Section 6. The Impact of Trauma

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

Reference: Brian Rogers. Trauma & Resilience-Informed Solutions Institute of Southern Africa – Proposal of a Trauma-Activist; PTG-RR; Sep 2015/6

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

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

The Impact of Trauma

1. Social Stress
2. Witnessing Trauma
3. Community
   ▪ Community Psychology
4. Culture
   ▪ Cultural Competence
   ▪ Historical Trauma
   ▪ Refugees
5. Socio-Cultural Impact of Trauma
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“... the narrative of distant trauma, which may be interpreted as an unwarranted transformation of the iconic (DSM) version of mental trauma, becomes valid. The phenomenon, that is invisible at the level of individual, becomes taken for granted (unquestioned) at the level of collective.”

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

There are times when researching this proposal that frustrations run very high. One wants to scream out - where have you been South African Psychologists and Psychiatrists? The evidence is staring you in the face. What holds you back? Why is it that every research proposal ends with “further research needs to be done” and not with “this is what we think should be done”? What holds you back from giving honest human strategic opinion?

Why is it that time and again one reads of so much infighting and power mongering? One faction bringing down another, then switches sides to lampoon a different theory. Why can’t you get out there and be competitive in the market place? Let the consumer decide in public forums whether you are right or wrong? Why do you hide behind
societies and ethics committees that are not answerable to the people of South Africa? Do you think you are above the basic rights of public accountable?

You have not succeeded in alleviating the incredible burden that stress and Trauma has loaded our communities and cultures with. And our Health resources and our Criminal Justice System! You have failed. You have not even tried to design a culturally relevant community Trauma relief programme, let alone implement one. Oh, you have been debating it since the 1980’s in your comparative way, but why have you not collectively tried something in the market place of human suffering?

For the last 20 years a revolution in Health Care has been taking place that puts Trauma at the forefront of Mental Health challenges. Before your very eyes, globally Behavioral Health and Trauma-Informed Care are being embraced, implemented, researched, measured, shared, communicated, invested in... yet you have not even debated these phenomena in your normal go-nowhere style? They simply are not on your agenda.

Despite the fact that you don’t hold yourselves accountable, this tragedy is your responsibility PsySSA and SASOP. Where is the leadership? The character? The courage? What are you waiting for - e’Freud? For you not to actively progress public discourse on these subjects and initiate co-operative solutions is morally indefensible.

(With apologies to all those who honestly go about helping others and lack the leadership and resources you so desperately require. Your honesty will set you apart. There is a great need among you, particularly the younger people who need this country to be the Eden it so definitely can be, to stand up and say – enough is enough. If you don’t, then you will be the architects of this countries demise. You will have to take the responsibility.)

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.

“Most companies have a vast reservoir of fresh thinkers all around them. But they refuse to utilise them because they refuse to cross-pollinate. They choose to believe that we are all not equal before the idea. They don’t understand that new perspectives can come from anywhere.”

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

Social Stress


Social stress is stress that results from relationships with others and a person's social environment. Social stress is often exacerbated when people have less capability of changing their own circumstances. Sources of social stress are multiple and can be generated in almost every area of life.

Susan K. Wood, Seema Bhatnagar; Resilience to the effects of social stress: Evidence from clinical and preclinical studies on the role of coping strategies; Neurobiology of Stress; http://www.journals.elsevier.com/neurobiology-of-stress/

The most common form of stress encountered by people stems from one’s social environment and is perceived as more intense than other types of stressors (Almeida, 2005). Socially stressful events such as bullying, loss of a loved one, and psychological abuse are well documented to contribute to psychopathology (Kendler et al., 1999; Kessler, 1997; Bjorkqvist, 2001). In fact, stress exposure is an independent risk factor for psychiatric disorders such as depression, anxiety and posttraumatic stress disorder (PTSD) (Kendler et al., 1999; Kessler, 1997; Javidi and Yadollahie, 2012). However the pathogenic potential of a stressor does not solely depend on the severity of the stress exposure as evidenced by the great individual variability in the consequences of exposure to stressful events.

It is generally considered that two coping response patterns are distinguishable in response to social stress (Koolhaas et al., 1999). One is considered the active (or proactive) response and is characterized by territorial aggression and control, as was originally described by Walter Cannon (Cannon,1915). The second category of stress coping response is defined as passive (or reactive) and is characterized by immobility and low levels of aggression (Engel and Schmale, 1972). These two coping strategies have distinct and opposing sets of behavioral characteristics (reviewed in Koolhaas et al. (1999)).
In addition to the distinct behavioral characteristics displayed by the active and passive coping strategies, these strategies are also characterized by differences in physiological and neuroendocrine endpoints (reviewed in Koolhaas et al. (1999)). Freezing, a characteristic behavior of passive coping, is accompanied by low plasma norepinephrine and high plasma corticosterone levels. Furthermore, passive coping is associated with high HPA axis reactivity (Korte et al., 1992). In contrast, active coping is distinguished by low HPA axis reactivity and high sympathetic reactivity to stressful situations (Fokkema et al., 1995). Based on these diverse physiological responses to stress in actively versus passively coping individuals, under conditions of chronic stress when the coping response is not adequate to mitigate the impact of stress on the body, negative stress-induced physiological and psychological consequences may ensue.


'Social stress is stress that stems from one's relationships with others and from the social environment in general. A person experiences stress when he or she does not have the ability or resources to cope when confronted with an external stimulus (stressor), or when they fear they do not have the ability or resources. An event which exceeds the ability to cope does not necessarily have to occur in order for one to experience stress, as the threat of such an event occurring can be sufficient. This can lead to emotional, behavioral, and physiological changes that can put one under greater risk for developing a mental disorder and physical illness.'

'Humans are social beings by nature, as they typically have a fundamental need and desire to maintain positive social relationships. Thus, they usually find maintaining positive social ties to be beneficial. Social relationships can offer nurturance, foster feelings of social inclusion, and lead to reproductive success. Anything that disrupts or threatens to disrupt their relationships with others can result in social stress. This can include low social status in society or in particular groups, giving a speech, interviewing with potential employers, caring for a child or spouse with a chronic illness, meeting new people at a party, the threat of or actual death of a loved one, divorce, and discrimination. Social stress can arise from one’s micro-environment (e.g., family ties) and macro-environment (e.g., hierarchical societal structure). Social stress is typically the most frequent type of stressor that people experience in their daily lives and affects people more intensely than other types of stressors.'

'Mental Health - Research has consistently demonstrated that social stress increases risk for developing negative mental health outcomes. One prospective study asked over fifteen hundred Finnish employees whether they had "considerable difficulties with [their] co-workers/superiors/inferiors during the last 6 months, 5 years, earlier, or never". Information on suicides, hospitalizations due to psychosis, suicidal behavior, alcohol intoxication, depressive symptoms, and medication for chronic psychiatric disorders was then gathered from the national registries of mortality and morbidity. Those who had experienced conflict in the workplace with co-workers or supervisors in the last five years were more likely to be diagnosed with a psychiatric condition.'

'Social stress occurring early in life can have psychopathological effects that develop or persist in adulthood. One longitudinal study found that children were more likely to have a psychiatric disorder (e.g. anxiety, depressive, disruptive, personality, and substance use disorders) in late adolescence and early adulthood when their parents showed more maladaptive child-rearing behaviors (e.g., loud arguments between parents, verbal abuse, difficulty controlling anger toward the child, lack of parental support or availability, and harsh punishment). Child temperament and parental psychiatric disorders did not explain this association. Other studies have documented the robust relationships between children’s social stress within the family environment and depression, aggression, antisocial behavior, anxiety, suicide, and hostile, oppositional, and delinquent behavior.'
**Witnessing Violence**

South Africans witness bloody violence daily. Children, who grow up in caring homes, are exposed to the effects of intergenerational traumatic violence as they make their way to school. Witnessing Trauma is now clearly the greatest passageway to the Traumatic epigenetic marker of the children of 2030.

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

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

The Department of Social Development Integrated Crime Prevention Strategy (ISCPS) introduces us the hazards of witnessing violence.


‘Violence is a part of daily life for many children who, from a very early age, are either directly victimised or abused or witness violence as a normal part of home or community life (Friedman 1998; Fraser-Moleketi 1998; Nel & Kruger 1999).’

‘Dawes (2007) also emphasises that in South Africa, thousands of children who had been exposed to political violence were not able to attend school because of the loss of their family members. Amidst this violence, children learned that violence was an approach to solving conflict. He argues that this type of exposure to violence is deeply disturbing to young children and that many children live in communities in South Africa where violence is endemic. One survey conducted in a poor area in Cape Town showed that 70% of 8-year olds had witnessed violence and 47% had been victims of assault.’

Lukoye Atwoli, Dan J Stein, David R Williams, Katie A Mclaughlin, Maria Petukhova, Ronald C Kessler and Karestan C Koenen Trauma and posttraumatic stress disorder in South Africa: analysis from the South African Stress and Health Study; 2013

‘The occurrence of trauma and PTSD in South Africa is not distributed according to the socio-demographic factors or trauma types observed in other countries. The dominant role of witnessing in contributing to PTSD may reflect the public settings of trauma exposure in South Africa and highlight the importance of political and social context in shaping the epidemiology of PTSD.

This may reflect the fact that political and criminal violence often occurs in public settings in South Africa, and highlights the importance of the political and social context in shaping the risk of PTSD related to specific events. The prominent role witnessing PTEs plays in PTSD causation in South Africa may be related to the culturally prescribed linkage of one’s well-being to the wellbeing of one’s family and community. This philosophy of Ubuntu has been described as an African world-view that emphasises “group solidarity, conformity, compassion, respect, human dignity, humanistic orientation and collective unity”. Alternatively, compared to directly experiencing a traumatic event, witnessing may have differential effects on memory and feelings of helplessness that may be important in PTSD aetiology. Indeed, it has been argued that “the impact of witnessing trauma is likely to be more distressing for individuals who have experienced multiple traumas. The witnessing experience may have more impact on individuals who are sensitized to trauma through enhancing memory formation; thus, intrusive and vivid recall is more likely.

A crosscutting theme from these findings is that interventions aimed at reducing PTSD in the South African population will need to increase the focus on special groups that have not traditionally received much attention after traumatic events- observers, retirees and bystanders during the occurrence of traumatic events. The traditional focus on direct victims has left out these important groups, and it is clear that reducing the occurrence of PTSD among these groups will significantly reduce the overall burden of PTSD in the general population.’
Epidemiology of posttraumatic stress disorder: prevalence, correlates and consequences; PubMed, 2015 July 01

(T)hese differences highlight the role of culture in determining mental health outcomes of traumatic event exposure. For instance, as argued in Atwoli et al., the prominence of witnessing events for PTSD burden in South Africa may be related to the cultural philosophy of ubuntu, which has been described as an African world-view that emphasises 'group solidarity, conformity, compassion, respect, human dignity, humanistic orientation, and collective unity'. Previous research on witnessing infliction of pain on others, and among high-risk groups such as war journalists and rescue workers supports the notion that witnessing trauma can be just as 'toxic', or even more 'toxic' than direct experience of trauma.

The concept of circles of vulnerability is based on three axes: geographical proximity - how close one is physically to the incident (the closer one is the more likely one is to be affected); social proximity - how close one is socially to the victims; and psychological proximity - how close one feels psychologically to the victim or the incident. The basic idea is that every critical incident is akin to a stone cast into a pool of water, the ripples spreading throughout the pool out to its edges. Similarly, the effects of the incident are felt throughout the entire community.

From the above definition it can be inferred that the proximity to the direct victims and the traumatic event, whether it is geographic, social or psychological, serves as an efficient theoretical tool that explains the growth of the victim population into collective proportions.

"Distant trauma" is based on a sub-type of partial PTSD that expresses itself with only some of the symptoms, listed in DSMs. The boundaries of the category are blurred, because it does not relate to a well-defined clinical population, but to an approximated population of potential victims. Since partial PTSD cannot be distinguished clinically from other disorders (such as depression or anxiety disorders), it is actually invisible in the level of individual (Young 2008). However, at the collective level, "where many individuals are aggregated for epidemiological research – the 2008). However, at the collective level, "where many individuals are aggregated for epidemiological research – the wholeness of the phenomenon becomes visible...What is explicit in the collective body is now implicit (taken-for granted) in the body of individual" (Young 2008, 24).

If we apply this argument to the psychotherapeutic field in Israel, we can state that the psychiatric-psychological researches that attributed a variety of traumatic symptoms to wide circles of Israelis and connected these symptoms to the Intifada events acted as social mechanisms of mass traumatization. Thanks to these mechanisms, the narrative of distant trauma, which may be interpreted as an unwarranted transformation of the iconic (DSM) version of mental trauma, becomes valid. The phenomenon, that is invisible at the level of individual, becomes taken for granted (unquestioned) at the level of collective.'

From the USA...

Trauma Culture: Who's a “Normal” Now? Ethnography.Co; February 3, 2015

'Then there are the attacks on September 11, 2001. For weeks, we were saturated with images of death, disfigurement, and grief. Fiery images played repeatedly, and we were helpless not to watch the desperate jump to their deaths or listen to testimony after testimony of survivors. It was an abnormal event and our very normal response—given the media onslaught—was to consume the violence as if it had happened to us. Because in many ways, it did.

In fact, one research study found similar levels of PTSD in those who witnessed the attacks in NYC and those who only watched them on TV. According to neurobiologist Robert Acaer, “We’re a frozen culture. The country is traumatized and dissociated.” Furthermore, he argues that the institutions of the culture—schools, government, healthcare, and the legal system—are also traumatizing to deal with because they are “so adversarial.”
From the UK...


Over 80% of children living in urban areas have witnessed community violence; as many as 70% of them report being victims of this violence (Fitzpatrick and Boldizar 1993; Gladstein et al. 1992; Kliewer et al. 1998). Culture plays a role in the level of community violence to which youth are exposed (Cooley et al. 1995). Although a national phenomenon, violence is particularly acute in urban neighborhoods (e.g., Gladstein et al. 1992; Richters and Martinez 1993).

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

It is reasonable to assume that the development and ‘social validation’ of the narrative of collective trauma reflects more than changes in trauma theory (the appearance of “distant trauma” and its “raw material” - partial PTSD). It might be also evidence of moral and political assumptions that have become part of the current "trauma culture" (Brunner 2002, 2004). In inspiration of Brunner’s distinction between the "culture of suspicion" and "culture of compassion", it’s possible to define the trauma culture, developed in the Western therapeutic field, as a "culture of compassion". In this case, "compassion" refers to the expansion/adaptation/formation of the iconic (DSM) version of mental trauma so that it can include many psychologically normal individuals who were not directly exposed to the traumatic event.

Community Trauma

“Honey bees are social insects, which means that they live together in large, well organised family groups. Social insects are highly evolved insects that engage in a variety of complex tasks, not practiced by the multitude of solitary insects.

Communication, complex nest construction, environmental control, defence and division of the labour are just some of the behaviours that honey bees have developed to exist in social colonies.”


VIVEK DATTA, MD, MPH; Psychiatry and the Problem of the Medical Model – Part 1; December 21, 2014; https://www.madinamerica.com/2014/12/psychiatry-problem-medical-model-part-1/

Medical sociologists have noted there exists an ‘illness iceberg’ whereby the majority of people in the community who identify as experiencing illness do not seek medical attention, and if they were the system would be completely overwhelmed. Instead, most people tend to consult a ‘lay referral system,’ seeking explanation and remedy of their problems from friends, family, and informal experts within their community, before seeking medical attention. Even with the creeping medicalization of everyday life and professionalization of helping, it is still the case that the majority of those who may identify as ill, ‘mental’ or otherwise, do not seek medical attention. Thus it is incorrect to state that ‘illness’ implies medicalization when it is a subjective experience that may or may not correspond with disease. Many of the individuals I see endure immense suffering and understandably see themselves as sick. I think it would be incredibly invalidating of me to say they are not ‘ill’ though they do not have disease.

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

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

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

Andrea Blanch, for US Department of Health and Human Services; ‘The impact of violence is never restricted to individuals; it always affects groups and communities.”

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

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

‘(Entire) cultures can be traumatized when repeated denigration, attempts at assimilation and genocide occur.’

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


‘Community violence is defined as deliberate acts intended to cause physical harm against a person or persons in the community (Cooley-Quille et al. 1995). Although the direct victims are obvious, its indirect victims are far more numerous. They are affected because they are: bystanders, witnesses or familiar with victims, or are cognizant of or anxious about the potential for violence (Horn and Trickett 1998; Lorion 1998). Chronic community violence is widespread among settings or social groups; its consequences impact significant portions of the community over a substantial period of time (Lorion 1998).’

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

Benjamin, L and Crawford-Brown, S; The psychological impact of continuous traumatic stress -- limitations of existing diagnostic frameworks

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

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

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

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

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

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

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.’

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

‘Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.’

And this is what happens to children...


‘Children’s exposure to, and victimization by, multiple forms of violence have reached epidemic proportions and, therefore, represent a major public health problem (Glodich, 1998; Margolin & Gordis, 2000). Rates of community violence and domestic violence are alarmingly high in inner city neighborhoods, with as many as one-third of pre-teen and adolescent children having been the direct victims of a violent episode and virtually all children having experienced some exposure to violence (Farrell & Bruce, 1997; Margolin & Gordis, 2000). Hence, in addition to the primary prevention of violent behavior, the development of interventions focused on reducing the harmful effects of exposure to violence is critical for ensuring the well-being of such children (Groves, Zuckerman, Marans, & Cohen, 1993).’
Exposure to violence potentially jeopardizes the development of urban, minority children (Bell & Jenkins, 1993; Dyson, Yeung, Brooks-Gunn, & Smith, 1990; Gasch, Poulson, Fullilove & Fullilove, 1991; Martinez & Richters, 1993). In addition to its impact on children’s physical and psychological well-being, violence may interfere with basic developmental trajectories by negatively impacting social, academic, and behavioral functioning and peer relationships. Possible effects of violence exposure on children can include difficult behavioral functioning or traumatic stress responses, such as aggression or intrusive symptoms respectively, which may interfere with academic performance and positive peer relationships. The experience of violence exposure also may profoundly alter children’s perceptions of themselves and others. Specifically, “[Violence] affects children’s views of the world and of themselves, their ideas about the meaning and purpose of life, their expectations for future happiness, and their moral development” (Margolin & Gordis, 2000, p. 446).

The experience of multiple traumatic events during childhood, such as those events experienced by youth in inner-city communities where violence is endemic, has been referred to as “compounded community trauma” (Horowitz, Weine, & Jekel, 1995). According to these authors, compounded community trauma, including the direct witnessing of domestic and community violence, has been linked to the development of childhood posttraumatic stress disorder (PTSD), depression, anxiety disorders, and adolescent substance use.

Stress theory has been primarily used as the theoretical foundation to investigate the emotional and behavioral effects of children’s exposure to community violence (Horn and Trickett 1998). Typically, community violence is the identified stressor and is used to predict maladaptive outcomes. Chronic exposure to community violence is believed to have a negative impact on various aspects of youth’s development and adaptive functioning (Attar and Guerra 1994; Fitzpatrick and Boldizar 1993; Jenkins and Bell 1994; Martinez and Richters 1993). Youth growing up in urban environments with high levels of poverty, overcrowding, and violence show a wide range of maladaptive outcomes, including internalizing symptoms such as anxiety, post-traumatic stress symptoms, depression, academic failure, and school disengagement (Gibbs 1984; Lorion et al. 1999; Myers et al. 1992; Osofsky et al. 1993; Singer et al. 1995). Youth with higher levels of exposure to community violence (via incidence and/or severity) report significantly more distress than those with lower exposure (Fitzpatrick and Boldizar 1993; Freeman et al. 1993; Jenkins 1993; Martinez and Richters 1993).


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.


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

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

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

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

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

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

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

‘Social learning theorists such as Bandura have proposed that self-efficacy is a critical dimension of well-being and behaviour change. When people feel as though they have more control of the outcome, they are more likely to support the process. Since gacaca is community-based and trials are held publicly within the community, people may be more involved and committed. ’152

And on a constructive note from the ISCPS –


‘Community Mobilisation and Development

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

The community development approach moves away from the usual approach to crime prevention, which involves addressing the results of crime through rehabilitation, community service orders, victim empowerment and substance…’

‘The ISCPS should focus on promoting social cohesion, youth, families and groups at risk, as well as the implementation of socio-economic interventions to undercut the causes of crime. The promotion of social cohesion most likely refers to conflict resolution, reconciliation and rebuilding the social fabric of our society by promoting institutions that are sources of “social capital”. Interventions aimed at preventing youth crime and victimisation are seen as vital to effective social crime prevention. Social crime prevention should focus on economic upliftment and social development. The provision of more secure employment would affect crime (Ingrid, 2001: np).’

And back in 1997 South Africa, Hamber and Lewis remind us that not all communities will be traumatised. They also nail the cultural point home. (See: Trauma and Resilience).


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

“Community psychology is like clinical psychology and community mental health in its action orientation. That is, community psychology aims to promote human welfare.

But community psychology arose largely out of dissatisfaction with the clinician’s tendency to locate mental health problems within the individual.”

Douglas D. Perkins; AN INTRODUCTION TO COMMUNITY PSYCHOLOGY; Vanderbilt University; September 12, 2011

Mohammed Seedat, Nico Cloete, & Ian Shochct; Community psychology: Panic or panacea; Psychology in society, 1988, 11, 39 – 54

‘The community psychology movement developed in the U.S.A. during an era when there was growing concern about both the lack of resources and treatment facilities and the impact of social systems on the human psyche. Psychologists and other helping professionals began to take note of the effects of social variables like poverty and alienation on mental health (Iscoe & Spielberger, 1977).

This theoretical shift in emphasis which represents a concern about where to locate the seat of pathology was accompanied by a critical re-appraisal of the philosophy underlying the conception and treatment of mental illness. This concern generated controversy and debate around the dominant intra-psychic model in psychology. Many writers criticized the strong intra-psychic orientation of mainstream psychodynamic therapy, for its “elitist” and “exclusivist” nature which automatically excludes the poor (Ryan, 1973; p.23). They questioned its selectivity in that it appeared to ignore the more serious and yet socially relevant problems like substance abuse, crime, violence and women-battering (Heller & Monahan, 1977). They also questioned the extent of its efficacy subsequent to Eysenk’s spontaneous remission thesis (cited in Zax & Specter, 1974). The point here, nonetheless, is that even if psychotherapy is effective, it appears to be elitist and selective in nature, in that it does not seem to address the needs of the majority in society. Instead, community psychologists appear to stress issues that pertain to the community and its collective destiny, rather than those of the individual subject.’

‘Community psychology is construed as the community division of psychology, which means that like industrial or clinical, it has to take relevant content from psychology and apply it to the social. However, if this content is generated from within an individualistic paradigm then the fundamental contradiction of the enterprise becomes apparent. The obviousness of the contradiction raises the question as to whether panic has blinded the adherents or whether it is a calculated tactic to keep the discipline intact within the individual paradigm while pretending to be concerned about the majority. The contradictory class location of intellectuals enables them to signal support to the oppressed while continuing to enjoy the privileges of the class that they are helping to maintain (Disco, 1979).’

Douglas D. Perkins; AN INTRODUCTION TO COMMUNITY PSYCHOLOGY; Vanderbilt University; September 12, 2011

To read any introductory text in the field of psychology, one would guess that the typical psychologist spends all of his or her time dreaming up and conducting arcane laboratory experiments, often of questionable relevance to pressing real world concerns. On the contrary, however, most psychologists work in naturally occurring situations and settings. In addition to the clinical and testing psychologists, with whom the public is most familiar, many people—at all levels of professional training—are entering a relatively new field called community psychology. Community psychology is fundamentally concerned with the relationship between social systems and individual well-being in the community context. Thus, community psychologists grapple with an array of social and mental health problems and they do so through research and interventions in both public and private community settings. One of the most exciting aspects of community psychology is that the field is developing rapidly and is still in the process of defining itself. It is not easily reduced to the traditional content categories in psychology for several reasons. First, community psychologists simultaneously emphasize both (applied) service delivery to the community and (theory-based) research on social environmental processes. Second, they focus, not just on individual psychological make-up, but on multiple levels of analysis, from individuals and groups to specific programs to organizations and, finally, to whole communities. Third, community psychology covers a broad range of settings and substantive areas. A community psychologist might find herself or himself conducting research in a mental health center on Monday, appearing as an expert witness in a courtroom on Tuesday, evaluating a hospital program on Wednesday, implementing a school-based program on Thursday, and organizing a community board meeting on Friday. For all the above reasons, there is a sense of vibrant urgency and uniqueness among community psychologists.
psychologists—as if they are as much a part of a social movement as of a professional or scientific discipline.

What Isn’t Community Psychology?
It may be useful to describe community psychology by distinguishing it from other disciplines with which it is closely allied. Community psychology is like clinical psychology and community mental health in its action orientation. That is, community psychology aims to promote human welfare. But community psychology arose largely out of dissatisfaction with the clinician’s tendency to locate mental health problems within the individual. Community psychologists are more likely to see threats to mental health in the social environment, or in lack of fit between individuals and their environment. They typically advocate social rather than individual change. They focus on health rather than on illness, and on enhancing individual and community competencies.

Community psychology is like public health in adopting a preventive orientation. That is, community psychologists try to prevent problems before they start, rather than waiting for them to become serious and debilitating. But community psychology differs from public health in its concern with mental health, social institutions, and the quality of life in general. In many ways, community psychology is like social work, except that it has a strong research orientation. Community psychologists are committed to the notion that nothing is more practical than rigorous, well-conceived research directed at social problems.

Community psychology is like social psychology and sociology in taking a group or systems approach to human behavior, but it is more applied than these disciplines and more concerned with using psychological knowledge to resolve social problems. It borrows many techniques from industrial and organizational psychology, but tends to deal with community organizations, human service delivery systems, and support networks. Plus, it focuses simultaneously on the problems of clients and workers as opposed to solely the goals and values of management. It is concerned with issues of social regulation and control, and with enhancing the positive characteristics and coping abilities of relatively powerless social groups such as minorities, children, and the elderly.

What Community Psychologists Do
The new and disparate areas of community psychology are thus bound together by a singular vision: that of helping the relatively powerless, in and out of institutions, take control over their environment and their lives. This should, in turn, foster in all of us a greater “psychological sense of community.” Community psychologists must, however, “Wear many hats” in working toward the creation of social systems which: (1) promote individual growth and prevent social and mental health problems before they start; (2) provide immediate and appropriate forms of intervention when and where they are most needed; and (3) enable those who have been labelled as “deviant” to live as dignified and self-controlled a life as possible, preferably as a contributing member of the community.

For example, a community psychologist might (1) create and evaluate an array of programs and policies which help people control the stressful aspects of community and organizational environments; (2) assess the needs of a community and teach its members how to recognize an incipient problem and deal with it before it becomes intractable; or (3) study and implement more humane and effective ways for formerly institutionalized populations to live productively in society’s mainstream.

Community psychology is not only a professional and scientific discipline. It is also an intellectual/value orientation that is applicable to virtually any field or profession. The community perspective challenges traditional modes of thought. It looks at whole ecological systems, including political, cultural, and environmental influences, as well as focusing on institutional and organizational factors. It realizes that the “interaction” between a person and the environment may have as important an effect on his or her behavior as the effect each factor has separately. The community approach also emphasizes the effects of stress and social support, and the practicality of prevention and self-help. Furthermore, it recognizes the demand for local empowerment and bureaucratic decentralization (and anti-professionalism) and the importance of cultural relativity and diversity. The community perspective simultaneously stresses the utility of research, not only for theory development, but for program evaluation and policy analysis—and the omni presence of values (implicitly or explicitly) throughout society and even science. An important aspect of the community orientation is its appreciation of the authority of historical and structural contexts. And, finally, it emphasizes community and personal strengths and competency, as opposed to weaknesses and pathology.
Community psychology: Panic or panacea; Psychology in society, 1988, 11, 39 – 54

Mohammed Seedat, Nico Cloete, & Ian Shochet;

‘By remaining reformist within the system, community psychology has not endeavoured to theorize the relationship between madness and oppression. Bulhan contends that the problem of madness and oppression will “continue to elude us so long as the questions of inequity, power and liberty are evaded”. This problem will be perpetuated as long as the individual and the society are construed as separate “immutable givens” (Duveen & Lloyd, 1986). As sociopsychological categories they are not independent categories, because there is no ‘pure individuality’ which can be understood separately from social relations (Duveen & Lloyd, 1986; Muller, 1985). Separating these two concepts is as futile as the nature-nurture categorization in the intelligence debate. This means that community psychology still awaits a Freud to develop a unification of the individual-social dualism. Since few theories have contributed so much to entrenching the individual - social split, it is highly unlikely that this will be achieved by a Freudian.’

‘The second fundamental issue that faces community psychology is to develop an intervention method that will liberate the “patient” from psychological oppression. It is imperative to do so without reproducing conventional psychology’s “therapist-patient” relationship which itself is “suffused with the inequities, non-reciprocity, elitism, and sadomasochism of the oppressive social order. What is needed in situations of oppression is a mode of intervention that bridges the separation of insight and action, internal and external, individual and collective. “The oppressed are economically and socially too pressed to wait indefinitely for an insight apart from lived realities” (Bulhan, 1985; p. 272).’

‘In the mental health model, the control is firmly vested with the expert who renders professional services to a client population that is a direct emulation of the hierarchical patient-therapist relationship in individual therapy. On the other hand, social action experts such as Rappaport (1981) argue that in the empowerment process the professional as an advocate of change should become a “collaborator”. While this prescription aims to democratize the professional-community interaction, the differences in skills cannot simply be resolved by the professional declaring himself/herself as “just another one of the people”. Such a move does not contribute to an understanding of what is the appropriate place and function of expert skills. This can easily lead to what Gouldner (1979) would call an obfuscation of the role and the interests of intellectuals.’

‘It should also help to clarify the simplistic notions of community espoused by many community psychologists. Rather than defining ‘community’ in terms of catchment area or locality, it could start to perceive community work as part of the process of consent creation during the formation of a counter hegemony (Sayer, 1986). According to Gramsci (1971) hegemony “represents the advance to a class-consciousness, where class is understood not only economically but also in terms of a common intellectual and moral awareness, a common culture” (Adamson, 1980; p. 171).’

‘Community psychology may have to start looking at social theorists such as Lenin (1971), Gramsci (1971), Freire (1970), Habermas (1974) and Tourraine (1981); to mention but a few of the names that seldom appear in psychology texts. Familiarity with some of these theorists may enable psychologists to start responding to the demand of community organizers (Berger & Lazarus, 1987) for a greater political content and awareness in the subject matter of psychology.’

Desmond Pointer and Martin Terre Blanche; Critical Psychology in South Africa: Looking back and looking forwards;

http://www.criticalmethods.org/collab/critpsy.htm

‘Community psychology always promised to be more than merely a semi-departure from mainstream, mainly American approaches to psychological intervention. In the words of Seedat, Duncan and Lazarus (2000, p. 4), “community psychology came to be associated with broad democratic movements seeking to dismantle oppressive state structures and ideological state apparatuses” and “embraced a radical challenge to the discriminatory foundation, theory, method, and practice of psychology”. This promise was fulfilled only partially, and perhaps mainly by becoming a site where psychology, mental health and the nature of psychological service provision could be radically interrogated. It is not surprising then that community psychology was the second most frequent topic addressed in PINS between 1983 and 1988 (Seedat, 1990).

However, community psychology was, despite its revolutionary promise and a number of exceptions, still an American product, and still a psychological approach that located itself mainly in conventional academic and clinical training programmes. As such it reproduced many problematic assumptions about knowledge production and application, social action, and psychology as a profession - not to mention assumptions about "community", "culture" and "race". That community psychology as such was (and is) not a panacea for all social and psychological...
ills is made clear by the limitations identified by authors like Seedat, Duncan and Lazarus (2001), Pretorius-Heuchert and Ahmed (2001) and Hamber, Masilela and Terre Blanche (2001): some conceptions of community psychology, by celebrating or simply accepting the categories of community, culture and race, have come dangerously close to reinforcing the racial and cultural divisions used to justify and practically organise apartheid; community psychology has remained largely dominated by white middle class practitioners and mainstream approaches to research and intervention; there has been surprisingly little substantial confrontation with issues of race, class, political violence and collective social action, accompanied also by a general lack of translation of macro-level critical theory into actual political practice; community psychology often adopted the typical conservative self-preservation strategies characteristic of professions; while community psychology at times served as a progressive set of practices, it might also have helped to simply divert and absorb challenges to mainstream psychology and mental health services. In the words of Hamber et al (2000), then, “South African community psychologists, despite some noble efforts to engage with ‘relevant’ social issues, have historically fallen prey to (...) individualizing, idealist, and relativizing tendencies” (p. 63).

Cultural Trauma

“Cultural trauma occurs when members of a collective identity feel they have been subjected to a horrendous event that leaves indelible marks upon group consciousness, marking their memories forever and changing their identities in fundamental and irreversible ways”

Alexander et al 2004

Ime Kerlee; Cultural Trauma - Understanding and treating your whole client; PDX Trauma Free

‘Cultural and social factors can be important determinants of susceptibility to the disorder by shaping ideas of what constitutes a trauma and what constitutes abnormal responses to trauma, and by affecting known vulnerability factors such as early childhood experiences, co-morbidity (e.g., alcohol abuse), and social resources for responding to trauma. Post-traumatic stress disorder, like all psychiatric disorders, is bound by culture.’

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

‘Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.’

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

**Cultural Competence**

*Dr A Burke; Mental Health Care During Apartheid In South Africa: An Illustration Of How “Science” Can Be Abused*

‘When dealing with people in a therapeutic context, cultural awareness and sensitivity are of paramount importance. In a multi-cultural society like South Africa, one would expect that the mental health professionals would reflect the demographic characteristics of the country, however, in South Africa, especially during the apartheid years, the psychiatrists were mainly white. These psychiatrists are far removed from the cultural milieu of their black patients and cannot even speak the language of their patients. Kale (1995) quotes an interview with a senior, academic, psychiatrists who states that although it is important to understand the client, but that the psychiatrist does not necessarily have to be from the same culture or language group as the patient. With this attitude, the importance of having black psychiatrists is downplayed, resulting in black South Africans being kept out of the profession, and patients not being understood.’

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

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

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

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

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

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


‘Cultural competency practices have been widely adopted in the mental health field because of the disparities in the quality of services delivered to ethnic minority groups.’

‘The notion that culturally competent services should be available to members of ethnic minority groups has been articulated for at least four decades. Multiculturalism, diversity, and cultural competency are currently hot and important topics for mental health professionals (Pistole 2004, Whaley & Davis 2007). Originally conceptualized as cultural responsiveness or sensitivity, cultural competency is now advocated and, at times, mandated by professional organizations; local, state, and federal agencies; and various professions.’

‘Many prominent health care organizations are now calling for culturally competent health care and culturally competent professionals (Herman et al. 2004).’
To evaluate the validity, utility, and empirical basis of cultural competency, one must first be able to define the construct. Competence is usually defined as an ability to perform a task or the quality of being adequately prepared or qualified. If therapists or counselors are generally competent to conduct psychotherapy, they should be able to demonstrate their skills with a range of culturally diverse clients. Proponents of cultural competency, however, believe that competency is largely a relative skill or quality, depending on one’s cultural expertise or orientation. Their definitions of cultural competency assume that expertise or effectiveness in treatment can differ according to the client’s ethnic or racial group. As Hall (2001) noted, advocates of cultural competency or sensitivity appreciate the importance of cultural mechanisms and argue that simply exporting a method from one cultural group to another is inadequate.

It is not surprising that cultural competency or multiculturalism has come under attack. Because of the lack of research on cultural competency, some have challenged it as being motivated by “political correctness” (Satel & Forster 1999) and untested in clinical trials (Satel 2000). One of the important debates in the literature concerning cultural competency can be found in the attempt to establish multicultural counseling competencies or multicultural guidelines for the American Mental Health Counseling Association. The guidelines, many of which are highly similar to the ones adopted by the American Psychological Association (2003), stimulated civil but contentious exchanges. The debated issues revolved around several key questions, articulated largely by Thomas & Weinrich (2004), Weinrich & Thomas (2002, 2004), Vontress & Jackson (2004), and Patterson (2004):

1. Are cultural competency proponents stereotyping ethnic minority clients?
2. By advocating for multicultural competencies for ethnic minority groups, are we discriminating against or ignoring other diversity characteristics such as gender, sexual orientation, and social class?
3. Is the role of culture and minority group status in mental health overemphasized in multiculturalism?
4. Is the emotional and political context of the debate creating incivility?

Peter Cordell  
*Intergenerational Trauma in Aboriginal Peoples* - The Importance of Understanding Historical Context as a Health Professional;  
*Cultural Safety* - Cultural safety involves health professionals’ recognition that they bring their own culture and attitudes to the relationship with the patient and need to be respectful of the patient’s nationality, culture, age, sex, political and religious beliefs, and sexual orientation. In order to achieve cultural safety, health professionals must learn to move beyond the concept of cultural awareness – being aware that a difference exists—to analysing power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to health care.”

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;

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

‘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.’
Socio-Cultural Impact of Trauma

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.’

Ronelle Burger et al. 2014; Poverty traps and social exclusion amongst children in South Africa; A report to the South African Human rights Commission; Submitted by Research on Socio Economic Policy; Department of economics; University of Stellenbosch.

‘Moreover, it is not simply cognitive and physical capabilities that are important markers for a child’s future socio-economic outcomes, but also non-cognitive skills such as motivation, self-control and self-confidence (Heckman, 2007: 13250). These non-cognitive abilities and traits are largely influenced by the quality of parenting and household structure and research suggests that deficiencies in these ‘soft skills’ are correlated with other measures of cognitive ability (such as lower IQ test scores) as well as lower wage earnings (Cunha et al., 2005).

Social exclusion may also arise due to fear of, as well as victimization by, personal violence and maltreatment. Children living in poor circumstances are often exposed to community violence, with deleterious consequences for their long-term development. Fowler et al. (2009: 228) specifies some of these consequences, which include posttraumatic stress disorder (PTSD), ‘externalising problems’ – which refers to deviant behaviour – and the acceptance of violence as appropriate behaviour. Yehuda, Spertus and Golier (2001) also cite anxiety, depression, dissociation and a greater proclivity for substance abuse in later life as outcomes of childhood trauma. In communities where violence is pervasive a “communal sense of insecurity” may develop and foster a general sense of helplessness (Fowler et al., 2009). Such an environment is antithetical to the enabling conditions required for the realization of children’s developmental potential.

Indeed, Yehuda, Spertus and Golier (2001) suggest that trauma suffered by children induces psychological problems that are carried into adulthood. It is further found that PTSD is more prevalent among children whose parents suffered childhood trauma, implying an intergenerational transfer of PTSD which negatively impacts the psychosocial development of the child (Yehuda, Spertus and Golier, 2001: 118). This is especially evident in cases of child abuse and neglect. In a study comparing the psychological health outcomes of abused children to a matched sample, it was found that children who suffered maltreatment reflected higher rates of PTSD, and were more likely to come from families with a history of behavioural problems (Yehuda, Spertus and Golier, 2001). The implications for life outcomes from suffering violent or sexual abuse as a child are devastating. Currie and Tekin (2006) find that victims of child maltreatment are significantly more likely to engage in criminal activity than non-victims. Currie and Widom (2010), furthermore, find significant differences in educational attainment and earnings in the labour market between adults who are documented as child abuse victims and other matched individuals. Besides behavioural and psychological effects, victims of abuse demonstrate reduced cognitive capacity that arises indirectly through behavioural patterns unfavourable for cognitive capability development, but also directly through neurochemical pathways which physically impair optimal brain functioning (Yehuda, Spertus, & Golier, 2001, p. 141) Abuse thus
lowers the life chances of children, harming their socio-emotional and cognitive development and thereby reduces their earnings prospects in the labour market.”

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

‘To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma. As demonstrated in Exhibit 1.12, many factors shape traumatic experiences and individual and community responses to it; one of the most significant factors is culture. It influences the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviours’

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*Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects*

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

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

‘Milroy (2005: xxi) concluded that Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality.’

*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*

Of course, biological legacy doesn’t predetermine the personality or health of any one child. To say that would be to grossly oversimplify the socioeconomic and geographic and irreducibly personal forces that shape a life. At the same time, it would be hard to overstate the political import of these new findings. People who have been subject to repeated, centuries-long violence, such as African Americans and Native Americans, may by now have disadvantage baked into their very molecules... On the whole, the children of Cambodian survivors have not enjoyed the upward
mobility of children of immigrants from other Asian countries. More than 40 percent of all Cambodian-Americans lack a high school diploma. Only slightly more than 10 percent have a bachelor’s degree.’

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

‘After conducting studies of medications for PTSD, I have come to realize that psychiatric medications have a serious downside, as they may deflect attention from dealing with underlying issues. The brain disease model takes control over people’s fate out of their own hands and puts doctors and insurance companies in charge of fixing their problems.

The brain-disease model overlooks four fundamental truths: (1) our capacity to destroy one another is matched by our capacity to heal one another. Restoring relationships and community is central to restoring well-being; (2) language gives us the power to change ourselves and others by communicating our experiences, helping us to define what we know, and finding a common sense of meaning; (3) we have the ability to regulate our own physiology including some of the so called involuntary functions of the body and the brain, through such basic activities as breathing, moving, and touching; and (4) we can changes the social conditions to create environments in which children and adults can feel safe and where they can thrive.

When we ignore these quintessential dimensions of humanity, we deprive people of ways to heal from trauma and restore their autonomy. Being a patient rather than a participant in one’s healing process, separates suffering people from their community and alienates them from an inner sense of self.’

*The South African Context*

*Padraig O’Malley; Consequences of Gross Violations of Human Rights; The Nelson Mandela Centre of Memory.*

‘Psychological Consequences of Gross Violations of Human Rights

10. South Africa’s history of repression and exploitation severely affected the mental well-being of the majority of its citizens. South Africans have had to deal with a psychological stress which has arisen as a result of deprivation and dire socio-economic conditions, coupled with the cumulative trauma arising from violent state repression and intra-community conflicts.

33. Feelings of helplessness also undermine people’s sense of themselves as competent and in control of their fate. This makes them incapable of picking up the pieces of their previous lives.’

*Lukoye Atwoli, Dan J Stein; Trauma and Posttraumatic Stress Disorder in South Africa: Analysis from the South African Stress and Health Study*

‘South Africa is a developing country with a history characterised by past constitutional racial segregation and exploitation in the form of apartheid that gave way to a non-racial democracy only in 1994. This transition was achieved by a protracted liberation struggle, characterized by political violence and state-sponsored oppression. After apartheid, high levels of often criminal interpersonal violence continued, fuelled by rapid urbanization and ongoing socioeconomic disparities, that resulted in a high level of trauma exposure, over 80% in some studies.’

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

‘**Conclusion:** First, although traumatic event prevalence rates are higher in countries emerging from conflict, the distribution of traumatic event types varies significantly by region. The impact of the socio-political environment on the distribution of traumatic events is apparent from these findings.’

‘**Conclusion:** Third, several socio-demographic factors are associated with traumatic event exposure and PTSD in high-income settings, but not in low-income and post-conflict societies such as South Africa. Although the risk factors in the high-income settings reflect existing knowledge on PTSD risk factors, the high rate of traumatic event exposure across all socio-demographic groups in South Africa eliminates most possible associations between the socio-demographic factors and traumatic event exposure and PTSD.’
Hoosain, Shanoaz; *The transmission of intergenerational trauma in displaced families* University of The Western Cape; A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in the Department of Social Work, University of the Western Cape; Supervisor: Professor Vivienne Bozalek

‘The trauma of displacement and historical trauma of slavery was not acknowledged as traumatic by the dominant society because South African society was based on institutional racism. The grief and loss of the trauma therefore became unresolved and disenfranchised. The findings indicate that disenfranchised grief, silence, socialisation in institutional racism and shame have been the main mechanisms in which the historical trauma of slavery and trauma of displacement has been transmitted within the families. The effects such as intimate partner violence and substance abuse and community violence in the form of gang violence are forms of internalised oppression which has also been transmitted inter-generationally. In addition overcrowding, poor housing and poverty has been transmitted via socialisation which is a societal mechanism of trauma transmission. The research findings indicate that the trauma of displacement and historical trauma of slavery was transmitted because the trauma was not included in the social discourse of society.’


‘The consequences of the high levels of violent victimisation permeate increasingly widely into South African society, and few, if any, South Africans can remain unaffected. Vast numbers of South Africans are likely to struggle to relate to other individuals due to shattered trust, and feelings of grief and loss; to have difficulty in the workplace due to intrusive trauma symptoms; and to be left with an overwhelming sense of anxiety, anger and vulnerability. This leaves many South Africans with raised levels of fear, suspicion and aggression - all of which deleteriously affect their daily functioning.

‘The majority of South African victims of violent crime are likely to feel unsupported and hopeless, and to have lost faith in the effectiveness of the criminal justice system. These feelings are likely to intensify if they receive no psychological and social support, and if their first interface with the criminal justice system, for example with the police, is contentious and fails to meet their immediate needs. If ignored, certain victims of past violence are at risk for becoming the perpetrators of retributive violence or displaced social and domestic violence (National Crime Prevention Strategy - NCPS, 1996; Simpson, 1996). The recent trends in increased violence through vigilantism (usually targeted against criminals but frequently resulting in clashes with the police) and the ongoing spiral of political revenge and retribution in KwaZulu-Natal, bear testimony to this thesis.’

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

‘In environments of continuous trauma the family structure is threatened. The breakdown of family for example due to death or imprisonment of family members, and the high rates of absent fathers play a significant role in the maladaptive development of the child. Children are left on their own in communities where adults are absent emotionally and / or physically. Low self-esteem coupled with growing up in a neighbourhood where violence is the norm for resolving conflict, leaves the young person feeling alienated at an individual and community level (Abrahams & Jewkes, 2005). Feelings of demoralisation, vengeance, fear and social exclusion are reflected in South African society and in our disadvantaged communities....’

‘Violence, terror and threat permeate the lives of too many children, youth and adults in South African society. When fear is omnipresent, research has shown that these experiences work to literally changing the brain of a traumatized individual.’

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

‘An estimated 20% of children... suffer from a mental [disorder] due to the levels of violence and family problems... and eventually a quarter of the entire population will have suffered from a depressive disorder. Fifty percent of visits to general practitioners are usually due to some sort of mental problem... In South Africa about 10,000 people commit suicide yearly and most of those are young people with economically active lives. And yet only 10 to 15% of people worldwide with mental disorders seek help. To make matters worse, in our country, many of those seeking help find it is not available.’
The Socio-Economic Effects of Trauma

Dr Cathy Kezelman; Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery. Adults Surviving Child Abuse (ASCA) Authors: Dr Cathy Kezelman and Dr Pam Stavropoulos Funded by the Australian Government Department of Health and Ageing

‘Trauma is not simply an individual misfortune. It is a public health problem of major proportions. The costs of unrecognised and untreated complex trauma are enormous. This is not only in terms of reduced quality of life, life expectancy and lost productivity, but in ‘significant increases in the utilization of medical, correctional, social, and mental health services’. In 2007 alone, the cost of child abuse to the Australian community is conservatively estimated to be at least $10.7 billion, and is almost certainly far higher.’

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

‘Psychological trauma is a major public health issue affecting the health of people, families and communities across Canada. Trauma places an enormous burden on every health care and human service system. Trauma is not only a mental health issue, but it also belongs to every health sector, including primary/physical, mental and spiritual health...Although trauma is often the root cause behind many of the public health and social issues that challenge our society, service providers all too often fail to make the link between the trauma and the challenges and problems their clients, patients and residents, and even co-workers, present.’

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 following 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.”

Source reference: Adverse Childhood Experiences Study (CDC and Kaiser Permanente, http://www.ACEstudy.org)

‘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.‘,

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

‘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.’

The Thrive Initiative; Main, USA.; System Of Care Trauma-Informed Agency Assessment (TIAA)© Overview

‘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).’

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

The economic burden of mental disorders: Given the prevalence of mental health and substance-dependence problems in adults and children, it is not surprising that there is an enormous emotional as well as financial burden on individuals, their families and society as a whole. The economic impacts of mental illness affect personal income, the ability of ill persons – and often their caregivers – to work, productivity in the workplace and contributions to the national economy, as well as the utilization of treatment and support services. The cost of mental health problems in developed countries is estimated to be between 3% and 4% of GNP. However, mental disorders cost national economies several billion dollars, both in terms of expenditures incurred and loss of productivity. The average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those incurred by a typical beneficiary. However, the cost of treatment is often completely offset by a reduction in the number of days of absenteeism and productivity lost while at work.

Alleviating the problem: prevention, promotion and management programmes A combination of well-targeted treatment and prevention programmes in the field of mental health, within overall public strategies, could avoid years lived with disability and deaths, reduce the stigma attached to mental disorders, increase considerably the social capital, help reduce poverty and promote a country’s development. Studies provide examples of effective programmes targeted at different age groups – from prenatal and early infancy programmes, through adolescence to old age – and different situations, such as post-traumatic stress following accidents, marital stress, work-related stress, and depression or anxiety due to job loss, widowhood or adjustment to retirement. Many more studies need to be conducted in this area, particularly in low- and middle-income countries. There is strong evidence to show that successful interventions for schizophrenia, depression and other mental disorders are not only available, but are also affordable and cost-effective.

The gap between the burden of mental disorders and resources
The indirect cost of mental disorders outweighs direct treatment cost by two to six times in developed countries and may be even higher in developing countries. In the first nationally representative survey of mental disorders in South Africa, lost earnings among adults with severe mental illness during the previous 12 months amounted to R28.8 billion. This represented 2.2% of GDP in 2002, and far outweighs the direct spending on mental health care for adults (of approximately R472 million). In short, it costs South Africa more to not treat mental illness than to treat it.


‘There is a feeling that there isn’t enough money for mental health services and research,’’ he (Professor Dan Stein, after winning a National Science and Technology Forum (NSTF) Award) said. ‘‘The problem is that not providing enough services and doing the related research on how to optimise such services is vastly more costly than doing so. So every year, we as a country lose more and more money because we haven’t made the right investments in the past.’

‘And despite the fact that neuro-psychiatric disorders have been ranked third in their contribution to the overall burden of disease in South Africa – and mental disorders comprise five of the 10 leading causes of health disability – at the last count, just 4% of the national budget was going towards mental healthcare. In 2014, national director of the South African Federation for Mental Health, Bharti Patel, challenged the national government ‘‘to make mental health a national priority by increasing the budget allocated to the mental health sector.’


‘Children and youth with serious mental health conditions are an expensive population to serve. In addition to high prevalence rates, mental health conditions are the costliest conditions of childhood (Agency for Healthcare Research and Quality [AHRQ] Research Brief #242; Soni, 2009). It has been estimated that providing care to children with serious mental health conditions costs the public around $247 billion annually (Institute of Medicine and National Research Council, 2009). Although the population of children with the most serious and complex mental health conditions is relatively small, costs for these children are disproportionate to the costs of serving all children with mental health conditions. This finding has been attributed to their high utilization of expensive and restrictive treatment in psychiatric inpatient and residential treatment settings, costs that are borne largely by the public sector (Cooper et al., 2008).’