The psychological impact of continuous traumatic stress
-- limitations of existing diagnostic frameworks

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Abstract
For people within vulnerable neighbourhoods in South Africa, experiences of violence may be one event of many within a lifetime of threatened community and criminal violence. The authors propose that this experience of “Continuous Trauma” is a sub-category of Post Traumatic Stress Disorder (PTSD), sharing many of the symptoms and associated symptoms, but with a distinctive pattern of impact, presentation and recovery.

In this paper the term “Continuous Trauma” is used to describe a mental health presentation arising from living in a neighbourhood with high levels of community, gang and criminal violence from an early age, where violence has been witnessed or experienced repeatedly, and where the person recovers within this context of ongoing threat. This paper contextualizes “Continuous Trauma” within international and South African literature, and offers a case study to explore the concept within a South African context. It considers the impact of continuous violence at individual, family and community levels.
Introduction
The urgency and horror of acute psychological trauma often beguiles practitioners and researchers into focusing on the impact of a single event within the person’s current life experience. Yet for many victims of violence, this single event may be one event of many traumatic experiences. For people living within violent neighbourhoods in South Africa this may be one event of many within a lifetime of threatened community and criminal violence. The authors propose that this experience of “Continuous Trauma” is a sub-category of Post Traumatic Stress Disorder (PTSD), sharing many of the symptoms and associated symptoms, but with a distinctive pattern of impact, presentation and recovery.

Mainstream research within the field of psychological trauma centres on understanding single incident trauma (Spinazzola, Blaustein & Van Der Kolk, 2005). This reflects the assumption that this is the typical presentation of psychological trauma. The diagnostic criteria of PTSD defined in the Diagnostic and Statistical Manual of Mental Disorders – fourth edition (DSM-IV) further draw our gaze to the impact of the single incident, through the required initial criterion that a person must be exposed to a traumatic event that involves a response of horror, helplessness or fear (American Psychiatric Association (APA), 1994).

Reviewing the progress within the field over the past twenty years Jackson, Veneziano and Ice (2005: 471) remind us that the appreciation “of single traumatic incidents is inadequate for understanding trauma among victims of violence”. Building on the arguments of Herman, Hess and Gold, they challenge:

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

Over the past two decades, South African mental health practitioners have begun conversations about the impact of “continuous violence”. Faced with communities where there is a confluence of gang activity, substance abuse, community violence, crime and family violence, layered on top of historic experience of political and structural violence, practitioners have found that PTSD does not fully capture the presentation of many of the survivors. The founding four organizations of a national trauma network identified “continuous trauma” as a distinct dynamic of practice across the country (Themba LeSizwe, 2001). Practice experience indicates that traditional understandings of PTSD are not adequate in describing the distinct dynamics of continuous trauma. Yet these conversations have not developed into a focus of research.

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

This paper thus contextualizes the concept of continuous trauma within the international and South African literature on traumatic stress. The authors discuss the limitations of PTSD while also reflecting on the value of the associated symptoms in understanding multiple experiences of violence. Finally, the paper explores the typical presentation of continuous trauma within a practice setting, drawing on these associated symptoms of PTSD as an initial framework for discussion. The authors propose that “Continuous Trauma” is a sub-category of PTSD with a distinctive pattern of impact, presentation and recovery. This echoes the developments in the literature concerning “Complex Trauma” or “Developmental Trauma Disorder” which describe a particular presentation after experiencing chronic interpersonal violence from an early age.

**The concept of continuous trauma**

In this paper, we define continuous trauma as a pattern of mental health presentation arising from living within a neighbourhood with high levels of community, gang and criminal violence from an early age, where violence has been witnessed or experienced repeatedly, and where the person recovers within this context of ongoing threat.

Implicitly this definition offers many challenges. The first is the temptation to assume that an experience of violence is inherently traumatic with pathological impact. There is a wide body of literature exploring the risk factors for developing post traumatic stress disorder (McFarlane & Yehuda, 2007), resilience (Bonanno, 2004; Mancini & Bonanno, 2006) and post traumatic growth
(Tedeschi & Calhoun, 1995) that illustrates that violent events vary in their pathogenesis and individuals differ in their capacity to cope across events, time and resources available to them. The exploration of continuous trauma requires the consideration of the complex effect of multiple experiences of violence, and of living within an environment of the continuous threat of violence from an early age. This multifaceted effect may involve decreased bio-psycho-social functioning and quality of life, as well as coping, resilience and post traumatic growth. This will no doubt differ across individuals and communities.

Similarly, the above definition considers the context and site of the experience of violence as important. It determines an exploration of the effect of violence within community-shared spaces, rather than of that within close interpersonal relationships. A review of international literature directs consideration of “cumulative trauma”, “complex trauma” and “developmental trauma disorder”, all of which discuss a violation of close interpersonal relationships at a young age where there is an expectation for trust and safety (Herman, 204; Van Der Kolk, 2009; Cloitre, et al., 2009).

The nature of these relationships is very different to those within a community, where criminal, community or gang violence may occur. Thus, whilst the researchers recognize that many people who live within environments of persisting community and gang violence may also be experiencing violence within intimate relationships, this is not included within the frame. The definition also does not include circumstances of war or political violence, recognizing that in many of these situations the underlying identities, histories and interests may offer systems of meaning for those drawn into the conflict that are different to those outside of war.

The inclusion of the element “from an early age” raises a dimension where people living in these communities may never have had an experience of a safe community or safe environment, and suggests an intergenerational experience of violence within their neighbourhood. This element draws attention to the developmental impact on ongoing neighbourhood instability.

And finally, the discussion of “recovering in a context of ongoing threat” identifies that this experience of violence is very different to those in more developed contexts where interventions and indeed recovery are founded on the client establishing a sense of internal and external safety (Herman, 1994; Briere & Scott, 2006). It is likely that this ongoing lack of safety will alter the experience of violence by shaping its meaning; thereby forming a pattern of impact, presentation, resilience and recovery that may be different to those of individuals in more protected environments.
Thus the presentation of “continuous trauma” arises through someone growing up within a violent community context, experiencing or witnessing multiple incidents of violence and then recovering within this same context. Within this presentation there may be many facets of resilience and post traumatic growth, as well as adaptational responses which inhibit or strengthen a person’s social, familial, occupational and psychological functioning.

**Questioning the value of Post Traumatic Stress Disorder as our primary lens viewing psychological trauma**

Researchers and clinicians draw on PTSD as the fundamental framework for thinking about the impact of experiencing or witnessing a life-threatening event on people. Perhaps this has arisen because PTSD is the only psychiatric disorder within the DSM-IV (APA, 1994) that includes the cause or precipitant as a criterion within the diagnostic category. This may reinforce an assumption that PTSD is the likely diagnosis after an experience of trauma. When undertaking epidemiological research, assessment or interventions concerning the psychological impact of violence, the DSM-IV PTSD core symptoms are usually the central focus. These are:

A) experiencing a traumatic stressor;
B) repeatedly re-experiencing the trauma;
C) avoiding activities and stimuli associated with the trauma and emotional numbing; and
D) heightened arousal (APA, 1994).

Yet, as the primary lens through which psychological trauma is perceived, PSTD is particularly problematic. The disorder does not fully capture the range of psychiatric or psychological response to trauma – particularly when the experience of violence is of a chronic and continuing nature.

Psychiatric diagnostic categories are by definition brief, containing only the most common and characteristic elements of a condition to create a nosology to guide intervention, research and communication. Thus, diagnostic categories are sketchy maps rather than detailed descriptors of territory (Edwards, 2005). This is particularly apparent where the associated symptoms of PTSD are listed during the DSM-IV’s description of the disorder as:

- powerful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Avoidance patterns may interfere with interpersonal relationships and lead to marital conflict, divorce or loss of job. Auditory hallucinations and paranoid ideation can be present in severe and chronic cases. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering); impaired affect modulation, self-destructive and impulsive behaviour; dissociative symptoms; somatic complaints; feelings of ineffectiveness or shame; despair or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; a change from the individual’s previous personality characteristics (APA, 1994: 465).
These associated aspects are rarely included as a focus in research or in treatment protocols that tend to focus on the core diagnostic criteria. Kilpatrick (2005) defends the diagnosis by reflecting on the epidemiological studies that have shown that whilst PTSD may not capture all the symptoms experienced by diverse groups of victims, those who present with the associated and co-morbid presentations, also have the symptoms of PTSD.

Although there is strong support for the argument that PTSD is a useful construct to assist in identifying and supporting people affected by trauma, only a small proportion of victims of trauma develop PTSD (McNally, 2004; Briere & Scott, 2007). The DSM-IV PTSD diagnostic criteria tend to be inadequate in their differentiation between the frequently co-morbid diagnoses of depression, dissociation and substance abuse (Briere & Scott, 2007). In fact, a significant proportion of trauma survivors develop depression or substance abuse either as the primary diagnosis or as co-morbid syndromes (Briere & Scott, 2007; Kessler, 2000). Epidemiological research suggests a lifetime prevalence of 7.8%, despite much higher levels of experiencing violence (Kessler, 2000). This indicates both resilience as well as the possibility that people may have a range of response not captured by PTSD.

The difficulties of the diagnosis have been compounded by the DSM-IV widening the first mandatory diagnostic criterion to include traumatic experiences that i) threaten physical integrity and ii) overwhelm through hearing of someone else’s experience. This has increased the population who may be affected by the disorder (McNally, 2004). Despite this widening of the definition of traumatic stressor, the PTSD criteria do not capture the complex personality adaptations that take place after experiences of child abuse or intimate partner violence (Van Der Kolk, 2009; Herman, 1992) and possibly those adaptations made by people living within contexts of continuous violence.

Responding to this gap, there has been a strong lobby to include “Disorders of Extreme Stress Not Otherwise Specified” (DESNOS) (Van Der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005) within the DSM-IV, and more recently “Developmental Trauma Disorder” within the DSM-V to describe this more specific pattern of impact, presentation and recovery (Van Der Kolk, Pynoos, Cicchetti, Cloitre, D’Andrea & Ford, 2009). These aspects tend to be listed as “associated symptoms” rather than held as important in research and treatment. Thus, the core symptoms of PTSD perhaps form a proxy for the identification of psychological trauma. It appears there is a wider syndrome, which varies according to the traumatic stressor or stressors.

The socio-political dynamics surrounding the emergence of PTSD within the DSM-third edition (DSM-III) (American Psychiatric Association, 1980) have been widely documented (Herman,
1994; Summerfield, 2001; McNally, 2004). In the late 1970’s American veterans of the Vietnam War, supported by anti-war psychiatrists, lobbied for a diagnosis to describe the serious pathology with which the veterans were presenting. These patterns of presentation became the foundation to form the diagnostic criteria held in PTSD in the DSM-III. Not only did this assist the veterans in accessing treatment and compensation, but also it validated their symptoms as victims, thereby reducing the stigma rising from a war weary and shamed public. Reflections on history offer similarities in the symptoms of the World War I and II veterans in terms of war neurosis and shell shock. The feminist movement raised parallels in presentation after sexual assault and intimate partner violence (Herman, 1994). Thus, despite being criticized as a social and cultural construct which responded to a particular socio-political context (Summerfield, 1999), “PTSD has been found to be an enormously useful diagnostic construct with wide applicability to different victim populations and with its own unique neurobiology and therapeutics” (Van Der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005: 389).

PTSD is critiqued as a culture-bound syndrome as evidenced by the changing nature of veteran presentation across the First and Second World Wars, Vietnam, Korean and Iraq wars; each of which tended to mirror the wider socio-political response to the conflict (Herman, 1994; Summerfield, 2001; Van Der Kolk, 2007). There are therefore reservations around the application of the diagnosis in contexts other than the developed world, where the meaning of violence may influence the experiences of people (Briere & Scott, 2007). In particular, the Criterion C symptoms of avoidance and numbing may take differing forms within various cultures (Dinan, McCall & Gibson, 2004). Mainstream research holds evidence that PTSD has validity across many nations and contexts (Friedman, Resick, Keane, 2007; Osterman & De Jong, 2007). The diagnosis is further criticized as pathologising normative human suffering, thereby strengthening a mental health industry, rather than demanding socio-political change (Summerfield, 2001; Swartz & Levett, 1989). Yet recognizing that not all survivors of trauma have the symptoms of PTSD and medicine as a whole is based on constructs of diagnosis and intervention, the construct has utility (Friedman, Resick & Keane, 2007; Edwards, 2005).

As raised earlier, whilst mainstream trauma research continues to focus on single incident posttraumatic stress, an alternative field of literature exploring the impact of multiple experiences of violence and chronic interpersonal violence is growing. The literature concerning Complex Trauma or Developmental Trauma Disorder is extensive, deepening understanding of the trauma caused by family and childhood interpersonal violence and abuse (Herman, 1994: Gold, 2001; Van Der Kolk, 2009). Research on Cumulative Trauma is broadening the consideration of adult experiences of interpersonal violence after a history of child abuse (Cloitre, et al., 2009). A wide body of literature considering the impact of community violence on children and adolescents
Aisenberg & Herrenkohl, 2008), and of transgenerational effect of trauma has developed (Bar-
on, 1996). In the last decade, the view is broadening from single incident to multiple experiences
of violence, but does not describe the impact of ongoing exposure to violence.

Herman (1992) has framed the exploration of the concept of Complex Trauma by describing the
impact of the violation of personal integrity taking place within intimate interpersonal relationships
at an early age. She arranged the twenty-seven symptoms which were commonly associated
with intimate interpersonal trauma into seven categories: dysregulation of a) affect and impulses,
b) attention or consciousness, c) self-perception, d) perception of the perpetrator, e) relations with
others, f) somatisations, and g) systems of meaning. This categorisation has also been known
as Disorders of Extreme Stress Not Otherwise Specified (DESNOS). The DSM-IV Field Trial
(Van Der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005) investigated the definition of
Criterion A within the PTSD diagnostic framework, and explored whether the symptomatology of
victims of chronic interpersonal trauma could be described using the PTSD framework. After an
extensive literature review, the field trial used Herman’s categorization of symptomatology (1992)
as a foundation to explore DESNOS in relation to PTSD.

The field trial found that there is a pattern of associated features, in addition to or beyond the
criteria of PTSD experienced by both children and adults who have been affected by child abuse
or intimate partner violence (Van Der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). This is
supported by research within the fields of developmental psychopathology and neurobiological
research (Courtois & Van Der Kolk, 2005). The DSM-IV committee on PTSD ultimately decided
that the symptom pattern of Complex Trauma or DESNOS shared sufficient commonality with
PTSD, so as not to require a separate diagnostic category.

Research into the differential impact of single incident and multiple incident trauma, as well as
non-interpersonal and multiple interpersonal exposure has found that disorder increases with the
number of reported experiences. Multiple interpersonal exposure leads to higher distress and
worse outcomes. Interpersonal trauma is more distressing and linked to higher rates of disorder
than non-interpersonal violence (Green et al., 2005).

Aisenberg and Herrenkohl (2008) review the extensive research concerning the impact of
community violence on children and adolescents within the United States of America. This body
of literature explores the epidemiology, protective and risk factors, ecological factors and family
context, the varying cumulative impact of different types of traumatic stressors to understand the
impact of community violence on children and adolescents. The research shows that “exposure
to community violence is a cumulative stressor that can have detrimental effects on children’s
physical and emotional health as well as on school and social functioning” (Aisenberg & Ell, 2008:
Whilst there are gaps and difficulties in research definitions within this literature, there is evidence that children who are exposed to community violence have increased risks of cognitive impairments, fear, negative life experiences, substance abuse, internalizing behaviors, psychological problems including anxiety, depression and post traumatic stress disorder (Aisenberg & Herrenkohl, 2008). This area of research is unusual in that it considers the impact of violence as having broader consequences than posttraumatic stress disorder. Most of the epidemiological information suggests that some South African children and adolescents are experiencing far higher rates of violation than children within these samples (Ward, Flisher & Lombard, 2003).

In considering the data raised in a range of epidemiological studies, Kessler (2000) discusses the complexity of multiple traumatic stressors. Kessler (2000) reviews the research on the long term effects of PTSD and finds that people with PTSD have 40% increased likelihood of high school and college failure, 30% increased chance of teenage parenthood, 60% increased probability of marital instability and 150% increased likelihood of unemployment at the time of the interview, in comparison to people without PTSD. Thus, the costs of trauma to society are great.

The concepts of posttraumatic stress, multiple trauma, complex trauma, developmental trauma, cumulative trauma, intergenerational trauma recognize that trauma is changed by its context or chronic nature, but assume that the violence is in the past. Recovery is widely understood as to require the achievement of physical and psychological safety as the first condition. What happens when the violence has been a facet of a person’s whole life and is ongoing, as in so many communities in South Africa?

**Research on the psychological trauma in South Africa**
The authors undertook a literature search of the post 1994 South African research on psychological trauma using the search terms “South Africa” and “trauma” in the PsychINFO, South African Studies, SA e-publications, SocIndex Complete and Humanities International Complete databases. The references within each of the identified articles were also included, to create a Refworks database of the available research within the South African psychological trauma field. The research may be considered within twelve broad areas:

- nation-wide epidemiological studies
- community-based prevalence studies
- child and adolescent epidemiological studies focusing on the effects of community violence on children and adolescents
- the phenomenology of trauma within South Africa
- the psychobiological aspects of trauma, and pharmacological approaches to treatment
• the psychotherapeutic intervention with people who have been effected by trauma – aside from the WITS intervention model, intervention in acute trauma and research on therapist attitudes toward CBT, these are largely case studies and psychoanalytic
• the effects of child neglect, physical abuse and sexual abuse
• the epidemiology and effects of intimate partner violence
• the epidemiology and effects of sexual assault
• the effects past human rights abuse and the Truth and Reconciliation Commission
• the effects of trauma on particular professional groupings: eg. the police, mineworkers, journalists, military, emergency service personnel and students
• the supervision of trauma mental health workers

For the purposes of this paper, the authors will review the literature regarding multiple or ongoing violence, the epidemiology of violence and trauma within South Africa, the psychotherapeutic approaches and the phenomenology of trauma related to criminal violence within the South African context.

With a few exceptions, the South African literature concerning the psychological impact of violence focuses on PTSD as its key reference point. Concern is raised about the impact of ongoing violence and cumulative trauma (here discussing criminal, community and complex trauma) (Williams, Williams, Stein, Seedat, Jackson and Moorman, 2007; Gibson, 2001; Edwards, 2005; Dinan, McCall & Gibson, 2004). In discussing treatment protocols for post traumatic stress, Connor and Stein raise that: “It is widely believed that full recovery is unlikely in the setting of ongoing trauma, such as with continued exposure to abuse and violence in a relationship” – however there is no published evidence or clinical evidence of this (Connor & Stein, 2005: 903).

Straker and the Sancturies team (1987) introduced the concept of continuous trauma within the context of their work with South African youth in the anti-Apartheid struggle. A few South African writers refer to this term (Benjamin & Crawford-Browne, 2001; Bowmann, Bhamjee, Eagle, Crafford, 2009; Gibson, 2001; Swartz, 1999; Hajiyianis & Robertson, 1998) – although there is no further research. Straker’s term is also cited in international literature (Desjairsais et al., 1995; Macksoud & Eber, 1996; Murphy & Stewart, 2006; Garbarion & Kostelny, 1996; Wessels, 2006; Wessels & Monterio, 2008; Reeler, 1995).

The South African Stress and Health Survey (SASH), Williams, Williams, Stein, Seedat, Jackson and Moorman (2007) found that 56.1% percent of South Africans had experienced more than one traumatic event and a quarter of the population had experienced four or more traumatic events
during their lifetimes. The SASH study is the most comprehensive psychiatric epidemiological study using national prevalence data through a representative sample of 4351 South African adults.

Despite the high levels of exposure to violence, the SASH epidemiological study found that only 2.3% of South Africans had a lifetime experience of PTSD (Stein, Seedat, Herman, Moomal, Heeringa, Kessler, 2008). This is particularly low relative to other countries with similar rates of trauma exposure. This study also identified unusually high levels of agoraphobia without panic (9.8%) amongst predominantly people under the age of 40 years – and high levels of substance use disorders with a particularly early onset.

In contrast to this national data, a study of the mental health of patients at a Xhosa speaking primary health clinic found that over 90% of participants had experienced a traumatic event, with 37% meeting the diagnostic criteria of depression, 20% of PTSD and 18% of somatisation. Within this study there were very high levels of co-morbidity, with 75% of the people with PTSD also having a diagnosis of depression. Amongst the sample there was a lifetime PTSD diagnosis of 45.5% amongst women, 42.3% amongst the men, with the PTSD lasting a mean of 4.9 years (Carey, Stein, Zungu-Dirwayi & Seedat, 2003). The duration of PTSD echoes American studies where the worst lifelong trauma lasts 3 years if treated and 5 years if untreated (Kessler, 2000). Of great concern was that these patients were not diagnosed or treated for these illnesses by their primary care medical staff. A rural study of 250 consecutively reporting patients in a rural primary setting in South Africa found a mean trauma exposure level of 3.5 lifetime events, with 12.4% diagnosed with current PTSD (Peltzer, Seakamela, Manganye, Motsei, Mathebula, 2007). In a study of urban people who had experienced violent crime during the previous 8 years, a prevalence of current PTSD of 25.8% was found (Peltzer, 2000).

A community-based study in a violent Cape Town neighbourhood found that two thirds of a sample of 90 help-seeking women had experienced a violent event within the past twelve months, with an annual median of 23 traumatic events (Dinan, McCall & Gibson, 2004). Half of the sample met all the criteria for a diagnosis of PTSD. Significantly, almost the entire sample experienced at least one symptom of intrusion and three quarters had sufficient symptomatology for hyperarousal, but only 55% of the sample had sufficient symptoms within the category of avoidance or numbing to be diagnosed with PTSD. Of concern is the psychological functioning and quality of life of those who within this sample receive a partial diagnosis of PTSD. This possibly echoes the SASH study’s identification of high levels of substance abuse and agoraphobia – and low levels of actual PTSD. This Dinan, Gibson and McCall study was based
in a community where many people grew up under the threat of violence, have had multiple experiences of violence and must recover under ongoing threat.

A recent Master’s thesis research project (Edross, 2008) tracked the comparative recovery of a small sample of 10 women from violent communities on the Cape Flats that had experienced non sexual or sexual assault. After one month, six of the women met the criteria for PTSD, but after three months only one woman met the criteria for PTSD. Despite most of the symptoms of post traumatic stress disorder abating, the research noted that most of the women continued to experience a range of psychological adaptation that affected their relationships, perceptions of self and perceptions of the world.

The SASH data indicate a significant association between the number of traumatic events experienced and levels of global distress (including symptoms of anxiety and depression) (Williams et al., 2007), suggesting that PTSD may not be the best or only diagnostic framework for capturing the impact of multiple trauma exposure in the South African population. This study found that people who have experienced more than six traumatic events were at five times greater risk for high distress. From the same data Myer, Stein, Grimsrud, Seedat and Williams (2008) found associations between higher levels of psychological distress amongst those with lower levels of social economic status and social support – where the increased exposure to traumatic events only partially explained these associations.

Thus, the data on the prevalence is very varied, with a focus on PTSD as the assessment framework. The levels of current PTSD vary between 2, 8% (Stein, et al., 2007) and 55% (Dinan, McCall & Gibson, 2004), despite all four of these studies using measures based on clinical assessment rather than pure self-report. The SASH study describes national data, rather than an examination of the mental health within a violent community – yet these scores seem extremely low given the wide experience of multiple traumas also identified within this study.

There is extensive literature regarding the impact of political violence and community violence on children and adolescents within South Africa. Most of these studies have sampled communities where there are high levels of violence, and there has tended to be a focus on PTSD. A study considering the exposure of youth in Cape Town and Nairobi to violent events and their experience of posttraumatic stress disorder, found that the grade 10s in Nairobi and Cape Town had very similar exposure with Kenyans having a lifetime exposure to violence of 85% and Capetonians 83%. Yet the South Africans had far higher rates of PTSD at 22% and the Kenyans showed 5%. The researchers were unable to account for this, suggesting that perhaps culture or type of exposure may be involved (Seedat, Nyamai, Njenga, Vuthinlingum and Stein, 2004).
Other cross sectional studies considering urban and rural youth in South Africa noted high rates of exposure to violence from between 67% to 95% of the children. Within these studies the percentages of children meeting the diagnostic criteria of PTSD are 5.8% (Ward, Fleisher, Zissis, 2001), 8% (Peltzer, 1999), 19% (Suliman, Kaminer, Seedat & Stein, 2005) and 22% (Ensink, Robertson, Zissis & Leger, 1997). The differences may be understood in terms of the populations studied, and the assessment tools used. Again all these studies have relied on PTSD to describe a presentation that may be far more complex and may include dissociation, depression or substance abuse.

Echoing the international context, the literature concerning the impact of child abuse, child neglect, stress and community violence on children and adolescents considers the issues of risk and resilience within the ecological context of community violence more closely, albeit through the lens of PTSD (Fincham, Altes, Stein & Seedat, 2009). Suliman, Mkabile, Fincham, Ahmed, Stein & Seedat (2009) show that adolescents in the Western Cape are more likely to experience multiple events of violence rather than single incidents. They found that multiple exposures to violence increases the levels of PTSD and depression symptomatology. This study is particularly relevant in indicating that the threat of violence within a community setting is more pathogenic than actual experiences of violence.

Groups based both at the Universities of Cape Town and Stellenbosch are developing a strong body of work regarding post traumatic psycho-biological changes (Stein, Harvey, Uys, Daniels, 2005), and offering treatment protocols drawing on pharmacological and psychotherapeutic strategies for adolescents and adults (Traut, Kaminer, Boshoff, Seedat, Hawkridge & Stein, 2003, Connor & Stein, 2005; Stein, Bandelow, Hollander, Nut, Okasha, Pollack, 2003). This work uses PTSD as its foundation and whilst there are occasionally references to ongoing trauma (Connor & Stein, 2005) the impact is not explored.

The most extensive and focused discussion of psychological trauma in the South African literature arises from a special issue of the "Journal of Psychology in Africa" in 2005. In the first framing article, the editor of the issue, Professor David Edwards, discusses the use of PTSD within the South African context at length. He raises the challenge of cumulative trauma, and the competing schools of thought between the collectivist-individualist schools of psychology. Yet, the construct of PTSD forms the framework for the issue which goes on to explore the epidemiological research regarding PTSD (Edwards, 2005), therapeutic responses to acute trauma (Van Wyk & Edwards, 2005), and a range of case studies and treatment approaches which draw on PTSD or complex trauma. This issue does reflect on African phenomenology
within therapy (McDermott, 2005) and the complex nature of the supervision of trauma practice within South Africa which may be fraught with very particular dynamics of power, advantage, safety and trust (Eagle, 2005).

The WITS Trauma Intervention Model is arguably the most influential psychotherapeutic framework within South Africa (Eagle, 1998a). This offers a brief integrated model drawing on both psychodynamic and cognitive-behavioural therapy to assist survivors of violence. It is extended with a reflection of the psychodynamic issues raised by violence within South Africa (Eagle & Watts, 2002a). The psychoanalytic writers offer analysis of the phenomenology of trauma within the South African context (Walker, 2006), which is broadened to explore the complexity of western trauma treatment models when engaging with the understanding of the meaning of trauma within an African cosmology (Eagle, 1998b; Eagle, 2005; Magwaza, 1999). These later articles remind one of the complexity of working with trauma within cross cultural contexts, particularly as the meaning of violence is core to understanding its impact on a person.

Thus, the literature regarding the psychological impact of violence on South Africans offers a few conclusions, and raises many more questions. It is striking that a large proportion of South Africans have experienced multiple incidents of violence. The research arising from the SASH study suggests that South Africans are perhaps not responding to the high levels of violence with reactions of PTSD specifically, but there are high levels of distress, agoraphobia and substance abuse that are interesting to note. The less resourced community based studies which tend to focus on people living in particularly violent neighbourhoods, suggest higher rates of PTSD, with larger groups within their sample partially meeting the criteria of PTSD. The treatment literature, although brief, focuses the therapist on integrated practice rather than on cognitive-behavioural therapy. This perhaps reflects the more complex presentation of South African clients. A largely invisible, but an essential element of exploration lies in how people interpret and make meaning of the violence that they experience. In contexts where there has been ongoing threat involving more than one generation, where people feel marginalized and have very few opportunities; violence may be perceived differently to less fraught situations. African cosmology, traditional beliefs and cultural practices may shape the meanings given to experiences, and therefore the impact of experiences of violence.

**Continuous trauma – a dynamic within South African trauma practice**

In South Africa, and in the Western Cape in particular, current traumatic experiences of criminal and community violence follow a lifetime of systemic and structural political violence where people were forcibly moved from one neighbourhood to another, oppressed by prejudice and civil
unrest. With this historical background, many adults living in disadvantaged communities still experience oppression and are living in environments characterised by psychosocial problems such as crime, violence, unemployment, poverty, alcohol and substance abuse. It is this repetitive cycle of violence and ongoing lack of safety, that is likely to influence how individuals and communities attach meaning to their experiences of violence, and ultimately manifests in the symptoms and features with which they present.

The four core criteria of PTSD within the DSM-IV diagnosis are not adequate in exploring the psychological impact of violence on people within South Africa’s context of continuous violence. The authors therefore explored the symptoms associated with PTSD, to determine whether this would offer greater resonance with practice experience. The symptoms described by DESNOS bring a wider spectrum of symptoms to the fore and describe the pattern of presentation of Complex Trauma. These symptoms include: dysregulation of a) affect and impulses, b) attention or consciousness, c) self-perception, d) perception of the perpetrator, e) relations with others, f) somatisation, and g) systems of meaning (Herman, 1992).

Other symptoms associated to PTSD include: guilt, dissociative symptoms, self destructive and impulsive behaviour, feelings of ineffectiveness or shame; despair or hopelessness, feeling permanently damaged; hostility; social withdrawal; feeling constantly threatened (APA, 1994). These broader DESNOS and associated symptoms resonate in practice with people affected by Continuous Trauma – although again further exploration is needed to describe the precise character or presentation pattern of this experience. The discussion of how Continuous Trauma manifests in individuals is, therefore, even more far-reaching than PTSD in its complexity and its implications for interventions.

Clients who have experienced violence are strongly associated with having alterations in attention and consciousness (Van der Kolk et al., 1996), which, for purposes of this discussion, forms a possible common denominator across the symptoms of dissociation. Dissociation can be defined as a person’s disconnection or lack of holding connection between things usually associated with each other.

“Dissociative experiences are characterised by a compartmentalisation of consciousness, that is, certain mental events that would ordinarily be expected to be processed together (e.g. thoughts, emotions, motor activity, sensations, memories and sense of identity) are functionally isolated from one another and, in some cases, rendered inaccessible to consciousness and/or voluntary recall” (Steinberg, 1994 cited in webpage of International Society for the Study of Trauma and Dissociation, 2004).
The past recognition of the dissociative symptoms as a significant feature of trauma seems to have become lost more recently (Nijenhuis & Van der Hart, 1999b; Van der Hart, Van Dijke, Van Son & Steele, 2000). There are some authors who acknowledge dissociation as a core feature of traumatic memories (Van der Kolk & Van der Hart, 1991 cited in Van der Hart, Nijenhuis & Steele, 2005). Research shows that the phenomenology of trauma has many more dissociative elements than is indicated in DSM-IV (Dell, 2002). Van der Hart, Nijenhuis & Steele (2005) proposed that traumatized individuals are characterized by structural dissociation that occurs at different levels. They describe that one or more parts of the personality avoids traumatic memories and continues to function in daily life, while other parts remain arrested in traumatic memories and defences. As a result, these symptom groups involve significant and enduring changes in the personality structure. Therefore, the relationship between the dissociative nature of complex PTSD and the underlying structural dissociative effects on the personality are important to consider.

Although the symptoms discussed are largely psychological, there is much recent evidence to support the symptomatology on a neurological level as being researched internationally as well as by the Universities of Cape Town and Stellenbosch discussed earlier. 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. This paper does not allow for an extensive exploration of research on the brain and trauma but much of the research has been shown to provide physical evidence of the long-term impact of continuous trauma (Karr-Morse & Wiley, 2001; Perry, 2001).

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

The case discussion will draw on the criteria of DESNOS and those listed as associated with PTSD, proposing that they all potentially involve some degree of dissociation, and are key features of the Continuous Trauma phenomenology. It is also important to bear in mind that the DESNOS categories are all highly inter-related.

**A CASE study to illustrate the common pattern of presentation of people who have experienced Continuous Trauma**
In order to consolidate an understanding of continuous trauma we have drawn on the experiences of clients seen over the years. A large number of clients have come through the CASE (Community Action towards a Safer Environment) organisation based in Hanover Park since 2001. CASE was founded as an holistic and integrated community-based intervention in response to the nature of continuous trauma in this community.

Hanover Park, a coloured township on the Cape Flats, has become notorious and often referred to as one of the most violent places in South Africa. The population of Hanover Park is about 45,000 with only 26% of the population employed. Of those who earn a monthly income, 57% survive on less than R1600 per month. About 50% of the adults over 20 have dropped out of high school (Statistics South Africa [SSA], 2002).

The people of Hanover Park are exposed to overwhelming community violence from a very young age. It is a community characterised by poverty, unemployment, learning problems, absent male role models and fathers, family dysfunction, broken relationships, domestic violence, alcohol and drug abuse, gangsterism, inadequate access to recreational facilities and all forms of child abuse. These factors provide a foundation for a growing gang culture, fuelling the recruitment of young people into gangs, the drug trade and prostitution.

Many of the children, youth and adults who present at the CASE counseling project share a history of 1) having witnessed or experienced violence repeatedly from an early age, 2) remaining in a context of real threat of life threatening experiences on a daily basis through community violence, and 3) never feeling safe.

Below is a typical presentation of a young man from Hanover Park.

Jonathon*, 19, lives in a low-income urban violent community. He was referred to a CASE school counselor, following an incident where he was stabbed by a fellow learner with a screw driver. He was in Grade 11 and was struggling with aggression and had behavioural problems in school. He also displayed confusion about his sexual identity and was very promiscuous. His teachers also thought he had a learning problem but did not really know what to do with him or where to refer him.

Jonathon struggled to talk in sessions and displayed very aggressive non-verbal behavior. He did not seem to display many traumatic symptoms directly related to the incident but expressed a lot of anger and aggression in the sessions. The stabbing incident soon became the secondary issue. Having grown up and still living in a context of continuous violence, a history of multiple traumas became a more important but broad focus in the counselling. The expected fear of the
perpetrator was masked by anger and vengeful thoughts. There was no expectation or consideration given to reporting the incident as there was hopelessness about justice ever being done. Laying charges, may have also lead to further intimidation by the perpetrator or his fellow gangsters.

During the sessions, as with many clients, the description of his history was sketchy and unsystematic. However, Jonathon became more verbal when it came to sharing more about his past. During this process it was discovered that he was abandoned by his father at 4 years old who had not maintained contact. His mother was abusing tik and left him with his maternal grandmother. She was living on the street with her boyfriend and periodically visited when she needed something. His home consisted of two-roomed flat in the courts, which he shared with his grandmother, his uncle, his aunt and her boyfriend and three of the aunt’s children (4 adults and 4 children). His uncle and aunt’s boyfriend were also using tik. When he was younger he had been physically abused by his uncle and was still constantly verbally abused by his grandmother. He had been molested between the ages of 12 and 14 by a soccer coach in the area. In the last 7 years he had lost several friends and acquaintances to drugs, gangs and prison. This grim picture was described in a very matter of fact tone and with the underlying acceptance of this being normal life. He seemed to be quite cut off from what he was describing.

He was unable to sleep at night and was often on the street with friends until the early hours of the morning. On occasion he would smoke dagga or drink alcohol.

He was agitated and seemed hyperaroused, reading into non-verbal cues and misinterpreting them as threats even prior to the stabbing.

Jonathon appeared dissociated when talking about the stabbing and the sexual abuse. When referring to relationships or sex, he was glib and he displayed little emotion. He felt disconnected from people. He lacked a healthy support structure and believed that he needed to just look after himself. He said that he did not feel he could trust anyone, expressed several violent fantasies and had no other future plans or goals.

**Discussion of the symptoms: - Individual and Interpersonal Impact**

Many clients seen by CASE display similar patterns of presentation. A discussion of the clients’ common patterns of presentation offers insight into the impact of the ongoing community violence on the individual, family and community. However, it is clear that not everyone in the community displays violent behavior nor can every individual living in a violent context be labeled as “traumatized”. The majority of neglected or traumatized children never become violent (Belmore
& Quinsey, 1994). It appears that the impact of living in an environment of continuous trauma, affects many people to varying degrees.

I) Alteration in regulation of affect and impulses
On presentation clients may seem as though they are in initial crisis and unable to cope. However, their defences resume very quickly – due to the urgency of survival in an unsafe environment. It is then extremely difficult to reflect on the trauma – or their overwhelming lack of safety. Affect dysregulation and mood swings can involve dissociative symptoms, where there is a sudden flattening of emotions in response to possible threatening cues or a heightened sense of strong emotion where there is no actual threat. This hyperarousal can occur even when there is no traumatic event. This seems to happen to people who never feel safe, have become used to getting hurt physically and emotionally or experiencing loss, that they start to live with an expectation that something traumatic is about to happen.

Hyper-vigilant children living in a persistent state of low level fear, frequently develop remarkable non-verbal reactions in proportion to their verbal skills. They often misinterpret non-verbal cues. For example, eye contact is read as a threat, or a friendly touch is interpreted as an antecedent to rape or abuse. These assessments might have been accurate in the world they came from. As a result, high levels of aggressive behaviour is observed. A striking difference between individuals with continuous trauma and those who experienced one traumatic incident and lived in a relatively safe environment, was that, the former were more able to express anger, hostility and revenge fantasies while their expression of fear was inhibited while the latter were more able to express their fear.

Clients such as Jonathon express difficulty in controlling their anger. Considerably minor incidences can trigger an aggressive and violent reaction. Several forms of affect or impulse dysregulation may be seen as dissociative symptoms of intrusion. These symptoms can manifest in crying, rage reactions, self-destructive behaviors and impulsive sexual behavior as displayed by many clients. Considering the extent of alcohol and substance abuse in low income communities, this becomes an important cause-effect feature of continuous trauma. Many of the youth and adults who present, either abuse or sell drugs, and young people are exposed to this self-destructive pattern from a very early age. Poor impulse control and the tendency to use drugs and inappropriate sexual behaviours has been seen to be a significant feature of young people in order to express their anger, numb their feelings and to escape from their reality.

These levels of dissociation can lead to lack of empathy and a sense of being unable to connect with and feel for other people and, therefore, not care about others, which in turn can easily result
in the perpetration of aggressive, high risk and violent behaviour. The dissociative phenomenology, therefore also has a significant influence on how trauma manifests within the community, which will be discussed later.

II) Alterations in attention or consciousness

Continuous trauma may involve a more complex structural dissociation that should be distinguished from alterations of consciousness. The PTSD diagnosis does not consider avoidant or numbing symptoms to be dissociative, but in Acute Stress Disorder these very symptoms are labeled dissociative (APA, 1994: 432).

In environments of continuous trauma, memories of some events are avoided or cut off in a dissociative manner to enable the person to cope and the person may lose a continuous memory. This may enable them to survive in their community. Clients sometimes describe feeling like they were out of control or that something else takes over when they are in a rage or committing a violent act. These kinds of descriptions address the possibility of the continuum of the dissociative parts of the personality or transient dissociative episodes.

Dissociation due to trauma also negatively influences the process of academic learning because of its effect on memory. Clients who are traumatised often report fragmented memories and struggle with recalling declarative memory. Children from violent communities are often labeled as learning disabled partly due to their inability to remain attentive, concentrate and process new material in a logical, organized and systematic way. Hyperarousal also presents in the form of other behavioural difficulties such as hyperactivity and attentional problems which is widespread in schools. These difficulties with cognitive organization contribute to a more primitive, less mature style of problem solving - with violence often being employed as a tool (Perry, 2001).

III) Somatization

An aspect of dissociation lies in symptom conversion or somatisation. The connection between early childhood trauma and somatization has been acknowledged by several researchers (Nijenhuis, Van der Hart & Steele, 2004; Van der Kolk et al., 1996; Waldinger, et al., 2006 cited in Tucker & Foote, 2007). Chronic physical symptoms with no medical explanation are very common amongst those living in situations of continuous trauma. Medically unexplained physical symptoms often present in primary care settings such as day hospitals and community medical resources as clients’ unresolved emotional pain manifests in the form of headaches, backaches, stomach aches, problems with diabetes and unregulated blood sugar levels, digestive and heart problems.
IV) **Alterations in self-perception**

When children or adults are continuously exposed to potentially traumatizing events, and when they are unable to integrate these experiences, dissociation of parts of the personality structure can develop. Continuous trauma can lead to very distinct changes in self-perception, and these dissociated parts can also have very different perceptions of self. Individuals often report parts of their dissociated self in a very negative way i.e. a low self-esteem, a sense of worthlessness, guilt and shame and an inability to change. Other parts may see themselves as powerful and taking control even if it is in an abusive, destructive way. These conflicting parts of Jonathon for example lead to an increased sense of self-loathing, internal conflict, and impulsive aggressive behaviour. Clients often tend to minimize the impact of the traumatic events they have experienced in order to create the perception of being tough and resilient despite their circumstances.

V) **Alterations in perceptions of the perpetrator**

For a young man like Jonathon, the physical and emotional resources within the community are deemed to be limited. With his negative self perception of being worthless and powerless, it is very easy for someone like Jonathon to idealise individuals who are perceived to be wealthy, powerful and in control. These individuals often tend to be the perpetrators in violent communities. Gang leaders and drug lords are often revered by children as powerful.

There is also the sense of rationalizing and justifying deviant behavior as a means to an end, which in turn often leads to the victim becoming the perpetrator. On a societal level, there exists the perception that perpetrators can get away with their wrong-doing. Some young people view going to prison as a right of passage and have distorted beliefs about the reality of what happens in prison. These kinds of perceptions shift young people’s sense of morality and their distorted beliefs about becoming a perpetrator.

In relation to this, individuals affected by continuous trauma express more violent fantasies towards perpetrators.

VI) **Alterations in relations with others**

With acute trauma basic assumptions about the world, self and others are shattered and need to be rebuilt. In a situation where traumatic incidences are consistent, trust is constantly being shattered with very little space to restore the ability to trust, which often has not been learned in the first place. Trust is the most difficult aspect of working with victims of continuous trauma. Anyone who has some measure of control over the person i.e male figures, police, teachers, can
be seen as someone who is a threat, reminding them of past perpetrators or their life experience of being out of control.

In situations of prolonged and unresolved stress, the individual’s self-confidence is reduced. When self-esteem is low and individuals become detached from the people around them, it limits his/her capacity for empathy as it is difficult for a person to recognise, acknowledge and appreciate other people’s situations, and therefore, puts the individual at risk for victimizing others.

In violent communities sometimes the caretaker, experiencing continuous trauma, becomes the perpetrator of violence towards the child. This creates a dynamic where the continuously traumatised adult perpetuates an act of violence in the form of abuse that could lead to the presentation of complex trauma in a child. Chronic abuse or neglect negatively influence the ability to develop a secure attachment, and the development of interpersonal relationships with oneself and with others, is therefore, inhibited by a severe experience of disconnection from other people (Ogawa, Sroufe, Weinfeld, Carlson & Egeland, 1997 cited in Van Der Hart, Ellert, Nijenhuis & Steele, 2005).

VII) Alterations in systems of meaning
Dissociated parts of the personality may have quite different systems of beliefs and meanings associated with trauma. The identity of being a powerless victim in a community is a greater focus than being a victim of a traumatic incident. This sense of helplessness, hopelessness and powerlessness may result in the victim behaving rudely or aggressively, in order not to appear helpless. Clients may try to find meaning in being a victim of their environment or system as opposed to just an incident. In the context of shame and very low self-esteem, some survivors may make others the victim, such as the gangsters who impose their power on a powerless community from which they too have grown, or men who impose their power on women and children. The sense of hopelessness in individuals living in continuous trauma environments is seen in their inability to plan for the future or establish set goals for themselves. The ongoing belief for some seems to be that their situation is hopeless and because their world-view has always constituted some belief that their environment is an unsafe place, they feel unable to thrive physically and psychologically, and develop to their full potential.

Again there are others who seem to refuse the victim identity and seek to empower themselves and not appear helpless or powerless. Many clinicians would describe individuals such as these as “resilient”. Harvey (2007) suggests that resilience is multidimensional and that perhaps people can present with both complicated trauma and resilience for example in a situation where they
seem to be coping during the day but may struggle with nightmares and insomnia in the evening. This can also be explained by the idea of structural dissociated parts of the personality, and therefore, brings a possible relationship between dissociative features of continuous trauma and the notion of “resilience”.

Resilience has been a very controversial concept and there have been many different critiques levied at the construct due to the many ambiguous and contentious ways it has been defined in research (Luthar, Cicchetti & Becker, 2000). For purposes of this paper “resilience: can be defined as: “the ability to thrive, mature and increase competence in the face of adverse circumstances...further the adverse circumstances may be chronic and consistent or severe and infrequent. To thrive, mature and increase competence, a person must be able to draw upon all of his or her resources: biological, psychological or environmental” (Gordon, Longo & Trickett, 1995).

Individuals living in violent environments may seem to find a level of resilience in order to survive. They may seem to be stoically moving on. However, these clients may also seem to have at some level dissociated from and depersonalized their ongoing trauma. In a sense they have cut themselves off from the biological, psychological and their environment, thereby, inhibiting their ability to thrive, mature and become competent. Some literature (Freidman & Higson-Smith, 2002), would therefore, argue that this resilience may just be a masking of their experiences, and does not necessarily exclude the existence of dissociated, unresolved pain and grief or other underlying maladaptive responses. The notion of resilience, particularly amongst those living in marginalised and violent contexts, has been questioned, citing neurological and emotional consequences as core reasons for scepticism about how clients present.

When one considers the fact that very few people seek assistance with PTSD in South Africa, (Freidman & Higson-Smith, 2002), it is important to reflect on whether this small presentation reflects resilience, or rather a larger group of people who are not actually identified by current definitions because the dissociative parts of themselves hold the belief that they need to move on as they do not have the resources to be distressed.

This kind of “resilience” can be seen on a continuum of trauma-related structural dissociation of the personality that then impacts one’s ability to function as a human being with feelings, reduces one’s capacity to work and learn, as well as to parent one’s children. Already strained by economic disadvantage, a family’s nurturing and protective capacities may be further disrupted or incapacitated by existence within an environment of violence in which issues of safety and survival take precedence. The ability to nurture, protect and reassure a child may be stretched
for a parent who is equally at physical risk and therefore emotionally drained and disengaged. Individuals who have developed these kinds of strategies to cope may have an adverse effect on their communities. Although this negative resilience occurs at an individual level, high violence exposure occurs on multiple levels including family, community and society.

**Discussion of the symptoms: - Community impact**

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.

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 commonly believed that violence begets violence (Widom & Maxfield, 2001). These cycles of violence occur when individuals or groups become trapped in a circular process that perpetuates violence or leads to the repetition of violent acts. For example there is also considerable evidence that men who abuse children are traumatized through their own abuse as children are at risk for suffering PTSD symptoms (Widom, 1999 cited in Lisak & Beszerczey, 2007). This evidence extends to children who are traumatized through exposure to violence, whether in the home, or in their surrounding communities (Suglia, Ryan & Wright, 2008). PTSD and associated experiences of trauma have long been identified as a risk factor for violence.

Through identifying the key causes of violence, we will be better able to develop strategies to prevent violence in the first place. There has been extensive research on the subject of violence across the various disciplines– including anthropology, biology, criminology, psychiatry, psychology, social work, and sociology. Wortley (2008) describes how each discipline has developed specific theories to explain criminal and violent behaviour. Some of these perspectives focus on the influence of the biological and psychological characteristics of an individual. At the other end of the continuum, structural theorists propose that social challenges such as poverty, oppression, social inequality and racism must be considered when developing an explanation of violent behaviour. Others place the emphasis for the source of violence on family dynamics, neighbourhood characteristics or peer socialization.

Given the literature, perpetuating influences on the cycle of violence and trauma need to be further explored ecologically. In addition to being cyclical, violence and, therefore continuous
trauma is intergenerational. The effects of dissociative and other traumatic symptoms can be transferred from one generation to the next if no intervention takes place.

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.

In addition, socio-economic factors such as unemployment, over-crowded housing, lack of recreational activities, high drop-out rates from school, substance abuse and gangsterism all contribute to the momentum of the cycle of violence. A young child born into an environment of cyclical violence, experiences the impact of continuous trauma, and consequently, easily becomes the newest generation to suffer the effects of abuse, neglect and trauma. Thus, developing a further pattern of complex trauma and increasing the likelihood of becoming a future perpetrator. According to Goldsmith, Barlow & Freyd (2004) abuse by a parent or other trusted caregiver is more likely to evoke dissociation than is abuse by a stranger. If no intervention is undertaken with this child, this in turn, among other issues, can lead to this child repeating the patterns of the previous generation of dissociation, instilling the same lack of values, low self-esteem, demoralization and aggression in raising his / her own children. In this way the cycle continues.

Many children and youth have no other experience other than living in unsafe environments where they witness and/or are victims of violence and death on an almost daily basis in their families, in their schools and in their communities. This is the reality for many young people growing up in South Africa and particularly in the Western Cape.

These kinds of traumatic events “breach the attachments of family, friendship, love and community”, “undermine the belief systems that give meaning to human experience” (Herman, 1993 cited in Pomeroy, 1995, 90).

Trauma in these communities disables human connection, and impacts not only the individual but the traumatised individual also has an impact on the wider social system. This destructive cycle compromises the resilience of communities and the connectivity of individuals and families. The
impact of violence then becomes pervasive and extends across different systems. This is when many regard communities, for example in the Cape Flats, to be dysfunctional and where the individual’s ability to function adaptively is hampered not only by the mental health difficulties but economic and social challenges too.

In conclusion
PTSD does not adequately capture the pattern of symptom presentation by people who live in contexts of continuous violence. The majority of people living in violent contexts do not become violent. However, these individuals may carry their scars in other ways, stoically living their lives disconnected from themselves and others. Continuous trauma, therefore, is better described as an underlying pattern of dissociation that has an enduring maladaptive psychosocial impact on the individual. This in turn influences the interpersonal relationships of the individual and the environment in which he/she lives.

Although the concepts of “Complex” and “Continuous” trauma differ, there appears to be a need for further research into the relationship between the two concepts, particularly in the context of the cycles of violence experienced in many South African communities. Further research using inductive reasoning is required to understand the experience of continuous trauma on individuals, families and communities. The systems of meaning and perceptions around this violence, the psychosocial impact of such experience in terms of culture, resilience as an ecological concept and related patterns of illness are areas that need to be further explored.

South African mental health practitioners and researchers can no longer ignore the very specific challenges faced by communities that are already marginalized and facing unbelievable odds. It is essential that these experiences are better understood so that more effective and integrated intervention strategies and programmes may be designed.
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