficient funds for ongoing therapy sessions or completing homework outside of treatment. Low-income women in particular may have difficulty affording the needed childcare to attend therapy, and as a result of structural oppression, people of color may have less access to insurance to pay for trauma treatment (Dutton, Bermudez, Matas, Majid, & Myers, 2011; Snowden, 2001). In addition, perpetrators of abuse may prevent women from seeking treatment or use their knowledge of their partner’s treatment to continue their violence or threats.’

‘Providing trauma treatment in the context of ongoing IPV raises a number of practice related concerns. For example, incorporating an understanding of the dynamics of IPV is essential for responding to the types of issues IPV
survivors face related to safety, confidentiality, coercive control, parenting, custody, legal issues, immigration, social support, and economic independence, all of which influence how a survivor is affected by the abuse, her ability to participate in treatment, and her response to treatment.’

Prof Juan A. Nel, Anene. A national symbol of the tide that has turned, or...simply another, ‘bloody’ South African Statistic. PsyTalk, 2013, Issue 1.

‘In the words of Premier of the Western Cape, Helen Zille, we need “…a whole of society approach”, and she is right.... We require a multidisciplinary approach and interventions and activism at multiple (macro-, meso- and micro-) levels aimed at the reduction and prevention of GBV (Gender Based Violence) and the impact thereof. Both proactive and reactive interventions may be the terrain of legislators and policy makers, but it is also that of educators, spiritual leaders social scientists, counsellors, and/or therapists, depending on the nature and extent of the violence and its consequences.’

The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007)-
Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007) was a large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.’


‘SAMHSA’s goal was to develop and evaluate comprehensive and integrated behavioral health services for this group of women, who are often frequent users of publicly funded services.’

![Image of a table or diagram related to violence and abuse]

Figure 1. The impact of violence and abuse on physical health. This figure shows a model of the relationship between violence and abuse and physical health problems, including possible pathways of this relationship and the impact of intervention.


‘Victims of domestic abuse, who are at a high risk of sexual violence, are at a particularly high risk of contracting HIV/AIDS. In abusive relationships, there is an imbalance of power, which sees the victims, mainly women, being largely unable to negotiate safe sex practices with their violent intimate partners. The pervasive and ongoing nature of domestic violence in South Africa should be viewed in the broader context of the country’s exceedingly high levels of violent crime, in general. Given the high levels of crime and violence in the country, the notion of a “culture of violence” looms large.’
‘In an examination of intimate femicide in South Africa, Mathews et al (2004) highlight that one in every two women killed by a perpetrator that is known to her is killed by an intimate partner. Artz (2008) interviewed 365 victims of domestic violence to determine why they failed to return to court to finalise their protection orders and the following disturbing findings emerged:

- 65% of respondents reported physical abuse
- 15% of respondents had experienced sexual abuse or rape
- 38% of respondents reported economic abuse
- A staggering 85% reported having experienced verbal abuse
- 83% of respondents reported psychological abuse
- 40% of respondents stated that their abusers had threatened to kill them at some stage during their domestic relationship.’

Denise A. Hines Kimberly J. Saudino; Boston University; Intergenerational Transmission of Intimate Partner Violence A Behavioral Genetic Perspective;

‘Violence in intimate relationships is a widespread problem in the United States. Findings from the last nationally representative survey of family violence show that more than 16% of married American couples experienced an incident of physical assault in the previous year, which translates into approximately 8.7 million couples nationwide... Moreover, when violence is considered over the course of a lifetime rather than in the course of just 1 year, it is estimated that at least half of all male and female Americans will be the recipients of at least one form of aggressive behaviour from their partner at least once (O'Leary,1988).’

Men

Prof Kopano Ratele The Most Urgent Question Facing South African Psychologists Today; Psychology Society of South Africa
http://www.psyssa.com/

‘Whereas the most important question facing South African psychologists in the 1970s and 80s was the transformation of a racist society into a multiracial democracy, today’s imperative is to transform the lives of boys and men toward healthier, happier, fulfilling and generative lives and relations with themselves, other males, girls and women in the world in which they live.’

‘Psychologists need no convincing of the fact that even when material needs are taken care of, there can be no health, happiness, fulfillment, or generativity without emotional and mental health. Boys and men without spaces to emote and reflect on their lives can neither connect nor grow. Men feeling superfluous to and outside of culture can be dangerous to others and themselves. South African men need help in reattaching and finding their aims.

Gratuitous violence, it seems, which tends to be a male adventure against other males as well as females, is usually a response not to any immediate threat but an empty gesture against disconnection and purposelessness. To be sure, the barrenness of dominant forms of masculinity and the private and public misery they produce are not a local problem. Neither are they not an Indian, Chinese, American, Russian, white, or black thing; nor are they confined to poor, unemployed, working-or- middle class or rich men.’

‘From the US and Uruguay to the United Kingdom and Uganda, Kingston to Kinshasa, men are experiencing hitherto hegemonic but now infertile, unsustainable, and empty models of manhood to be unworkable in the face of the demands of recognition and equality from women and queer subjects. Many a man around the world, but more so in those societies characterized by high levels of poverty, inequality, dark globalization, and carnage, are looking for help in helping to re-knit masculinities.’
Men and Emotions

Robot Hugs; The Media Is Lying to You About Men’s Emotions, And It’s Really F*cked Up – Here’s a Healthier View; Everyday Feminism; June 24, 2015; http://everydayfeminism.com/2015/06/the-media-mens-emotions/

While there a number of factors that contribute to the fact that men commit the majority of violence towards all genders, we must consider that one of the factors is that multiple avenues for men to express and feel both negative and positive emotions are socially discouraged.

Celia Edell; Here’s How the Patriarchy Damages Men’s Emotional Literacy – And Why That Matters; Everyday Feminism ; June 2, 2015  http://everydayfeminism.com/2015/06/men-and-emotional-literacy/

When you see that macho man in the movies punching the wall or getting in a fight because he’s upset, because he’s hurt by someone, because he got broken up with, these are ways that we’re taught to understand how a man expresses his emotional pain and vulnerability. There really are very few socially acceptable outlets for men to express these feelings otherwise, so men find violent outlets, whether against other people or against themselves.

Repressing emotional vulnerability is not only dangerous in that it causes men to lash out with physical violence, but it also leaves men incredibly alienated and isolated from their feelings. Isolated in the sense that they’re not able to connect with other people on a deeper level very easily because they are not allowed to express these emotions, and also alienated, because expressing these emotions means learning what these emotions are. Women are granted more specific to do that in our society even though it also comes with the attached dismissal of what they’re saying. Also women are allowed to express these emotions in a way that still grants them the status of woman, whereas when men express these emotions they can lose the status of men.

Given the fact that manhood greats a great degree of school status, especially for men of color and marginalized men, this idea of being the masculine man will grant them a lot of social power that they might otherwise not have access to.

Ultimately, it’s important that we understand why men continue to attempt to live up to these expectations, just like us women, even feminist women like myself, why I continue to try to live up to these norms of femininity even though I know that they are not real constructs. They’re something that I’ve been conditioned to take on. I think that a lot of men understand that masculinity is this construct and it is something that is potentially harmful, or at the very least, it’s not something based in total reality. Yet, it does really affect them and it really affects the way that move through society. The same goes for femininity.

It’s also something that we’ve all internalized so deeply that it’s really hard to distance ourselves from it. It’s important to understand where men are coming from, but also to understand why masculinity is so harmful, not only to other people, but to men themselves it’s harmful. If we can understand that and we can start talking about that, then it’s more likely that men can start to challenge these norms and start to understand how important it is to be emotionally literate and to grant men that space to express their emotions in a more healthy way.
Macho culture – the perpetuation of hypermasculinity, dominance, violence, bravado – can be deadly, particularly for women.

According to the World Health Organisation, women in the US are victims of intimate partner violence at a rate about five times that of men, and the, has found that the most common form of violence experienced by women around the world is physical violence inflicted by an intimate partner.

While men experience much lower rates of violence, and are privileged in many respects, it’s both naïve and harmful to ignore the ways in which macho culture negatively affects their psyches.

Sexism is detrimental to society as a whole and should be examined as a cultural and systematic structure. Thoroughly understanding the effects it has on women as well as men can help reduce all manifestations of violence. Since gender is a performance, men are not inherently more violent, so this behavior can certainly be changed.

Here are four ways macho culture hurts men:

1. Causes Emotional Repression
Men are often discouraged from showing any sort of physical or emotional weakness. This can begin at a very young age.... Celia Falcov, clinical professor in the Department of Psychiatry at the University of California-San Diego and author of Latino Families in Therapy, says that the fear of being perceived as vulnerable or weak can also keep men or boys from asking for help.

2. Encourages Aggression and Violence
 “Tendency towards domination and violence also has negative consequences for the machista man,” says Falicov. She believes that perpetually being in defensive mode can make these men unable to relax.
3. Perpetuates One Dimensional Representations
The media doesn’t do a good job of offering diverse and nuanced representations of women, but men are also often portrayed as one-dimensional.

4. Damages Relationships
When men grow up in sexist and macho environments, the way they perceive women and sex can be incredibly harmful.

Celia Edell; Here’s How the Patriarchy Damages Men’s Emotional Literacy – And Why That Matters; Everyday Feminism ; June 2, 2015  http://everydayfeminism.com/2015/06/men-and-emotional-literacy/

In patriarchal society, men hold a more powerful position relative to women and non-binary people in the hierarchy of gender. Although men might be evaluated by women seeking sexual partners, the standards against which their masculinity is measured are really held in place by other men. Men are prisoners of masculinity in so far as they internalize these cultural definitions of manhood.

Some of these definitions would be that masculinity requires men to build this invisible wall of toughness around them. They’re not allowed to show vulnerability. This is something that men are often taught as very young children to “man up,” and, “Don’t cry. Be a man.” These are things that we are constantly told growing up, so they sort of become incorporated into ourselves. That’s what I mean when I say that we internalize the male gaze. We internalize them so deeply that we cannot tell whether we’re evaluating ourselves or we’re being evaluated by this gaze.

Men also might have inner conflicts about masculinity and the norms of appearance, but they’re very often compelled to hide this kind of confusion by acting more confident than they even really feel, because confidence and assertiveness is itself tied to masculinity.

Another thing is manliness is often associated with the external aspects of performance like physical size, willingness and ability to fight, and dominance over other people. This helps explain why men commit far more acts of violence than women, because these concepts are built into the idea of manhood, so in order to prove one’s manhood, often it requires one to act out violently. As we’ll see, men also act out violently because these are the only socially sanctioned ways that they can express their emotion in a lot of cases.
Also because men and masculinity exist in relation and in reaction to femininity, men have to constantly be distancing themselves from feminine traits in order to gain respect from other men. That could mean that men don’t want to show any kind of emotion because emotion is tied to being a woman and being feminine. I’m not saying that it’s easier to be a woman, because obviously there’s a lot of negative connotations attached to being emotional. Oh, women are overemotional. Women are too emotional. They’re not rational. All of this stigma attached to it.

There’s also a negative side to not being able to express the emotion and still have the status of manhood. Here we come to the damage on men’s emotional system. This kind of hegemonic masculinity that I very briefly outlined is the kind that supports the view that violent behavior in men is a normal means of dealing with emotional pain.

**Sexual abuse of men**

“If you think it is difficult to raise funding for trauma, try male rape!”

MARTIN PELDERS, Founder of Matrix Men

In honour of that statement the subject was investigated on Martin Pelders’ behalf. What was discovered may have more of a profound impact on the conclusions of the discourse than female gender abuse!

*National Center for PTSD; Men and Sexual Trauma; US Department of Veterans Affairs*

‘There is a bias in our culture against viewing the sexual assault of boys and men as prevalent and abusive. Because of this bias, there is a belief that boys and men do not experience abuse and do not suffer from the same negative impact that girls and women do. However, research shows that at least 10% of boys and men are sexually assaulted and that boys and men can suffer profoundly from the experience. Because so few people have information about male sexual assault, men often suffer from a sense of being different, which can make it more difficult for men to seek help.’

‘At least 10% of men in our country have suffered from trauma as a result of sexual assault. Like women, men who experience sexual assault may suffer from depression, PTSD, and other emotional problems as a result. However, because men and women have different life experiences due to their different gender roles, emotional symptoms following trauma can look different in men than they do in women.’

*Brown University Health Male Survivors*

http://www.brown.edu/Student_Services/Health_Services/Health_Education/sexual_assault_&_dating_violence/male_survivors.php

‘Many people don’t take sexual assault of men seriously. This is one of the reasons why men have a difficult time reporting what happened and why the rates of male sexual assault are thought to be significantly underreported. If a male survivor’s friends think that male sexual assault is a joke, he will feel isolated and afraid to tell anyone. Sexual assault is a painful, traumatic experience for any victim.’

‘Many people believe that sexual assault is only committed by men against women. The majority of sexual assaults are perpetrated by men, but the fact is that 1 out of every 10 men is sexually assaulted. Victimization can also include childhood sexual abuse … Because our society fails to see that men can be sexually assaulted, men often have a difficult time accepting their own victimization and delay seeking help and support.’

“RESULTS:

Contact CSA (Childhood Sexual Abuse) was reported by 16% of males and 25% of females. Men reported female perpetration of CSA nearly 40% of the time, and women reported female perpetration of CSA 6% of the time. CSA significantly increased the risk of the outcomes. The magnitude of the increase was similar for men and women. For example, compared to reporting no sexual abuse, a history of suicide attempt was more than twice as likely among both men and women who experienced CSA (p<0.05). Compared with those who did not report CSA, men and women exposed to CSA were at a 40% increased risk of marrying an alcoholic, and a 40% to 50% increased risk of reporting current problems with their marriage (p<0.05).

CONCLUSIONS:

In this cohort of adult HMO members, experiencing CSA was common among both men and women. The long-term impact of CSA on multiple health and social problems was similar for both men and women. These findings strongly indicate that boys and girls are vulnerable to this form of childhood maltreatment; the similarity in the likelihood for multiple behavioral, mental, and social outcomes among men and women suggests the need to identify and treat all adults affected by CSA.”

Yet it’s not just a case of Childhood Sexual Abuse. Female on Male rape is a reality.

So, yes, I’ve suffered my share of victim-blaming. Just like a woman in my situation, my entire sexual history was called into question, and just like a woman, my sexual history is irrelevant -- I could’ve banged every girl in the county, it doesn’t mean I can’t ever say no. My relationship with my girlfriend fell apart pretty soon afterward, partially because, for a long time, she didn’t really believe I’d been raped either, treating it as if I’d cheated on her. I’d also completely lost interest in sex, turning to porn to regain the control over the sexuality I felt I’d lost”. Anon.

Amanda Mannen; 5 Bizarre Realities of Being a Man Who Was Raped by a Woman By Anonymous. Cracked
http://www.cracked.com/personal-experiences-1666-5-awful-realities-being-man-who-was-raped-by-woman.html
January 30, 2015

From the UK:

Martin Daubney; Why doesn’t society care about male rape? The Telegraph; August, 13; 2015.
‘Police crime figures for 2014 in England & Wales show there were 38,134 incidents of rape or sexual assault of a woman and 3,580 against men. Yet due to the shame and stigma surrounding perhaps the darkest male taboo of all, Survivors UK believe only 2-3 per cent of men report their rapes (official figures for women are 10-12 per cent reporting) meaning many thousands of men are suffering in silence. Furthermore, there are an estimated 1.5 million adult male survivors of childhood sexual abuse in the UK – abuse against boys accounts for around 70 per cent of cases.’

From the USA:

Hanna Rosin; When Men Are Raped A new study reveals that men are often the victims of sexual assault, and women are often the perpetrators. DOUBLEX: What Women Really Think About News, Politics, And Culture.
http://www.slate.com/articles/double_x/doublex/2014/04/male_rape_in_america_a_new_study_reveals_that_men_are_sexually_assaulted.html

‘Last year the National Crime Victimization Survey turned up a remarkable statistic. In asking 40,000 households about rape and sexual violence, the survey uncovered that 38 percent of incidents were against men. The number seemed so high that it prompted researcher Lara Stemple to call the Bureau of Justice Statistics to see if it maybe it had made a mistake, or changed its terminology. After all, in years past men had accounted for somewhere between 5 and 14 percent of rape and sexual violence victims. But no, it wasn’t a mistake, officials told her, although they couldn’t explain the rise beyond guessing that maybe it had something to do with the publicity surrounding former football coach Jerry Sandusky and the Penn State sex abuse scandal.’

‘The experience of men and women is “a lot closer than any of us would expect,” she (Lara Stemple) says. For some kinds of victimization, men and women have roughly equal experiences. Stemple concluded that we need to “completely rethink our assumptions about sexual victimization,” and especially our fall-back model that men are always the perpetrators and women the victims.'
One of those surveys is the 2010 National Intimate Partner and Sexual Violence Survey, for which the Centers for Disease Control invented a category of sexual violence called “being made to penetrate.” This definition includes victims who were forced to penetrate someone else with their own body parts, either by physical force or coercion, or when the victim was drunk or high or otherwise unable to consent. When those cases were taken into account, the rates of non-consensual sexual contact basically equalized, with 1.270 million women and 1.267 million men claiming to be victims of sexual violence.’

Amanda Mannen; 5 Bizarre Realities of Being a Man Who Was Raped by a Woman By Anonymous, Cracked

Most of us realize in theory that men can be raped by women as well, but it’s just not seen as that big of a problem. Unless the victim is a child, female-on-male rape is considered so absurd that the only time we really see it is when it’s being portrayed as a carousel of slapstick wackiness in mainstream comedies.

‘It’s easy to see why people think of female-on-male rape as thoroughly bizarre -- historically, the data has shown that men don’t get raped, period. As recently as 2003, men accounted for only 10 percent of sexual-assault victims, and it’s so widely assumed that all of the attackers were other men (think: prison) that most studies on the subject don’t even include that data. However, more recent studies have produced some revealing numbers -- a 2012 survey of 40,000 households found that a staggering 38 percent of the sexual assault victims were male. Nearly half of those men reported that their attacker was a woman.’

The following is not a movie script:

“She pulled out a small kitchen knife and placed it against his throat, this is when he felt terrified. Trying not to choke up he let out a fake laugh and said "that’s funny, but I really have to" and then she cut him off by saying "no, you’re not going anywhere you filthy piece of s**t, you’re going to be my toy for a little bit". As soon as he put his arms up to fight her off she dug the knife into his neck and drew blood, so he backed down. Pulling his pants off she started licking his penis, he said to me "it’s difficult for you to understand, I was terrified, completely un-aroused, and yet I still got an erection; it was like my penis didn’t know what was happening, I tried not to cry". Anon


So why are men suddenly showing up as victims? Every comedian has a prison rape joke and prosecutions of sexual crimes against men are still rare. But gender norms are shaking loose in a way that allows men to identify themselves—if the survey is sensitive and specific enough—as vulnerable. A recent analysis of BJS data, for example, turned up that 46 percent of male victims reported a female perpetrator.

It’s probably because men are so afraid of being victimised they would not even answer anonymous questionnaires honestly.

(...it took researchers years to even think to ask men this question, by the way). But they eventually figured out that if you rephrase the question and ask whether or not he has been "made to penetrate" another person, they're more likely to respond in the affirmative.

And it’s not just a matter of sex. In a study of ‘Intergenerational Transmission of Intimate Partner Violence’, Denise Hines and Kimberly Saudino of Boston University had the following to say:

Amanda Mannen; 5 Bizarre Realities of Being a Man Who Was Raped by a Woman By Anonymous, Cracked

Several studies have also shown that there is no difference in the amount of violence in a married relationship versus the amount of violence in a dating relationship, and cohabitating couples have the highest rate of violence (e.g., Stets &Straus, 1990). Therefore, it is not just spousal abuse that we should be concerned about; violence tends to occur without discrimination in all types of intimate relationships.

In addition, males and females are both the perpetrators and victims of this violence. Males and females commit violence at approximately the same rate within their relationships (e.g., Archer, 2000; Hines & Malley-Morrison, 2001 2001a OR 2001b?; O’Leary et al., 1989; Straus & Gelles, 1990), and female-perpetrated violence cannot always
be dismissed as self-defence. In one study (Straus & Gelles, 1988), both males and females were equally likely to strike the first blow in cases of spousal abuse.

**Men and Inter Partner Violence (IPV)**

The ManKind Project , UK

*Mark Brooks and Nicholas Bradley, Male Victims of Domestic and Partner Abuse 30 key facts; the ManKind Initiative (April 2015)*

(1) 14.7% of men state they have been a victim of domestic abuse since they were 16 (28.3% women). For every three victims of domestic abuse, two will be female, one will be male. These figures are the equivalent of 4.6 million female victims and 2.4 million male victims.

(2) 8.5% of women and 4.5% of men were estimated to have experienced domestic abuse in 2013/14, equivalent to an estimated 1.39 million female victims and 737,000 male victims. For every three victims of domestic abuse, two will be female, one will be male."

**Could the 2013/14 figures possibly indicate an emerging trend?**

*Mark Brooks and Nicholas Bradley, Male Victims of Domestic and Partner Abuse 30 key facts; the ManKind Initiative (April 2015)*

Younger people are more likely to be a victim of domestic and partner abuse than those in older age groups. In 2013/14, 7.5% of men aged 16-19 were victims of domestic abuse and 3.4% were victims of partner abuse. The figures were 13.1% and 8.2% for women respectively. For male 20-24 year olds, the figures were 6.5% and 3.6% for domestic and partner abuse - and for women they were 10.1% and 7.1% respectively. It shows that amongst those under 25, roughly for every three victims, two will be female and one will be male.

**So, in terms of trauma, how does male abuse play out? From the American Psychological Association:**

*American Psychological Association Male Victims of 'Intimate Terrorism' Can Experience Damaging Psychological Effects; April 7, 2011*

WASHINGTON—Men who are abused by their female partners can suffer significant psychological trauma, such as post-traumatic stress disorder, depression and suicidal thoughts, according to two new papers published by the American Psychological Association.

Although most reported domestic abuse is committed by men against women, a growing body of research has picked up on the prevalence and significance of domestic violence perpetrated against men, says research published in the April issue of *Psychology of Men & Masculinity.* “Given the stigma surrounding this issue and the increased vulnerability of men in these abusive relationships, we as mental health experts should not ignore the need for more services for these men,” said British researcher Anna Randle, PsyD, lead author of a paper summarizing two decades of research into domestic violence effects on men.


This is the first study to show that PTSD is a major concern among men who sustain partner violence and seek help...


Multidimensional Treatment Foster Care The purpose of this review was to examine the evidence on male experiences of IPV. Several studies have reported that men experience significant psychological symptoms as a result of IPV. In particular, associations have been found between IPV and PTS (Dansky et al., 1999; Hines, 2007; Hines et al., 2007), depression (Cascard & O'Leary, 1992), and suicidal ideation (Chan et al., 2008). Research into the specific effects of IPV on male victims is, however, in its infancy. To date, the literature has focused on prevalence and outcome studies. Significantly, with the increase of research from the family violence perspective, the understanding of IPV has displayed a cultural shift and a growing acceptance that men and women may be both perpetrators and victims of IPV.
Our study, the first to investigate the associations among PTSD and IPV victimization among a clinical sample of men, provides strong initial evidence that PTSD is a major concern among men who sustain IPV and seek help. In addition, by comparing levels of PTSD and its associations with other key variables, we were able to provide some support to the theory that such associations would be different when researchers study clinical versus convenience samples of men.

Nonetheless, our findings that there is an additive influence of childhood and adult experiences of intrafamilial aggression on PTSD symptoms in this helpseeking sample are informative and provide tentative treatment implications. First, it is important for any treatment provider who encounters a man who discloses physical IPV and controlling behaviours against him by his partner to acknowledge that this man likely has been traumatized. This is an important first step, because previous research on this sample showed that not only did men experience more negative than positive experiences with treatment providers, but every time a man in our helpseeking sample experienced a negative response from a treatment provider, his odds of exceeding the clinical cut-off for PTSD increased significantly (Douglas & Hines, provisionally accepted).

So are we missing A VERY BIG TRICK in South Africa? If men are more likely to be trauma affected due to their bottling up of the assault then how might they be manifesting their frustration?

### SAMSOSA South African Male Survivors of Sexual Abuse VOL 2: JULY 2013

### “The Impact Sexual Abuse Has On Men

‘Anyone who has been sexually abused will react in a certain way and experience lasting effects and shifting emotions. Like women, men are also likely to experience post-traumatic stress disorder (PTSD), depression and an array of emotions, yet due to gender socialisation and upbringing men find it a lot more difficult to come to terms with what they are facing.

Some unique reactions affecting men following a sexual assault may include more aggression and hostility than fear and tearfulness. They are likely to begin questioning their sexual identity or orientation and may downplay the severity of the experience, making it seem as if the sexual abuse had no importance or traumatic value. They could act out or express emotion through sexual nuances or hints.’

‘The rape and sexual abuse of both adult and young men around the world has been so greatly ignored, disrespected and discounted for, that it has created a major misconception in many that such an occurrence does not exist. Many services currently available are solely focused on meeting the needs of female victims who have been abused and sexually assaulted, marginalising men. The vast majority of male rape and abuse victims will never report their trauma due to a lack of awareness and misconceptions of male sexual abuse as well as the current lack of support services available, instead they choose to suffer its effects alone and in silence.’

### ‘Myth: Boys and Men Can’t Become Victims of Sexual Abuse.
Boys and men can, and do become victims of sexual abuse and violence. Male sexual abuse is a serious crime that affects 1 in 6 men all over the world.

### Myth: You Will Become Gay or Bisexual after Being Sexually Abused.
In no way is an act of sexual abuse related to your sexual orientation and your choices.

### Myth: Men Can Deal With Sexual Abuse Better Than Women.
Males may be even more damaged by society’s rejection and reluctance to accept their victimization. The belief that men are strong and emotionless has created a trend for men to put up with their abuse alone and in silence.

### Myth: It Was Your Fault If You Were Sexually Abused.
Being sexually abused is never your fault! For no reason should you ever blame yourself for what happened. The only way for a rape or sexual violation to occur is if there is a sexual criminal or rapist present. They are responsible for everything and are the ones to blame.’

The ISCPS also goes on to discuss the male gender and how this plays out in the cycle of violence...
‘Crime and violence are perpetuated in two kinds of cycles. The first cycle is the most immediate and obvious demonstration, for example, when someone is provoked, they react with violence. Boys are often socialised from an early age to use violence as a strategy to deal with victimisation and by the time they become men, it is often ingrained and habitual (Simpson 1996; Du Plessis 2001).’

Gordon R. Hodas MD Statewide Child Psychiatric Consultant, Pennsylvania Office of Mental Health and Substance Abuse Services; 
RESPONDING TO CHILDHOOD TRAUMA: THE PROMISE AND PRACTICE OF TRAUMA INFORMED CARE; February 2006

‘It is recognized that females tend to develop internalizing symptoms and become passive, while males tend to externalize and turn to activity and aggression (Schwartz and Perry, 1994). At the physiological level, females tend to use dissociation and the surrender response pattern as their primary defense, while males tend to use an active emergency response (the flight-and-fight response) and become hyper-aroused (Perry et al, 1996).

Nevertheless, there are exceptions to the above generalization. For example, young children, including males, subjected to maltreatment may preferentially use dissociation, which is adaptive given their relative powerlessness in the presence of an offending adult. In addition, females may develop externalizing behaviors in addition to their internalizing symptoms. The increasing number of females with a history of trauma who are arrested and enter the juvenile justice system (in 1997, 26% of juvenile arrests were females) reflects the vulnerability of many females to develop externalizing behaviors, including drug and alcohol abuse, as they get older (Hennessey, 2004).

The social consequences of trauma typically increase as abused, symptomatic individuals, particularly women, enter adulthood. This exacerbation of symptoms and maladjustment potentially affect the quality of life of these women as well as that of their own children. It is the latter reality that perpetuates poor quality of life for females and inter-generational cycles of trauma.’

**LGBT**


‘Stigma and discrimination on the basis of sexual orientation have an impact on the mental health of lesbian, gay, bisexual, two-spirited, trans-gendered, and trans-sexual (LGBT) people. Sexual and physical assault are also risk factors, as is bullying for youth. Risks for LGBT youth can be reduced by an accepting family and connection with other LGBT youth. Older people may be particularly reluctant to access mental health services because of past negative experiences with the service system, including prejudice, discrimination and lack of knowledge.

Stereotypes of all kinds can have an impact on the way LGBT people living with mental health problems and illnesses are treated both within the mental health system and within the LGBT community. On the one hand, mental health service providers must be mindful not to stereotype or discriminate against LGBT people because of their sexual orientation, and also to recognize the impact that discrimination and stigma can have on an LGBT person’s mental health. People who provide mental health services, treatments and supports to the LGBT community need to have a positive attitude and to be knowledgeable about the needs of people from these communities, while at the same time not making global assumptions that can obscure differences among the individual people whom they serve.’
Trauma and Violence

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

'Democratic South Africa is struggling with social dynamics that facilitate violence (Seedat, Van Niekerk, Jewkes, Suffla, Ratele, 2009)....

'Within these communities people tend to have numerous experiences of criminal, community, gang and family violence as children, and later as adults. Not only have people grown up within these contexts, but after an experience of violence, they must also recover within an environment of threat. In describing trauma in one such neighbourhood Dinan, McCall & Gibson (2004: 739) reflect: “Certainly, trauma exposure in Lavender Hill/ Vrygrond is multiple and ongoing rather than single and discrete”. These conditions differ markedly from the trauma experiences in those economically developed countries from which mainstream trauma theories and interventions have emerged.’

‘Building on the arguments of Herman, Hess and Gold, ():
"If we are to truly understand trauma and its impact on the lives of victims of violence, we must begin to understand trauma as a complex issue of multiple traumatic experiences, where the single incident is only a major traumatic event along a continuum of traumatic experience within the lives of victims of violence" (2005: 471)


‘It is commonly believed that violence begets violence (Widom & Maxfield, 2001). These cycles of violence occur when individuals or groups become trapped in a circular process that perpetuates violence or leads to the repetition of violent acts.’

‘The relationship between trauma and violence does not only take place at an individual level but can be conceptualised at individual, interpersonal and community levels. Violence is complex and multidimensional. In terms of how violence is defined, the WHO provides an understanding that violence does not necessarily only result in injury or death, but that the effects of all forms of violence have an adverse biopsychosocial impact on individuals, families, communities and health care systems all over the world.’

‘In addition, socio-economic factors such as unemployment, over-crowded housing, lack of recreational activities, high drop-out rates from school, substance abuse and gangsterism all contribute to the momentum of the cycle of violence. A young child born into an environment of cyclical violence, experiences the impact of continuous trauma, and consequently, easily becomes the newest generation to suffer the effects of abuse, neglect and trauma. Thus, developing a further pattern of complex trauma and increasing the likelihood of becoming a future perpetrator.’

‘Violence and injuries are the second leading cause of death in South Africa. The injury death rate is almost double the global average and almost half of deaths are due to interpersonal violence. Approximately 16 000 road traffic accidents are responsible for deaths each year. Gender-based violence is high, with the female homicide rate six times the global average and 28% of men admitting to have raped someone. Violence and injury may be exacerbated by high levels of poverty and unemployment, and images of masculinity embracing toughness and defence of honour, alcohol and drug abuse, and the widespread availability of firearms.’


‘Criminal violence: An ongoing traumatising environment. Despite the demise of apartheid and the advent of democracy, PTSD remains a significant public health concern. Not only are there those suffering from chronic PTSD as a result of past violence and human rights abuses, but rates of domestic and criminal violence in South Africa are high.’

‘Rates of rape and indecent assault in South Africa are particularly high, and it is widely recognised that the actual figure may be two or three times higher since sex crimes are often not reported.’
The Psychological Effects of Violence

New Republic. The Science of Suffering Kids are inheriting their parents’ trauma. Can science stop it? With Rachel Yehuda (Director of the Mental Health Patient Care Clinic at the Peters Medical Center, and a professor of psychiatry and neuroscience at the Icahn School of Medicine at Mount Sinai Hospital.) Nov 16 2014; Judith Shulewitz. Senior Editor

There is biological PTSD, and familial PTSD, and cultural PTSD. Each wreaks damage in its own way. There are medicines and psychotherapies and the consolations of religion and literature, but the traumatized will never stop bequeathing anguish until groups stop waging war on other groups and leaving members of their own to rot in the kind of poverty and absence of care that fosters savagery. All that, of course, is improbable. The more we know about trauma, though, the more tragic that improbability becomes.

Bruce D. Perry, M.D., Ph.D.; INCUBATED IN TERROR: Neurodevelopmental Factors in the ‘Cycle of Violence’; The ChildTrauma Academy

"Children are not resilient, children are malleable."

RESILIENT
1. Marked by the ability to recover readily, as from misfortune.
2. Capable of returning to an original shape or position, as after having been compressed.

MALLEABLE
1. Capable of being shaped or formed, as by hammering or pressure: a malleable metal.
2. Easily controlled or influenced; tractable.
3. Able to adjust to changing circumstances; adaptable.

‘In order to understand the origins and impact of interpersonal violence, it is essential to appreciate how violence alters the developing child. The child and the adult reflect the world they are raised in. And, sadly, in today's world, millions of children are raised in unpredictable and violent settings -- incubated in terror.’

‘Violence is heterogeneous -- in etiology, quality, quantity and impact on its victims. Physical violence can be the result of impulsive, reactive behavior or predatory, remorseless aggression. Physical violence can be related to intoxication from alcohol or from psychosis or from other neuropsychiatric conditions (e.g., dementia, traumatic head injury) . Physical violence may be the result of personal (Oklahoma City bombing) or a cultural (political terrorism) belief system. Physical violence can be sexualized (rape) or directed at a specific victim (domestic violence) or at a specific group (e.g., African-Americans, homosexuals, Jews). Violence may be physical or emotional. Indeed, some of the most destructive violence does not break bones, it breaks minds (Vachss, 1994). Emotional violence does not result in the death of the body, it results in death of the soul.’

‘All violent behavior impacts the children in its wake. There is heterogeneity of impact, however. Important factors in the differential impact on the developing child include the type of violence, the pattern of violence, the presence (or absence) of supportive adult caretakers and other support systems, and, of key importance, the age of the child. Under all circumstances, however, the organ which allows the child victim to adapt to a violent trauma is the brain -- just as the brain is the organ that is the origin for the violent behaviors of the victimizer.’

‘The structural organization and functional capabilities of the mature brain develop throughout life, with the vast majority of the critical structural organization taking place in childhood. Brain development is characterized by 1) sequential development and 'sensitivity' -- from the brainstem to the cortex -- and 2) 'use-dependent' organization of these various brain areas. Essential to understanding the neurobiology of violence is that the brain’s impulse-mediating capacity is related to the ratio between the excitation of the lower, more-primitive portions of the brain and the modulating activity of higher, sub-cortical and cortical areas (Figure 3). Any factors which increase the activity or reactivity of the brainstem (e.g., chronic traumatic stress) or decrease the moderating capacity of the limbic or cortical areas (e.g., neglect, EtOH) will increase an individual’s aggressivity, impulsivity and capacity to be violent (see below). A key neurodevelopmental factor which plays a major role in determining this moderating capacity is the brain’s amazing capacity to organize and change in a 'use-dependent' fashion.’
FIGURE 6. The Persisting Fear Response: Developmental Trauma. A child raised in an environment characterized by persisting trauma (e.g., domestic violence, physical abuse, community violence) will develop an excessively active and reactive stress-response apparatus. The majority of the stress response systems reside in the brainstem and midbrain (e.g., locus coeruleus). Overdevelopment of these areas, even in the presence of optimal emotional or cognitive experience will result in an altered Cortical Modulation ratio and, a predisposition to act in an aggressive, impulsive, behaviorally reactive fashion.

FIGURE 7. Neglect and Trauma: The Malignant Combination. Developmental neglect or traumatic stress during childhood can profoundly alter development. Unfortunately, emotional and cognitive neglect usually occur in combination with traumatic stress. The combination of a lack of critical emotional experiences and persisting traumatic stress leads to a dramatic alteration in the brain's modulation and regulation capacity. This is characterized by an overdevelopment of brainstem and midbrain neurophysiology and functions (e.g., anxiety, impulsivity, poor affect regulation, motor hyperactivity) and an underdevelopment of limbic and cortical
neurophysiology and functions (e.g., empathy, problem solving skills). This experience-based imbalance predisposes to a host of neuropsychiatric problems -- and, violent behavior.

Figure 9. Malignant Combination of Experience: Neurodevelopmental experiences of trauma or neglect alter a variety of brain areas and functions important in predisposing to violence. Depending upon the time in development, the nature and extent of the abuse and the presence of attenuating factors, the developing brain will be impacted differentially. These experiences may occur in utero or in the perinatal period, impacting the brainstem and resulting in symptoms of anxiety. Experiences in the perinatal and first few years of life can impact the midbrain resulting in impulsive and aggressive symptoms. Trauma and neglect during infancy and childhood can impact the sub-cortical and limbic areas, resulting in dysthymic, depressed or unattached individuals. Finally, experiences throughout childhood can impact the development of cognitive capabilities resulting in processing and problems solving styles which predispose to violent solutions. Ultimately, however, being anxious or impulsive or depressed or unattached or cognitively impaired do not alone lead to violence. It is a malignant combination of one or more of these vulnerabilities in concert with a facilitating or encouraging belief system that leads to violent behaviors.

National Association of State Mental Health Program Directors; Shining the Light on Trauma-informed Care; Breaking the Silence Trauma-informed Behavioral Healthcare

‘The psychological effects of violence and trauma are pervasive and highly disabling, yet largely ignored. Responding to the behavioral healthcare needs of all trauma survivors across the lifespan is crucial to treatment and recovery and should be a priority of state mental health programs; the prevention of traumatic experiences is a fundamental value held by state mental health authorities. Toward this goal, it is important to implement trauma-informed systems and trauma-specific services in mental health systems and settings. The experience of violence and trauma can cause neurological damage and can result in serious negative consequences for an individual’s health, mental health, self-esteem, potential for substances use, and involvement with the criminal justice system. Indeed, trauma survivors can be among the people least well served by the mental health system as they are sometimes referred to as “difficult to treat”— they often have co-occurring mental health and substance use disorders, can be suicidal or self-injuring, and are frequent users of emergency and inpatient services.’

‘Trauma crosses service systems and requires specialized knowledge, staff training, and collaboration among policymakers, providers, and survivors.’


According to current literature, beliefs, expectations and assumptions about the world play a pivotal role in determining the effects of victimisation (McCann & Pearlman, 1990). Janoff-Bulman (1985) asserts that the
experience of trauma shatters three basic, healthy assumptions about the self and the world. These are: the belief in personal invulnerability ("it won't happen to me"); the view of the self as positive; and the belief that the world is a meaningful and orderly place, and that events happen for a reason. Violence, or trauma that is inflicted by a fellow human being, shatters a fourth belief: the trust that other human beings are fundamentally benign. These four assumptions allow people to function effectively in the world and to relate to others. After an experience of violence, the individual is left feeling vulnerable, helpless, and out of control in a world that is no longer predictable.

There is always a significant subjective component in an individual's response to a traumatic event. This can be seen most clearly in disasters where although a broad cross-section of the population is exposed to objectively the same traumatic experience, individual psychological reactions are markedly different. Some of these individual differences in susceptibility may stem from pre-existing social, cultural and psychological factors. The individual's reaction is as much about the actual traumatic incident as it is about their pre-traumatic personality structure and their available personal resources, coping strategies and extended support structure.

It is also important not to adhere to a static view of victimisation. An individual can assume multiple roles over a period of time. For example, a person may have been a victim, a perpetrator and a witness to violence across their life time. When considering the emotional response to a trauma, all of these factors need to be considered. Furthermore, traumas are not always isolated and can extend over a period of time. For example, surviving torture or prolonged incarceration during a hostage drama. Often, individuals may be exposed to multiple traumas simultaneously. In one incident an individual may be traumatically wounded, while at the same time witness another person being killed. Other individuals live in a state of continuous trauma, for example, in a war situation.

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

I concluded that, if you carry a memory of having felt safe with somebody long ago, the traces of that earlier affection can be reactivated in attuned relationships when you are an adult, whether these occur in daily life or in good therapy. However, if you lack the deep memory of feeling loved and safe, the receptors in the brain that respond to human kindness may simply fail to develop. If that is the case, how can people learn to calm themselves down and feel grounded in their bodies?

Violence and Trauma – A South African Context

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

‘Variation in the rates of trauma exposure across the world, as well as the prevalence of specific traumatic events, appears to reflect historical, cultural, and political factors that vary across regions. For example, South Africa's history of state-sanctioned discrimination and political violence, coupled with rising rates of criminal assault in public spaces may contribute to the higher rates of trauma exposure compared to Europe and Japan.’

‘Although violence became a focus of research in the 1980s, South African history, from the time of colonisation, has always been characterised by violence.

Violent crime and trauma are currently normative within South African society. Many commentators have come to refer to South Africa as a "culture of violence" - a society which endorses and accepts violence as an acceptable and legitimate means to resolve problems and achieve goals (Vogelman & Simpson, 1990).’


The injuries resulting from violence may be either physical or psychological. Often, however, psychological abuse is an aspect of the violation of the victim in physical violence, as is the case in torture and wife battery. Acts of violence include suicide or attempted suicide, as well as interpersonal crimes such as rape, domestic and child abuse, elder abuse, or assault (Foege, Rosenberg, & Mercy, 1995). Thus violence can be physical and/or psychological in nature, and there can be a further distinction between intentional and unintentional forms of violence.

South Africans still remain exposed to high levels of differing forms of violent crime, including public violence, rape, hijacking of cars, aggravated assault, aggravated robbery and murder. Some victims of violence subsequently also
seem to be committing violent acts themselves. Their actions are often associated with vigilantism and self-administered "justice". Increasing reports of this type of action against suspected criminals have been reported (Weekly Mail, 1997) and there is a likelihood of an increased trend of citizens taking law into their own hands. Increasingly perhaps, summary justice appears quicker and more effective (Shaw, 1997) and there is a lack of faith in the criminal justice system. Morris (1987) asserts that victims of criminal violence, if untreated, are at risk for perpetrating acts of rettributive violence, or for displacing their aggression within the familial context.

Although the more public forms of criminal and political violence have been discussed here, and generally receive the majority of focus in the media, this should not overshadow the numerous other forms of violence, in particular, intentional violence committed in the home. This includes child abuse, wife battery, domestic assaults and acquaintance rape. These "hidden" forms of violence, which are generally targeted towards women and children and the other more vulnerable sectors of society, affect more people than the types of violent crime documented above. Wife battery and child abuse are frequent occurrences in South Africa, although few reliable statistics are available. Many researchers are of the opinion that the incidence is widespread (Welch, 1987; Segel & Labe, 1990). A report by the Institute for Security Studies (1996) comments on the lack of adequate documentation of acts of violence against women and children:

In addition, many South Africans are subject to structural forms of violence. Structural violence refers to unequal power relationships and manifests in unequal life chances. In its most basic form, the systematic deprivation and racism underpinning apartheid can be seen as a form of structural violence. Structural violence also results in other types of violence. In the past this has been evident in explicit state violence (for example, forced removals and the persecution of those opposed to state structures and policies). The devastating impact of structural forms of violence on mental health should also not be ignored. The psychological consequences of deprivation are endless. These include the mental and physical developmental impact of poor nutrition on children and the anxiety, depression and stress-related conditions caused by poor living conditions and occupational circumstances.

While large scale political conflict and criminal violence and particular brutal acts of violence tend to receive attention, the more micro-effects of violence that ripple through communities may go unnoticed. For example, violent intra-community conflict can cause the destruction of the social fabric and culture of communities, and disrupt schooling, resulting in incremental disadvantage over time. These different types of violence affect both individuals and society as a whole.


‘...the South African Stress and Health Study (Kaminer et al 2008) indicated that 38% of the sample representing the South African population had been exposed to violence, with men most commonly experiencing criminal and miscellaneous assault and women most frequently experiencing intimate partner violence, childhood physical abuse and criminal assault.

In order to proactively break the cycle of crime and violence, government departments and the civil society are expected to make provision of a range of services and programmes to vulnerable and targeted groups. The underlying rationale is to make primary, secondary and tertiary prevention accessible and responsive to individual, families and communities that are at risk and already involved in violent and criminal activities.

Dawes (2007) names three types of violence that children are exposed to. These include structural, political and interpersonal violence. Structural violence relates to a situation where the political and economic system excludes people from full participation in society, either by law or by the nature of the economic system. The implication for children is that the “survival, development, protection and opportunities of the poor child are likely to be severely compromised, particularly when there are inadequate welfare provisions”. The child support grant and free nutrition programmes in South Africa offset some of these implications, although more demands have been made on the DSD.

Research and literature on domestic violence acknowledge that, although to a lesser degree, women do play some role as perpetrators of domestic violence. The deadly nature of domestic violence becomes even more glaring when considered alongside the HIV/AIDS pandemic.
In addition, the proliferation of legal and illegal firearms in the country contributes greatly to the overall level of violence and the level of destruction it causes. Domestic violence contributes to the normalisation of violence. Disturbingly, violence in the South African context is widely viewed as an acceptable and valid means of self assertion, and obtaining cooperation, respect and compliance from others.’

6.12 Schooling
School is the place where children spend up to two thirds of their waking hours. It is one of the two most significant spheres of influence in the developmental pathways of children. Safe schools contribute to the development of positive social skills, healthy relationships among peers, and between children and adults, sound educational outcomes, positive self esteem, and a sense of identity and attachment.

Yet many schools are not safe places. Violence in schools can take many forms. Most commonly, violence refers to incidents of physical violence (often high-profile) that make it onto the radar of authorities, parents and the media (Burton 2008b). In reality, however, violence is comprised of a range of dimensions, such as physical violence (including corporal punishment); sexual abuse; sexual violence; neglect; verbal and emotional abuse; bullying; peer-to-peer, educator-to-peer or learner-to-educator violence; youth gangs; the use of weapons; harassment; stigmatisation, or any of the above on the way or from school. Much of the attention is focused on higher profile incidents involving weapons, which result in hospitalisation or some form of medical treatment.

Within violent and hostile external environments, schools can also serve as a refuge and a place of safety for children. Conversely, the school can serve as an environment where negative behaviour is learnt, condoned and perpetuated. This includes violent behaviour, bullying (both psychological and physical), drug and alcohol use, and fear and distrust. School violence has two levels of impact. The first level is the direct impact on the psychological, physical and developmental well-being of the child. Exposure to direct and secondary victimisation to violence has a number of negative consequences on most children. These can include depression, poor self-esteem, disturbed eating patterns, lack of concentration, anxiety, sadness, feelings of isolation, fear, feeling humiliated by their experience, and/or developing an aversion to school (South African Human Rights Commission 2007).’
Interrupting the Cycle of Intergenerational Trauma and Violence

THRIVE; Maine’s Trauma-informed System of Care; Final Evaluation Report; Prepared by Hornby Zeller Associates, Inc.

‘In light of mounting evidence about the impact of trauma, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) recognized violent trauma as a root cause of pervasive, harmful and costly public health problems in January 2010. SAMHSA has begun a strategic initiative to reduce the behavioral health impacts of violence by integrating trauma-informed services with prevention and treatment program.’

Psychotherapeutic Work with Intergenerational Trauma - Confer – Seminars, conferences and online resources for psychotherapists

Clinical Psychologist, Dr Pamela Alexander - Interrupting intergenerational cycles of trauma and violence - The parent-child attachment relationship can either exacerbate or mitigate the effects of a history of maltreatment on intergenerational cycles of violence. We will see that intimate partner violence both results from a history of child maltreatment and contributes to these intergenerational cycles through the impact on the child’s ability to regulate emotions and through internal working models of self and other.

Angela BeiBei Bao; Preventing Intergenerational Transmission of Domestic Violence; The Social Worker Web Exclusive;

Breaking the Cycle - Through individual and group therapy, the Violence Intervention Program—and a few other programs in New York—not only aims to help children work through trauma with therapy. They are also looking to “break the cycle”—stop the generational repetition that often comes with victims of domestic abuse.

Cynthia C. Wesley-Esquimaux; The Intergenerational Transmission of Historic Trauma And Grief; Indigenous Affairs; 4/07;
For indigenous people, self-actualization means one simple thing: to become everything that they are capable of becoming. In this regard, and certainly within the last fifty years, First Nations peoples have been witnessing a revival of indigenous strength and determination across Canada. The impetus behind this revival takes many forms:

- the restoration of traditional systems of belief and practice,
- the resurgence and reclamation of languages,
- the growth of a First Nation sense of national identity and the growing (re/de) construction of indigenous peoples’ history by their own scholars.

Judy Atkinson, Jeff Nelson and Caroline Atkinson; Trauma, Transgenerational Transfer and Effects on Community Wellbeing;

“We-Al-Li: A successful community-based program

Achieving sustained positive in-community change requires a substantial investment of resources, personnel and time, and many organisations cannot afford this investment. It is partly because of this demand that successful programs such as the Family Wellbeing Program (Tsey et al., in press) and the We-Al-Li Workshops (Atkinson & Ober, 1995) use the ‘train the trainer’ model to achieve and support community change over the longer term.

The We-Al-Li workshops provide opportunities for interested community members to pursue formal qualifications up to doctoral level through the Gnibi College of Indigenous Australian Peoples at Southern Cross University. The successful completion of the community based program (four units) allows its participants to graduate with an accredited Certificate of Community Recovery. The units offered in this course include Community Wellbeing, Indigenous Counselling, Trauma and Recovery, and Family Violence and Recovery. Completing these units allows participants to work through personal issues, to develop the skills necessary to initiate and support positive changes in the community, and to work with individuals as required.

Urban Society for Aboriginal Youth, YMCA Calgary and University of Calgary; Intervention to Address Intergenerational Trauma: Overcoming, Resisting and Preventing Structural Violence;

The primary recommendations established from the reviewed papers in the academic report were to:

- Integrate Aboriginal worldviews into interventions;
- Strengthen cultural identity as a healing tool;
- Build autonomous and self-determining Aboriginal healing organizations;
- To integrate existing, but isolated interventions into mainstream health services; and
- Involve mainstream professionals learning more about Aboriginal approaches to healing.

Nataly Woollett, Curbing the intergenerational transmission of trauma: outcomes of an intervention for child witnesses of domestic violence and their mothers SVRI Conference - Bangkok October 2013 - Powerpoint

‘One of the critical pathways through which the childhood home environment, particularly in early childhood, is understood to impact upon psychological development is through attachment to primary caregivers – John Bowlby & Attachment Theory; Jeremy Homes.’

‘Trauma Focused Cognitive Behavioural Therapy TF-CBT (documented as a best practice model for PTSD , Foa et al, 2009 ‘Effective Treatments for PTSD’).

- centres on psycho-education regarding trauma and its effects – teaching skills that improve affect modulation and stress management
- followed by cognitive processing interventions that challenge any distortions or false beliefs and aid in effective problem solving skills

Expressive Arts Therapies (incl. art, play, bibliotherapy, etc.)

“You can tell more about a person in an hour of play than in a year of conversation” – Plato

The study...

‘Measures before and after intervention with both children and mothers

Mothers: Child Behaviour Checklist (CBCL), Post Traumatic Stress Disorder-Reaction Index Parent Version (PTSD-RI)
Children: Children’s Depression Inventory (CDI), Post Traumatic Stress Disorder-Reaction Index Children’s Version (PTSD-RI).

- Almost 90% children met criteria for PTSD before group began; almost 70% children met criteria for depression before group began. (Findings were ‘surprising’ to mothers/worst events for trauma were different for mothers and children).
Significantly lowered scores were recorded after group treatment.

‘Outcomes:

Mothers reported improvement in parenting, increased ability to empathize with their children and understand “bad behaviours”.

Children report group helped them with: understanding their bodies, feelings and thoughts; managing their behaviours and their boundaries (understanding what ‘no’ means); realizing their strengths; respecting each other (and thus not hurting each other); having fun together; feeling a sense of belonging and of being understood.

(we) Can’t treat one part of the system without the other. If mothers know some tools to manage difficult behaviours/ emotions in their children, and they can see that these work, they will sustain what is learnt by children in groups and parenting becomes easier.

• When mothers and children understand behaviours that are driven by mental health problems such as PTSD and depression, they are more likely to engage in treatment.
• This understanding has additional benefit of leading to insight into the mother’s own behaviour and symptoms.
• Treatment of DV needs to be targeted at the parent-child dyad if symptom reduction is to be sustained and parenting practices improved.
• Evidence based interventions that focus directly on PTSD and depression in children and that include working with primary caregivers in terms of skills transfer and informed parenting strategies, particularly with regards to discipline and attachment, are needed to curb intergenerational transmission of trauma.’