PRINT: ISSN 0973-5070 ONLINE: 2456-6772
Ethno Med, 8(2): 173-185 (2014)
DOI: 10.31901/24566322.2014/08.02.08

Trauma in Context: Narrative Themes on Responses of Trauma Survivors in South Africa

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KEYWORDS Trauma. Trauma Survivors. Cause of Illness. Treatment. South Africa

ABSTRACT In this paper, the researchers investigate trauma survivors' understanding of causes of illness and the treatment choice. The study was conducted in the rural communities of the Vhembe District in South Africa. Seventy-five participants were purposively selected for the study. Focus group discussions were conducted with the participants. Data were analysed using thematic content analysis. It emerged from the study that the participants perceived trauma as the financial problem that an individual experiences after a traumatic event and a feeling of loss and grief. They gave symptoms of trauma that fit the DSM-IV criteria. Future study with a larger sample is recommended to increase the transferability of the findings to people in similar situations.

INTRODUCTION

Hamber and Lewis (1997) define trauma as an event that overwhelms an individual's coping resources. This definition mostly includes events involving death or injury, or the possibility of death and injury that are said to be unusual and out of ordinary, and do not constitute part of the normal course of life. Generally, trauma includes both natural catastrophes (like hurricanes, floods, or fires), and man-made violence (like war, concentration camp experiences and other forms of victimisation). Violence also constitutes some form of trauma. This psychosocial distress is defined by Walter in Hamber and Lewis (1997) as a"destructive harm that does not only include physical assaults which damage the body, but also the many techniques of inflicting harm by mental or emotional means".

Injuries that may result from violence may be either physical or psychological. Psychological abuse is referred to as an aspect of the violation of the victim in physical violence, such as in torture and wife battering. Therefore, violence can be physical and/or psychological in nature, which might result is posttraumatic stress disorder.

Posttraumatic Stress Disorder (PTSD)

According to the American Psychological Association (2000: 463), PTSD refers to a set of typical symptoms that develop following exposure to an extreme traumatic stressor. For instance, it involves direct personal experience of an actual event or threat of death, serious injury or other threat to one's physical integrity. In addition, it entails witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. Traumatised individuals experience some changes after traumatic incidents.

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Origination of PTSD

The modern concept of PTSD originated in combat-related trauma. In World War I, the term "shell shock" was employed, implicating brain damage associated with exposure to explosions. In World War II, terms like "combat fatigue" continued to imply that physical reactions were at the root of the disabling symptoms. The psychiatric morbidity associated with Vietnam War veterans finally brought the concept of "posttraumatic stress disorder" to fruition. The appearance of the disorder was roughly correlated with the severity of the stressor, that is, the most severe stresses (for example, incarceration in concentration camps) (Kaplan and Sadock 1998).

Neurobiological Changes Associated with Post-traumatic Stress Disorder

Posttraumatic stress disorder is associated with numerous neurological, physical and psy-

chological changes. There may be neurobiological alterations in the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdala. The hippocampus and the amygdala are involved in the processing and integration of memory. The amygdala has also been found to be involved in coordinating the body's fear response (Dunitz 2000).

People with posttraumatic stress disorder tend to have abnormal levels of key hormones involved in the body's responses to stress. Furthermore, thyroid functioning also seems to be enhanced in people with posttraumatic stress disorder. Cortical levels, in people with PTSD are lower than normal and epinephrine and norepinephrine levels are higher than normal. People with posttraumatic stress disorder also continue to produce higher than normal levels of natural opiates after the trauma has passed (Kaplan and Sadock 1998). PTSD also impacts on psychosocial functioning that include family and other interpersonal relationships, problems with employment, and involvement with the criminal justice system**.**

Psychological and Physiological Characteristics

Individuals with posttraumatic stress disorder tend to develop avoidance behaviour. They might seek, whether consciously or unconsciously, to avoid contact with anything, anyone or any place associated with the original incident. These individuals may avoid talking about major incident, which is a complicating factor where intervention or treatment is concerned (Friedman 2002). There is also an attempt to avoid thoughts, and emotions associated with the traumatic incident. This results in problems associated with concentration, skills deterioration, difficulties in expressing emotion, and the development of a pessimistic outlook (Kinchin 1994).

Physiological and psychological arousal is also noticeable in the startle response. For example cases such as when a person over- reacts to a sudden noise or flash of light. Individuals with posttraumatic stress disorder's general stress levels can be quite high. This can lead to physical symptoms including irritability, outbursts of temper, frustration, and even violence. These individuals may feel unsettled at home and work, and may also feel that they have nothing in common with anyone. Another common characteristic is hypervigilence (Dunitz 2000).

Re-experiencing

Victims of posttraumatic stress disorder experience reactions and emotions associated with the incident. This may result from the direct association with the incident or can apparently come out of nowhere as the result of subconscious associations. In direct association, something experienced or seen reminds the victim of the original trauma. The reminders are not always obvious, covering as they do the entire range of sense, sight, sound, smell, taste and touch. These subconscious reactions can happen at any time and anywhere. They are so unexpected that they can be very frightening, even to the extent of being terrifying for both the victim and for those around them.

Denial

Denial is a common characteristic, particularly amongst men, and this complicates intervention and treatment options. In denial, a person refuses to accept that a problem exists and will quite strongly resist and ignore any evidence to the contrary.

The Likelihood of Developing Posttraumatic Stress Disorder

Individuals who are likely to develop PTSD include those who have experienced greater stressor magnitude, the sexually victimized, those who are vulnerable to factors such as genetics, early age of onset and longer lasting childhood trauma, lack of functional social support, and concurrent stressful life events. Other victims of PTSD include those who report greater perceived threat or danger, suffering, terror, horror or fear' and those with a social environment that produces shame, guilt, stigmatization, or self-hatred (Friedman 2002).

Friedman (2002) furthermore states that posttraumatic stress disorder can become a chronic psychiatric disorder that can persist for decades and sometimes for a lifetime. Patients with chronic posttraumatic stress disorder often exhibit symptoms marked by remissions and relapses.

There is also a delayed variant of posttraumatic stress disorder in which individuals exposed to a traumatic event do not exhibit the posttraumatic syndrome until months or years have passed. This is precipitated by a situation that resembles the original trauma in a significant way.

The Health Belief Model

The Health Belief Model was originally proposed by Rosenstock in 1966 and modified by Becker. It highlights the function of beliefs in decision-making (Naidoo and Wills 1994). According to this model, individuals are influenced by how vulnerable they perceive themselves to be to an illness, injury or danger (that is, their susceptibility) and how serious they consider it to be, that is, severity (Royal College of Psychiatrists 2010). In an African culture, for example, it is generally believed that witches fly by night, delight on eating human flesh, and use familiar animals like hyena, or baboons, as their means of transport. They are believed to be wicked and malicious human beings whose intention is simply to kill, which they do by poisoning, or cursing their victims. This belief system influences most Africans to perceive themselves as being vulnerable to any type of disease as bewitchment can take any form (Foulks et al. 1977).

Most Africans perceive themselves as vulnerable to bewitchment (their susceptibility). They believe in magical power, which they believe can be used through spells and curses to harm or kill, as well as to protect members of their families, their homestead, cattle and other property, from witches and all those considered to be enemies of the family. Any disease or disorder that befalls a family is viewed as punishment from displeased ancestors. In cases where families experience sickness that is believed to originate from the dissatisfaction of the ancestors, such sickness is perceived as a threat and thus families consult traditional healers for advice with regard to the performance of the necessary rituals. Performing such rituals is regarded as a cure to the disease and it is perceived as beneficial.

If, in the perception of the family, a move to consult a traditional healer is regarded as being expensive or if the sick family member is opposed to consulting traditional healers and prefers western doctors at the hospital, perceived barriers in the belief system occurs. This leads to family members weighing the threat of the disease against the difference between benefits and barriers, with subsequent decision made on whether to consult or not to consult a traditional healer, with the likelihood of taking recommended preventative health action.

Cognitive Theories of Posttraumatic Stress Disorder

Cognitive theories propose that individuals bring to a traumatic experience a set of pre-existing beliefs and models of the world, of others, and of themselves. These mental representations are a product of an individual's prior experiences. When trauma occurs to individuals, information provided might be highly salient or incompatible with these pre-existing meaning structures. Cognitive theories maintain that the process of attempting to integrate trauma-related information into existing models leads to various phenomena that characterize posttraumatic stress reaction (Yule 1999). Successful resolution of trauma is possible when new information is well integrated into the existing models. Unsuccessful resolution occurs when individuals are unable to bring the new trauma- related information into accord with their pre-existing conceptualizations of both the self and the world (Kinchin 1994). Different cognitive theories focus on different aspects of disparity between pre-existing mental representations and new trauma related information.

Horowitz's formulation of Stress Response Syndromes

The most influential cognitive model of reactions to trauma was formulated by Horowitz (1986). This theory emphasises a "completion tendency which is the psychological need to match new information with inner models based on older information, and the revision of both until they agree". Horowitz (1986) further states that there is an initial "crying out" or stunned reaction subsequent to the experience of trauma. This is then followed by a period of information overload in which thoughts, memories and images of the trauma cannot be reconciled with current meaning structures. Therefore, there is an initial failure to complete. A number of psychological defense mechanisms come into play

to keep the traumatic information into the unconscious. The individual then experiences a period of numbing and denial (Yule 1999).

The completion tendency maintains the trauma-related information in the active memory. It causes the information to break through these defenses and intrude into consciousness in the form of flashbacks, nightmares and unwanted thoughts as an individual endeavours to merge the new information with pre-existing models.

Janoff-Bulman's Cognitive Appraisal Theory

According to Janoff-Bulman (1992), posttraumatic stress disorder is the result of basic assumptions about self and the world as being shattered. It is assumed that personal vulnerability, the perception of the world as meaningful or comprehensible, and the view of the self, all provide structure and meaning in the individual's life and they cannot be maintained in the face of a traumatic experience. He furthermore indicates that the experience of vulnerability, the perception of the world as meaningful and comprehensible, consequently shatter, thus plunging an individual into a confusion of intrusion, avoidance, and hyper arousal.

Janoff-Bulman (1992) further maintains that individuals with a premorbid history of psychological problems are more likely to develop posttraumatic stress disorder following a trauma. It might be presumed that these individuals might be characterized within Janoff-Bulman's self in a negative light. Such premorbid negative assumptions are unlikely to be shattered by a traumatic experience; rather the assumptions are more likely to be confirmed.

Foa's Fear Network

Foa and Riggs (1993) formulated the Fear Network that encompasses information about cognitive, behavioural and physiological reactions to an event. Information links these stimulus and response elements together. Foa and Riggs (1993) further mention that the activation of the trauma related fear network by cue stimuli (that is, reminders of the trauma) causes information in the network to enter conscious awareness (the intrusion symptoms of posttraumatic stress disorder). When such activation of the network is avoided and suppressed, a cluster of avoidance symptoms of posttraumatic stress disorder develop. According to Foa and Riggs (1993), successful resolution of trauma can only occur when the information in the fear network is integrated with existing memory structures.

Cognitive Action Theory

According to Chemtob et al. (1998), the Cognitive Action Theory is a product of research with veterans of the war in Vietnam. This theory's perspective is similar to that of Foa and Riggs (1993) though it has more detailed analysis of the structure of fear network which is formulated in terms of a localized connectionist architecture. Chemtob et al. (1998) argue that with individuals with posttraumatic stress disorder, the fear network is permanently activated, hence causing them to function in a "survival mode". A survival mode is a way of functioning that was adaptive during the traumatic incident. The permanent activation of the network leads to the symptoms of hyper arousal and intrusion. This theory is compromised by its narrow emphasis on combat-related trauma and the fact that it offers little explanation why individuals remain in "survival mode" while others do not. The two above-mentioned theories contributed to the formulation of The Information Processing Theory

The Information Processing Theory

The Information Processing Theory was formulated by Creamer et al. (1998) and derived from the themes of Horowitz, Foa and Chemtob theories. Like Creamer et al. (1998) argue that the network must be activated for recovery from trauma to occur and this is referred to as Network Resolution Processing. Creamer et al. (1992) differ from Horowitz since they suggest that there is an initial period of intrusion during which an individual copes by calling upon a range of defensive and avoidant strategies. They argue that this initial intrusive experience can be used as an index of the degree of network resolution processing that is occurring. Hence, high levels of initial intrusion are a predictor of successful recovery whereas low levels of initial intrusion are a predictor of poor outcome or chronic pathology.

Brewin's Dual Representation Theory

This theory was formulated by Brewin (1989). It proposes two levels in memory at which trau-

ma related information can be presented. The first level of representation is of an individual's conscious experience of the traumatic event, which is called Verbally Accessible Memories (VAM). The Verbally Accessible Memories contain sensory, response and meaning information about the traumatic event. The second level of representation is the Situationally Accessible Memories (SAM), which contains information that cannot be deliberately accessed by an individual and is not available for progressive editing. This theory suggests that the VAM and SAM representations are encoded in parallel at the time of trauma. For example, symptoms of dissociative memories or flashbacks would be considered to be resultant from the activation of SAM. On the other hand, a person's ability to recount the trauma in a therapeutic situation would be a function of the accessibility of VAM representations.

The above-discussed cognitive theories of PTSD pose different ideas about how trauma-related information leads to various phenomena that characterise posttraumatic reaction. However, the central assumption is that traumatised individuals bring pre-existing beliefs and models to the traumatic experience. The cultural framework is important to discuss, as people can be more easily understood from their cultural background. In this study a cultural framework is discussed in order to understand Africans' worldview of their belief system, their understanding of causes of illness and the treatment choice.

METHODOLOGY

Research Design

This was an exploratory study whereby a qualitative method using focus group discussion for data collection, was utilised. Neuman (2000) argues that an exploratory study is a study into an area that has not been fully researched. Much is not yet researched about on how Africans understand PTSD, especially in the Limpopo Province of South Africa.

Participants and Setting

Ten focus groups with a total of seventy-five participants were drawn using purposive sampling method. Participants were drawn from people who were involved in traumatic incidents that include road accidents, murder, rape domestic violence and housebreaking. The sample was drawn from the rural communities of the Vhembe District. Each group consisted of six to ten members from different villages in Thulamela and Makhado municipalities. For the purpose of this study, the direct victims of violence, as well as their family members and relatives were found relevant, as they were involved in trauma inducing events either directly or indirectly.

Sampling

Purposive sampling was used to select the participants. It refers to the selection of participants who can make meaningful contributions to the issue under study (Neuman 2000). Such participants have knowledge and/or experience with the phenomenon under investigation. Thus, purposive sampling focuses on sampling techniques that are based on the *judgement* of the researcher. The *participants who were* selected for inclusion in the *sample* were survivors of PTSD.

Research Instrument

Focus group discussions were conducted. According to Struwig and Stead (2001), focus group discussions refers to a carefully planned discussion designed to obtain individuals' perceptions on a defined area of interest in a permissive, non-threatening environment. The discussions that were held between the research participants enabled the participants to discuss issues that were relevant to the study. The discussions focused on the participants' understanding of trauma, symptoms of trauma, impact of trauma on the survivor, social support and the coping styles used. The above listed issues formed part of the interview guide.

Procedure

Telephonic requests were made with some known members of the Thulamela and Makhado Municipalities to contact people who were involved in traumatic incidents. These people, those who were requested to contact traumatised people, were told about the purpose of the focus groups and the confidentiality involved. Members of civic structures and pastors were

among other people who helped to organise group members from the mentioned communities. Appointment dates were organised for each focus group and discussions took place as arranged.

Two sessions were held per week for each focus group. Each session lasted for an hour and a half. Some sessions were conducted in churches and others were held at the victims' homes. The focus groups were conducted in Venda which is the mother tongue of the participants and the researchers. It was explained to the participants that the sessions will be confidential. Participants' consent was sought for the use of a tape recorder to keep record of the sessions. Tape-recorded information was transcribed immediately after the sessions and later translated from Venda to English, and back translated for validation purposes.

Trustworthiness

Marshall and Rossman (1999) maintain that research should respond to principles that are regarded as criteria in which trustworthiness can be evaluated. These principles are viewed by Lincoln and Guba in Marshall and Rossman (1999) as classical contribution to the methodology of qualitative research. They are credibility, transferability, dependability and confirmability. These four constructs establish the "truth–value" of a study. The truth-value refers to the applicability, consistency and neutrability. One may argue that credibility; transferability, dependability and confirmability may be matched with internal validity, external validity, reliability and objectivity, which are appropriate for the positivist paradigm and inappropriate for qualitative inquiry (Marshall and Rossman 1999). The four constructs that are appropriate for qualitative inquiry are discussed next.

Credibility

In qualitative research, credibility is maintained by an inquiry that ensures that the subject is accurately identified and described (De Vos et al. 2002). In this study, continuous interaction with participants through focus groups ensured that the subjects were accurately identified and described.

Transferability

Transferability refers to the applicability of one set of findings to another context (De Vos et al. 2002). They further argue that the demonstration of applicability of one set of findings to another depends on the investigator who should make the transfer rather than the original investigator. Interestingly, there are researchers who regard transferability as a weakness in the approach. In order to counter challenge this idea, the researcher can refer back to the original theoretical framework in order to show how data collection and their analysis will be guided by concepts and models (Marshall and Rossman 1999). In this study, the findings might be useful in clinical setting to help traumatised people. That is, the findings can be used by helping professionals in South Africa, considering the fact that the study is conceptualised from the African cultural perspective.

Dependability

Dependability is the third construct. It refers to an attempt by the researcher to change conditions in the phenomena chosen for the study. This applies to the changes in the design created by a refined understanding of the setting. However, qualitative researchers can assert that qualitative research cannot be replicated because of the changing world. They plan to keep notes or log that record each design decision and the rationale behind it. Their procedures, protocols, and decision can thus be inspected (De Vos et al. 2002). In this study the protocols, procedures and decisions have been recorded. All collected data are well organised in a retrievable form and are easily available in order to challenge the notion of the changing world.

Confirmability

Lincoln and Guba in Marshall and Rossman (1999) emphasise the need to ask whether or not the findings of the study could be confirmed by another. Due to the fact that the sample of this study was small, the findings are less generalisable.

Data Analysis

Thematic content analysis was used to analyse the data. Tapes were transcribed from Venda (the language of the interviewees) to English and back translated to Venda for validation purposes. The data were coded, analysed, through

reading and re-reading of responses. The rationale for reading and re-reading is that the researcher becomes familiar with the data in intimate ways. People, events, and quotations sift constantly through the researcher's mind (Marshall and Rossman 1999). The data were then analysed using four steps:

Step 1: Analysis of Individual Transcripts

This step involves reading individual transcripts in several different ways. Firstly transcripts were read as a whole noting general impressions. Major opinions and attitudes that were expressed by the groups were considered. When transcripts were read for the second time specific things that were looked for, which were mainly from the objectives of the study, were noted. Sections that were poorly transcribed and did not make sense were removed. The transcripts were coded through marking sections in a way that indicated what the participants talked about. The final step in reading the transcripts involved using the list of required information and checking what information have been obtained.

Step 2: The Logbook

The logbook was used to keep all the responses together according to the topic of interest. Each response was entered, unless it was exactly the same as another. The main aim was to retain the full range of responses.

Step 3: Writing the Results

Results were not only written from the logbook, but also from the notes that were made while reading transcripts as a whole. As many reported results from the focus groups did not indicate how many focus groups or participants discussed a certain issue, results will say "many respondents said…" or "only a few groups discussions raised the issue of…."

Step 4: Interpretation

Throughout the study the researchers were thinking about the significance of the information that was collected in terms of the problem or question that they wanted to answer and to develop ideas about what the respondents said. Results were looked at and summaries were written.

Ethical Considerations

Participants in this study were informed about the nature and purpose of the study. Complete information about the study was explained for participants to comprehend the purpose of the study. This was done in order for participants to make a voluntary decision about their participation (De Vos et al. 2002). Participants were informed that they will be involved in focus groups and the study is for educational purposes. It was clearly indicated that each focus group would last approximately 45 to 90 minutes. The researcher also explained to the participants that freedom is respected and as such they had to participate voluntarily, without any physical or psychological force.

Furthermore, they were informed that they would benefit from the focus groups as they would share their traumatic experiences among themselves. Confidentiality and privacy was assured so that participants were safe from exposure (Denzin and Lincoln 2000). Information from focus groups was given anonymously in order to ensure privacy of subjects. However, participants were informed that a tape recorder will be used so that participants' privacy cannot be affected if the tape recorder is used as a hidden apparatus.

RESULTS

Figure 1 shows that the participants reported that trauma refers to the financial problem that an individual experiences after a traumatic event and a feeling of loss and grief.

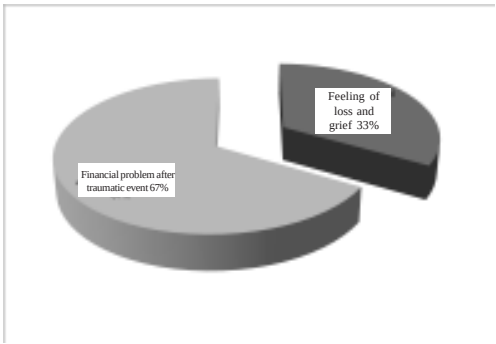

Fig.1. Participants' understanding of trauma

Figure 2 shows that the commonly reported symptoms of trauma were avoidance of people, places and activities (30), difficulty falling asleep (22), recurrent thoughts, images and memories (22), physical diseases (18), helplessness (13) and fear (13).

Recurrent Thoughts and Images

Some participants reported to have thoughts and some images about the trauma incident, especially in cases where traumatic incidents ended in death. This is demonstrated by the following statements:

…I just have these images of him which I am not sure of and I do not know whether he was just pieces or what? (RP 12)

Sometimes even if I am sitting alone that whole part of the accident just come back. (RP 17)

Somatisation of Symptoms

In many focus group discussions, many participants reported of being diagnosed of physical conditions after trauma. Some participants had some physical conditions after exposure to a traumatic event. The following response reflects this idea:

I was so terrified by the death of my husband during house breaking…… I feel the pain in my whole body. (RP 35)

Impact of Traumatic Event on the Trauma Survivor

Lack of Trust

It was reported that after being raped, the survivors developed lack of trust in male individuals. The finding is illustrated by the following statements:

My case made me to feel that maybe it is better for me not to walk around anymore because I do not trust any male person who I come across. (RP 41)

…She does not become free with male people even her father, which means that she does not trust him. (RP 63)

After the two incidents that I experienced, I am telling you that even today I do not trust any male person. (RP 68)

Self-blame

Some participants also reported that they blamed themselves for the incident. It appears that they think they should have done something that could have prevented the traumatic incident. Some participants said:

After the death of my son the biggest problem that I had was that I blamed myself that if I could have gone to church such an incident would not have happened. (RP 15)

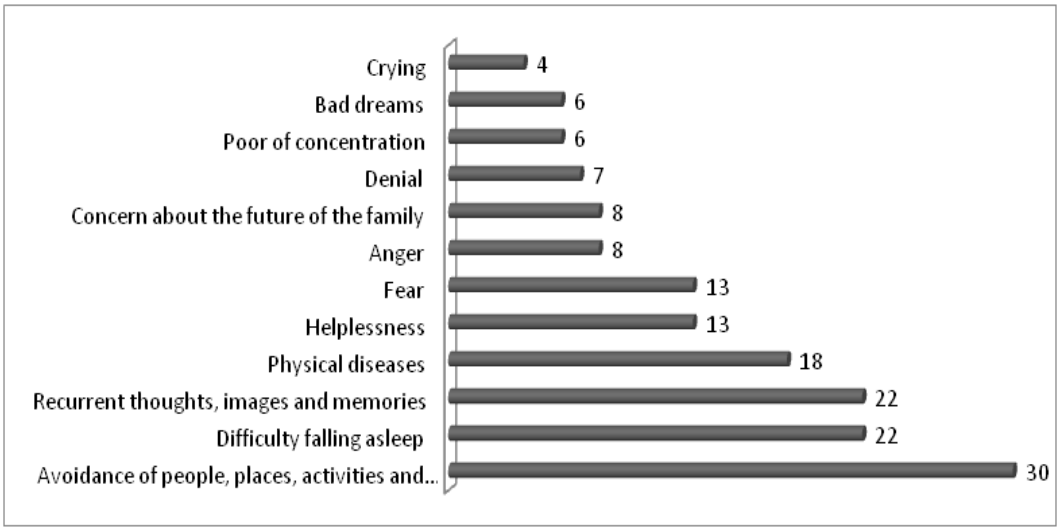

Fig. 2. Symptoms expressed following trauma

After my uncle's death I recalled that someone told me that my uncle will be killed but I ignored it and I blame myself for not doing anything about it. (RP 34)

Anger

It emerged from the discussions that it reacted to the traumatic incident with anger as in the following extracts:

…..those people who killed my husband should be heavily sentenced because it is painful to see them walking freely when one is suffering with the children. (RP 10)

So whenever I see that gentleman or even when I think of him I feel very angry and sometimes feel like I do not even want to meet him in the streets. (RP 46)

From the discussion above it is evident that people are indeed living in a violent environment. People experience violence in all forms and that traumatises them extremely. Belief systems held by people seem to influence their choice of treatment. It also appears that age too contribute to the choice of the method of intervention. Of great concern is that it seems there are those who are not exposed to any type of intervention especially that lack of early intervention might lead to complications and the development of PTSD which could have been avoided. The cultural aspects that seemed influential in the decision on the type of intervention include interdependence and the need for acceptance by the family. However, respondents seem to associate the symptoms that they experience with the traumatic incidents that they experienced. A Venda term for the experiences is "mazhuluzhulu".

Economic Impact after Trauma

In some instances, traumatic incidents included the death of the breadwinner. Family members and relatives experience grief and loss and do not concentrate on the trauma itself. They usually become concerned about the financial responsibility that they are faced with after the incident. They do not even talk about their feelings concerning how the incident happened. This is reflected in the following extracts*:*

The financial burden that I carry, I always think is because of what really happened. (RP 11)

My biggest problem is that my late brother used to help me financially. The other thing is that I feel I am missing him more especially when I have financial problems. (RP 27)

Some participants who survived traumatic incidents did not want to focus on their feelings following the traumatic experience but wanted to replace expression of those feelings with complaints around lack of finances. The following statements support the finding:

…after the accident it was difficult for me to continue working because I was unable to stand on my own, so my business stopped and that was my source of income. This thing depressed me as I was no longer working and the children look at me for financial support. (RP 4)

I think it will be better if we really get help because sometimes after the accident we are unable to work for ourselves and it becomes a problem of who will support us. (RP 32)

Like myself, I stated that I am a single parent and my children are looking at me for financial support then it means I should somehow be helped. (RP 41)

Role Change After the Experience of a Traumatic Incident

For some participants, the traumatic incident, which ended up in death of a relative, did not only bring financial responsibility, but also the parental responsibility as in this response:

I think about what happened always when there is an accident. It disturbs me and I am always forced to think and feel that it is because of what happened that is making me face the responsibility that I have. This is also because being responsible for your siblings is a big task more especially because I am a male person who is supposed to see that everything is in order. (RP 16)

Lack of Self Disclosure

Culturally, Venda speaking people do not easily disclose their secrets, to strangers. During focus group discussions, it was not easy for the participants to disclose feelings and even the incidents that happened to them. A few participants indicated that it was unable to disclose their traumatic incidents to strangers. Some participants mentioned people who have never been traumatized couldn't understand what they are

going through that is why they feel that they cannot talk about their experiences. The following responses reflect this:

…the worst thing with me is that this happened after some trauma which I cannot talk about now. (RP 18)

I can say that it is not easy to talk about our experiences because they were traumatic in such a way that we do not want to talk about them anymore. (RP 54)

The above given extracts indicate that participants were unable to talk about their feelings and emotions after they were being traumatised. This is different from the western method of treating PTSD whereby debriefing is done immediately after the victim experiences a traumatic incident. The victim is encouraged to talk about what he /she saw, heard, experienced and also about his/her feelings. In some cases debriefing prevents the development of PTSD.

Social Support and Coping Style

Perceived Lack of Emotional Support

Almost all of participants indicated that after a traumatic incident, traumatized people need emotional support from family members and relatives. In some cases, traumatised people do not get that support and this appears to add more trauma to them. This is supported by the following statements:

Sometimes you rely on relatives and you find out that they do not even support you in anyway. (RP 8)

On the issue of not being supported by family members, I think I experienced that myself as I had to go to the hospital alone and no single relative came with me. Maybe this was because my husband's blood brothers had all died so lack of support made the pain worse. (RP 60)

I think a person needs help, as sometimes you do not get support from the family members. (RP 72)

I think traumatized people need support as sometimes we feel like no one wants to come next to us. (RP 73)

Avoidance as a Coping Strategy

As a coping strategy, forty percent of the participants reported the use of avoidance to deal with the trauma that they experienced. These people avoid places, people or activities that remind them of the trauma. It appears that it is also because they want to repress their feelings so that they do not deal with the trauma directly. This is reflected in the following extracts:

Since that time of the accident, I do not want to be in a car anymore. (RP 19)

The problem with me is that I do not want to walk alone at night. (RP 32)

My case made me to think that maybe it is better not to walk around anymore…If the topic about rape is discussed on the radio sometimes I prefer to switch it off. (RP 40)

With me the biggest problem is that I cannot walk alone. (RP 63)

I think the accident affected my life because I felt like I do not want to use a car anymore in my life…When other children are talking accidents, I feel that I do not want to talk about it. (RP 64)

I experienced a problem of not wanting to meet my co-worker even in the passage because I always thought he will still be having the gun with him. (RP 72)

Some participants avoid talking about their feelings and use their spirituality to deal with trauma. They repress their feelings and avoid talking about those feelings as they believe God will help them deal with trauma without talking about it. This is reflected in the following:

You know, myself as a Christian I am the happiest even though I went through that pain because I believe that God is going to carry this entire burden for me. (RP 6)

…So I really believe in prayer as something that helps in many problems. (RP 65)

DISCUSSION

The findings from this study provided important insights concerning the understanding of PTSD and how it is managed in the Limpopo province. The study revealed different kinds of traumatic incidents that cause trauma in South African, the Limpopo Province in particular. Such events, that impact on people's lives, include rape, murder, road accidents, and house/business breaking and domestic violence.

Participants perceived traumatic incidents to be caused by unemployment, poverty, substance abuse, witchcraft and belief in ancestors. Unemployment and poverty were viewed as fac-

tors that lead to crime and violence that traumatise people. It is maintained that perpetrators of violence commit crime as a means of getting money for survival since most of them are unemployed. Collins (2004) holds that poverty and unemployment in the community result in stealing, with subsequent drop in interpersonal relationship.

Participants indicated that substance abuse by young people in different communities leads to many forms of violence. Jewkes (2002) holds that connections between violence, drinking and drunkenness are socially learnt. Thus, alcohol was noted as a cultural "breaktime" that provides the opportunity for antisocial behaviour. It also became evident from the study that some of the acts of violence involving the use of guns and knives are committed by people who are under the influence of drugs. Martin (1998) found that research undertaken at 10 mortuaries throughout South Africa indicate that young males are most at risk of firearm injuries or death.

Interestingly, though many participants reported unemployment, poverty and substance abuse as causes of traumatic incidents, others attributed their traumatic experiences to external locus of control. They were able to link their traumatic incidents to punishment by their ancestors. Van Dyk (2001) maintains that blaming factors such as witches and sorcerers prevent feelings of guilt and alleviates anxiety. It also helps people to impose meaning on the things that happen to them to provide answers that are scientifically unexplainable.

Some participants indicated that witchcraft is caused by jealousy in cases where some families or individuals show progress in life. It also became evident that in those instances where traumatic events happen and participants lack explanation for such events, witchcraft became the sole explanation. Such ideas stem from the cultural interpretation of mishaps and misfortunes that befall people. Such personal belief system sometimes play a protective role for trauma survivors in that the impact of trauma on existing beliefs allow individuals to view the trauma positively (Ogden et al. 2000).

The study pointed out that after exposure to trauma, participants were presented with anger, denial, avoidance, experience of loss, which had economic consequences and a need for emotional support. These are some of the symptoms of PTSD according to western method of diagnosis. Dean (1997) holds that veterans often express their PTSD by self-blame, survivor guilt, and grief and anger. With self-blame and survivor guilt, the veteran felt as if he was in some way responsible for the death of a comrade. As a result of this self-blame and survivor guilt, these veterans also feel grief and anger. This was also expressed by participants in this study.

As noted in the findings, participants expressed anger that was directed towards perpetrators who caused the traumatic incident to their family members and themselves. Some participants expressed their anger at perpetrator that they attributed to witchcraft. Some went to the extent of relocating from their long term residences to avoid sharing their neighbourhood with people they regarded as witches.

Participants used denial as a coping strategy in cases where there was death after a traumatic incident. It became evident that belief in witchcraft was an important contributing factor in the use of denial in dealing with trauma. This was mostly evident in cases where there was death after a traumatic incident. Death was attributed to witchcraft and denial was a prominent reaction at the time of receiving death news and after the funeral which sometimes seemed to complicate the process of dealing with trauma effectively. Most participants use avoidance to cope with the loss that they experience following trauma. They avoid talking about the experienced traumatic incidents, places and people that remind them about the traumatic incidents. This leads them to making claims of having reached closure on the issue, and thus end up not wanting to talk about their experience during the focus group discussions.

Triandis (1994) argues that Africans disclose more within the in-group and less towards the out-group than do individualistic cultures. This idea is supported by Canive and Castillo (1997) who maintain that Africans, like traditional Hispanics cultures confide in family members and do not believe in disclosing intimate emotional problems to strangers. That is why some participants in this study too were not keen to disclose their traumatic experiences during the focus group discussions. Similarly, some victims of domestic violence were reported to have declined help from outsiders to protect their family from being shamed. Some people did not mind protecting their marriages as against getting divorced, since all that may be required is that they disclose their abuse to strangers.

The study indicated the need for emotional support for traumatized people by family members and relatives after an experience of trauma. Participants expressed need for family members to support them emotionally after their loss. Their concern was worsened by the fact that victims experienced financial problems, especially in cases of the death of a breadwinner. Traumatized people are reported to be vulnerable towards the development of physical or exacerbation of pre-existing conditions of the cardiovascular system, the gastrointestinal tract and the respiratory system. Hypertension, heart attack, stroke, ulcers and asthma are also known conditions that develop as a result of intense events (Friedman 2002). The current study indicated that after exposure to traumatic incidents, participants suffered from physical conditions that include stroke, hypertension and arthritis.

According to the DSM-IV-TR (APA 2000), abnormalities in sleep patterns and dreaming are associated with PTSD. Traumatic nightmares may arise out of REM (Rapid Eye Movement) or non-REM sleep Friedman (in Everly and Lating 1995). Similarly, participants from this study also reported dreams related to trauma related incidences they experienced and the inability to sleep the whole night or at least part of the night following experiences of trauma.

The study also revealed that many participants experienced recurrent thoughts and images concerning the traumatic incident. This, in many instances, was accompanied by financial problems that participants reported, especially after the death of a family member. This was most evident from participants who were still students. They maintained that, after the traumatic incident they were unable to concentrate on their studies. This contributed to poor performance.

CONCLUSION

In the present study, some participants reported that they talk to pastors and this is similar to the debriefing process in the Western methods of treatment. There were, however, some participants in this study who reported the inability to disclose traumatic experiences to strangers. This is contrary to the western psychotherapists' expectations in debriefing whereby traumatised individuals are encouraged to talk about their feelings, emotions and what they experienced. Participants indicated that social support from family members is crucial, especially because some traumatic incidents lead to health and economic hardships for survivors. Religion has a prominent place in the lives of many survivors. Prayer was used as a method of suppressing nightmares, intrusive thoughts, and images about traumatic experiences. Thus, the participants used prayer as a coping strategy to deal with feelings of loss experienced by participants.

Whereas the Western method of treatment concentrates on treating symptoms, some participants in this study were concerned about the causes of the traumatic incident rather than the symptoms that they experienced. That is why in seeking treatment they consulted traditional healers who usually point out their perceived cause of a traumatic incident. This becomes a challenge to psychologists who received Western training, as their training does not include pointing out the causes of a traumatic incident. Both the Western and African methods of treatment are aimed at helping patients. One may now argue that it seems, from the findings in this study that the treatment methods from the Western and non-western perspectives adequately complement each other and in some cases the methods indicate similarity in the conceptualisation of the impact of trauma on the individuals.

RECOMMENDATIONS

There seems, however, that there is a need for patients to use both Western and African treatments as there are some methods that treat PTSD symptoms better than others. For the use of methods like debriefing, which seems to be difficult in the African way, therapists need to show sensitivity to the belief system of Africans. It is recommended that the study be conducted among different ethnic groups in South Africa in order to get both a broader and deeper understanding of the phenomenon. Furthermore, there should be an increase in the size of the sample to enable the generalisability of the findings.

LIMITATIONS OF THE STUDY

This study has some limitations. Key among them is the fact that the sample comprised of only Vendas, which is one tribal group in the province that is mainly dominated by Tsongas, Pedis, and Afrikaans and English speaking peo-

ple. It could be interesting to find out how these different groups understand and interpret PTSD from their cultural perspectives. Another limitation is that the sample size for this study was small. In addition, the topic is also sensitive; therefore, the findings from this study are less generalisable.

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