Trauma in context: a conceptualisation of traumatic stress among rural Zulu-speakers in KwaZulu Natal

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Abstract

This research explores the relationship between social, cultural and politico-historical factors and the interpretation of events as causing disruption and significant distress in the lives of rural Zulu-speakers in KwaZulu Natal. Focus groups, each comprising a different category of first-language Zulu speakers were conducted, namely a youth group, a women's group, a group of traditional and faith healers and a group of community health workers. The groups were conducted in Zulu, recorded and then transcribed and translated into English. The translated transcripts were then analysed for common themes. It was found that explanatory systems of illnesses, based on the African worldview produce a tendency to cluster events into 'paths of distress' that are endowed with traumatic meaning. These paths are initiated by events that are significant in terms of people's history and culture. They are an attempt to describe how the connection and relationship between events, which are to a large extent outside of one's control, contribute to a concept of 'trauma' or 'suffering' that implies disruption and distress on an ongoing and wider scale than is captured in the Western concept of PTSD. A profound sense of failure and a breakdown of community relationships and processes are some of the effects of such paths.

Introduction

Recourse to the definition of Post-Traumatic Stress Disorder (PTSD) as the dominant model of traumatic stress, has been called into question many times since it first appeared in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980. This has been largely due to the difficulties involved in attempting to define something as personal and subjective as the distress that results from external threats to a person's life or physical integrity, whether they be experienced directly, or witnessed.

While the DSM classification of PTSD does capture the essence of the traumatic stress that results from one-off traumatic stressors that involve threats to life or actual taking of life, it has been suggested that in many instances such a formulation is limiting, both in terms of traumatic stressors and people's experience of them. Thus numerous alternative models of traumatic stress have emerged in response to a need to understand the experiences of people who do not meet the PTSD criteria, but who are nevertheless suffering traumatic stress and in need of some kind of intervention (Becker, 1995; Bracken, 1998; Brown, 1995; Eagle, 2002; Herman, 1998; Root, 1992; Straker, 1987; Summerfield, 1995).

In terms of its applicability to non-Western cultural contexts, Marsella, Friedman & Spain (1996: 116) describe PTSD as an ethnocentrically-biased concept that does "not encompass or include the experience of non-Western people, particularly with regard to their notions of health, illness, personhood, and normality, as well as their expression of symptomatology and phenomenological experiences...".

This is the first of a two-part article and constitutes an extensive review of the literature that has informed the research on the conceptualisation of traumatic stress amongst rural Zulu speakers in Kwa-Zulu Natal. Specifically, the aim of this research was to explore the relationship between cultural values, norms and attitudes, and the experience, expression and interpretation of events that cause distress and disruption in their lives to the extent that they are motivated to seek help. The methodology and discussion of findings are presented in the second part.

Psychology - a form of 'cultural colonization'?

Western psychological thought is based on certain assumptions about the person and the world, which are derived from the Western developed world. However, the resulting psychological theories of human functioning are often held up as being universal, suggesting that the same mental illnesses exist across cultures. This view is most evident in the DSM, now in its 4th edition (DSM-IV), which attempts to provide a classification of mental disorders that can be applied across all cultures.

While the DSM-IV has made some attempts to incorporate cultural considerations into its diagnostic categories, according to many writers it still has a long way to go towards making any significant gesture to differentiating between the experiences of mental disorders cross-culturally (Castillo, 1997; Swartz, 1998). Good (1997), while acknowledging that there may be broad categories of mental illness that are universal, maintains that cultural differences constitute more than the superficial differences of labelling and expression. In his view, "definitions of normality, psychological experience, specific symptom presentations, patterns of onset and duration, and even the clustering of symptoms into categories vary across cultures" (Good, 1997: 238).

Mkhize (in press) maintains the spread and adoption of Western psychological thought in the developing world is a form of "cultural colonization" and has resulted in psychology, both in research and practice, not meeting the needs of people from different cultural backgrounds. He calls for a recognition of indigenous approaches to psychology that take a collective sense of self and the African worldview into consideration.

Concepts of self

Markus & Kitayama (1991: 224) believe that "construals" of self not only "influence, but in many cases, determine the very nature of experience, including cognition, emotion and motivation". Therefore, they surmise that the basis of the failure of Western psychological theories and practices to address the needs of people from non-Western cultures, lies in their foundation on an independent, self-contained, and autonomous concept of self, made up of internal attributes that influence behaviour.

Markus & Kitayama (1991) refer to this construal of self as the *independent* view of the self. They contrast this with the *interdependent* view of the self, to which many cultures other than Western

subscribe. Markus & Kitayama (1991: 227) describe the experience of interdependence as "seeing oneself as part of an encompassing social relationship and recognizing that one's behavior is determined, contingent on, and, to a large extent organized by what the actor perceives to be the thoughts, feelings, and actions of *others* in the relationship". Internal attributes are not seen as stable within the person, but as being specific to situations and do not have a huge role to play in influencing behaviour.

In the case of psychological trauma, Markus & Kitayama (1991: 246) suggest that "a given event involving a particular actor will be perceived as arising from the situational context of which this actor is an interdependent part, rather than stemming solely from the attributes of the actor". Thus, feelings of guilt commonly associated with traumatic stress responses (APA: 1994), may not be present in someone with an interdependent sense of self. Similarly, responses such as personal stigma and loss of self-esteem will most likely be experienced differently, as what it means to be "a person of worth" will have a different meaning according to an interdependent construal of self (Markus & Kitayama, 1991).

The African worldview

According to Markus & Kitayama (1991), the basis of the interdependent or collective sense of self of indigenous African populations is their metaphysical system or worldview". People draw on their metaphysical system or worldview to explain their reality, as well as their place and purpose in the world.

Four interdependent philosophical assumptions of the African metaphysical system are directly relevant to psychological processes as they influence attitudes, values and opinions as well as thoughts and behaviour. These are the *hierarchy of beings*, the *notion of vitality*, the *principle of cosmic unity* and the *communal view of personhood* (Mkhize, in press).

According to the African worldview, all things in the universe are arranged in a hierarchy with the Divine power or 'God' at its apex. The relationships and lines of communication between the living, the ancestors and the Divine power or 'God' are defined by this structure. The ancestors comprise people that commanded respect when they were living and for whom certain rituals were performed so that they could be integrated into the ancestral body. They play a pivotal role in people lives as they have

the means to protect and discipline the living and they also provide the conduit through which the living can communicate with 'God'. They are essentially benevolent and do not actively act against people, however can withdraw their protection leaving people vulnerable to misfortune and sickness (Mkhize, in press; Ngubane, 1977).

The *notion of vitality* or life force refers to the belief that all things in the hierarchy are interconnected and interdependent, bound together by a common spiritual energy (Azibo, 1996; Mkhize, in press) This is relevant to psychology due to its influence on ideas of causality, particularly of negative events. Usually, life forces are positive and harnessed to enable people to live harmoniously together with each other and nature. However, the interactional nature of life forces almost gives them a life of their own and so can influence events in a way that is not readily understandable. The implications of this are two-fold: on the one hand, nothing happens by chance; and things happen outside of people's control. Thus, an essential part of understanding a misfortune such as illness or 'accident' would be to ask questions around why something happened, why it happened to a particular person, in a particular place and at a particular time.

The assumption of *cosmic unity* means that all things are interconnected, both influencing and being influenced by each other. This particularly applies to knowledge and refers to the fact that things cannot be understood out of context. This is in sharp contrast to the Western concept of knowledge, which implies a certain distance and abstraction. This assumption underlies the fact that the African medical model or explanatory system of illness does not separate problems of the mind from those of the body or those of the self and societal problems. This can result in a meaningful clustering of symptoms that appears unusual to Western practitioners. The meaning of symptoms and the way in which they are clustered together will be further discussed below.

Finally, *communal life* refers to the collective view of relationships. Thus, identity is achieved through communion with others and particularly through family relationships. People find meaning in their lives through their community.

The dynamic nature of culture and ethnocultural identity

In undertaking research with a particular ethnic group, such as the Zulu ethnic group, it can be tempting

to want to try and find true representatives of a particular cultural group. Not only is the possibility of achieving this more and more unlikely, it is in fact not at all desirable as it does not reflect reality. According to Swartz (1998: 215), the search for the "true rural village, homogeneous and untouched by other cultures" assumes that the world is "neatly-divided" into different cultures. However, it has become a truism that cultures, and groups within cultures, are influenced by and influence others. In other words, cultural meaning systems are dynamic and perpetually in dialogue with other bodies of knowledge (Mkhize, in press).

In order to understand human experience in any context, not only does one need to take into account the particular worldview of the culture that operates in that context, but also the ethnocultural identity of the person. Marsella defines ethnocultural identity as the "extent to which an individual or group is committed to both endorsing and practicing [sic] a set of values, beliefs, and behaviors which are associated with a particular enthnocultural-cultural tradition" (cited in Marsella, Friedman & Spain, 1996: 117). This definition suggests that individual ethnocultural identity can be placed on a continuum from a point which implies a large commitment to the other end, where an individual has a small commitment.

Furthermore a person's ethnocultural identity may change according to changing needs and circumstances. This leads to the existence of multiple identities within one person that "emerge in response to situation demands and prerequisites" (Marsella, Friedman & Spain, 1996: 118). This notion was supported in a study of Xhosa-speakers' experience of schizophrenia, in which Lund and Swartz (1988) found that the patients drew simultaneously on both traditional African and Western scientific cultures depending on which was more appropriate for their needs at the time. As such they concluded that "people can simultaneously maintain different sets of meaning in a context of multiple cultural belief systems" (Lund & Swartz, 1988: 67). This was particularly evident in the anomaly that was shown to exist between their explanatory models and their preferred mode of treatment in that they tended to understand their condition in terms of mystical or spiritual terms, but believed that psychiatric medication was the most effective treatment.

The implications of these definitions are that variations in how people define their ethnocultural identity within an ethnocultural group are large. One must be careful in doing studies on ethnic groups to be aware that the labels used to differentiate between groups, such as 'ethnicity', 'language' and 'cultural

area', while implying homogeneity, actually mask an enormous social, economic, and cultural diversity of the people and their communities (Good, 1997). "Culture is far less associated with place or community today than ever before, and any study of culture must begin with heterogeneity, stratification of power and wealth and contested claims" (Good, 1997: 243).

Models for understanding illness

At the most fundamental level, different worldviews bring with them distinctly different ways of understanding illness. Then, if one combines this concept with the dynamic, interactive nature of cultures, it is evident that there will be many different ways of experiencing and interpreting illness.

Explanatory systems

One of the major proponents of the relativist view, Kleinman (1988) called for clinicians to make the patient their starting point in understanding illness in order to make more appropriate and effective interventions. Drawing on medical anthropological research, Kleinman referred to the patients' experience, expression and interpretation of their health situation as the *illness narratives* or *explanatory systems.* These explanatory systems, also referred to as medical subcultures by Good & Delvecchio Good (1981), provide distinctive ways of understanding human suffering and healing. They "provide models of illness, models of human physiology and personality and forms of therapy which are grounded in a particular cosmology, epistemology and set of values" (Good & Delvecchio Good, 1981: 175).

The following processes all contribute to the experience of illness - the monitoring, evaluating, categorising and explaining of signs, coping with the practical problems, as well as deciding when to seek care and from whom. People's commonsense knowledge of how to understand and treat illness is shaped through local cultural orientations. However, there will always be variations within each cultural group and between individuals, as expectations change during interactions in different social situations (Kleinman, 1983). In other words, "an illness or a symptom condenses a network of meanings for the sufferer: personal trauma, life stresses, fears and expectations about the illness, social reactions of friends and authorities, and therapeutic experiences" (Good & Delvecchio Good, 1981: 176).

Kleinman (1988) terms the patient's subjective interpretation of their health problem, *illness.* This is

differentiated from *disease*, or the health professional's re-interpretation of the problem according to theories of a disorder. It is in this process of re-interpretation that the psychosocial aspects of the patient's *illness* are lost and so often not attended to (Kleinman, 1988).

Lastly, *sickness* as the "understanding of a disorder in its generic sense across a population in relation to macrosocial (economic, political, institutional) forces" (Kleinman, 1988: 6). What this means is that everyone - patients, families and healers - interpret the illness further as a reflection of social problems, such as poverty, oppression and this, in turn, can influence the course or outcome of the disorder.

An African view of illness

It is recognised that due to the dynamic nature of culture and variations in ethnocultural identity within ethnic groups, not all Africans will subscribe exactly to the worldview described here. However, according to Ngubane (1977), there does appear to be "an affinity between the different [African] cultures regarding the worldview", and as such, it can be expected that the African worldview will produce a particular medical subculture or explanatory system, through which people understand illness.

Writing specifically about the Zulu ethnic group, Ngubane (1977) identifies two categories of illness. Firstly, there are illnesses that are linked to biological factors that present as somatic symptoms. These are common to all people, both in and outside Africa. These are usually identified by symptoms, which are treated with appropriate medicines, including Western type medicines.

A second category of illness is linked to elements or influences in the environment to which people may be vulnerable. The existence of these things is explained by the notion of the *hierarchy of beings* in the African worldview, which implies an interactive relationship between all things in the universe, including people and the environment. It is believed that people and animals leave something of themselves in the environment as they move through it and also that through healing practices elements of disease are removed from a patient and discarded into the atmosphere. Thus, the environment naturally contains many dangers that can potentially cause someone to fall ill. In addition, the existence of these dangers opens up the possibility that others can manipulate these elements to intentionally cause harm to others others through sorcery.

In order not to fall prey to these elements, people need to strive to maintain a form of balance between both themselves and their environment and between each other. Good health or balance in an individual is conceived "not only as consisting of a healthy body, but as a healthy situation of everything that concerns him [sic]. Good health means the harmonious working and coordination of his [sic] universe" (Ngubane, 1977: 27-28). This includes maintaining good relations with the ancestors.

This last category of illnesses are identified by their cause, not their symptoms. This concept becomes important in the treatment of such diseases, as one needs to treat both their symptoms and remove their source for treatment to be effective.

The meaning and clustering of symptoms

An important part of the explanatory system used by the patient and cultural group as a whole is the types of bodily sensations they respond to and group together. Recognised as contributors to an illness, these sensations become symptoms, which in turn clustered together, become an illness or disorder.

Origins of this phenomenon hark back to the worldview of the people who experience the sensations, specifically, how things are related to each other in the universe, and in particular, the relationship between the mind and body. For example, it is evident that people from Western cultures, who view the mind and body as being separate, are likely to have more difficulty in associating somatic symptoms with psychological problems than people from collective cultures who believe that "the body is an open system linking social relations to the self, a vital balance between interrelated elements in a holistic cosmos" (Kleinman, 1988: 11).

In fact, in an empirical, predominantly Western psychological model, symptoms are integrated and related to each other in a "physico-functional manner". This is not necessarily the case in other cultures. Good & Delvecchio Good (1981) propose that "given a certain disease or pain stimulant, culture affects the way an individual attends to the diverse sensations and transforms them into medical complaints. The most critical and problematic variables seem to be the meaning a symptom has for the patient and the idiom or language in which distress is experienced and communicated" (Good & Delveccio Good, 1981: 173). The concept of an illness, then, is constructed by the grouping together of configurations of meanings and experiences based on culturally accepted knowledge about the body and the self. At

some point, these 'meanings' become 'truths' and certain symptoms become expected responses to certain illnesses (Kleinman, 1983). Thus, people from non-Western cultures may group together symptoms that are seemingly unrelated from a Western perspective.

The way in which Western psychiatry deals with such exotic clusters of symptoms is to place them into categories known as *culture-bound syndromes*. There are many examples of such syndromes, an extensive list of which are included in an appendix of the DSM-IV. According to a psychiatric-medical model, they are understood as "culturally-dressed up versions" of existing disorders, such as anxiety disorders and depression (Kleinman, 1987: 26). However, according to Kleinman (1987) and other medical anthropologically-grounded theorists (Good, 1997), culture-bound syndromes are better understood as 'idioms of distress' that use the body as a medium to communicate personal, social and political distress.

Treatment implications

The existence of multiple explanatory systems has important implications for treatment of health problems. Practitioners need to be aware of these different perspectives and that these can interact with each other to influence the lived experience of the patient. Furthermore, they need to be aware of what symptoms are seen as relevant to each other and discover why. Commenting on the work of Kleinman, Swartz (1998: 15) writes, "the job of the clinician is not only to understand the patient's explanatory model, but also to negotiate between the professional explanatory model and that held by the patient, so that there can be some common ground and a basis for treatment which will be acceptable to both. Conversely, Kleinman (1983) states that ignoring or not examining the meanings that a person attaches to their illness can contribute to a vicious cycle, in which the person does not receive the care they need which increases their distress and leads them to seek further help, and so on.

Based on the explanatory model framework, Good & Delvecchio Good (1981) propose what they call a *cultural hermeneutic model of clinical practice.* The purpose of such a model "is to enable the physician to elicit and analyze the meaning illness has for a patient and consciously and successfully translate across medical subcultures" (Good & Delvecchio Good, 1981: 178). This entails investigating the patient's explanatory model and 'decoding' the patient's semantic illness network. The explanatory model consists of significant experiences and symbols that define the patient's reality. These

experiences are likely to cluster together and be linked to important values of a patient's subculture or to powerful conscious or unconscious affects. "Several such clusters of seemingly diverse phenomena may be condensed by a single illness or symptom and these clusters related to each other through a network of cross-cutting meanings" (Good & Delvecchio Good, 1981: 180).

Attribution of meaning to trauma

There is general agreement amongst those who take a critical view of the DSM-IV's diagnostic category of PTSD, that responses to trauma are mediated by culture. Not only does culture influence ways of expressing distress, but also how meaning is attributed to traumatic events (Eagle, 2002; Summerfield, 1995; Kirmayer, 1996; Jenkins, 1996; Bracken, 1998; Lykes, 2002).

Why do many people who have witnessed or experienced traumatic events not become what Summerfield (1995) describes as 'psychosocial casualites'? In his view the answer lies more in social, cultural and contextual factors than in individual psychological factors. How someone attributes meaning to the event is a major factor in determining whether or not they become "traumatized" (Summerfield, 1995). Witchcraft is a classic example in African societies. Events that appear trivial to some people can take on terrifying proportions if they are interpreted as evidence of black magic or witchcraft. "Where such beliefs are prevalent they may not, in themselves, indicate individual pathology but may reflect widespread social concerns or conflicts, manifested in particular individuals who are vulnerable not only because of their personal characteristics but also because of their social positions" (Kirmayer, 1996: 139). Similarly, in groups where fear is a major attribution for illness, people will identify recent upsetting events and reinterpret them as being more intensely fearful than they were. This can complicate the identification of traumatic stressors where the effects of traumatic stress are suspected.

Attribution of meaning is especially relevant in cases where there is differential exposure to different kinds of stressors and specifically, where personal stressors are combined with social stressors. In such contexts one 'trauma' or a set of 'traumas' may disguise the existence of others. This phenomenon has been observed in context of wars and political oppression (Summerfield, 1995; Becker, 1995; Straker, 1987; Straker, Moosa, Becker & Nkwale, 1992). For example, Summerfield (1995) observed in his work with people displaced by war in Nicaragua that while PTSD signs were very often present, they were not a priority for them to attend to. Often they were not even concerned with the PTSD symptoms to the

extent that people saw a symptom such as hypervigilance as useful and necessary for surviving in a dangerous situation.

There is also a need to look at the relationship between culture, gender and trauma. For women in contexts of war, or in situations of high levels of criminal and community violence and extreme poverty, the stressors will be multiple. Not only may they experience traumatic events on a daily basis, but they may also be subjected to interpersonal violence such as rape and assault (Summerfield, 1995; Lykes, 2002; Jenkins, 1996). In cases such as these, it is not clear which trauma they will respond to, or if indeed they will respond at all. Commenting on women who have experienced rape and destruction of their communities during the Bosnian war, Summerfield (1995: 20) suggests, "these women have all experienced multiple traumas, and we cannot necessarily assume that it is "rape victim" that primarily defines them in their own eyes, or that the rape victim can be meaningfully separated from the "bereaved mother", "widow", or "refugee." Nor can we predict which of these experiences may be the hardest to survive in each woman's case". As such, Jenkins (1996: 176) states in the case of women, "differential exposure to particular kinds of stressors must be examined in the separate context of gender status, power inequities, and culturally sanctioned misogyny, which generate particular types of socially produced disorders".

The meaning a person assigns to trauma then is informed by their relationship with society, which takes into account the cultural, social, and political forces operating in that society (Summerfield, 1995). Kirmayer (1996) proposes a model of how illness and traumatic experience take on meaning in which the individuals experience, expression and interpretation of sensations are embedded in a wider social context and are influenced by social practices and culturally based illness and symptom schemas. In his view, understanding trauma is not a matter of linking cause and effect . It is a process of coping and adapting that takes place over time and in which memories and attributions are called upon to make sense of the experience and maintain a person's position in society (Kirmayer, 1996: 155). Therefore by focussing on the narrow definition of trauma, practitioners may ignore the wider dimensions of the situation and intervene inappropriately.

Contextual models of trauma

There is substantial literature that lends support to the concept that the experience, expression and

interpretation of trauma is embedded in the social and cultural context. Proponents of this view do not reject the Western conceptualisation of trauma, but rather view it as a culturally-determined product that is appropriate for a particular cultural and moral context. The social, political and cultural realities of the context in which trauma occurs "structure the individual's response to violence by determining the practical context in which violence occurs and in which the individual recovers. They also structure and determine the meaning of the event for the individual and the community involved" (Bracken, 1998: 55).

Contexts of war, oppression and human rights abuses

In response to the widespread trauma experienced by black South Africans due to political upheaval and accompanying political violence in the 1980s, Straker (1987) developed a model of intervention for what she called the *continuous traumatic stress syndrome.* Her model took into consideration cultural, political as well as social issues. However, her main focus and concern was on the social and political realities of these people, which meant that they had no safe place to return to. This had major implications on the type of therapy she proposed.

In addition, she found that many of the black youth she counselled did not display the classic symptoms of PTSD, or if they did, recovered very quickly. Apart from some factors relating to personality traits and resilience, she proposed that the absence or failure to display symptoms may have been due to societal and cultural factors, such as their identification with a political movement.

In contexts of human-rights abuses, Becker (1995) suggests that the traumatic experience of people is likely to be cumulative and continuous. He refers to such experiences as *extreme traumatization*, or "an individual and collective process that occurs in reference to and in dependence of a given social context (Becker, 1995: 107). In other words, trauma cannot be separated from its context. Becker (1995), therefore proposes that interventions in this type of trauma should focus on the traumatic process rather than on symptoms. However, he recognises that this is difficult to achieve and calls for an interdisciplinary approach to interventions as such a conceptualisation of trauma means that people may present "with any kind of symptomatology in any kind of health service" (Becker, 1995: 108).

Trauma in collective societies

In societies that subscribe to a collective worldview, like traditional African societies, when trauma

occurs on a large scale, for example, in contexts of war or situations in which there is widespread criminal violence, it can also affect whole communities by disrupting community bonds and relationships (Eagle, 2002; Lykes, 2002; Summerfield, 1995).

If one considers the African metaphysical concepts of the interconnectedness of all things in the universe and 'balance', then it follows that a traumatic event is likely to be seen as disrupting the harmonious flow of energy and cosmic unity of the universe. The result of this can be an extreme form of social alienation in individuals, not only from people around them, but from their ancestors as well (Eagle, 2002).

Other writers also note that such social alienation is a common experience of individuals belonging to a collective culture who experience traumatic events, and it may be of greater concern than the experience of individual distress or the experience itself. For example, Summerfield (1995) reports that Filipino women who had been raped by soldiers often ended up as prostitutes in Manila because there was no longer a place for them in their rural communities. The trauma for them was about the destruction of their community more than their individual experiences. Similarly, Eagle (2002) writes that the social rupture that occurs in mass-traumatic situations, such as war and politically-based violence may override in importance the classic symptoms of PTSD suffered by individuals. Similarly, Manson (1997) found that the social isolation, avoidance and psychic numbing experienced by Vietnam veterans had a more devastating effect on the interpersonal lives of American Indian veterans, than on that of their white counterparts. "The salience of this appears to be much greater for them than for their white counterparts whose alienation from more nuclear families in unlikely to pose as widespread a disruption of personal identity" (Manson, 1997: 254). Conversely, the inability to hold down a job was not viewed as impairing as it was to white veterans as steady employment and educational qualifications do not contribute so much to the male identity in Indian society (Manson, 1997).

In South Africa the disruption of social networks that has resulted from political violence and the more recent spread of criminal violence, appears to have resulted in feelings of distrust amongst members of communities that is manifested as passiveness and/or aggression in the face of violence. This goes some way to explain the measure of desensitization that has been observed in people exposed to violence, and in some cases the rise of incidents of vigilantism. Furthermore, the disruption of social

cohesion in a community means that people who experience traumatic events are less likely to receive the support they need from their families and other members of the community and so risk experiencing the trauma more profoundly (McBride, 2002).

Treatment issues

The social, political and cultural realities mentioned above will also influence which interventions will be available and appropriate (Bracken, 1998). Most writers agree that there has to be a shift in focus from healing individual mental states to collective recovery of communities (Summerfield, 1995; Lykes, 2002; Bracken & Petty, 1998; Draguns, 1996; Crawford-Browne & Benjamin, 2002).

Wider treatment plans involving whole communities may be more appropriate than treating the PTSD symptoms of individuals. Specifically, the focus of treatment should be on getting people to function and restoring or building social and economic networks and cultural identity (Summerfield, 1995; Swartz, 1998). The alleviation of poverty also appears to have an important part to play in the recovery process. As such, the World Health Organisation (WHO) stresses that in the third world, mental health should be an integral part of public health and social welfare programs (Summerfield, 1995).

Having worked in communities in South Africa that were identified as 'traumatized', Crawford-Browne & Benjamin (2002), found that the most useful interventions at the level of community involved working with groups of children on the development of interpersonal skills, self-confidence and coping with emotions. Groups of adults in the communities were also encouraged to meet, talk, acknowledge their pain and develop more adaptive coping skills and a sense of survivor identity within the community.

Traditional healing practices and purification rituals may also have a part to play in the recovery process. For example, in Mozambique there is a widely held belief that purification rituals can heal people who have suffered trauma. These may involve herbal treatments and communication with the spirits of the ancestors. Such traditional therapies were used in the healing of the trauma people had experienced in the course of the civil war (Chicuecue, 1997). However, Draguns (1996: 474) cautions that such traditional healing rituals may be largely irrelevant to many people, particularly those who have been exposed to "the worldwide trends towards urbanization, modernization, and secularization".

Conclusion

Psychiatric research, operating from a medical standpoint, has tended to focus on the similarities between mental disorders across cultures. Thus, attempts to understand the impact of culture on psychological processes has been largely limited to the exploration of culture-bound syndromes, concluding that they are simply exotic manifestations of particular underlying (biologically-based) disorders.

Studies following the tradition of medical anthropology, on the other hand, have been more interested in understanding the *differences* in disorders and illness between cultures. They have identified that different worldviews and concepts of self produce fundamentally different ways of understanding and expressing illness. The meaning that people ascribe to symptoms combines with individual experience to bring about "substantially different forms of illness behavior with distinctive symptoms, patterns of help seeking, and treatment responses" (Kleinman, 1987: 25). As such, the *illness*, or the lived experience of the patient, should become the determining factor in treatment decisions.

The exploration of trauma in different contexts has also revealed that the meaning that people ascribe to an event or situation appears to be an important determining factor in both the type and degree of distress they experience. It is suggested that this is informed by their worldview, their status, and the social, cultural and political context in which they live.

The deconstruction of the idea of the universality of mental illnesses offers the possibility of alternate ways of thinking about them. By combining ideas about the experience of illness from medical anthropology, the impact of worldviews and different concepts of self on psychological processes and contextual views of trauma, it is envisaged that the current research will reveal a concept of trauma amongst rural Zulu speakers that is informed by their worldview and takes into consideration the social and historical context in which they live. This could then form the basis of more appropriate and effective interventions.

Introduction

This is the second part of the article, *Trauma in context: a conceptualisation of traumatic stress among rural Zulu-speakers in Kwa-Zulu Natal.* It comprises a description of the methodology and the discussion of the findings of the research. A detailed literature review of this research is presented in the first part.

Methodology

The sample

This research was conducted in collaboration with Sinani, the KwaZulu Natal Programme for Survivors of Violence. People who had been targeted by Sinani for their community development and stress and trauma programmes were selected to take part in the research. Additional criteria for selection were that firstly, people were first-language Zulu speakers and identified themselves as belonging to the Zulu ethnic group. Secondly, people participating in the research should have had as little exposure as possible to Western psychological concepts of trauma and healing. As such a purposive sampling strategy was employed.

Data collection

The data for this research was collected from focus groups conducted in Zulu. As mentioned above, all of the participants were contacted through Sinani. Four focus groups were conducted: a youth group, a women's group, a group of traditional and faith healers and a group of community health workers. Apart from the women's group, all of the groups were of mixed gender.

The focus group method of data collection was chosen as it is regarded as an effective way of understanding and comparing the experiences of a sample that comprises different categories of people (Morgan, 1998).

Each group began with the facilitator relating an abridged version of a story taken from Swartz (1998: 167-169). The story is one of general hardship with some particular traumatic incidents interleaved into the story. The protagonist of the story, a woman called Ms Mbanga, witnesses the killing of her close friend when she is 14 years old and then is a victim of a shooting incident ten years later. The group was then invited to discuss the story and relate it to experiences in their own communities. In opening

the groups with a story that in Western psychological terms would be described as traumatic, it was assumed that the participants and the facilitators had a topic in common, but no attempt was made to establish similarities by making overt comparisons with PTSD as the Western model of trauma.

Drawing on a model of clinical questioning that aims to investigate explanatory models of illness developed by Good & Delvecchio Good (1981) called the *cultural hermeneutic model of clinical practice*, questions put to the group focussed on the context of problems of distress, the impact of these problems on their lives, and the reactions of others in the community.

Each focus group was recorded and subsequently transcribed and translated into English for the purposes of analysis.

Data analysis

The data was analysed using an inductive approach. Both the steps comprising the *constant comparative approach*, developed by Glaser and Strauss (cited in Maykut & Moorhouse, 1994) and those outlined in Terre Blanche & Kelly (1999) were used to induce and elaborate themes from the transcribed focus group discussions, with a view to placing "real-life events and phenomena into some kind of perspective" (Terre Blanche & Kelly, 1999: 139).

Findings and discussion

'Ukuhlukumeseka'

The participants in the focus groups all used the word *ukuhlukumeseka,* which may be translated as 'troubles' or 'suffering', to describe situations or events that interrupt the continuity of their lives or upset the order of things and cause a degree of distress that motivates them to seek help.

It is important to remember that almost all of the participants in the groups had been exposed to what would usually be described as traumatic events according to the Western model of trauma. They either had experienced, witnessed, or been confronted with "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2002: 467). Yet these things were not the focus of the discussion in the groups as perhaps they would be in a group of people from a Western cultural tradition. Discrete instances of personal tragedy and

suffering were mentioned and they were important, however only in terms of the contribution they made to a much wider scenario of suffering. Furthermore, they were seen as an outcome of a social and cultural context rather than a result of people's own actions or attributes. A woman related an incident in which she was accosted in her house by two men who threatened to kill her if she did not disclose the whereabouts of her brother... *"The following day, they came and I was alone. It was 6.30 in the morning. I was planning to go to Umlazi to hide since people were dying like flies. I had just got up when two males came into the house. They looked old. They had guns and they said, "don't move". Then they asked for my brother and I told them that he did not come back last night... They said that if I was hiding him, they would kill me. Can you imagine how I felt? I was finished. I was thinking that they might kill me or that they might decide to rape me and then kill me....They demanded that I tell them where he had slept and threatened to kill me again..."* The woman managed to get away but when she returned she found that they had ransacked her house and destroyed it... *"They went to my home and took everything...they even undid the roof and took it. That is how my family broke up and has remained separated and without a home until now. My home ceased to exist from 1990, it was finished...I am trying to give you the feeling of how the violence affected me in a very big way. Even now when I think about it, I feel the pain"*.

Paths of distress

Good (1997) suggests that 'macrosocietal forces' are important determinants of the course and prognosis of mental illness. In terms of outcomes, not only do social environments seem to be more important than treatment effects, they interact with mental illnesses to produce 'new trajectories of illness'. Good (1997) cites studies showing that in contexts of poverty and homelessness, alcohol and substance abuse and HIV/AIDS infection change the nature of mental illnesses seen in these populations. From such studies, he extrapolates that the study of specific social environments can help us to "understand how major mental illness, as well as violence and substance abuse, may be produced and reproduced, or effectively treated" (Good, 1997: 236).

For the participants of this study, a particular historical and cultural context has produced a different experience and understanding of traumatic stress, in terms of both the types of events or situations that produce traumatic stress and the responses to them. For these people, traumatic stress is conceptualised as a series of disruptive 'paths of distress', with violence, poverty and bad luck as the

initial disruptive factors. Violence, poverty and 'bad luck' do not only constitute the backdrop against which lives are played out, but they interact with all aspects of people's lives to the extent that there is a belief that these 'macro-forces' are the root causes of their suffering.

Political violence

Political violence, both in the form of the state-sponsored violence during apartheid as well as the faction-fighting that took place in the build up to the first democratic elections, is seen as the cause of significant suffering. It has established its own 'path of distress' shown in the Figure 1.

As has been observed in other situations in which personal stressors are combined with social stressors, the meaning that people attach to these stressors will influence which ones they attend to (Summerfield, 1995; Becker, 1995; Straker, 1987). In this case, the overwhelming concern in all groups was the poverty that political violence introduced into the community. *"Violence has made people poor in the communities"*. In areas strongly affected by violence, many men were killed or lost their jobs, families lost houses and development in these areas largely ground to a halt. "*Violence has destroyed so much. I wish you could go outside and look at the buildings that were shops before, they are now ruins. Those were butcheries and people's houses. Really, it has destroyed a lot of things. It is because of it [violence] that there is poverty*". In addition, many of the youth were forced to interrupt their schooling to join the fighting and *"violence stopped them from fulfilling their dreams"*.

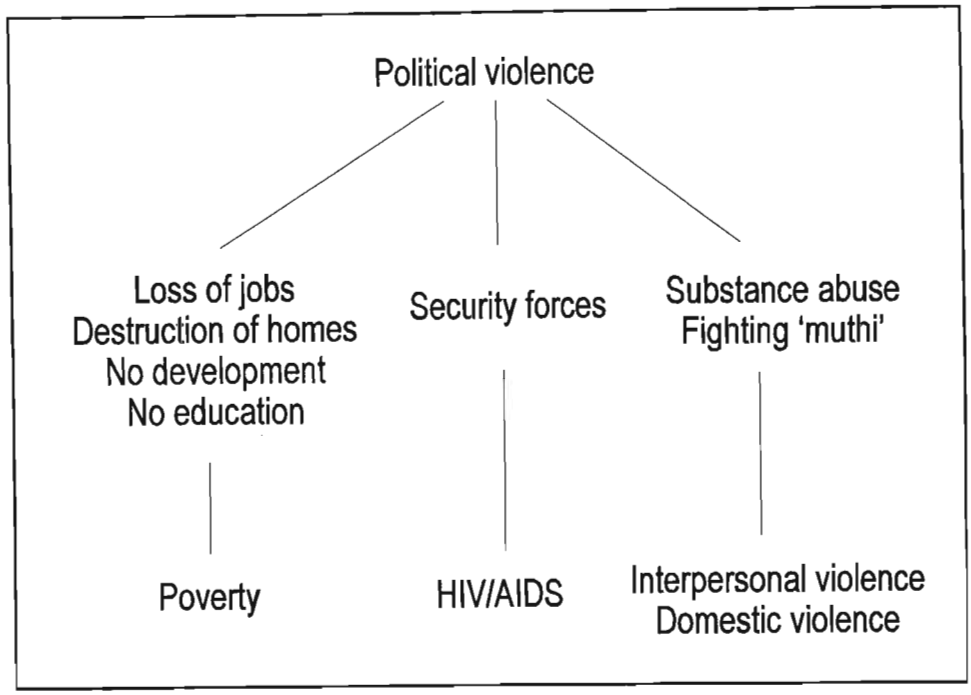

Figure 1

According to African cosmology, illness may be introduced into a community by 'things' from outside. These 'things' are undesirable elements in the environment or atmosphere and are usually brought into the community by people from different areas or by members of the community returning from other areas (Ngubane, 1977). Thus, some kinds of illness are attributed to foreign elements. Amongst the youth in this study, HIV/AIDS is directly attributed to the security forces that were brought into their area to help keep the peace during the political violence that racked their area during the early 1990s. The members of the security force brought money with them, but also the HIV/AIDS virus. They used their money to attract the women of the community away from the local men. *"They came here with big money and gave it to us for sex... That is why I am saying that HIV/AIDS was spread by violence, as you can see that all those ladies got sick and died. I don't say that ladies that were not involved with security forces are not sick and not dying, but most people who died and who are sick right now are those who had dealings with the security forces, and they are known".* When the security forces left, the women turned to the local men again and so HIV/AIDS was spread.

The use of alcohol and other drugs is a well-documented means of people coping with the effects of having experienced trauma (Herman, 1998). Substance-related disorders are also among the *Associated descriptive features and mental disorders* cited for PTSD in the DSM-IV. Thus, it was no

surprise that the abuse of alcohol and other substances was frequently cited as a way of coping with distress, particularly for men. *"He won't show us that he is suffering. He will pretend that everything is in order. But he will think and think and then decide to go out and have beer, dagga and drugs, so that he won't think about his troubles and won't feel them".*

Thus, men were described as using alcohol and dagga as a means of forgetting. However, paradoxically, there seems to be an urge to repeat the past. *"They still want to be involved with negative things and that keeps them thinking about things that happened in the past. So they decide to drink alcohol, hoping that it will make them forget their troubles".*

Through its effect on the use of alcohol and drugs, political violence is also linked to what is regarded as the recent increase in domestic violence in communities. For some men, violence has become a way of life and the intimidation of women through violence is common. *"Mothers are now scared of their sons. Grannies are afraid of their grandsons and so they give them their pension money. They know that they are will be hurt if they don't give it to them. This is because of the past involvement in violence. They don't care about women...I am not saying that they don't fight other men, but it is worse with women".*

Another explanation for men's violent behaviour is the *muthi* that was inserted into cuts in the skin of these men to make them want to fight. In the words of one young man, it was never *"...neutralised. Something must be done to calm the 'muthi' in the bloodstream since this can make you want to continue fighting".* Many youth have been left in this heightened aggressive state. As a result they drink and *"then end up being crazy...and fighting and stabbing each other".*

Poverty

According to Jenkins (1996: 176), "gender status, power inequities, and culturally sanctioned misogyny" mean that women's experience of stressors differ from men. For the people of this study, living in impoverished circumstances in a context of violence, both past and present, poverty produces two distinct paths of distress for women and men (see Figures 2 and 3, respectively).

For both, poverty is construed as a direct result of violence, as was discussed above. While men make

a direct link between violence and poverty through the loss of jobs, women associate men with both political and domestic violence, and so are more likely to regard men as a causal factor of their suffering. Women talked of 'suffering' and 'troubles' as 'entering' a woman's body or being 'contracted' from a man, as if they were a disease. *"Mostly suffering and troubles are passed from men to women and then all people get it...I mean women suffer, as men are involved in violence"*. Women also view poverty in terms of 'God's will', that is, as a kind of suffering outside of their control and decided by God. *"I am married and have children and I am battling to survive. My husband is not working, and I am also not working, so we are battling for a living. Maybe that is the life that God has given me to live. I will always live like this and nothing better will ever come... Suffering comes like that and is a result of being poor"*. Another woman commented, *"If you don't have a husband anymore, then you will suffer as there will be no money coming in. You did not plan for your husband to die, it is God who has allowed this to happen"*.

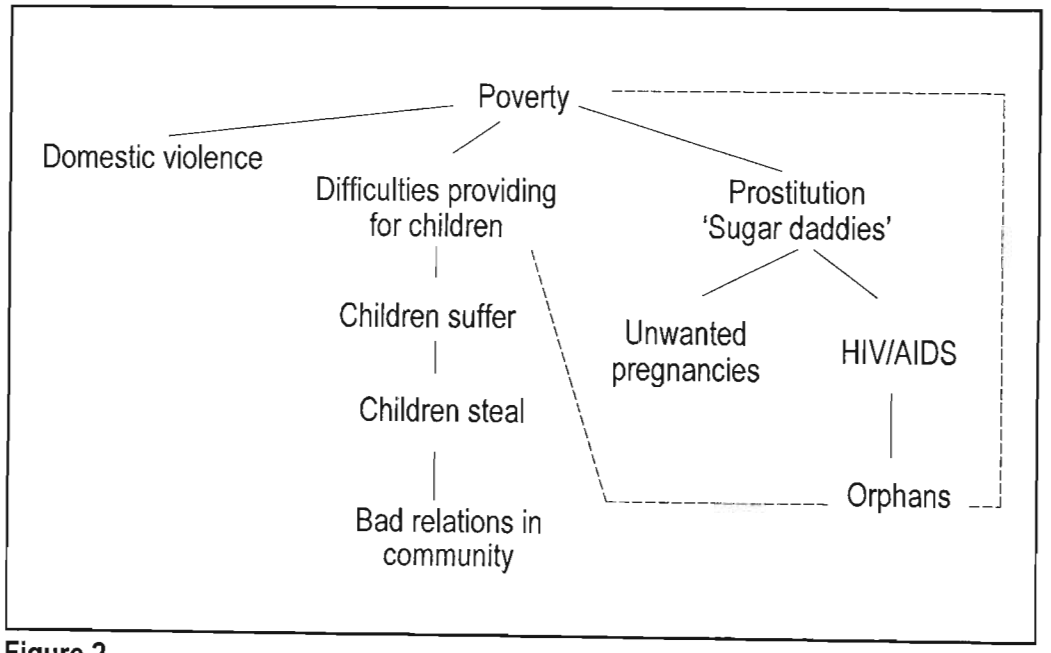

Figure 2

Various writers (Summerfield, 1995; Lykes, 2002; Jenkins, 1996) suggest that for women who live in contexts of community violence, domestic violence and extreme poverty, it is not clear which stressor they will respond to. The women who participated in the women's group had all been exposed to such

multiple stressors. In all cases, the major stressor was the responsibility they have to take care of the children and the rest of the family in situations of extreme poverty. Finding food in such situations can mean the difference between life and death. *"A man can see that there is nothing to eat, and go away wherever he goes to. When he comes back home, he won't ask how you managed to sort out a child. The first thing that he will ask for is food. You have to go out and find something to cook and also provide him with food. He does not care how you get the food. Then you suffer worrying about what you will give the children and him to eat the following day".*

The responsibility that women carry for taking care of children and other members of their family mean that in situations of extreme poverty, women may be driven to exchanging sex for money, food and other goods they need (Cohen, 2001; Crothers, 2001; Harrison, Xaba, Kunene & Nutuli, 2001). According to Cohen (2001: 56), "...many of the poorest persons are women who often head the poorest of households. Such women will often turn to prostitution, sometimes as regular sex workers, but more often as occasional ones who work when they or their dependents need money".

Thus, the spread of HIV/AIDS was also attributed to poverty and the need for women in such situations to sell the only commodity they possess - their bodies. *"Women would come from outside ...., looking for money. Sometimes you would find that a woman is the only person left in the family...They were trying to keep themselves going. Trying to find money. They ended up being prostitutes and having unprotected sex".*

Transactional sex, in which women receive 'gifts' in exchange for sex, is also an important factor in the spread of HIV/AIDS amongst young black women (Leclerc-Madlala, 2001). Thus, poverty is also seen as a causal agent for both HIV/AIDS and unplanned pregnancies amongst the youth. *"Most of them [pregnant schoolgirls] are involved with people who are rich. So, they have their own ABSA bank [a man]...one gives them a car, and another one, clothes".*

The spread of HIV/AIDS has resulted in a vast number of orphans, the care of whom falls to the women in the community. This has further increased pressure on their already stretched resources. The effect of this reverberates throughout the community as out of desperation, many of these children resort to stealing. *"Let's say that you don't have anybody to give the children to, in that case you*

experience a miserable life at home, in so much that children could even decide to steal. This would affect not only you, but the whole community. If your child steals from your neighbour, the neighbour will come back to you to complain that your child is doing this and that. But the child is stealing because of the conditions at home. The child is hungry".

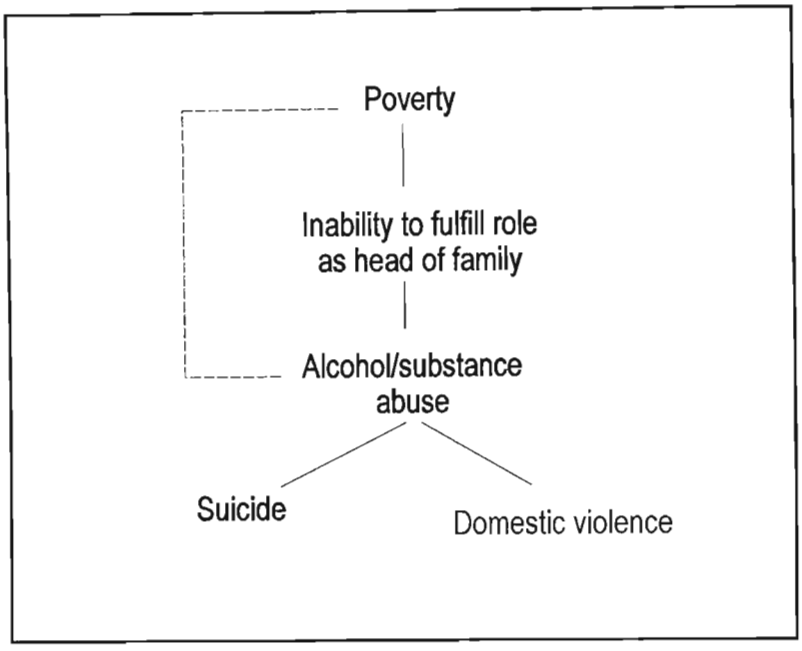

Figure 4

For men, the 'path of distress' initiated by poverty is more about the loss of face associated with not being able to fulfill his duties as head of the household. This causes a degree of despair, for which often the only means of escape is through alcohol, dagga and other drugs, or suicide. Men and women's 'paths of distress' intersect when substance abuse is associated with domestic abuse. *"He will go out and come back drunk like anything. That also affects you as he will come back with a 'bad attitude', so your load will be doubled. He is affected by the fact that he is not working and he does not know how to take care of his situation. He knows that he is expected to carry out his duty as a man and the head of the household..."*

Negative life force or 'bad luck'

The life force given to all things, inanimate, living and spiritual, while essentially a creative and positive form of energy, may also be the cause of misfortunes and distress. It may be manipulated with the intention of causing harm or distress, as in the case of 'witchcraft' (Mhkize, in press), or it may simply

manifest as 'bad luck'. In any case, Ngubane (1977) states that "undesirable elements" are always in the environment, so that people are continuously exposed to them. The occurrence of such misfortunes are endowed with a strength of meaning that can produce extreme fear and a sense of foreboding in the people (Kirmayer, 1996).

Ancestors play a crucial role in the prevention of such illness and misfortune as they offer protection against such things. Failure to perform certain rituals can result in the ancestors withdrawing their protection and leaving people vulnerable to illness and misfortune (Ngubane, 1977). The people in this study referred to such misfortunes as 'bad luck'. The 'path of distress' initiated by 'bad luck' comprises the same elements as the other paths mentioned above, however, it differs in that the end point is some kind of sickness or madness (see Figure 4).

'Bad luck' and *ukulingwa* ('trials') were mentioned as causes of suffering that *"you don't see coming"*, unlike physical abuse from a husband that is 'visible'. The term *ibhadi*, meaning 'bad luck', was used to refer to misfortunes caused by others. *"People came to steal and left clay pots with 'muthi' in her sugar cane field....If you notice anything that is not supposed to be in your yard, things that are mutilated, then you start asking yourself, why are these things left in my yard, why me, why would that person hate me? It is obvious that someone hates me, that is why they have decided to do something to hurt me".*

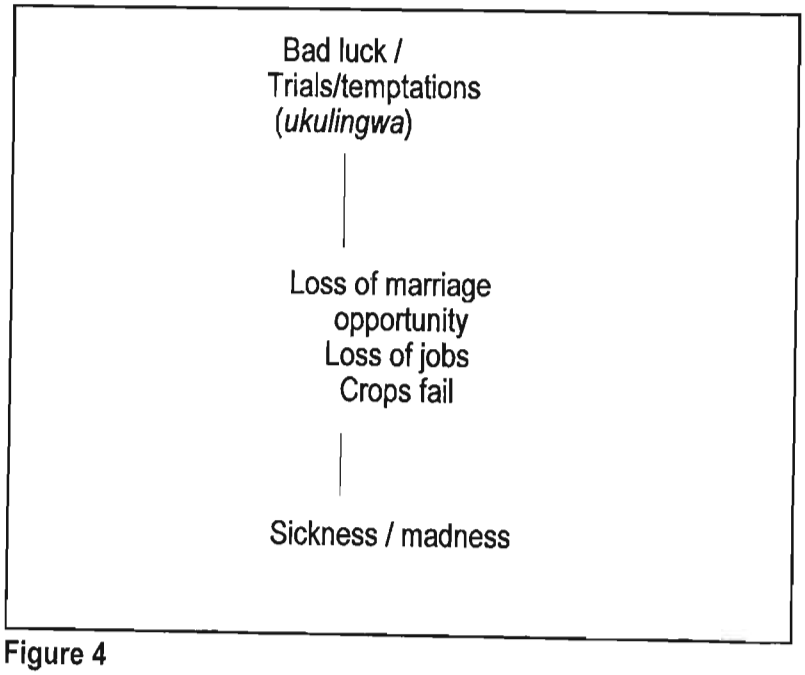

Figure 4

Sometimes there is no evidence of witchcraft or 'foul play', however, a radical change in someone's circumstances is often attributed to 'bad luck' caused by other people who are jealous. For example, a story of a woman who had everything was related. This woman was to marry, she had a good job and money for nice clothes. *"Everything looked good. Even her man had promised to start paying 'lobola'. But that is where it ended, destroyed. Another female came into the picture"*. After that, she lost her job and she could no longer provide for her two children, then her father lost his means of living, and they only had the pension to live on. Eventually she became sick and listless and was taken to a 'seer' to find out the cause of this sickness. *"They [seers] say that she is being bewitched. People are jealous of her because of the way of life she was living. After some time, she looked like a mad person. At home she was arguing with her father, taking her parents' pension money by force...demanding things from her parents"*.

Ukulingwa is a form of bad luck that make things harder for someone who is already suffering and thus may be translated as 'trials'. When asked where does suffering come from, one woman said, *"I think it is all about 'ukulingwa'.... Let me give an example, I am battling and I don't have money, then a child comes and tells me that they want money at school tomorrow. It has to be paid by tomorrow. Since I don't have money, I say that the teacher is bringing me bad luck. Where am I going to get money from right now? I don't have money, so the teacher asking for money is 'ukulingwa'"*.

In a context of substantial everyday hardship, people may be more vulnerable to these types of things. Suffering may occur because a crop fails and so the family has nothing to eat, or someone in the family gets sick. Whether or not that person be the breadwinner, it may mean a significant amount of resources have to be re-directed to caring for them. In addition, if these happenings are attributed to 'bad luck', then they can cause a degree of suffering that may drive a person to 'losing their mind' or even suicide.

Meaning as a determinant of the experience of distress

Kleinman (1988) draws attention to the importance of understanding the subjective experience of illness. Similarly, critics of the Western model of trauma suggest that an individual's social context and personal history can endow traumatic meaning to events that is not shared by others (Eagle, 2002; Summerfield, 1995; Root, 1992; Brown, 1995; Kirmayer, 1996; Jenkins, 1996; Bracken, 1998; Lykes,

2002).

All of the aforementioned 'paths of distress' cause a degree of distress that these people experience as significant and for which they seek help. It is suggested that this is due to the important strands of meaning that run through them that are intricately connected to their worldview, interdependent concept of self and explanatory models of illness. These strands of meaning are 'failure' and the disruption of community cohesion and processes.

Failure

A sense of failure that accompanies the experience of *ukuhlukumeseka* was evident in all the groups. *"Another thing that troubles you a lot is failing...It affects the mind a lot".*

An explanation for this observation can perhaps be found in the notion of interconnectedness and interdependence of all beings in the universe according to African cosmology. God, the ancestors, the newly passed away, the living and the children-yet-to-be-born are all bound together by a common life force or spiritual energy (Azibo, 1996). This gives rise to an interdependent sense of self that has been described as "extended, [and]...an unbroken circle encompassing an infinite past, an infinite future, and all contemporary Africans" (Azibo, 1996: 52). Implied in this description is a sense of continuity and a path that is not only predetermined, but vital for the maintenance and survival of the African people (Azibo, 1996).

Failure to fulfill roles and responsibilities

In a context of interconnectedness and interdependence, the experience of failing to fulfill one's obligations is likely to be more significant than it is in a Western cultural context that values independence, as it involves a sense of failing one's family, one's community and ultimately one's extended world, including ancestors.

"Of those illnesses and deaths that are attributed to the anger of the ancestors nearly all are in connection with failure to fulfil marriage obligations" (Ngubane, 1977: 59). A failed marriage has more stigma attached to it than in a Western society. For women, events like not being able to conceive, losing a child, being overlooked by a husband for another wife are just some of the events that cause

women significant distress. In the case that *"the marriage fails for certain reasons - maybe because the husband is beating the wife up, and she has to come back home. When she comes back to the neighbourhood, they will start taunting her - 'you can't make it. You couldn't hold on to the marriage. You couldn't be patient enough, that is why you failed in your marriage"*.

Not only are women likely to be affected emotionally, but they may lose their means of survival. Such women may have to turn to neighbours for help. This *"troubles her a lot as she left her home dedicated to being a wife. This troubles her in such a way that she even loses her self-confidence [lit. being a person] in the community"*.

Being unemployed means that a man is unable to perform his *"duty as a man and head of the household"*. For some men, this can *"drive them crazy and he will start drinking and doing all the bad stuff"*. In this case, in the translation, 'crazy' was used to capture meaning of 'doing things outside the norm for a man'. *"It can affect them so much that they decide to hang themselves, to commit suicide"*.

Failure to achieve goals

Failure to achieve life goals can result in, what one particular woman termed, 'stress'. She said stress results from outside factors preventing you from achieving your life goals. These goals involve providing a future for your children in accordance with the 'extended self concept' (Azibo, 1996) . *"For example, maybe I plan to get married, and then when I am married, work hard so that I can get a house and buy a car. But, maybe I have a child before I even get married, and have to drop out of school because of the child. After that I can no longer get a good job and succeed. So all that causes stress - failing to accomplish all those things I wanted to do...Maybe I end up not even being able to finish school, not even getting a job, not being able to raise the children that I had before I got married. So this stress keeps on piling up until it develops into depression, then I'm a failure, I see myself as a failure in life... I start to think that maybe it is better for me to kill myself. I'm living a life I never thought I would live. Maybe it is better to leave this life I'm living. I couldn't achieve what I planned to achieve. So I'm at rock bottom of my life. It is better to kill myself, or else just become nothing in life and feel hatred for those I see succeeding"*.

As a result of the political fighting that took place in the early 1990s, the education of many young rural

people was interrupted. The result was that many could not achieve what they had planned for their futures. This has resulted in a lack of confidence that has led many to *"look for other alternatives [such as drugs and alcohol]"*.

Bereavement in a context in which there has been a failure to accomplish something with the person who died, may cause someone to "lose their mind". A woman whose fiancé died before they were married now *"loses her mind a lot so that when you are talking to her, she will just change the topic to talk about this guy she was in love with. We have tried to stop her, but she is too affected by this loss. They couldn't see through the promise that they made to one another. That is very painful. A person can be affected in the mind if whatever they planned to do isn't seen through"*.

Breakdown of social and community cohesion

The existence of widespread political and criminal violence in communities can result in a significant disruption of the sense of cohesion in a community (Eagle, 2002; Lykes, 2002; Summerfield, 1995). For people who have an interdependent sense of self and so derive their self concept from relations with others (Markus & Kitayama, 1991), this breakdown of community ties will be experienced as more distressing than it would be for someone who subscribes to an independent sense of self. Thus, for these people, the 'macrosocietal forces' discussed above often have resulted in a sense of suffering and disruption of harmony and balance that has extended beyond individuals to their community and spiritual world.

Disrupted families

Many families lost members through the political violence of the early 1990s. For others, the political violence also meant their family separating and never being as one again. In the case of the woman whose house was destroyed and land taken away from her, described earlier, the members of her family were separated never to live together as one again. *"That is how my family separated and has remained without a home until today. I ended up getting married. My home ceased to exist from 1990, it was finished"*.

Similarly, political differences broke up many families *"...like mine. My father went to join another organisation somewhere else and left us behind. Now, even though there is no more violence, he*

can't come back home to us...he does not have the guts to face us, you see".

Like the beings in the universe according to African cosmology, members of a family are also arranged in a hierarchy with the oldest member at the apex (Mhkize, in press). In these communities, a large number of people of parenting age have been lost to violence, HIV/AIDS or both. Thus the normal family structure and associated roles have been forced to change. The oldest members of the family, who in normal circumstances should command the greatest respect, are more likely to have escaped these destinies and have been left to take care of children of all ages with little resources. With the breakdown of the family structure, these old people are often not respected by the younger people. *"You find that the grandchildren are troubling their grandparents because they are demanding too much money from them. The grandparents are troubled as they are not respected. The children do not take care of them or help them".*

The innocence of children and their right to protection is also not being observed. In many instances they are left alone because of the breakdown of the extended family and they become "soft targets of rape". This is exacerbated by high rates of unemployment in the communities, which leaves men unoccupied. *"Since there are no job opportunities, the child become a job, and he works the child. Sometimes this happens for 6 years and nobody notices it. The child just keeps quiet about it and this person continues with his unacceptable behaviour".*

A traditional healer summed up the disruption of the family as follows - *"we are in times when people have no conscience. The head of the household, himself, is able to rape his own child. And that is very painful. Then, our children, our children have lost respect for us. They leave their homes and sleep away. Even though you talk to them and give them advice".*

Social and spiritual alienation

An extreme form of social alienation resulting from traumatic stress has been documented in people from more traditional African cultural backgrounds (Eagle, 2002). Such people who subscribe to an interdependent concept of self are more likely to try to make sense of a misfortune or traumatic event by understanding why it happened to them and not others. They may question the role of bad luck, the withdrawal of ancestral protection or other spiritual influences (Mhkize, in press).

A story of a young woman was told in which she suffered a series of misfortunes to the point that she went 'mad'. It illustrates how the suffering of one person was related to other people in the community and ultimately the spiritual world. *"...Now she starts getting sick from certain diseases. She is wasting away. We think she is being bewitched and so we take her to 'seers' to find out why she is like this. They cannot understand what she is suffering from, but they say that she is being bewitched, people are jealous of her because of the way in which she was living [she had money and enjoyed a comfortable lifestyle]. As time went by, she began to look like a mad woman...Her parents ended up separating because of her. The father was left to raise her and her children with only his pension money. There was more trouble and so they went to the 'seers' again...and then the herbalists came and they said that the source of these troubles was failing to carry out traditional rituals which had made the ancestors angry..."*.

Similarly, the effects of experiencing or witnessing violence can extend from interpersonal violence and domestic violence to strong feelings of jealousy and suspicion towards others who have not experienced such things. *"I'm talking from experience...a man becomes violent and destroys things, let's say even things in his house, his relationships...This is what happened...His parent's marriage ended in divorce and his mother ran away from home and left the children with her parents...One day, their mother returned. On her return, their father, who was still hurt by what she did, killed her by the gate in front of the children...They grew up with this memory...This grows inside the person and he ends up being a violent person who likes to destroy things and doesn't want to see other people being successful. He becomes possessive with other people's property"*.

Protection from the ancestors is essential in strengthening a person against misfortune and illness. An important ritual in this regard is the slaughtering of a goat as an offering of thanks to the patrilineal ancestors (Ngubane, 1977). In many cases of children who are born out of wedlock, it is not possible to perform this ritual and such children are known as 'Peterson' children after the association with children born of mixed racial parentage. Not only does such a child have a tenuous sense of belonging in the community, the sense of alienation from one's ancestors can cause a measure of distress so that *"some end up committing suicide - perhaps they shoot their parent [mother] first and then themselves"*.

Notions of cure

An understanding of the lived experience of an illness or in this case, distress, is crucial in order to make appropriate and effective interventions (Kleinman, 1988; Good & Delvecchio Good, 1981). This includes how a person sees themselves being cured. In this regard, in traditional African societies, finding out the cause of an illnesses is crucial as it determines its treatment and ultimately, its cure. This is especially important in the case of those illnesses that are believed to be linked to environmental influences. In such cases, the appropriate treatment is to in some way correct or remove it (Ngubane, 1977). Whether the cause of *ukuhlukumeseka* was political violence, poverty, 'bad luck' or otherwise, the need to identify it was a prominent feature in the participant's stories.

Restoration of community

It has been suggested that suffering that is experienced at the level of community needs to be addressed by the rebuilding of social and economic networks and cultural identity (Summerfield, 1995; Swartz, 1998). The World Health Organisation (WHO) has also acknowledged that measures to alleviate poverty should be an integral part of mental health programmes in developing countries (Summerfield, 1995).

Similarly, it was suggested that the economic development of the community would help to heal the divisions that were caused during the political violence and restore a sense of a united community. One member of the youth group described her vision of her community being restored as the provision of *"things that could help the community and keep them busy, get them together and know each other well. I don't know how to put this, but to be able to tolerate each other, be patient with each other and know and respect each other's feelings".*

Restitution

Having identified poverty as the cause of much of their suffering, the young people identified getting a job as a way of healing their emotional pain, *"I don't think [a job] could make me forget, but I think it could calm down my anger...It could calm down the certain level of pain in my heart...That we were now able to meet our needs, get what we need would set my mind free..."*

However, for others, particularly the older women who identify violence as the cause of their suffering,

a cure is seen as less accessible, especially when it involves the restitution or compensation for lost assets as symbols of a united family. *"Even now I feel the pain of not having a home because of the violence. Nobody tried to heal me in any way. I sometimes imagine what would things would be like now, if I still had my home. The pain comes back again, whenever I think about it...Maybe if I can have my home back, maybe I'll be healed in that sense...But there is nobody to rebuild it again. I think I could be healed, if I could have it back. Otherwise, I don't see myself being healed".*

In situations where there is no restitution, many women find comfort in prayer and trusting in God and believe that somehow He will provide. *"I go out trusting that the Lord will do His job and fulfill my needs. God helps me in that way. We trust in Him when we don't have anything...When the sun goes down at the end of the day and you don't have anywhere to go, anything to cook, he provides you with things. We trust in the Lord because he always has plans for us".*

Restoration of identity - "becoming a person again"

According to Markus & Kitayama (1991: 230), two important features of an interdependent construal of self are 'belonging' or 'fitting-in' and "occupying one's proper place". Thus, not achieving life goals or fulfilling roles is experienced as a profound sense of failure in these people, as was discussed above.

The cure for such a sense of failure is often cited as "regaining the confidence to move on" or "to become a person again". *"A person sets a certain goal they want to achieve. If they don't achieve it, then that person ends up with stress. This stress develops into depression. We keep praying with him and advising him...Little by little, he sees that he is not alone. You tell him about Job and how much he suffered until he 'becomes a person again'".* This also applies to situations of violence and sexual abuse. While it is recognised that people who have experienced such things *"will never forget what happened [sexual abuse] to her, you must always try to help her live [become a person] again".*

Restoring relations with the ancestors

The attainment of good health and happiness comes from harmonious relationships between people and their ancestors and between each other (Ngubane, 1977). Thus, when someone suffers an illness that cannot be explained biologically or they experience misfortunes, then people examine their family relationships and their conduct in terms of performing traditional rituals. The cure, then, may lie in the

improvement of relationships with particular members of the family and/or the performance of certain rituals so that the ancestors restore their protection.

The story of a young woman who suffered a series of misfortunes to the point that she went 'mad' illustrates the importance of finding the cause of her suffering as a way of correcting it. *"...Now she starts getting sick from certain diseases. She is wasting away. We think she is being bewitched and so we take her to 'seers' to find out why she is like this. They cannot understand what she is suffering from, but they say that she is being bewitched, people are jealous of her because of the way in which she was living [she had money and enjoyed a comfortable lifestyle]. As time went by, she began to look like a mad woman...Her parents ended up separating because of her. The father was left to raise her and her children with only his pension money. There was more trouble and so they went to the 'seers' again...and then the herbalists came and they said that the source of these troubles was failing to carry out traditional rituals which had made the ancestors angry..."*.

Conclusion

Different concepts of self and worldview open up the possibility of a different conceptualisation of psychological trauma. People whose ethnocultural identity is strongly associated with the Zulu ethnocultural tradition tend to define themselves in relation to others and are informed by the African worldview. This means that they have an extended concept of self and are part of a system of relationships that exists between all beings in the cosmos, both living and spiritual and takes account of the past, present and future.

The value that these people place on the notion of the interconnectedness of things in the universe and the relationships between them influences the meaning or significance given to events they experience. There is no Zulu word for a separate category for events such as those described in the DSM-IV definition of PTSD. This is not to suggest that their experience of distress is any less than distress as it is experienced by people with an independent concept of self. The effects of experiencing particular events or situations that have disrupted their lives and continues to do so, is described as *ukuhlukumeseka*. Some events cause more distress and suffering than others, thus, *ukuhlukumeseka* can be variously translated as the experience of emotions as diverse as "offense', 'shock', 'troubling' to 'suffering' and extreme fear.

The clustering of events that cause *ukuhlukumeseka* may be described as 'paths of distress'. These paths are initiated by events that are significant in terms of people's history and culture. They are an attempt to describe how the connection and relationship between events that are to a large extent outside of one's control, contribute to a concept of 'trauma' or 'suffering' that implies disruption and distress on an ongoing and wider scale than is captured in the Western concept of PTSD.

Violence is one such initiating event that has played a significant role in the disruption of these people's lives - firstly, the state-sponsored violence during apartheid and more latterly, the violence resulting from faction fighting in the run-up to the first democratic elections in South Africa. The significance of this violence is far-reaching. It has resulted in a cluster of events that has contributed to conditions of extreme poverty and deprivation. These include the loss of jobs, destruction of homes and a situation in which no resources have been given to communities in terms of economic development and education. The spread of HIV/AIDS infection and the increased incidence of interpersonal and domestic violence is also attributed ultimately to violence in the communities.

Similarly, poverty has left people without the resources necessary to fulfill their roles and responsibilities in the community. For women, poverty sets them on a path of 'doing what they can' to care for their children and wider family members. In many instances this places them in conflict with others in the community as they and the children in their care are forced to focus on their own survival at the expense of others in the community. This brings about distrust in the community and contributes the breakdown of its social fabric. It also places them at risk for HIV/AIDS infection as some women resort to 'occasional' or 'permanent' prostitution.

The significance of being poor and a man in these communities, is that it results in his inability to provide and fulfill his role as head of the family. The feelings of impotence that result from this are seen as a major cause of the widespread alcohol and drug abuse amongst men. Together with the tendency of men to use alcohol and drugs to forget the painful or distressing memories of their experiences during the times of violence, the loss of face associated with having no place or role in the family or community contributes to a cycle of increasing poverty, increased use of drugs and domestic and interpersonal violence.

Events that are believed to be associated with 'bad luck' constitute another 'path of distress'. Any event that is associated with the disruption of relationships with ancestors and consequent removal of their protection can cause a degree of distress that may result in the person going 'mad' becoming ill and dying, if not attended to in the appropriate way.

In many cases the result of being 'carried along' these paths of distress is a profound sense of failure in terms of not being able to fulfill the roles and responsibilities implied in the African worldview and achieve the individual goals associated with them. This sense of failure also appears to bring about feelings of social alienation that feed into the breakdown of the social structures, trust and respect that is being experienced in communities. Families have been disrupted, both in terms of their composition and their relationships. Thus, a disruption of the former cohesive nature of communities has occurred. In such a context, misfortunes are more likely to be interpreted as 'bad luck' or malevolence on the part of others, the experience of which can be very frightening and disturbing.

Finally, notions of curing and healing centre around issues of restitution, in terms of material goods and having needs met; the restoration of community networks through economic development; the restoration of a sense of identity and confidence to continue with one's destiny; and lastly, the restoration of relations with the ancestors through the performance of certain rituals and/or by making peace with others in the family or the community.

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