



A socio-cultural understanding of trauma in Black Africans in KwaZulu-Natal

by

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DECLARATION

I declare that this dissertation is my own work. All citations, references and borrowed ideas have been accordingly acknowledged. It is being submitted for the partial fulfilment of the degree Master of Social Science (Counselling Psychology) at the University of KwaZulu-Natal. This work has not been submitted before for any other degree or examination at any other University.

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Date

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ABSTRACT

For many South Africans, exposure to potentially traumatic events is an unavoidable part of daily life. However, trauma interventions which are developed on Western principles are used to treat people from non-Western cultures. Research has shown that the best treatment for a client is one that is tailored to the needs and sociocultural context of the individual. The aim of this study was to understand what cultural factors, social factors, traditional methods and beliefs should be considered when adapting a trauma intervention model to the South African context, specifically for Black Africans in KwaZulu-Natal. Kleinman's explanatory model of illness was used as the theoretical framework in order to inform the questions asked, and for analysis of the emergent data. A mixed method approach was employed, with data collection involving a PTSD screening measure and semi-structured interviews. Participants were Black individuals who had been through a traumatic experience. The research was conducted at Open Door Crisis Centre and 1000 Hills Community Helpers, and data was analysed using a thematic analysis approach. In support of studies reviewed, results showed that sociocultural factors, such as the culture of violence, culture of blame, poverty, patriarchy, alcohol use and an African worldview influenced victims' understanding of their traumatic event, consequences they experienced and what intervention they felt they required. It was deduced that much of the experience of the participants is not idiosyncratic to Black Africans, and therefore Western evidence-based treatments could be beneficial, with slight changes. A number of recommendations are made with regard to adapting a trauma intervention to make it more culturally applicable, including the need to test a CBT based intervention in a controlled study. There is also a need for prevention interventions at a community and policy level which aim to address the mentioned sociocultural factors.

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CHAPTER 1: INTRODUCTION

The after effects of trauma have been documented in historical literature since the third century. However, it has only been since the 1980's when the American Psychiatric Association included Posttraumatic Stress Disorder (PTSD) in the DSM-III, that trauma-related conditions like PTSD have been sanctioned as a psychiatric diagnosis. Historians and writers of various disciplines have conveyed an understanding that contact with distressing and life-threatening events can make an enduring impression on the human body, mind and soul (Lasiuk & Hegadoren, 2006). However, trauma goes beyond the individual and has a much wider context. Traumatic stress does not happen in a vacuum, but rather victims thereof live in specific situations and societies. Culture, society, values and norms influence how we interpret war, violence, loss and disaster. Thus the social and cultural climate is very important in determining the after effects and intensity of psychological disturbances after extreme stress (Kleber, Figley, & Gersons, 1995).

1.1 Trauma in the South African Context

Van Dyk defines trauma as “a psychologically distressing event that is outside the range of usual human experience” (Van Dyk & Van Dyk, 2010, p. 380). The DSM-III-R criteria for PTSD describes a traumatic event as (1) “outside the range of usual human experience” and (2) as “markedly distressing for almost anyone” (Evans & Swartz, 2000, p. 51). These criteria were omitted from the DSM-IV, but the notion that trauma is out of the ordinary remains. South African society however, creates a context foreign to the concept of trauma being unusual (Evans & Swartz, 2000).

For many South Africans, trauma is a regular, even normal part of their everyday lives. It has been regarded as one of the most violent countries in the world, and labelled the “rape capital of the world.” Over the past 15 years, widespread political violence has been replaced by

high levels of criminal violence such as murder, assault and robbery, and physical and sexual abuse of women and children. Many individuals are also exposed to other traumas such as traffic accidents and burns. South Africa's political history and its struggle for liberation have contributed towards the current culture of violence in which violence is seen as a way of dealing with problems. This historical context was characterized by political violence being used as a means to an end (Kaminer & Eagle, 2010; Williams et al., 2007).

It is thus not surprising that most South Africans experience not one, but multiple traumas in their lives. A study by Dinan, McCall and Gibson (2004) examined traumas among women in South African townships and found that two-thirds had experienced multiple traumas in the previous year. Another study by Williams et al (2007) found that almost 75% of South Africans experienced at least one traumatic event during their lifetimes, and that the majority of these individuals experienced more than one traumatic event. Very few South African's live their lives unaffected by trauma. All too many are exposed to potentially traumatic events as an unavoidable aspect of daily life (Kaminer & Eagle, 2010).

The 2011/2012 crime statistics released by the South African Police Service show that an average of 1 232 contact crimes was reported in South Africa per 100 000 of the population. Contact crimes include murder, attempted murder, sexual assault and robbery. There were 15 609 reported cases of murder, and 14 859 of attempted murder. There were 192 651 reported cases of assault with grievous bodily harm, and 181 670 cases of common assault. Reports on sexual offenses totalled 64 514, with 49% of these cases being women and 40% children (South African Police Service, 2012). The national figure for rape was found to be 95 reported cases per 100 000 of the population (South African Police Service, 2012) but it is generally recognize that the real figure may be two or three times greater as sex crimes are regularly not reported. Though in many categories there seems to be a

significant decrease in the last decade, these rates are still very high in world terms (Edwards, 2005b).

As discussed, with the high rates of crime and violence in South Africa, people are vulnerable to traumatic events that cause distress. This distress affects an individual's thoughts, behaviour, emotions and physical reactions. People may feel helpless, vulnerable and fearful. Traumatic events can result in a range of reactions including anger, self-blame, fear and anxiety, and in some cases psychological disorders such as depression and Post Traumatic Stress Disorder (PTSD) (Van Dyk & Van Dyk, 2010).

1.2 Victim Empowerment Programme

In 1996 the South African government launched the National Crime Prevention Strategy, which made provision for the creation of a Victim Empowerment Programme (Davis & Snyman, 2005). The Victim Empowerment Programme aims to facilitate access to a range of services to people who have suffered harm, trauma or loss through violence, crime, natural disaster, human accident or through socio-economic conditions (Department of Social Development., 2009). Organisations who offer these services may be governmental, non-governmental (NGO's) or community based (CBO's). These organisations endeavour to, among other factors, assist victims to deal with their trauma by lending emotional and practical support (Nel & Kruger, 1999). Early interventions, such as psychological debriefing and trauma counselling is most often used, and these allow the victims to talk about their fears, feelings and behaviours related to the crimes, and strategies they could use to cope with comparable events in the future. It also assists people to understand that their reactions are normal and aims to prevent the development of mental illnesses such as depression and post-traumatic stress disorder (Davis & Snyman, 2005).

1.3 Psychological debriefing: A Western worldview

Psychological debriefing has become the most written about, generally practiced and well known form of early psychological intervention succeeding trauma (Van Wyk & Edwards, 2005). Debriefing is an early intervention given to trauma victims and aims to mitigate the effects of traumatic events and prevent the onset of post-traumatic psychopathology (Choe, 2009). Rose, Bisson, Churchill and Wessely (2009) in their Cochrane Review summarised the result of 15 trials that examined the effectiveness of single-session debriefing in preventing post-traumatic stress disorder (PTSD). The authors concluded that debriefing does not prevent the onset of PTSD, nor does it reduce psychological distress, with certain studies suggesting that debriefing increases the risk of PTSD and depression. Arendt and Elklit (2001) in their review on the effectiveness of psychological debriefing also found that debriefing does not prevent PTSD or reduce psychological distress, but individuals usually find it beneficial in the course of recovering from traumatic stress.

In light of these findings the following question needs to be considered: if early interventions, such as debriefing are ineffective in preventing the onset of PTSD or reducing psychological distress, then why is it still being used in South Africa? Honwana (1999) points out that prevailing western psycho-therapeutic models are frequently perceived as universal and therefore it is assumed that they can be used everywhere.

One of the key themes consistently revisited in psychology today is whether psychological treatments developed from Western perspectives are relevant to individuals from non-western cultures. This questioning relates to the theoretical foundations upon which the understanding of pathology and distress are built, as well as areas of intervention (Eagle, 2004). Western psychology (also a culturally constructed system) pinpoints the origins of psycho-social

distress within people, and therefore interventions are mainly based on individual treatment. Recovery is achieved through helping the individual deal with the traumatic experience by having individual sessions in which the traumatic experience is talked about (Honwana, 1999). Western-style therapy can result in ‘individualising’ the distress of the person involved. This kind of intervention may be inappropriate and actually harmful in ‘collectivist’ societies where the individuals’ recovery is closely intertwined with the community (Bracken, Giller, & Summerfield, 1995). It must be remembered that in contrast to the individualistic Western worldview, within the African worldview the individual is viewed as part of an holistic system that includes nature, social system (family and community) and the supernatural (Eagle, 2004). Thus by focussing on the individual, the family and community efforts to offer care and support is undermined (Honwana, 1999). In addition, sociocultural factors such as patriarchy, blame, the culture of violence and poverty can also play a large role in influencing the individuals understanding and experience of the trauma, the consequences thereof, and their help-seeking behaviour.

1.4 Culturally adapted interventions: Is this a better alternative?

It is apparent that what interventions will be effective for traumatised individuals will largely be determined by the cultural and social context (Bracken et al., 1995). In response to these issues, many mental health practitioners have recognised their responsibility to provide culturally sensitive treatments for use with individuals from other cultures. Although sometimes broadly considered culturally sensitive, culturally adapted treatments can be defined as “the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings and values” (cited in Smith, Rodríguez, & Bernal, 2011, p. 167). International research (Griner & Smith, 2006b; Smith et al., 2011) has shown

that mental health services are more effective when adapted to a specific cultural group. Research has also shown that interventions involving culturally adapted cognitive behaviour therapy (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011), culture specific group treatment (Nicholson & Kay, 1999a; Zraly & Nyirazinyoye, 2010), spirituality and social support (Paranjape & Kaslow, 2010) to be effective in addressing trauma related distress in individuals from various cultures.

1.5 Rationale for research

It has been argued thus far that interventions for trauma have been developed in the context of a Western worldview. While models such as trauma debriefing have been found to be ineffective for preventing PTSD, international research has shown that culturally-adapted models of trauma intervention can be effective in treating PTSD and dealing with trauma related distress. Swartz (1998) argues that in order to formulate culturally appropriate intervention models which truly serve local needs and perceptions, we need to understand suffering and distress at a local level. A person's explanatory model of illness will indicate not only how they understand the causes of the trauma they are experiencing and what effect it is having on them, but also what treatment they think they need and what will be effective.

While research has been done on trauma in South Africa (Dinan et al., 2004; Eagle, 1998b; Hirschowitz & Orkin, 1997; Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 1999; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Subramaney, Libhaber, Pitts, & Vorster, 2012; Williams et al., 2007) there seems to be little research (McBride, 2003) that examines people's explanatory model of illness with regard to trauma. Some studies (Boonzaier & de La Rey, 2003; Eagle, 1998b; McBride, 2003; Womersley & Maw, 2009), do consider socio-cultural context in individuals' understanding of trauma and acknowledge that it needs to be

taken into consideration in intervention, but this research is limited and there is no explanation of the implication for intervention. Thus this study aimed to address this gap by examining the explanatory model of illness with regard to trauma in Black Africans in KwaZulu-Natal. This includes exploring, within a sociocultural context, their understanding and expression of their trauma and what trauma intervention they require.

1.6 Aim of the Study

The aim of this study was to understand what cultural factors, social factors, traditional methods and beliefs should be considered when adapting a trauma intervention model to the South African context, specifically to Black Africans in KwaZulu-Natal. Kleinman's explanatory model of illness was used as the theoretical framework in order to inform the questions asked and analysis of the emergent data. The study examined victims' view of their distress, what consequences this has had for them, their perceptions of interventions that are helpful, and therefore what implication this would have for a culturally adapted model of intervention.

1.7 Definition of Terms

1.7.1 Trauma

The origin of the word trauma lies in the Greek word trauma, meaning 'wound.' Thus the word trauma is frequently linked to medical conditions which involve physical trauma to the body. The focus here however, is on psychological trauma and the related notion of psychological wounding in which unwanted thoughts, emotions and experiences penetrate into the psyche or being of the individual. The term trauma in psychological literature refers to experiences (usually unanticipated) that impact on many aspects of psychological

functioning and place excessive demands on the individual's coping strategies (Kaminer & Eagle, 2010, 2012).

1.7.2 Traumatic Event

The DSM-IV-TR defines a traumatic event as any event in which (1) “the person experienced, witnessed, or was 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 (criterion A1), and (2) the persons response involved intense fear, helplessness, or horror” (criterion A2). (American Psychiatric Association, 2000, p. 467) These events include situations of war, rape, torture, violent crime, natural and man-made disasters, and a life-threatening illness. It is important to note that it is not necessarily the event itself that is traumatic, it is the effect that the event has on the individual that makes it a traumatic event. Many people recover from seemingly traumatic events and do not display long-term symptoms (Doctor & Shiromoto, 2009). The definition given in the DSM-IV-TR supports the argument that traumatic events are not solely defined by an external stressor, but also by the individual's subjective response. An individual's reaction to an event helps to determine whether or not the event was traumatic, or whether it was just a stressful incident (Bedard-Gilligan & Zoellner, 2008). In addition to this subjective response, what constitutes trauma is also influenced by the response of the family, community and wider society. Culture also influences the individuals experience of the trauma, their perception and interpretation of the event, how it is expressed and explained, what meaning is given to it how it is coped with and adapted to, and patterns of help-seeking and response to treatment (Kirmayer, Kienzler, Afana, & Pedersen, 2010).

In this study, the focus will be on trauma as a result of interpersonal violence. Interpersonal violence refers to violence between individuals, and thus the traumatic events considered include events such as rape, abuse, domestic violence, assault, robbery or witnessed violence. Numerous studies have shown that exposure to interpersonal violence increases risk of developing Post-Traumatic Stress Disorder (PTSD) and other comorbid disorders such as depression and alcohol/substance abuse (Cisler et al., 2012; Dutton et al., 2006; Griffing et al., 2006; Kaminer et al., 2008; Kilpatrick et al., 2003; Patrizia Romitola, Turanb, & De Marchic, 2005). Interpersonal violence is more likely than other potentially traumatic events (e.g. illness, road accidents and natural disasters) to be associated with PTSD (Kaminer et al., 2008).

1.7.3 Post-Traumatic Stress Disorder

After a traumatic event, most people will experience some distress in response to what happened. Common reactions include experiencing distressing thoughts, feelings of anxiety and memories about the event, feeling hyper-alert and difficulty sleeping. These reactions can last days or weeks after the event, but gradually fade over time and do not impact on the individual's ability to continue with normal daily functioning. However, for some individuals the symptoms do not fade and create substantial impairment in the person's ability to function in their work and social roles. Posttraumatic Stress Disorder is used to describe such responses to trauma (Kaminer & Eagle, 2010).

According to the DSM-IV-TR, the essential feature of Posttraumatic Stress Disorder is the development of certain symptoms following exposure to a traumatic event. In addition to criterion A discussed above, in order to be diagnosed with PTSD, the individual must also meet the following criteria (American Psychiatric Association, 2000):

Criterion B: intrusive recollection

The traumatic event is repeatedly re-experienced in at least **one** of these ways:

(1) “recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;” (2) “recurrent distressing dreams of the event;” (3) “acting or feeling as if the traumatic event were recurring, including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes;” (4) “intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;” and (5) “physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event” (American Psychiatric Association, 2000, p. 468).

Criterion C: avoidant/numbing

Repeated avoidance of stimuli connected to the trauma and numbing of overall responsiveness, as shown by at least **three** of the following:

(1) “efforts to avoid thoughts, feelings, or conversations associated with the trauma;” (2) “efforts to avoid activities, places, or people that arouse recollections of the trauma;” (3) “inability to recall an important aspect of the trauma;” (4) “markedly diminished interest or participation in significant activities;” (5) “feeling of detachment or estrangement from others;” (6) “restricted range of affect (e.g., unable to have loving feelings);” and (7) “sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)” (American Psychiatric Association, 2000, p. 468).

Criterion D: hyper-arousal

Repeated symptoms of growing arousal (non-existent prior to the trauma), as shown by at least **two** of the following:

(1) “difficulty falling or staying asleep;” (2) “irritability or outbursts of anger;” (3) “difficulty concentrating;” (4) “hyper-vigilance;” and (5) “exaggerated startle response” (American Psychiatric Association, 2000, p. 468).

The duration of criterion B, C and D must persist for at least one month (criterion E) and the disturbance must cause impairment in occupational, social and other areas of functioning. In order to be diagnosed with PTSD the person must show no less than one re-experiencing symptom, three numbing and avoidance symptoms and two arousal symptoms (American Psychiatric Association, 2000).

1.7.4 Sociocultural

The Oxford (2005) dictionary defines sociocultural as combining social and cultural factors. Social is defined as connected to society and the way in which it is organised. Society refers to a group of people (usually living close together) who share cultural, political and economic institutions, and similar values, rules and customs (Matsumoto, 2009). Culture is not so easy to define as the term is not always used consistently. Marsella (2010) defines the term culture as referring to a set of shared social norms, beliefs, behaviour, meanings and values that are acquired in certain contexts and passed on from generation to generation. Culture is represented externally through roles, objects, institutions and settings. It is represented internally through values, beliefs, expectations, ways of knowing and worldview. Similarly, Helman (cited in Swartz, 1998) views culture as a set of explicit and implicit guidelines which members of a specific society inherit. These guidelines tell them how to view the world, how to experience it, and how to behave in it in relation to others, the supernatural and the environment. These guidelines are also transmitted to the next generation via the use of language, symbols, ritual and art.

Sociocultural context is a significant factor in understanding the development, presentation, maintenance and treatment of PTSD. Traumatic events occur in a sociocultural context, and it is this context that influences the meaning the individual derives from the event, their response to the event and help-seeking behaviour. However, we are still in the initial stages of understanding the influence of culture on the experience of trauma, its consequences and response to treatment (Zayfert, 2008).

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Historically, an individual's reaction to trauma has been understood in terms of a Western perspective (Antai-Otong, 2002). The western worldview perceives the individual as an egocentric self, consisting of the body and mind, and as a self-contained, self-sustaining being. Trauma is seen as an individual, psychological problem. The African worldview sees individuals from a socio-centric perspective in which they are part of a bigger whole. Trauma is seen as affecting the whole person and community. These two different worldviews indicate two diverse ways in which trauma is viewed (Motsi & Masango, 2012).

The sociocultural context in which an individual lives and is traumatised is essential, as it influences their interpretation of the meaning of the traumatic event, and their response to it (Lebowitz & Roth, 1994). Victims react to a traumatic event in accordance with the meaning attributed to the event, and this meaning is influenced by social, cultural and often political factors. Culture supplies people with a "lens" through which they perceive and understand the world, and which therefore influences their behaviour, thoughts and feelings. An individual is raised in a culture, and these cultural influences become internalized by the person in the course of the socialization process, which in turn shapes the person's response to extreme life events. Culture influences how an individual appraises traumatic events, how these events are coped with (Kleber et al., 1995), how they experience and manifest symptoms, family and community support (Bernal & Sáez-Santiago, 2006), and what their expectations, whether vague or specific, is of therapeutic help (Marsella, Friedman, Gerrity, & Scurfield, 1996).

In the following sections I will review some of the sociocultural factors that influence individuals' understanding, experience and appraisal of traumatic events. I will also review the consequences of trauma from a sociocultural perspective, and treatment implications.

2.2 Sociocultural Context

2.2.1 Male dominance (patriarchal culture)

Men and women are socialized into societies and cultures with predetermined gender roles. Men are supposed to be dominant, aggressive, self-assured, assertive, breadwinners, and the head of the household. Women are expected to be submissive, passive, nurturing and subordinate to her husband (Boonzaier & de La Rey, 2003). As a result, gender power inequalities pervade South African society and therefore traumatic events, such as rape and domestic violence, need to be understood within this context (Jewkes & Abrahams, 2002).

Abrahams and Jewkes (2002) argue that both rape and domestic violence are an expression of male dominance over women, and an affirmation of that position. The dominant social constructions of gender identity and masculinity in South Africa feature characteristics of male control over women and ideas of sexual entitlement. Women are exposed to assault (including slapping and hitting with objects) and sexual coercion by partners, strangers and acquaintances. These methods are mostly used to guarantee sexual availability, to control the partner and the relationship, and to discourage or punish infidelity. Although women may be assaulted for various reasons, including not completing household chores, smoking or drinking alcohol (Sathiparsad, 2008). A study conducted by Sathiparsad (2008) in the Ugu District in KwaZulu-Natal found that violence in relationships is the norm. IsiZulu-speaking male youths between the ages of 16 and 24 were interviewed, and the justifications for violence given by them included the desire of males to be in control, to show love and to

chastise a woman for unfaithfulness. The ability to control women in these ways is seen as essential in order to attain that status of being a 'successful' or 'real' man (Jewkes & Abrahams, 2002).

This socially and culturally constructed dominant masculine position is referred to as *hegemonic masculinity*. Hegemonic masculinity embodies the prevailing sociocultural model of idealized manhood. It is the guide whereby men determine their 'success' as men, and in a country like South Africa where there is gender inequality, this perpetuates and legitimizes the subjugation and control of women by men. Hegemonic masculinity is an essential aspect of patriarchy - a social system that grants and ensures men's power and authority over women (Jewkes & Morrell, 2010). Although hegemonic masculinity is not always manifested in violence and aggression, rape and domestic violence can be seen as a manifestation of male dominance and control of women, and this is also essential to the establishment of dominant positions amongst other men (Jewkes & Abrahams, 2002).

It is important to remember that although violence against women is mainly perpetuated by unequal power relations, violence is a complex phenomenon that has its roots in various social, cultural, economic and political factors. These unequal power relations exist in patriarchal societies where structural factors such as poverty, limited education, social inequality, and traditional beliefs which negate women's rights, prevent equal participation of women in social, economic and political systems. Imbalances at the societal level are reproduced in the family when men exercise power and control over women, often in the form of violence. Thus, these factors allow violence to continue in communities and without consequences to the perpetrators (Biska, 2008; McCue, 2008).

Jewkes, Penn-Kekana, Levin, Ratsaka, and Schrieber (1999) conducted a study in the Eastern Cape, Mpumalanga and the Northern Province, involving predominantly Xhosa speaking women between the ages of 18-49 from 2 232 households. This study found that many women expressed personal agreement or acceptance of patriarchal gender relations. This reflects women's adoption of the socially and culturally scripted gender roles of women. This includes submission of women to their husbands, punishment of her by him for various reasons, male ownership of women, ideas of sexual entitlement and understanding beating as a symbol of love. While many women accept this behaviour, the study also reported that many find it unacceptable (Jewkes, Levin, & Penn-Kekana, 2002; Jewkes et al., 1999).

Rape, sexual violence or coercion and women's lack of power in sexual relationships is also related to an increased risk for HIV infection (Kalichman et al., 2005). Research conducted by Pettifor, Measham, Rees and Padian (2004) on South African women between the ages of 15 and 24 found that lack of sexual power was associated with inconsistent condom use, and thereby associated with increased risk of HIV infection. Women may be afraid (or unable) to request that their partners use a condom for fear of violence or rejection, or think that it is culturally inappropriate and thereby bring their own sexual behaviour into question (partners may see these requests as proof of prostitution and thus HIV in the woman) (Charles, James, Thorkild, & Kristian, 2006).

2.2.2 A culture of violence

Traumatic events such as rape, domestic violence and sexual coercion cannot be seen in isolation as only a manifestation of hegemonic masculinity, but it forms part of the larger problem of gender-based violence, which is affected by the culture of violence that permeates society (Jewkes & Abrahams, 2002). The term "culture of violence" has been used widely to

explain the high levels of violent crime in South Africa. The term can be used to refer to “a society which endorses and accepts violence as an acceptable and legitimate means to resolve problems and achieve goals” (Dirsuweit, 2002, p. 6). The roots of this culture can be traced back to before the 1980’s where violence was a means to obtain political power. This violence was characterized by arrests, civil unrest, detention without trial, and acts of sabotage, harassment, torture and murder. Whilst violence during this time was political in nature, post-apartheid South Africa has seen the culture of violence evolve from political to criminal violence such as assaults, murder, sexual violence and robbery (Hamber, 2000).

Many individuals live in communities where various forms of violence are exercised and witnessed on a regular basis. For many men, violence has been socialized into them as a way of coping with life. Experiences of violence in the home teach children that it is normal, and thereby they learn to use or tolerate violence. In numerous South African communities violence is accepted as a long-standing means of resolving conflict and problems in the family, in sexual relationships, in peer groups, in the community and politics. This social tolerance of violence serves to foster the perpetuation of violence. In addition, the use of violence to get what one wants does not result in social restriction, but often provides social status (Jewkes, 2002; Sigsworth, 2009).

A study conducted in Umtata by Wood and Jewks (1998) involving 30 youths between the ages of 16 and 26, found that forced sex and physical assault in young people’s relationships was a common occurrence, and as a result, perceived as normal. These forms of violence were used to impose the ‘rules’ of the relationship, such as ensuring fidelity. The authors state that this violence needs to be comprehended within the wider context of the community, where beating and violence was used as a strategy for punishment and in order to gain control

over others, thereby helping to 'normalise' violence. Even though there was no indication that the violence was viewed as positive, it was accepted by girls when they did not leave abusive men, by parents and teachers who failed to intervene, by community leaders in their descriptions of 'boyish' behaviour and by the inaction of the police.

Another study conducted by Harris (2001) explored foreigners' experience of violence within South Africa. 100 surveys were handed out and interviews conducted. Most of the participants were Black Africans from across the continent. This study found that, for most respondents, a central feature of South African society is the high levels of crime and violence. It was found that this violence infiltrates their daily lives, and they commented that violence is frequently used as a solution to problems.

Vogelman (cited in Dirsuweit, 2002) argues that criminal violence is related to a core sense of disempowerment and a desire to gain recognition and control. Violence has the ability to reverse power relations, and this can be appealing to those who experience powerlessness through economic deprivation or abuse. Violence is an act of self-assertion, and through this the offender can experience control over their lives and that of their victims. The majority of violence is committed by men. The power and control attained through violence, helps to affirm the offender's masculinity.

2.2.3 Blame

Traumatic events also need to be conceptualized in the culture of blame that pervades in society. The characteristics of the victim, as well as the sociocultural context in which the trauma occurs, influence individual's understanding of violence, especially with regard to the blame and responsibility that is attributed to the perpetrator and the victim. Women are also

more likely to be blamed for making themselves susceptible to violence by being in the ‘wrong’ place at the ‘wrong’ time (Richardson & May, 2001), or the victim is held responsible because she was considered as behaving immodestly, or for ‘provoking’ it in some way (Jewkes & Abrahams, 2002). The victim’s behaviour is seen as a mitigating factor in justifying the behaviour of the perpetrator. The victim can be seen as ‘deserving’ and as a ‘legitimate target’ – which in turn significantly influences the degree of culpability attributed to perpetrators (Richardson & May, 2001). As a result, many women are hesitant to reveal violence and abuse because of fears of being blamed for the event (Jewkes et al., 2002).

Culturally constructed norms of male dominance and entitlement, and pervading gender roles in society are influential in attributing blame. Lebowitz and Roth (1994) argue that our culture regards women accountable for male aggression, and therefore “self-blame is culturally inculcated in victims” (p. 365). A study conducted by Kalichman, Simbayi, Kaufman, Cain and Cherry (2005) on sexual violence, gender attitudes and HIV/AIDS risk among men and women in Cape Town found that many of the participants, both men and women, agreed that rape typically happens as a result of the action of the woman and therefore she can be blamed for it. The study found that women sanctioned the belief that they must be passive and subordinate to their men, and that they can be blamed for rape.

Two forms of self-blame after trauma include behavioural and characterological self-blame. Behavioural self-blame refers to the victims’ tendency to attribute the trauma to certain behaviours that he or she engaged in (e.g. went into an unsafe area) or failed to engage in (e.g. lock the doors). Characterological self-blame refers to the victims’ tendency to focus blame on their own personal qualities (e.g. the criminal chose me because I am weak). This tendency toward self-blame in order to make sense of what happened can be exacerbated by

the blaming reactions of others (e.g. you should not have been walking alone) (Kaminer & Eagle, 2010).

Despite prevalence of self-blame, many individuals need to understand the motivations of the perpetrator. A study with female rape survivors in Cape Town found that most participants had developed an explanation for the rapists' actions. For instance, they viewed the rapist as disturbed, as having a problem with sex, as hating women, or as having a need for power and control. A study of crime survivors in Cape Town generated certain explanations for why people rob and steal. For example, due to poverty, oppression, to support a drug habit and being part of a gang culture. In some instances, participants failed to understand why the perpetrator used violence and aggression during assault. They saw the violence as unnecessary and the victim was not a threat to the perpetrator (Kaminer & Eagle, 2010).

2.2.4 Poverty and alcohol abuse

Local and international literature and studies have consistently shown that poverty and unemployment are risk factors for numerous traumatic events such as rape and sexual violence (Sigsworth, 2009), domestic violence (Jewkes et al., 2002; Oyunbileg, Sumberzul, Udval, Wang, & Janes, 2009), crime (Breetzke, 2010) and lethal and non-lethal violence and abuse (Campbell, Sharps, Gary, Campbell, & Lopez, 2002). A review done by Kiser and Black (2005) on trauma within a family context found that living in a poor community increases risk for experiencing traumas such as family violence, crime, gang activity, chronic illness and death of family members.

Poverty and unemployment is also frequently associated with alcohol abuse. A study done by Oyunbileg, Sumberzul, Udval, Wang and Janes (2009) on domestic violence in Mongolian

women found that heavy drinking in a partner puts a woman at a greater risk for violence. The study also found that alcohol abuse, poverty and unemployment together produce a high risk for interpersonal violence. Similarly, a study conducted by Charles, James, Thorkild, and Kristian (2006) on intimate partner violence among women in Uganda found poverty and alcohol abuse to be significant risk factors in intimate partner violence. In South Africa, Jewkes, Levin and Penn-Kekana's (2002) study on violence in women involving 2 232 households in three provinces, also concluded poverty and alcohol consumption to be a risk factor.

Jewkes and Abrahams (2002), in their report on sexual coercion and rape in South African, explore the complex relationship between sexual violence and poverty. They explain that sexual violence needs to be perceived in context of a restricted range of recreational activities in some poor communities, where competition over women is a form of entertainment, and rape and violence may be used to achieve goals. Poverty also raises the possibility that women will participate in prostitution and forces them to engage in daily activities that jeopardise their safety, such as fetching food and water and accessing transport (Charles et al., 2006). Women may also be financially dependent on a partner, and may find it almost impossible to protect themselves from abuse and violence. Men may also lash out at women when they are not able to support them financially, as their ideals of 'successful' manhood (as providers of the family) cannot be met (Jewkes et al., 2002). The study by Charles et al (2006) found that because the husband could not provide for his family, it led to endless arguments and fights, and consequently resulted in intimate partner violence.

Alcohol and substance abuse is also associated with violence, as it is thought to diminish inhibitions, impair judgment and weaken the individual's ability to interpret social cues. Men

have also reported that they use alcohol to empower them to assault their partner because they think that socially, it is expected of them (Jewkes, 2002). In addition, alcohol and other forms of substance use are also risk factors for traumatic events such as road accidents. A high percentage of drivers and pedestrians in fatal and non-fatal road accidents have blood alcohol levels above the legal limit (Goosen, Bowley, Degiannis, & Plani, 2003).

2.2.5 An African Worldview

The African approach to trauma is more holistic than compartmentalized in the sense that it is one in which cognitive, emotional, physical and spiritual functioning are seen as fundamentally related (Eagle, 1998b). The Western dualistic understanding separates mind and body, but from an African viewpoint it is believed that “when part of me is ill, the whole of me is ill,” regardless of what the illness is (Eagle, 2004, p. 4). The African worldview sees the individual as interwoven with the community and tribe as a whole, and hence cannot be understood in isolation. An individual cannot exist alone as one is part of the whole. A person owes their existence to others, including contemporaries and persons of previous generations. The individual can only say, “I am because we are and since we are, therefore I am” (Motsi & Masango, 2012, p. 3). The Xhosa expression “*umuntu ngumuntu ngabantu*” which translates broadly as “a person is a person through persons,” illustrates this understanding that one’s personal existence is only realised as part of a collective existence (Eagle, 2004, p. 5). The community includes the person’s family and household, both living and dead. ‘Internal objects’ from the individual’s ‘inner world’ (which is the focus of the Western worldview) are changed with real people from the individual’s real world, who actively assist in finding a solution to the individual’s distress. Dead ancestors can also be ‘realised’ by a medium in order to be consulted, and if required they are pacified by means of appropriate rituals (Crawford & Lipsedge, 2004).

Ancestors occupy a dominant place and play an essential role in African society. A reciprocal relationship exists between the living and their ancestors, the role of each is to keep the other happy and healthy (Eagle, 2004). Ancestors are concerned with the welfare of their descendants, and when everything is going well, people believe that the ancestors are with them, and when life is not going well, people believe that the ancestors are not with them. When angered, it is believed that the ancestors withdraw their protection and good fortune, and without this protection, the descendants become vulnerable to all sorts of misfortune (Ngubane, 1977)

It is clear that this framework sees the individual as a more open and interactive system than Western egocentric explanations. This worldview also embraces not only aspects of the natural world, but of the supernatural world also. Traumatic events are thus caused not only by persons from this world, but also from another world (Straker, 1994) and will normally be perceived as severe forms of misfortune (Eagle, 2004). There are three main causes of misfortune: mystical, animistic, and magical causation. Illnesses brought on by magical and animistic causation refers to those illnesses imposed by others either in the natural or supernatural world. This can be either through the human employment of witchcraft as in magical causation, or through the ancestors as in animistic causation. In mystical causation, the misfortune is the result of the person being in a state of pollution, neither through outside intervention or his/her own fault (Straker, 1994). A study done by Crawford and Lipsedge (2004) explored how psychological distress is recognised and explained among isiZulu-speaking people, and found that both mental and physical illness can be classified in terms of their understood aetiologies, including sorcery and the ancestors.

2.3 Consequences of trauma

The majority of survivors of a traumatic event experience a brief period of distress following the trauma, but they recover quickly. However, some individuals will experience more severe symptoms and may develop conditions such as depression, substance abuse, anxiety disorders, acute stress disorder and PTSD (Kirmayer et al., 2010). In recent years there has been considerable debate around the relevance of PTSD as a diagnostic category in non-Western cultures. PTSD has been critiqued for being a socially constructed concept developed in Western nations, with Western population samples. Using these criteria on non-Western samples is what Kleinman calls a “category fallacy” (De Jong & Joop, 2002). As a result, some authors argue that this disorder cannot be applied to individuals from non-Western societies. Marsella and Friedman (1996) argue that this view may be too extreme, as there are various aspects of post-traumatic stress that are universal, but we must also remain open to the possibility that there may cultural differences in the expression of traumatic stress that may not necessarily follow the DSM-IV diagnostic criteria. The recently released (May 2013) DSM 5 attempts to make allowances for cultural differences and states that “the clinical expression of the symptoms or symptom clusters of PTSD may vary culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams and somatic symptoms” (American Psychiatric Association, 2013, p. 278). However, no recognition is given to these socio-cultural factors in the revised diagnostic criteria. Marsella (2010) argues that culture influences trauma-related aspects such as idioms of distress, patterns of onset, patterns of re-experiencing, manifestation of symptoms, avoidance and dissociation symptoms, patterns of coping and social resources, course, prognosis and outcome.

A study with traumatised Sudanese refugees in Uganda and torture survivors in Malawi found that the re-experiencing and hyperarousal symptoms of PTSD were common in these samples, but avoidance symptoms were rare (Kaminer & Eagle, 2010). A study by McCall and Resick (2003) of PTSD among the Kalahari bushmen found intrusive and arousal symptoms to be present, but the prevalence of avoidance symptoms was low. These authors, and various others (Hinton & Lewis-Fernández, 2011; van Rooyen & Nqweni, 2012) argue that ethnocultural investigations suggest that avoidance/numbing symptoms are considerably more influenced by culture than the more biological re-experiencing and arousal symptoms. In their review of studies that address the cross-cultural validity of PTSD, Hinton and Lewis-Fernandez (2011) found that various studies using samples in Algeria, Ethiopia, Vietnam and Gaza reported low rates of avoidance/numbing items. Thus the prevalence of PTSD will be elevated in cultures where the particular types of avoidance assessed by Criterion C are common methods of dealing with distress. However, in collectivist African cultures where the individual is bound up with family and community, avoidance becomes a less likely method of coping. As a result, PTSD will be lower in cultures where avoidance/numbing is not experienced (McCall & Resick, 2003).

Van Rooyen and Nqweni (2012) also argue for a middle ground which postulates that PTSD has common features across cultures, but it also cannot be decontextualized from cultural influences in its origin and symptomatic expression. When individuals from non-Western cultures express their experiences of and responses to traumatic events, they may not provide a typical account of PTSD symptoms. This is because there is cultural variation in the 'idioms of distress' that influence the expression of emotional states. Idioms of distress are those specific ways in which people of a sociocultural group express distress. Idioms of distress vary across cultures, depending on culturally pervasive norms, values, metaphors, traditions

and expressions. There are several types of idioms, including cultural illness syndromes (e.g, an “attack of the nerves” in Cambodian refugees); a somatic or psychological complaint (e.g, being sad or experiencing body pain); religious involvement (being part of a cult or witchcraft involvement); and acting-out behaviours (e.g, drinking). In each of these idioms, cultural elements combine to form a whole which includes etiologies, vulnerabilities, symptoms and remedies (De Jong & Joop, 2002; Hinton & Lewis-Fernández, 2010).

For instance, when discussing traumatic occurrences, rural Zulus explanations focus on a disruption between the natural and supernatural domains of life (Edwards, 2005a). A study conducted by Fox with the Mandinka people in West Africa found four posttraumatic reactions to trauma: *kidja faro*, or heart shakes; *masilango*, or extreme fear; *perrio*, or brain out of place; and *mira kurango*, or thinking sickness. However, several of these reactions would be recognised by Western practitioners as signs of PTSD, such as hypervigilance, flashbacks, nightmares, startled responses and concentration problems (Rasmussen, Smith, & Keller, 2007).

Matkin, Nickles, Demos and Demos (1996) further explain that in non-western cultures, psychological symptoms are often expressed through physical complaints. In their study with Cambodian and Vietnamese refugees, they found that the Cambodian group meet the criteria for PTSD, the Vietnamese group reported less PTSD symptoms and more somatic complaints such as body pain and impaired vision. In their review, Hinton and Lewis-Fernandez (2011) found that the PTSD diagnosis, because it excludes somatic symptoms, has limited validity. These symptoms are a significant part of reactions to trauma in various cultures, for example, a sense of body heat among Senegalese refugees, body pain among Bhutanese refugees and sudden shortness of breath among Rwandan genocide survivors. The study with Sudanese

refugees also found that avoidance appeared to be explained through somatic symptoms, such as body numbing (Kaminer & Eagle, 2010). Edwards (2005a) explains that among illiterate Black patients suffering from psychological disorders, physical symptoms are commonly reported, and as a result the psychological disorder is not recognised or treated.

De Jong and Joop (2002) point out that we are only in the beginning stages of comprehending the differences and similarities between cultures. The DSM-IV criteria may not be valid in the same way everywhere, and a different set of symptoms may be better indicators of psychological difficulties in response to traumatic events. The DSM 5 recognises that “cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders,” and thus a “comprehensive evaluation of local expressions of PTSD should include assessment of cultural concepts of distress” (American Psychiatric Association, 2013, p. 278). It is thus important to listen to the individuals’ stories, as these may not match the Western criteria. When considering the consequences of trauma, it is also important to have an understanding of the sociocultural context in which the individual lives, not only to provide more accurate diagnosis, but the local expression of traumatic stress may require different interventions when compared to the mainstream ones (Kaminer & Eagle, 2010; van Rooyen & Nqweni, 2012).

2.4 Treatment intervention

Over the last few decades, numerous authors have pointed out that non-Western populations have a tendency to underutilize mental health services, pursue help only when their problems are severe, and leave therapy prematurely. Numerous researchers agree that the reason for this is the failure of counsellors and psychotherapists to administer culturally sensitive therapy. Collectivist values and contextual conditions such as socioeconomic status, culture,

spirituality and the community environment are often ignored or underrated. (Griner & Smith, 2006b). There is also broad agreement that post-trauma interventions need to promote aspects such as a sense of safety, self-efficacy, calming, and feelings of connectedness and hope. However, converting these goals into interventions call for awareness of local social, economic, political and cultural systems, and these have been minimally integrated into current trauma intervention programs (Kirmayer et al., 2010).

2.4.1 Cultural adaptation of trauma interventions

Clinicians have known for a long time that the most effective treatment for a client is one that is tailored to the needs and sociocultural context of the individual (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). As a result, various guidelines for adapting interventions to the client's context and cultures have emerged in recent decades. Smith, Domenech and Bernal (2011) have identified the following common themes in the literature:

- Therapists must practice adaptably.
- Services should be valuable within the context that they are delivered.
- Assessment should be used before treatment.
- Therapists must be open to what clients bring to therapy.
- Traditional treatments should not be disregarded but used as a resource.
- Therapists must communicate empathy in a culturally acceptable way.
- Cultural differences should not be regarded as deficits.

There are various views in the literature regarding culturally adapted interventions. Many are calling for the development of new therapies based on the beliefs, values and practices of the cultural group, while others propose implementing traditional evidence-based treatments with slight changes (Smith et al., 2011). Ford (2008) argues that one cannot just assume that all

aspects of Western models are ineffective or inappropriate. Western models are not entirely irreconcilable with culturally-based practices, and have a common goal of promoting not only symptom reduction but also strengthening resilience.

Accordingly, numerous scholars argue for an integrated model of cultural adaptation that considers both fidelity and fit. They recommend the adaptation of existing models to existing sociocultural contexts, while keeping the original mechanisms of behavioural change or symptom reduction. However, when designing culturally adapted interventions, therapists should be careful and consider the tension between population fit and treatment fidelity. For example, if an intervention such as CBT is adapted for an Asian population by incorporating the Buddhist principle of mindfulness, then there may come a point where, for example, therapy facilitates relaxation and awareness over challenging irrational thoughts, and thus the causal explanations of CBT may no longer be foremost in the adapted treatment (Bernal et al., 2009; Smith et al., 2011).

2.4.2 A model of adaptation

Bernal and Saez-Santiago developed an ecological validity model for culturally sensitive interventions (Bernal et al., 2009; Bernal & Sáez-Santiago, 2006; Griner & Smith, 2006b; Smith et al., 2011). They identify eight elements that focus on content and methods, and must be incorporated into treatment. Considering these elements can assist the psychotherapist in aligning treatment with the client, instead of assuming that the client will accommodate to therapy:

1. Language – this refers not only to using the client’s preferred language, but also understanding the particular uses of language in different groups.

2. Persons – this includes characteristics such as race and ethnicity. Studies have shown that clients prefer therapists who match their race, ethnicity and language.
3. Metaphors – cultural metaphors, symbols and concepts are useful in aligning therapy with the client’s needs. Clients can use cultural sayings to express meaning or insight.
4. Content – the cultural values, customs and traditions also need to be attended to in order to align them with the client’s worldview. For instance, African American clients are more likely to remain in treatment when it is based on Afrocentric values.
5. Concepts – this refers to the constructs of the theoretical model to be used in treatment. The way in which the client’s problem is conceptualized and communicated should be congruent to their context and culture.
6. Goals – customs and cultural values need to be considered when setting treatment goals.
7. Methods – customs and cultural values also need to be considered when establishing the interventions needed to reach those goals. Mental health professionals should also cooperate with support sources and spiritual traditions within the client’s community.
8. Context of the intervention or services – larger issues such as social and economic factors also need to be considered. Interventions should be designed for the client’s context and delivered within the community they reside in.

A meta-analysis done by Smith, Rodriguez and Bernal (2011) summarised research of 65 studies concerned with adapting psychotherapy to clients’ cultural backgrounds. They found that the most effective treatments are those with a wider scope of cultural adaptations, and that mental health services adapted to specific cultural groups were more effective than those delivered to clients from various cultural backgrounds. They also found that an average of four out of the eight components was described by authors in adapting mental health interventions. 74% provided therapy in the client’s preferred language, 53% matched clients

with a therapist from similar backgrounds, 42% utilized metaphors from client's cultures, 77% included cultural content/values, 37% followed the clients understanding of the problem, 43% modified intervention methods based on cultural considerations, 59% mentioned consultation with indigenous healers and 55% addressed the client's contextual issues (Smith et al., 2011).

Another meta-analysis done by Griner and Smith (2006a) included 76 studies, and their findings demonstrated a general positive effect of culturally adapted mental health interventions. Their findings also implied that cultural adaptations may be even more effective when the adaptations are for a specific cultural group and when the interventions are conducted in the client's preferred language. The authors found that 50% of the studies included two to four adaptations, with 43% including five or more. The most frequently mentioned adaptation (84%) involved including cultural concepts and values into the intervention. Interventions also tried to match clients to therapist from the same cultural group (61%) and language (74%). Some studies also provided extra services such as child care during sessions, consultation with individuals familiar with the clients' culture, cultural sensitivity training for staff and referral to additional services.

2.4.3 Culturally adapted interventions

Although there is extensive importance placed on adapting interventions in the literature, in order to better help clients, the research literature relating to culturally adapted interventions remains diffused. There are many different opinions as to what defines effective cultural adaptation, but there has been limited study of the empirical basis of these adaptations (Griner & Smith, 2006b). Clinical guidelines for trauma intervention emphasize approaches such as cognitive behaviour therapy (CBT), psychoeducation, exposure therapy and trauma

focused psychotherapeutic interventions. CBT has proven to be useful with people with trauma related PTSD and works by changing ways of interpreting and responding to trauma cues, reducing catastrophising thoughts and emphasises adaptive coping (Kirmayer et al., 2010). A Cochrane Review (Roberts, Kitchiner, Kenardy, & Bisson, 2010) reported that trauma-focused cognitive behavioural therapy was found to be effective in treating individuals with traumatic stress symptoms.

Hinton, Pham, Tran, Safren, Otto and Pollack (2004) conducted a study in which they examined the acceptability, feasibility and therapeutic efficacy of a culturally adapted CBT intervention for Vietnamese refugees with treatment resistant PTSD and panic attacks. During 11 weekly sessions, they stressed elements such as psychoeducation regarding the characteristics of PTSD and panic disorder, relaxation training and instruction using culturally appropriate visualizations and metaphors and cultural restructuring of fear networks (especially of trauma memories, culture related fears and catastrophic misinterpretations of somatic symptoms). The study was regarded as acceptable and effective in reducing PTSD symptoms and comorbid panic attacks among the sample of traumatized Vietnamese refugees. Otto and Hinton (2006) conducted a study in which they modified a CBT program to facilitate the administration of an exposure based treatment for Cambodian refugees with PTSD. Their modifications included using culturally relevant examples and metaphors to help with communication of key concepts, addressing symptom interpretations that are culturally specific, focussing on the way in which treatment processes interacted with culturally specific beliefs, and efforts to incorporate treatment services within the community. Results showed that this 10-week period of modified treatment was an effective intervention with Cambodian refugees.

In addition to individual therapy, group therapy is also important in service delivery. In the treatment of traumatic stress, most current trauma literature endorses incorporating multimodal therapy. Group processes have significant value in promoting self-esteem, social skills, interpersonal learning and relationships and instilling hope (Chaikin & Prout, 2004). However, the most significant healing factor of support groups is mutual aid and normalization by members, and the all-important goal is the improvement of coping skills gained through this communal aid and sharing (Nicholson & Kay, 1999b). A study done by Hinton, Hofmann, Rivera, Otto and Pollack (2011) which focused on group therapy showed that culturally adapted cognitive behaviour therapy (CBT) can be beneficial in treating post-traumatic stress disorder (PTSD) in Latino women. Treatment was delivered over 14 weeks in the form of group therapy. Sociocultural adaptation of CBT included using culturally appropriate imagery and analogies, addressing cultural syndromes, idioms of distress and modification of culturally related catastrophic cognitions. A study done by Nicholson and Kay (1999b) which also found culture-specific group treatment of traumatised Cambodian women beneficial, emphasised the importance of a social support network in which the traumatised women developed and maintained a helping network where they found succour from those who shared a common culture and experiences. The importance of social connectedness is also illustrated in a study on the resilience among the survivors of genocide rape in Rwanda. Resilience among these women was found to be influenced by multiple sociocultural processes that allowed the women to connect with others who had similar experiences in order to derive meaning, bear their suffering and establish normalcy in their lives (Zraly & Nyirazinyoye, 2010). In addition, spirituality and social support has been found to be connected to better mental health among African American women who are exposed to trauma related family violence (Paranjape & Kaslow, 2010).

2.4.4 A South African context

Very little research has been done on adapting trauma intervention models for the South African context and culture. The Wits Trauma Model is a local model developed by the University of Witwatersrand (Kaminer & Eagle, 2010). This model was developed in the South African context and based on a psychodynamic and cognitive behavioural theoretical foundation. The fifth stage of intervention involves facilitating the creation of meaning which involves engaging with an individual's belief system at a political, spiritual, cultural or existential level – although this stage is optional (Eagle, 1998a). However, the efficacy of the model has not been subjected to any control based or comparative research (Kaminer & Eagle, 2010).

Traumatised people all over the world need assistance in understanding their pain and in developing specific strategies for coping with it. As argued, pre-packed universal interpretations and methods do not necessarily help. It is essential to consider the effects of the sociocultural context in developing culturally sensitive interventions in the South African context (Motsi & Masango, 2012). It is this context that affects the meaning the individual gives to the traumatic event, the consequences of the event and help-seeking behaviour. Sociocultural aspects such as male dominance, gender norms, blame, attitudes toward physical and sexual violence are culturally constructed phenomena and thus treatment must include a deconstruction and unlearning of these attitudes (Lebowitz & Roth, 1994). Incorporating sociocultural influences into treatment programs encourages “restoration of homeostasis and optimal functioning.” (Antai-Otong, 2002, p. 203) Interventions therefore cannot just focus on individual behaviour, but our attention needs to turn to the bigger picture. Interventions are needed at many levels including individual, policy, service and community levels. For instance, there needs to be: investment in education and information

campaigns; change in national policies regarding gender equity; empowerment of women; services must be widely available; work towards reducing poverty and alcohol abuse, and cultural attitudes (e.g toward the use of violence) and gender norms need to be addressed (Jewkes & Abrahams, 2002; Jewkes & Morrell, 2010).

Additionally, Eagle argues, from an African worldview perspective, that indigenous healing systems (such as the use of rituals and traditional medicine) can complement and supplement conventional Western psychotherapeutic interventions. In some instances, Western-acculturated African individuals hold explanatory systems that allow for the integration of both Western and traditional African premises. For example, a traditional healer may be consulted to perform protection rituals, but a counsellor seen for helping to deal with traumatic stress symptoms such as anxiety. In using an holistic approach to dealing with trauma, traditional healing practices may reach under-resourced communities and create an environment that promotes personal and community integration (Eagle, 1998b, 2004).

2.5 Theoretical Framework

In 1977, Arthur Kleinman defined a major direction in the field of culture and mental health when he criticised Universalist psychiatry for imposing Western models on other cultures. These models do not sufficiently consider the actual experience of illness and distress, and this is important because it is this experience which will influence how the individual behaves, the treatment pursued and their reaction to treatment (Swartz, 1998). People explain their distress in many different ways; some may blame their social circumstances, religious factors, relationship problems, witchcraft or ancestral influences, or a broken taboo (Bhui & Bhugra, 2002). For example, an African worldview would see a traumatic event as a severe form of misfortune caused either by mystical, animistic or magical factors (Eagle, 2004).

Kleinman and colleagues (Kleinman, Eisenberg, & Good, 1978) explain that explanatory models are influenced by culture and therefore are culturally constructed. How we perceive, experience and cope with illness is based on our explanation of that illness which is influenced by our social positions, and the systems of meaning that we use. Culture influences both patients' and practitioners' explanations and perceptions of symptoms, choice of care, goals for treatment and evaluation of treatment efficacy. Illness behaviour is a normative experience governed by cultural rules- in other words, we learn "approved" ways of being ill. Thus it is not surprising that there is clear cross-cultural variation in how disorders are defined and coped with (Kleinman, Eisenberg, & Good, 2006).

Discrepancies between practitioner and patient treatment explanations and activities may lead to inadequate or poor care. Empirical evidence suggests that patients are most satisfied when their mental health professional shares their model of understanding distress and treatment. The proposed method is for patient and practitioner to share information, a feature that distinguishes it from the Western model that focuses on knowledge held by the professional. This may be a difficult task for the clinician, as even though the open-ended questioning aims to embrace the worldview of the patient, this can be lost if questions tend to focus more on obtaining a diagnosis and prescribing treatment (Bhui & Bhugra, 2002).

Kleinman suggested that a patient's explanatory model of illness should be produced in which the following concerns are explored: "Why me? Why now? What is wrong? How long will it last? How serious is it? Who can intervene or treat the condition?" (Bhui & Bhugra, 2002, p. 6). Based on this theory, Kleinman developed the following set of questions (Hark & DeLisser, 2011):

- What do you think has caused your problem?

- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

The explanatory model thus aims to understand subjective experiences of distress and then apply that understanding in practice (Bhui & Bhugra, 2004). Swartz (1998, p. 15) states that “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.” Explanatory models may implicate sacred or secular causes or treatments (Kleinman, 1991). A study done by Bhui, Rudell, and Priebe (2006) found that Bangladeshi subjects who suffered from common mental disorders such as anxiety or depression most often gave spiritual or physical causal explanations for their distress, and preferred spiritual and medical treatments. From an African worldview, if the cause of traumatic distress is viewed as a result of having incurred ancestral displeasure, then the individual would have to perform certain rituals to overcome this misfortune and prevent future harm (Eagle, 2004).

As Bhui, Rudell, and Priebe (2006) point out, previous research on explanatory models has focused mainly on causal explanations rather than on all aspects of the explanatory model. To the knowledge of the researcher, few studies have been done in South Africa that look at an explanatory model of trauma in Black Africans in KwaZulu-Natal. One related study is an

unpublished master's thesis that used the explanatory model to examine the social, politico-historical factors and the interpretation of these events in causing distress in rural Zulus. The study found that there is a tendency to clutter events into paths of distress that are given traumatic meaning, and these paths are initiated by events in the person's history and culture. The study gave very little attention to treatment interventions (McBride, 2003).

2.6 Conclusion

Traumatic events do not occur in a vacuum. The sociocultural context in which an individual lives and is traumatised influences how the individual appraises the event, how the event is coped with, how they experience and manifest symptoms, family and community support, and their expectations regarding therapeutic help. The literature indicates that sociocultural factors such as male dominance and patriarchy, a culture of violence, a culture of blame, poverty and alcohol abuse, and an African worldview may play a role not only in creating and perpetuating the traumatic events that many individuals are exposed to in our society, but also their understanding and appraisal of traumatic events. The way in which individuals experience and express consequences related to the traumatic event, also varies across cultural and social contexts.

Sociocultural factors also influence the trauma intervention required. The literature reveals that the best treatment is tailored to the needs and context of the individual. While there are many guidelines on how to adapt trauma interventions in order to be culturally relevant, there is currently little research on culturally adapted trauma interventions for the South African context. The current study therefore aims to enrich existing literature through examining the explanatory models of illness held by Black trauma victims in KwaZulu-Natal. This will provide insight into those individuals' understanding and expression of their trauma, and the

influence of their sociocultural context. Additionally, the study aims to fill the gap in literature in determining, from the victims themselves, what trauma intervention may be useful for the victims, and the influence of the sociocultural context in this. This should assist in making recommendations for the adaptation of existing trauma models and interventions in order to make them more relevant to the local social and cultural context.

CHAPTER 3: METHODOLOGY

3.1 Introduction

In line with the aims of the study, a mixed method approach was employed, with data collection involving a PTSD screening measure and semi-structured interviews. Participants were obtained at two research sites, Open Door Crisis Centre, and 1000 Hills Community Helpers, and data was analysed using a thematic analysis approach. In this chapter the research process, including aims and research questions, data collection and analysis, ethical considerations and validity and reliability, is outlined.

3.2 Aims and Research Questions

3.2.1 Aim of the study

The aim of this study was to understand what cultural factors, social factors, traditional methods and beliefs should be considered when adapting a trauma intervention model to the South African context, specifically to Black Africans in KwaZulu-Natal. Kleinman's explanatory model of illness was used as the theoretical framework in order to inform the questions asked and for analysis of the emergent data.

3.2.2 Research Questions

1. How do the victims understand their experience and express their distress?
2. Do victims present with symptoms of PTSD?
3. What kind of interventions do victims think would be helpful to them?
4. What implication does this have for a culturally-sensitive model of intervention?

3.3 Research Design

In order to address the aims and research questions of this study, a mixed method approach was employed, with data collection involving a PTSD screening measure and semi-structured

interviews. The semi-structured interviews used a multiple case study approach. A case study research approach seeks an in-depth understanding of an occurrence or phenomenon within its natural, real life context. In other words, case studies can be utilised to describe, explain or explore events or phenomena within their daily contexts (Crowe et al., 2011). Another description defines case studies as “a method to deeply observe the characteristics of an individual unit such as a person, a group or a community, in order to analyse various phenomena in relation to that unit of study.” (Suryani, 2008, p. 118). In this study, traumatic events experienced by Black Africans in KwaZulu-Natal were explored within their real-life socio-cultural context. Crowe et al (2011) further explains that case studies aim to answer the more explanatory ‘*how*’, ‘*what*’ and ‘*why*’ questions about events. This study aimed to explore how the individual understood the traumatic experience that they went through: why did it happen to them? What consequences it has had for them? What intervention would they like?

Depending on the epistemological standpoint of the researcher, case studies may be approached in various ways: they may take a critical (questioning assumptions), interpretivist or positivist approach (testing and refining theory). The interpretative approach “involves understanding meanings/contexts and processes as perceived from different perspectives, trying to understand individual and shared social meanings” (Crowe et al., 2011, p. 4). Most qualitative researchers believe that people’s interpretation of reality tends to have a sociocultural, situational and contextual basis. Thus case studies emphasise these aspects during research (Suryani, 2008). The study aimed to understand the participants’ perspective of their trauma and thereby what meaning they attached to their experience and the consequences thereof. Throughout the research process, particular attention was also paid to

the sociocultural and contextual conditions of the participants that may have influenced their perspective.

According to Stake (cited in Crowe et al., 2011; Suryani, 2008) there are three main types of case studies: *intrinsic*, *instrumental* and *collective*. An *intrinsic* case study is used to learn about and gain a deep understanding of a phenomenon; an *instrumental* case study focuses on a particular case in order to understand a particular issue; and a *collective or multiple* case study is like an extension of an instrumental study case study and entails studying multiple cases in order to gain a broader understanding of a particular issue. The case study researcher also tries to find similarities and/or differences between the cases to gain a better understanding of the issue. The researcher selects cases to illustrate an issue and studies them in detail, while at the same time considers the specific context of the cases (Neuman, 2007). The researcher used a collective or multiple case study approach with 11 Black individuals who had been through a traumatic experience.

3.4 Data Collection

3.4.1 Site of Study

The research was conducted at two sites: the first site was the 1000 Hills Community Helpers in Inchanga, KwaZulu-Natal, and the second site was the Open Door Crisis Centre in Pinetown, Durban. Through medical treatment, feeding schemes, clinics, home-based care, counselling, crèches and support groups, 1000 Hills Community Helpers aims to improve the lives of HIV infected and affected children and adults. The centre employs home-based caregivers who provide services such as medical treatment, education about HIV/AIDS, support groups and counselling. Much of this counselling involves dealing with individuals who have been through a traumatic experience, such as domestic violence or rape – which in

many cases leads to HIV infection. Caregivers receive counselling skills training as part of their home-based care training ("Our Vision", 2012).

Open Door Crisis Centre primarily provides trauma counselling and “advice-desk” services to individuals who have experienced a crisis or trauma. They also provide training programs for individuals who want to address social issues in their schools, communities and workplace; they run an HIV/AIDS clinic and have a shelter for abused women and children. Counselling is provided primarily by volunteers who are either registered counsellors, or individuals who are in the process of training to practice as counsellors or psychologists ("Services", 2013).

3.4.2 Research Participants and Sampling Method

Purposive sampling was used to obtain the participants in this study. When the researcher has a definite aim, purposive sampling is used to select particular cases (Neuman, 2007). Researchers select information- rich individuals, groups, organizations or behaviours that render the most insight into the research objectives and questions (Devers & Frankel, 2000). Since the objective of this study was to gain insight into the explanatory models of victims of traumatic experiences in Black Africans in KwaZulu-Natal, the sample consisted of Black individuals who had been exposed to traumatic events. A traumatic event needed to have occurred at least one month before the interview with the researcher. This last requirement is based on the DSM-IV criteria for PTSD, which requires the symptoms to be present for at least one month. Participants were also required to have experienced PTSD symptoms and therefore the Davidson Trauma Scale was used in this regard. These individuals had also received assistance at either of the study sites.

Recruitment of the participants involved approaching the coordinators of both sites of study, and asking for their assistance with the research project. They were given a letter explaining the research aims, processes of data collection and sample requirements (Appendix 1). The coordinators then identified suitable participants based on the sample criteria, and contacted these participants in order to inform them about the study and determine whether or not they would be willing to participate. After identifying the participants, dates and times for interviews were set up. Initially, 12 potential participants were identified at 1000 Hills Community Helpers, but only 8 met the sample criteria. Five potential participants were identified at Open Door Crisis Centre, but only 3 met the sample criteria. Thus 11 participants were obtained in total. All of the participants were Black African women between the ages of 21 and 53, and traumatic experiences included rape and attempted rape, interpersonal violence and armed robbery. Many of these individual had also experienced not only a single traumatic event, but multiple or ongoing traumas. Nine of the participants were isiZulu-speaking, one was Xhosa-speaking, from the Eastern Cape, and one was Shona-speaking, from Zimbabwe.

3.4.3 Participant Profiles

What follows is a brief profile of each participant to convey the traumatic experience they went through, and thereby provide a context for the quotes provided in the results section.

Participant 1

Participant 1 is a 43 year old Black African female who was gang raped by six men after a night out at a local tavern.

As I was walking out of the gate, there stopped a dark car with tinted windows. I couldn't see the people inside as I was already drunk, so they took me and put me in the car and raped me. There were six of them- they took turns with me... all six of them.

Participant 2

Participant 2 is a 45 year old Black African female who was raped by two men on her way to work.

I got a job, and one day when it was cold and the bus had left me, I had to take the seven o'clock ride. I was alone in the bushes between the houses when two people came and grabbed me. I struggled, telling them that I would call the police, but they took my phone and pinned me down... and they raped me.

Participant 3

Participant 3 is a 27 year old Black African female who suffered physical abuse, not only throughout her childhood, but recently her mother's boyfriend and her cousin physically assaulted her over an argument about a cell phone.

I had a phone that I was using; my mother took the phone and gave it to her boyfriend. When I asked her to get it back, she told me to get it myself from her boyfriend, and so I spoke to him, but we ended up arguing. He cursed me out and he slapped me across the face, so I hit him back. He and my cousin beat me up under my mother's orders. As I was trying to escape, I got cut by pieces of glass from a window which broke during the assault.

Participant 4

Participant 4 is a 29 year old Black African female who was raped by men who burgled the house that she was staying in.

“While I was with my siblings, the house was burgled by some men. These men then raped me (during the burglary)... this occurred in August this year.”

Participant 5

Participant 5 is a 25 year old Black African female who has been repeatedly raped by her uncle from the age of 19.

My uncle started raping me at the age of 19 when my mother was sick. When I spoke about it nobody helped me... nobody called the police, and to this day he has never been arrested. I opted to leave home when my mother passed away.

Participant 6

Participant 6 is a 27 year old Black African female who was raped after a night out with friends.

I went out drinking with my friends and we enjoyed ourselves like we usually did as girls. When we decided to go home, it was late and there were no more taxis at the rank. There was this guy who had been watching us while we were drinking. He came up to us and asked if he could talk to me; I said that I don't want to talk to him. He pulled out a knife and pulled me into a dingy place; he then pulled down my pants and raped me.

Participant 7

Participant 7 is a 48 year old Black African female whose brother was shot in front of her.

My brother passed away, he got shot at the taxi rank. He was a sort of body guard, looking after the security of the taxi owner. I was with him (when it happened).

Participant 8

Participant 8 is a 23 year old Black African female whose brother, on the way home from a braai (barbeque), was stabbed in front of her.

We left the braai at about 10:00, and on our way back, as we were approaching the playground, there were two guys who stopped us and grabbed my brother. So I started screaming and one of them stabbed my brother. I then went back to where the braai was and came back with guys from the braai and we found my brother bleeding heavily. The attackers were nowhere to be seen. We called the ambulance, but when it arrived, he was already dead.

Participant 9

Participant 9 is a 24 year old Black African female who was mugged at knife point on her way to work, and the person who mugged her also tried to rape her.

The mugging ended in attempted rape... We struggled and he did have a knife with him... but the rape was more of a, "ok so you don't have money to give me" retaliation... If you don't have anything, they feel the need to show you that they can still take something, which is when they try and rape you.

Participant 10

Participant 10 is a 42 year old Black African female who was physically abused by her husband, whom she has consequently left.

“He (her husband) was not sleeping at home, and then I used to tell him that every Friday I am going to go to sleep at my mom’s house... but when I came back on Monday afternoons, he used to hit me.”

Participant 11

Participant 11 is a 21 year old Black African female who was assaulted by her boyfriend.

So he told me that when he remembers the circumstances in which he grew up (he was abused), he gets upset and takes out his anger on me (through hitting her). So he looks for opportunities to pick (a fight) - like the last time we had a quarrel about the baby’s name, and he ended up calling me bitch, assaulting me... all of that over a baby’s name.

3.4.4 The interview process

At the beginning of the interview, participants were given a letter (in English or isiZulu) explaining the research project to them (Appendix 2), and the interviewer also explained the research to the participants in order to answer questions and ensure clarity. Willing participants were then asked to sign a letter of informed consent (Appendix 2). The 8 participants at 1000 Hills Community helpers were interviewed in isiZulu, and the 3 from Open Door Crisis Center were interviewed in English.

The isiZulu-speaking interviewer has a BPsych qualification and has been translating and transcribing documents since 2008. The interviewer is fluent in both isiZulu and English and has experience in conducting interviews. This interviewer translated the interviews and Davidson Trauma Scale into isiZulu. Before the interviews, the researcher explained the purpose of the study, sample criteria, confidentiality and other requirements to the interviewer and provided guidance in interviewing techniques. After a set of two or three interviews the researcher held a debriefing session with the interviewer, which allowed the interviewer to express and process thoughts and feelings in relation to the interviews conducted.

Davidson Trauma Scale

After the introduction and informed consent, participants were asked to complete a self-administered questionnaire in order to determine whether or not they experienced symptoms of PTSD. This scale was therefore used to decide whether or not a participant should be included in the study. For the participants at 1000 Hills Community Helpers, the interviewer translated the questions into isiZulu and assisted them with the form where necessary. The questionnaire used was the Davidson Trauma Scale (DTS) (Appendix 3) which can be used as a screening measure to assess PTSD symptoms and to aid in treatment planning. It is used with individuals who have been through a traumatic occurrence. This self-rating symptom scale is used to measure the frequency and severity of PTSD symptoms during the previous week. It is a 17-item, five-point self-rating scale, in which each item corresponds to a DSM-IV symptom of PTSD (Brewin, 2005). It is quick to administer (takes about ten minutes), has been developed and tested in a range of population groups, including men and women who have gone through various traumas, and it has been translated into several languages. Each item is measured on a scale of 0-4, for both severity and frequency, with the maximum score

being 136. The items can also be grouped into intrusion, avoidance/numbing and hyperarousal symptom clusters, with subscores calculated for each cluster. These clusters reflect the DMS-IV criteria for PTSD (Davidson, Tharwani, & Connor, 2002).

In a study of 350 men and women who were exposed to various traumatic experiences, the DTS showed to have good test retest reliability (0.86) and internal consistency (0.99). Good concurrent validity was obtained against the Structured Clinical Interview, with a diagnostic accuracy of 83% at a DTS score of 40. Good convergent and divergent validity was obtained and predictive validity was good against response to treatment (Davidson et al., 1997). Although the DTS has not been standardised for use in South Africa, a study which developed a Korean version of the DTS found good internal consistency (0.97) and test-retest reliability (0.93). Good convergent validity was obtained as results demonstrated a positive correlation with the Clinician Administered PTSD scale (0.94). The highest diagnostic efficiency was with a score of 47. The authors suggest that the DTS is comprised of good psychometric properties and therefore is a valid and reliable tool for determining the frequency and severity of PTSD symptoms irrespective of the ethnicity (Seo et al., 2008). Thus, even though the DTS was standardised on a Western population, it was deemed suitable to use on a non-western population of Black Africans.

Semi-structured Interviews

Semi-structured interviews were used as the primary means of data collection. Semi-structured interviewing is a popular method of data collection in qualitative research. In addition to using open ended questions, qualitative interviews are generally loosely structured in format, which aim to obtain an in-depth account of a topic. It enables the interviewer to probe deeper in order to establish the meaning and impact of an event (Barker, Pistrang, &

Elliott, 2002). It allows the participant to describe to the researcher specific aspects of their life experience. In semi-structured interviews the investigator has questionnaire on an interview schedule which guides the interview. These questions act as triggers that encourage the participant to talk. Open-ended questions are used to help the participant to open up about their thoughts and feelings. However, it is the researcher's questions that drive the interview. It is through these questions and probing comments that the interviewer is able to steer the interview in a direction, not only to gain a greater understanding of what is being discussed, but so that data can be obtained that will answer the research question (Smith, 2008; Willig, 2008).

The focus of the interviews on this study was to gain a deeper understanding of individuals' experience and perception of traumatic events in order to determine what factors need to be considered when adapting a trauma intervention model to the South African context. A semi-structured interview (Appendix 4) of open-ended questions was drawn up on the basis of Kleinman's original eight questions that are used to elicit the person's explanatory model, and therefore their perceptions and experiences. In developing the interview schedule, Kleinman's original eight questions were tailored for use with trauma victims in order to elicit the victim's understanding of the traumatic event – its cause, effects, severity and treatment experiences and expectations.

Interviews were conducted in a room at the study site where the participant was identified, and lasted between 30 minutes and 1 hour. The participants at 1000 Hills Community Helpers were all isiZulu-speaking and interviewed in isiZulu by the isiZulu-speaking interviewer, as the majority of these participants could speak very basic English, and the 3 participants at Open Door Crisis Centre were interviewed in English by the researcher, as they were able to

converse fairly fluently in English. The participants were only interviewed once and the interviews were recorded on an audio tape.

The researcher also tried to anticipate any possible harm, such as secondary traumatisation and vicarious trauma, to participants and the isiZulu interviewer. As a result participants were offered the option of a referral to a counselling centre, should they feel upset or distressed as a result of taking part in the study. In addition, as explained previously, debriefing was conducted with the isiZulu interviewer in order to prevent possible harm.

3.6 Ethical Considerations

Ethical clearance (Appendix 5) for the study was received from the Research and Ethics Committee at the University of KwaZulu-Natal. Participants were also given a study information sheet (Appendix 2) on which the following was outlined:

- Who the researcher is, the purpose of the study, and why it is important.
- The types of questions that will be asked in the interview.
- What the interview process will also entail; such as being recorded on an audio-recorder, the length of the interview, the language in which interview will be conducted and financial reward.
- Measures to avoid harm to participants. For instance, the option to obtain psychological assistance if needed as a result of the interview.
- That participation is voluntary and the option to withdraw at any stage without discrimination or repercussions.
- That confidentiality and anonymity is ensured.
- How and by whom the interview data will be handled, stored and destroyed.
- Contact details for further information

This information sheet was also translated into isiZulu for those participants who did not speak English. This information helped participants make an informed choice as to whether or not they wished to participate in the study. The participants were given the opportunity to ask questions. If they agreed to participate, they were also required to provide informed consent (refer to Appendix 2). Participants' identities were protected by assigning an numerical letter to use in identification and to maintain confidentiality. Interview data, including the audio recording of the interview, the interview transcripts and informed consent forms were stored under lock and key at the University of KwaZulu-Natal. Participants were also given a monetary reward (which was personally funded) as a thank-you for participating in the study.

3.7 Data analysis

Interviews that were conducted in isiZulu were translated and transcribed into English by the isiZulu-speaking interviewer who conducted the interviews. As already mentioned, this interviewer has experience in translation and transcription. The interviewer reported that this translation and transcription process did not present with any real challenges as the interviews were easily understood. The interviews that were conducted in English were also transcribed by the researcher. The reliability of the transcriptions was checked by applying back translation checks and by reading through the transcripts while listening to the recording.

3.7.1 Thematic analysis

Thematic analysis was used to analyse the interview data. It is a widely used qualitative analytical method and can be seen as a foundational method in qualitative research analysis. Thematic analysis is “a method for identifying, analysing, and reporting patterns (themes) within data” (Braun & Clarke, 2006). It helps to organize and describe the data set in rich

detail. Codes are then developed to represent the identified themes and used in later analysis (Guest, MacQueen, & Namey, 2011).

In thematic analysis, a theme “captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). Themes can be identified at a semantic or explicit level, and latent or interpretive level. The researcher usually focuses more on one level than the other. At a semantic level, the themes identified and described revolve around the apparent or surface meanings of the data. Here the researcher is not looking for anything beyond what has been said or written. At a latent level, themes emerge as the researcher identifies or examines underlying ideas, conceptualizations and assumptions that shape or inform the semantic content of the data. Therefore, the analytic process ideally entails a progression from the description in which data is ordered to illustrate patterns in semantic content, to interpretation which will attempt to hypothesise the importance of the patterns and their wider meanings and implications (Braun & Clarke, 2006).

Braun and Clark (2006) provide a six step guide to thematic analysis:

1. Familiarisation with the data

This involves actively engaging in repetitive reading of the data in order to familiarise yourself with the data and to start searching for meanings and patterns.

2. Generating initial Codes

This phase involves the identification of initial codes from the data. These codes identify semantic or latent content which can be used in a meaningful way in order to answer the research questions.

3. Searching for themes

When all data has been initially coded and ordered, this phase involves looking at the broader level of themes and involves arranging the various codes into potential themes.

4. Reviewing themes

This phase involves refinement of identified themes. Themes may be discarded, combined or broken down into separate themes. The researcher needs to start determining which themes confirm the data and the primary theoretical perspective.

5. Defining and naming themes

This phase involves further refinement of the themes and analysing the data within them. The researcher needs to identify the “essence” of each theme (as well as the overall themes) and what facet of data each theme captures.

6. Producing the report

Final analysis and write-up of the report takes place in this phase. Here the researcher provides an account of the story the data tells – within and across themes. This story is illustrated through examples and makes an argument in relation to the research question.

Upon receiving the translated and transcribed interviews, the researcher read and re-read all the interviews in order to become familiarise oneself with the data. This familiarisation also aided in the initial identification of common patterns in the data. Transcripts of the interviews were transferred into the Nvivo 10 programme for qualitative analysis, and the programme was then used to identify dominant themes within the data. These dominant themes were identified using three different criteria:

- Understanding the causes of the trauma
- The consequences of the trauma
- Possible interventions

Segments that define the different criteria were coded and sorted into themes using the Nvivo. The transcripts containing the dominant themes were then read and re-read, and subthemes were identified, refined and coded using the Nvivo programme. When the themes had been finalised, these were reported including extracts to provide evidence of the themes given.

3.7.2 Davidson Trauma Scale

The Davidson Trauma Scale questionnaires were hand scored using the quick score form. A total score, which reflects both frequency and severity for all 17 items, was obtained. In addition, a total subscore for the intrusion, avoidance/numbing and hyperarousal subsets was obtained. These subscores reflected both the frequency and severity of the items in those subsets. Next, the mean of each subset score was calculated and compared to each other in order to determine, for each participant, which subset of symptoms was most prevalent (in a high range), least prevalent (low range), or in between most and least (medium range).

3.8 Reliability and Validity

Validity and reliability is a central element of qualitative research. All researchers want their research to be valid and reliable, as these are both important in establishing the truthfulness, credibility or believability of findings. Validity determines whether the research actually measures what it was intended to measure. It is important, as it assesses the capability of the researcher to comprehend and represent individuals' meanings (Banister, Burman, Parker, Taylor, & Tindall, 1995; Neuman, 2007). Reliability can be seen as the trustworthiness of procedures and data generated, and to the extent to which the results are repeatable (Roberts, Priest, & Traynor, 2006). A number of checks were done in order to ensure that reliability and validity was maintained.

3.8.1 Validity

Researcher bias was identified as a potential difficulty in validity. In the process of interviewing, the researcher should assume that self-reporting is accurate, but distortions can arise in the course of analysis and interpretation. This bias was avoided through the use of 'bracketing', in which the researcher tried to suspend her experience, judgment and belief. The researcher also used low inference descriptors and thereby used verbatim accounts within the written findings to demonstrate that the findings are grounded in the data (Roberts et al., 2006).

3.8.2 Reliability

In order to allow for replication of the research, the researcher also left an audit trail. An audit trail records the research process from beginning to end, in which the decision making trail is recorded. For example, it described how data was collected and how themes were derived. In order to enhance the reliability of the study, the researcher kept detailed accounts of how the study was conducted and data analysed (Roberts et al., 2006). With regards to generalizability, in qualitative research the focus is not on generalizing findings from a sample population to a wider population, but more on what can be called theoretical, vertical or logical generalization. In this the researcher hopes that the insights derived from studying one context will prove useful in other contexts that are similar (Smith, 2008).

3.9 Conclusion

In this study, a mixed method approach was used, with data collection involving a PTSD screening measure and semi-structured interviews. In this chapter, the research design, data collection, ethical considerations, data analysis and validity and reliability of the study was outlined. In order to achieve the aims of this research, these processes were carefully planned

and implemented. The data gathered during this process was analysed using thematic analysis. The following chapter will provide details on the results of this analysis.

CHAPTER 4: RESULTS

4.1 Introduction

As discussed in the previous chapter, during thematic analysis the computer program Nvivo was used to identify various themes and subthemes that emerged from the interviews conducted with a sample of Black Africans in KwaZulu-Natal who had been exposed to a traumatic experience. The major themes included:

- Understanding of trauma
- Consequences of trauma
- Possible interventions

These themes, as well as the subthemes identified, will be examined below and substantiated by quotations taken from the interview transcripts. Lastly, results from the Davidson Trauma Scale questionnaires will be presented.

4.2 Understanding of Trauma

Analysis of the transcripts revealed a varied understanding of the causes of the traumatic experience that the participants went through. The understanding expressed by the participants also reflects the influence of the socio cultural context in which they are rooted.

4.2.1 Crime and violence

Three of the participants understood the cause of their traumatic experience to be related to the crime and violence that is prevalent in the community in which they live.

“I think it was just the criminal activity associated with that area, because when I got the job, I was told that there were criminals there.” (Participant 2)

There is this taxi violence going on amongst the taxi owners. He was like a body guard for one of the taxi owners and he must have been killed because he was the owner's protector... there were two of them (bodyguards) and they both got killed at the same time. (Participant 7)

Participant 8, whose brother was stabbed in front of her, was not sure why it had happened (he was not robbed either, as nothing was taken). Although she may not have been aware of it, he may have been involved in something which resulted in his death. Violence in this case was a means to achieving an unknown goal.

"I don't know where these guys came from. I don't know if he had some argument with them or something, but they were not at the braai, they just came out of nowhere." (Participant 8)

4.2.2 Male dominance

Three of the participants also understood the cause of their trauma to be associated with the attempt of men to gain power and control over women.

When he was hitting me, he used to say that I am a bitch and he said that I'm having an affair, I'm doing this and that, why am I not sleeping at home? So he used to accuse me of sleeping around if I am not at home... I think he was trying to gain control of me so that I won't go anywhere, I'll stay at home and do the chores and he can walk around and can go and sleep over, but I must be at home. (Participant 10)

His former wife dumped him and ran away with another man. That is the other reason, because if he thinks that somebody just took his wife from him, then he ends

up upset again. Then if he looks at me, he ends up saying that I have a boyfriend and I am also going to leave him. (Participant 11)

We usually joke with friends: if you go out at night, just carry 50c for the boys, just in case they want money- at least you've got something, because if you don't have anything they feel the need to show you that they can still take something, which is when they try and rape you. (Participant 9)

4.2.3 Blame

Five participants attributed the cause of the trauma to certain behaviours that they engaged in, or failed to engage in.

"If I didn't drink alcohol that day, nothing would have happened." (Participant 1)

"I was the cause of the assault because if I didn't ask for my phone back, none of this would have happened". (Participant 3)

Participant: The house.... had broken windows and the door had no lock. It was easy to get into the house.

Interviewer: what if the house was in a safer location and it had windows and doors that lock?

Participant: I think this might not have happened because we would have awoken sooner when they tried to get in, and we would have made some means of preventing them getting in. (Participant 4)

Two of the participants also believed that because they did not do what men wanted them to do, they were punished.

I also think it's because of the way I behave around the community. I didn't date anybody because I was always stressed with having to look after the children. They say that I think I am better than everyone. I think they were trying to teach me a lesson. (Participant 4)

He might have liked me, and when he called me over to talk to me and when I refused, he thought he might as well rape me. He probably thought that I am being rude or stubborn so he will teach me a lesson - maybe because he thought I am full of myself. (Participant 6)

For three of the participants, their self-blame was reinforced by the blaming reactions of the police, their family and the community.

"The police... shouted saying that we shouldn't be walking around at night after drinking." (Participant 6)

"My child's father does not understand, he thinks that it was men I desired. He keeps cursing me about that. Each time we fight he would say no wonder I was raped." (Participant 4)

Elders, if you say, he hit me, he does this to me, these horrible things to me; they will say, you must have provoked him to do that to you. And then they don't even sit down to listen to your part of the story, and they just say that you are jumping to

conclusions, you have provoked him, what have you done, and stuff like that.

(Participant 10)

The response of one participant who was raped, and her description of what those around her said demonstrated the socio-cultural perception in society that women are in some way to blame for violence against women, putting no responsibility on the actions of men.

What happened was around half past eight at night. People were walking around, but they didn't understand what was going on between me and this guy. Some people thought that I am a drunk who is spending his money, some thought I might be his girlfriend and I have agreed to this. (Participant 6)

4.2.4 Safety in numbers

Participants were also asked why they thought the traumatic event happened when it did, and three participants concluded that it was as a result of them being alone and not in a group. Three participants saw themselves (self-blame) as simply in the 'wrong place at the wrong time', and therefore vulnerable to violence.

We usually go as a group because there are criminals. The bus left me and I had to take the seven o'clock one. I was alone in the bushes between the houses there, and two people came and grabbed me. I think they knew that the people that walk together as a group had left, so they can catch whoever is left behind- whoever is walking alone... rushing to work. (Participant 2)

I think he wouldn't have done this if it was early, because there would have been a lot of people. At night, people are in a hurry to catch the taxis- nobody minds anybody's business at that time. He figured I wouldn't easily get help. (Participant 6)

Um, around the area, usually in the mornings, you won't hear of a mugging in the mornings, and in the evening when people are going to catch busses and transport, you won't hear of a mugging.. But after nine, ten o' clock, then that is the time when they start taking chances on people who are walking alone, and at that time, I was the person they took the chance on. (Participant 9)

4.2.5 Drugs and alcohol

One participant also attributed the cause of the recurrent rape that she went through to the use of drugs by the individual who abused her.

“Participant: He smoked a lot of weed which resulted in him raping me. Each time he would smoke, he would come back to me.

Interviewer: Did he only rape you when he was high on weed?

Participant: Yes.” (Participant 5)

4.2.6 African worldview

Another participant believed that it was because her boyfriend was possessed by an evil spirit (put into him by his grandmother) that he beat her. The evil spirit would become angry, she said, and in turn her boyfriend would become violent, and take it out on her.

They told me that at the church, he was told by the prophet that he is possessed, and I can see if he starts to shout, if I look at his face, I can see he is possessed by a spirit... by the spirit of his grandmother that raised him. He was supposed to pay (his grandmother) because it was his grandmother who raised him from this age, until he became a man. So he didn't do anything, and the prophet told him that the grandmother is angry. So he's got demons because the grandmother is a witch- it's witchcraft. So she is using him, because the grandmother says 'He did not do anything for me, but I raised him'. (Participant 11)

4.3 Consequences of trauma

4.3.1 Course of the effects

It was evident from the interviews that the traumatic event which the participants went through influenced their daily lives and functioning considerably. Six of the participants said that the effects of the trauma which they experienced are severe, and would last a long time.

"It will take a long time (to heal) because I have been severely hurt." (Participant 1)

"This will last until I die because I have this sickness now, and it cannot be cured."
(Participant 2)

"...A very long time, because it hurts." (Participant 5)

4.3.2 Intrusive recollection

Eight of the participants detailed symptoms of intrusive recollection. Repeatedly thinking about the event was described by five of the participants.

“When I go out... at times, I feel like I’m going to fall over and a car is going to knock me, because I am constantly thinking. Since this event I think a lot.” (Participant 1)

“I am constantly thinking about this. Last week I was arguing with my boyfriend... this image came back to me, I felt so much pain.” (Participant 6)

I don’t sleep well. I find it difficult to fall asleep, and when I do, I get bad dreams about the event, and when I wake up from these terrible dreams, my whole body feels so sore and my heart feels like it’s going to stop beating. (Participant 4)

In some of the cases, drinking behaviour accompanied the intrusive recollections. Drinking was reportedly used by four of the participants to help them forget about what had happened, and to numb the pain they experienced when thinking about the event.

“The reason that I am drinking now, is that I no longer work and it helps reduce my stress, and think less about my life.” (Participant 1)

“I drink because I find it a better way to help me forget... I don’t think as much.”
(Participant 4)

I cried and went drinking at one of the local places here. It helps me, because when the music is playing, I don’t think about anything, I dance with my friends and talk about nice things... it makes me feel better. (Participant 6)

The image of my brother (being stabbed) is a problem for me. I prefer drinking. I don't want to drink, but when that image resurfaces, I find that there is nothing else that I can do, so I try by all means to find alcohol and drink. If I don't drink, I think too much. (Participant 8)

Six participants also detailed physical symptoms such as hot flushes, a sore body and trembling that they experienced when reminded about the event.

"When I think about it- I feel exhausted and have hot flushes, I feel like sitting in a place where I can get air." (Participant 7)

"When I think about this event, my one side of the body shakes." (Participant 3)

"my whole body feels so sore and my heart feels like it's going to stop beating." (Interview 4)

"I tremble, have hot flushes and I have trouble sleeping." (Participant 8)

Four participants also described emotional reactions that they had to the traumatic event they experienced.

"When I am alone I feel a lot of pain and then I start crying (when the images come to mind)." (Participant 3)

"I cried a lot." (Participant 5)

4.3.3 Social isolation and avoidance

As a result of the traumatic experience that they went through, four of the participants explained that they would isolate themselves and did not want to be around other people.

“I don’t like walking around where there are lots of people... concerts, parties or weddings, I just don’t go to such events anymore.” (Participant 2)

“I couldn’t face anybody. I thought my life was over and I couldn’t be with anybody, so I would just hang around by myself.” (Participant 4)

“I feel like being alone most of the time and not have people around me.” (Participant 7)

“When I am hurt, I don’t want other people to see that I am upset.” (Participant 8)

Four of the participants explained that they isolate themselves, either to avoid reminders of the event, or because they were afraid that if they went out, they might be put through a similar experience again.

“I avoid going out with friends because they might say something that will remind me of what happened to me, and the hurt will resurface.” (Participant 4)

“I don’t go drinking in Pinetown anymore, I don’t like going there during the daytime, too, because it feels like he is going to see me and do the same thing again.” (Participant 6)

“I don’t go near that place anymore, because I have told myself that I might forget if I don’t go near there.” (Participant 7)

Although participants reported their avoidance behaviour, some numbing symptoms were also explained by three participants.

“I don’t feel sadness anymore... just pain.” (Participant 1)

“I don’t care much about anything anymore.” (Participant 3)

“Yes, I don’t feel sorry for people anymore- before I use to sympathise, now my heart has turned a bit hard.” (Participant 6)

4.3.4 Hyperarousal

Six participants also described symptoms of hyperarousal and described becoming angry, having difficulty concentrating and sleeping, and being easily startled.

“I am now quick to anger... even with the children I get upset quickly.” (Participant 4)

“Ever since the event I am short-tempered... at times, I get mad at them for no reason- even when they are being nice to me.” (Participant 6)

“My thoughts are scattered and maintaining coherence is hard. I can only concentrate for a short while.” (Participant 4)

“Yes, I am forgetful now... I think to myself that I need to do something- then I forget, although I know I am supposed to do something.” (Participant 2)

“I don’t sleep well at night.” (Participant 7)

“When I hear guys fighting where I stay, I get a fright because I think the same thing might happen again.” (Participant 8)

So now even when I’m just walking, even if it’s just anywhere, the minute I see a dodgy guy, I start looking around where I am. (Participant 9)

4.3.5 Physical consequences

Two participants explained that they have high blood pressure since the event, and two reported that one of the most severe and distressing consequences of their traumatic event (rape) was that they contracted HIV.

“I have high blood pressure and my heart races. This is something new- I never used to have this condition, until the incident.” (Participant 7)

“In my being raped, I became HIV positive. HIV is an incurable disease. That is the one major thing that is a terrible effect of this experience.” (Participant 4)

It hurt me a lot, because now I am sick- I have HIV. I don’t know whether it happened when my husband came back from jail- he got it in jail- or I got it from the people who raped me. (Participant 2)

4.3.6 Other problems

In addition to the themes identified above, the traumatic events which the participants went through also caused certain problems. Five participants mentioned that they did not have work, provisions or a place to stay as a result of what had happened to them. One participant was unhappy that she was not able to go for virginity testing anymore.

“I then quit my job (after the incident). Even if I get a job now, I can’t work till late now, because I am scared.” (Participant 2)

“He was the bread winner at home, now I am battling with finding work.” (Participant 7)

“I now have to beg people for a place to stay, as I can no longer live with them because they have endangered my life too many times.” (Participant 3)

His death has caused me a lot of stress because I lived with him; he looked after me and my two children. After his death, I went to live with my children’s father- it is not a good arrangement because he abuses me... he beats me up. He knows that I am not going to leave because I have no one to go to (Participant 8)

I hang around other young people, and they go for virginity testing- and I can’t go anymore. That hurt me, because I am no longer a virgin like I used to be- my virginity is gone. I wanted to stay a virgin until I’m older, and if I get married, I wanted to marry as a virgin. (Participant 5)

Two of the participants expressed that as a result of their experience, they are having relationship problems, or lack desire for sexual activity.

I was upset by the argument that I had with my child's father, as I mentioned to you, because it felt like he is treating me the same way as the guy who chose me out of my friends as we were going together. It felt like he also thinks that I am the type of person who should be constantly having sex. However, I explained that when you don't want to have sex, you don't want to, but he thinks it's because I want to go to other men. It's as if when he looks at you, he thinks you are a bitch... something for sex. I don't want to have sex with him anymore. I can go without it for about two months- he gets cross with me... it has become something I really don't like doing anymore. (Participant 6)

"I'm not sexually active anymore; I'm too scared to be involved in sexual intercourse."
(Participant 10)

Six participants described some of the fears that they have experienced since the event, and the effect it has had on them.

I constantly fear being raped. It's that fear that it can happen any day now, you know. So now even when I'm just walking, even if it's just anywhere, the minute I see a dodgy guy, I start looking around where I am. (Participant 9)

"I am petrified of walking around at night, being completely alone in the house and walking alone. During the day, too, whenever I'm alone, I get that uneasy feeling." (Participant 4)

“I’m scared of men to this day; I’m too scared to date anybody.” (Participant 5)

“It makes me feel scared and mistrustful of men.” (Participant 6)

“I am scared of getting another man to stay with me again. I can’t stay with another man again... for now I hate men.” (Participant 11)

“I am scared; I’m kind of like in the middle: I want to be in a relationship, but at the very same time, I am scared. What if it happens again? How am I going to deal with it?”
(Participant 10)

4.4 Coping Strategies

Participants were also asked what helped them cope with their experience, and their replies mostly involved some way of avoiding thinking about what happened (including drinking, as previously mentioned), or through drawing from social support sources.

“I don’t want to think too much because I will be stressed out, so I just do the washing, clean the yard, because I don’t want to keep thinking about this thing.” (Participant 1)

“Yes, I spend my time with friends- just talking- because then I forget, but when they are gone... it comes back.” (Participant 2)

“I speak to my brother’s wife who is emotionally supportive, because we both experience the same pain.” (Participant 7)

“I speak to my mother in law, like I said before; she is the one who gives me advice and guidance.” (Participant 8)

You know when you start thinking about those negative feelings, they (family) can kind of come in and correct you, and be supportive of how you are feeling. So those feelings didn't really get a chance to last long because of the family system that I was in. (Participant 9)

4.5 Possible Intervention

During the interviews, participants were asked to recommend possible intervention plans which could be implemented to address trauma in Black Africans in KwaZulu-Natal. Responses varied, and some participants struggled to think of what they wanted, but their responses included the need of economic empowerment, psycho-education, a cultural ceremony, support from the police and individual or group counselling.

When asked what assistance they would like best, three participants said that they would like a job to provide for their needs.

“If I could get some kind of work... but as long as I won't finish late- at night.” (Participant 2)

“I can't look after myself or take care of my needs, because I need a job.” (Participant 3)

“I would like a job- if I am working, I won't have time to think, and I could fulfil the needs that we have at home.” (Participant 7)

One participant said that she would like a traditional ceremony which bonds her to her ancestors for blessing and protection.

I would like a traditional ceremony, isiphandla, which should be done at home. My father (who has to conduct the ceremony) said that he can't because he is a born again Christian, so he can't conduct it through slaughtering a goat; he would rather we use a sheep... I think he was just trying to get out of it. (Participant 1)

Support from the police was also mentioned by two participants. The one participant had a good experience when she went to report the rape, in which she was supported in reporting the event, going to the courts to apply for a protection order, and getting the police to serve the order. Another participant, however, was not happy with the way in which she was attended to and wanted that to be improved.

You need to be taken into a different room, and asked questions and stuff like that, because you've been through a trauma. That didn't happen, and it was kind of just like an open space, and you had to write your statement, and the policeman was asking you questions. That's not exactly the kind of environment you feel like being around at that time. (Participant 9)

4.5.1 Psycho-education

From the interviews it was clear that psycho-education was important to the participants, as it helped to empower them. Two participants expressed the need for psycho-education.

Well, we get taught about the different kinds of diseases. Other organisations come in and educate us- especially about HIV- and we learn about preserving our lives and living with it. We didn't know about all these things that they teach us- we just knew that if you have been raped, you have been raped and that's that... there's nothing you can do about it, but they are educating us. Now I also talk to other people and tell them it's not by choice that we are HIV positive... you can get it too. (Participant 2)

"It's like now I am talking to people here, they are telling me how to cope and manage HIV. They help me to be informed." (Participant 4)

One participant also expressed that she would like to know more about the symptoms she experienced at the time of the trauma, and thought that it might be beneficial for her family in order to help them understand better what she was going through.

The counselling would have helped me be more aware of the symptoms that I would have experienced at that time. Like telling me what I'm going to go through, what other possible things that I might be going through, so that when I do go through those things, it's not like, there is something wrong with me, or my family starts panicking. As supportive as they were, there were times when something happened, or something made me remember something that I would go into a state of panic. I think for me, an ideal kind of counselling session when you've been traumatised, is when your family members are also involved in it, so that they are also educated about what they may be experiencing and how to support you. (Participant 9)

4.5.2 Counselling

Seven of the participants from 1000 Hills Community Helpers reported that they had received counselling or debriefing after their traumatic experience, and two of the participants from Open Door Crisis Centre received informal counselling or support from colleagues (at Open Door Crisis Centre) and family. Seven of the participants reported that talking about their experience had helped them to feel better.

“Having someone to talk to about this makes me feel better.” (Participant 4)

“I see a caregiver at this centre about three times a week, and we talk- this makes me feel better because she also offers some advice.” (Participant 8)

When asked what intervention they would like, many participants did not initially say that they would like to receive counselling, as their immediate needs were of a more pressing concern. However, when asked if they would like to receive counselling, ten participants said that they would. It was also evident that some participants did not understand what counselling entails, and thus this process had to be explained to them.

“I would talk to them so they would help me with my problem.” (Participant 1)

“Counselling... just to talk about this. I think talking about this with other people might free me... I might be able to move past this.” (Participant 6)

“If I could get somebody to talk to and advise me- tell me that this is wrong and that is right.”
(Participant 8)

4.5.3 Group or individual

When it came to deciding whether they would like individual or group counselling, five of the participants preferred individual, while another four preferred group, with one participant saying that she did not mind either way.

The participants gave various reasons for wanting individual counselling, and why they preferred this option, or why it might be beneficial to them.

“I like talking to the home based care giver... I feel better when I talk to her. Being around a lot of people makes me irritable.” (Participant 2)

“I would like it to be just me and the counsellor, because it’s more private.” (Participant 3)

“I prefer to do it alone so that I can speak freely about what I am feeling, because if there are too many of us, each person might have their own opinion that I don’t necessarily agree with.” (Participant 4)

“I prefer individual counselling. I’m shy around too many people.” (Participant 5)

One-on-one. I prefer alone, because I will ask questions, and if he asks me questions, I can answer it... if we are too many maybe I can’t explain it. Maybe a counsellor can help me with the thoughts that I am having. (Participant 11)

Getting to talk through my problems (would help). The counsellor would help move my mind and my heart from the problem. I don’t know, but if something is hurting or

upsetting me, I feel like letting it out- not keeping it to myself... I feel like releasing it.

(Participant 7)

Participants also gave various reasons for preferring a group intervention, and why they preferred this option, or why it might be beneficial to them.

It can be a group if it's not people from around here. I would benefit from having people that have gone through a similar ordeal as I have, and might learn how they dealt with it, and how I can deal with some issues. (Participant 6)

I prefer it with others in a group. It would help me, as one person shares their problem with the next person; you would find that we end up talking, and when I share my problem, you'll find that we understand each other... it becomes pleasant- it would no longer be the way I thought when I see that I am not alone; there's a lot of us. (Participant 8)

When you talk about your traumatic experience to other people whom you don't know, you listen to their backgrounds, you sort of see it like, 'I'm not the only one'. There are some people, the way they overcome those events, sort of like, 'Wow, how did you get through it?' It's kind of like empowering each other, enlightening each other. (Participant 10)

Um, for most people, having a support group makes you feel like I'm not so different, you know. It actually depends on what kind of person you are and how you feel about having a support structure, and expanding your support system. I'm more an

expanding-the-support-system kind of person... I'm not the deal-with-it-by-yourself kind of person. (Participant 9)

One participant did not mind either option.

"I wouldn't mind either the individual or the group counselling. I am equally open to both."
(Participant 7)

4.5.4 Who would provide this help?

When it came to suggesting who would provide the intervention, five participants stated that they would like a caregiver, primarily because they were already familiar with the caregivers. Three participants mentioned a psychologist or counsellor. Seven participants described the kinds of qualities of the person that they would like assisting them:

"I have been talking about this event to the caregiver for some time now. I am used to her, she understands me." (Participant 5)

"A caregiver... I don't want to talk to someone who would judge me." (Participant 7)

"The counsellor must be there and facilitate the process because she/he might give us advice on how to deal with this." (Participant 6)

I would like the counsellor to be there and offer advice, because if it is just the members, we might not be able to help each other. But the counsellor can guide us. I would like an older lady... someone understanding. (Participant 8)

“If I could speak with somebody who has been through similar circumstances, maybe they could advise me, because I am lost.” (Participant 3)

“A person that understands what I am going through and is patient with me, who would allow me to take my time and cry, if need be.” (Participant 6)

One participant was also concerned about confidentiality.

“If I could, I’d like to get a counsellor- but not from this area, because they may breach confidentiality and have people talking about me on the road and where ever.” (Participant 6)

Two participants also expressed that they would like the counselling to be done in their own language, while two said that English would be acceptable. Two others said they did not mind isiZulu or English.

“I would prefer somebody who understands isiZulu because I don’t understand English well, so I want to be understood when I explain what I am going through.” (Participant 8)

“I don’t mind if it’s done in isiZulu or English because I can understand both languages.”
(Participant 7)

4.5.5 Where would it take place?

Six participants also said that they would like the intervention to take place at the 1000 Hills Community Centre, as many of them went there to obtain food or medicine. *“Here at the centre, because I come here anyway.”* (Participant 3) However, two participants wanted it to

be a place that was not in the area where they live, and not with people they know. Two participants said that anywhere would be fine with them.

“Not in this area, but places close to it; places that I can access- places like Hammersdale.”

(Participant 6)

“Anywhere, as long as it does not involve people around me, like home, work wise.”

(Participant 10)

“I don’t mind... anywhere is fine.” (Participant 4)

4.6 Davidson Trauma Scale

The table below contains the subset mean score for each participant, reflecting which subset of symptoms was most prevalent (in a high range), least prevalent (low range), or in between most and least (medium range).

Participant	1	2	3	4	5	6	7	8	9	10	11
Intrusion Score	8.8	8	5.8	6.8	8.8	1.6	7	7.2	5.4	6	5.2
Avoidance/ Numbing Score	7.1	4.5	6.2	6.5	5.2	5	3.4	4.2	2	5.7	5.2
Hyperarousal Score	7.4	3	4.4	6.2	6.6	4	3.6	5.2	5.4	6.4	5.4

- Results show that in more than half of the participants, intrusion symptoms were prevalent at the highest range. It appears that these symptoms are the ones that many participants experienced most frequently and most severely.

- Results also show that in just over half of the participants, avoidance/numbing symptoms were prevalent at the lowest range. Thus it appears that more than half of the participants experienced these symptoms the least frequently and least severely.
- Hyperarousal symptoms were experienced mainly in the medium range of severity and frequency, with some participants experiencing the symptoms in the low or high ranges.

4.7 Feedback session

A feedback session was held with caregivers of 1000 Hill Community Centre in which the results of the study were presented to them, and they were asked to provide recommendations for the best intervention. The following suggestions were made in the feedback session:

- There is a need for psychoeducation around the issues of rape and physical violence, especially with regard to defining their characteristics. Caregivers explained that community members often do not recognise when they are being raped, and believe that if they are living with their partner, what their partners are doing is not rape because they love them. For the same reasons community members believe that interpersonal violence is acceptable. Caregivers also felt that they themselves needed training around psychoeducation, as they often felt that they did not know what information to give the victims.
- They endorsed group therapy as opposed to individual therapy, stating that it helps the members to know that they are not alone and that others have been through similar experiences, and to support one another.
- They suggested the use of humming or singing groups to deal with intrusive thoughts, and also suggested that keeping busy with sewing, gardening and craft work would help. At

the same time, caregivers stated that making goods would allow for a means of income and thereby contribute to the victims' financial independence.

- Caregivers felt that helping women to gain some independence and resources is important because a lot of the violence is a result of a lack of resources. They emphasised that helping victims gain financial independence is essential.
- Caregivers also mentioned that many of the trauma victims that they work with struggle with issues around internalised and externalised stigma. One caregiver mentioned that one victim she was helping had stopped going to church because she thought that everyone knew that she had been raped.

4.8 Conclusion

In this chapter, the identified themes and subthemes which emerged from analysis of the interviews were examined and substantiated by quotations taken from the interview transcripts. Analysis of the transcripts revealed that victims' understanding of the causes of their trauma included factors such as crime and violence, male dominance, blame and the use of drugs and alcohol. The results also revealed that participants experienced various PTSD symptoms and other problems such as unemployment. Participants revealed that factors such as psychoeducation, practical support and counselling would be helpful to them as an intervention. In the following chapter these research findings will be discussed in relation to the research questions and literature reviewed.

CHAPTER 5 PART 1: DISCUSSION OF RESULTS

5.1 Introduction

It was argued that while most interventions for trauma have been developed in the context of a Western worldview, international research has shown that culturally-adapted models of trauma intervention can be effective in treating PTSD and dealing with trauma related distress. This study aimed to understand what cultural factors, social factors, traditional methods and beliefs should be considered when adapting a trauma intervention model to the South African context, specifically to Black Africans in KwaZulu-Natal. The participants' contribution to our understanding of trauma- and thereby trauma intervention- will be detailed in this chapter.

In line with the aim of the study, the following research questions were delineated:

1. How do the victims understand their experience and express their distress?
2. Do victims present with symptoms of PTSD?
3. What kind of interventions do victims think would be helpful to them?
4. What implication does this have for a culturally-sensitive model of intervention?

In this chapter, each of these research questions will be discussed below in relation to the findings of this study, and the literature reviewed. A discussion of the results is presented, with recommendations for culturally-adapted interventions and research. Lastly, limitations of the study are delineated.

5.2 How do the participants understand their traumatic experience?

As discussed in chapter 2, the sociocultural context of an individual who has been traumatised influences the meaning that he/she attributes to the event, their response to it and what help they expect. Results of the current study revealed that, in relation to the first research question, the participants' sociocultural context did influence their interpretation and understanding of the traumatic event they experienced.

The current study found that some participants understood the cause of their traumatic experience to be related to the crime and violence in their community. They identified certain areas to be associated with criminal activity, indicating that this was possibly an area in which violence was exercised or witnessed on a regular basis. As Kaminer and Eagle (2010) indicated, for many South Africans, exposure to potentially traumatic experiences is an unavoidable part of daily life.

As previously outlined, the term "culture of violence" has been used to explain the high levels of crime in South Africa. The term can be used to refer to "a society which endorses and accepts violence as an acceptable and legitimate means to resolve problems and achieve goals" (Dirsuweit, 2002, p. 6). Participants also indicated they understood the violence to which they were exposed was being used as a means to achieve some unknown goal, or to resolve some problem. This supports the argument of Jewkes (2002) and Sigsworth (2009), and the findings of Harris (2001), whose study on foreigners' experience of violence in South Africa found that violence not only infiltrates their daily lives, but is also frequently used as a method of resolving conflict and problems in families, relationships, peer groups, the community and politics

The results of the study also showed that participants identified the use of violence as a means to gain power and control over women. This is supported by the cultural concept of male dominance, or patriarchy, and the socially and culturally constructed concept of *hegemonic masculinity*, which aims to ensure male dominance and control of women (Jewkes & Morrell, 2010). Participants' partners subjected them to violence from their partners, to ensure that they stayed at home and did what was required of them, and to ensure fidelity. This concurs with the studies conducted in Umtata by Wood and Jewkes (1998) and in KwaZulu-Natal by Sathiparsad (2008) which found that involuntary sex and physical assault were common forms of violence used in relationships, in order to impose the 'rules' of the relationship (such as ensuring fidelity), and to gain control over others. Wood and Jewkes (1998) further say that this needs to be understood in the wider context of the community, where beating and violence were used as strategies for punishment, and in order to gain control over others. Many of the individuals in these studies viewed sexual or physical violence in relationships as the norm. This concurs with the feedback given by the caregivers that community members often do not recognise when they are being raped, and believe that if they are living with their partners, what their partners are doing is not rape because they love them. As a result, many community members believe that interpersonal violence is acceptable.

Participants also expressed a belief that men feel entitled to take something from a woman, even when she has nothing to give (e.g. rape her if she has no money to offer). This further illustrates the socially constructed notion of male dominance or entitlement over women, and an affirmation of that position (Abrahams and Jewkes, 2002).

The study also found that participants engaged in self-blame when trying to understand their traumatic event. Participants felt that if they had not engaged in certain behaviour, such as drinking alcohol, or asking for their property, then nothing would have happened. Participants also felt that if they had engaged in certain behaviour, such as ensuring better household security, nothing would have happened. This corresponds with the concept of behavioural self-blame, in which victims attribute the causes of the trauma to certain behaviours that they engaged in, or failed to engage in (Kaminer & Eagle, 2010).

As discussed in chapter 2, the culture of blame that pervades society often blames women for being in the 'wrong' place at the 'wrong' time, or because they behaved immodestly, or for 'provoking' the outcome in some way, justifying the action of the perpetrator (Jewkes & Abrahams, 2002; Richardson & May, 2001). Participants' beliefs illustrated this by indicating they thought they were raped possibly because they went against a man's wishes, and thereby had to be taught a lesson, or that they were mugged because they should not have been walking alone in a certain area during a particular time. The study conducted by Kalichman, Simbayi, Kaufman, Cain and Cherry (2005) found that participants believed that rape usually occurs as the result of the action of the women, and thus could be blamed for it. This also reinforces the argument of Lebowitz and Roth (1994) that our culture holds women responsible for male aggression, and therefore self-blame is culturally inculcated in victims.

Participants' explanations also revealed that often their self-blame was reinforced by the blaming reactions of the police, their family or partners, and the community. Participants were told that they should not have been walking alone at night, that it might have been because they had been drinking, or because they provoked the consequences in some way.

Drugs and alcohol were also identified by participants as an underlying cause of rape and violence. Some participants felt that if they had not been drinking that night, nothing would have happened. Another participant said that she was only raped when the perpetrator was “high on weed”. These results support the argument of Jewkes (2002) that alcohol and substance abuse are associated with violence, as these are thought to diminish inhibitions, impair judgment and weaken the individual’s ability to interpret social cues. Jewkes, Levin and Penn-Kekana’s (2002) study on violence in women also concluded that alcohol consumption was a risk factor for interpersonal violence.

Interestingly, although the participants did not make any connection between poverty and their traumatic event, some of them stated that they needed a job to provide for their family, or that they had lost their job as a result of the trauma, indicating a degree of poverty. Most of the participants in this study live in a poor community, and Kiser and Black (2005) found in their review that living in a poor community increases risk for experiencing various trauma. Charles et al (2006) argues for a link between sexual violence and poverty, and suggests that poverty also increases the likelihood that women will engage in prostitution, and it forces women to carry out a range of daily activities that place them at risk, such as accessing transport. This is shown by the fact that some of the participants’ traumatic experiences happened as they were accessing transport - some of the women in this study had to walk through areas where there is a high- risk of violence in order to access transport.

When it came to understanding the cause of their traumatic event, few participants presented the explanation of a traditional African worldview. One participant believed that her boyfriend beat her because he was possessed by an evil spirit. This supports the African worldview which encompasses not only the natural world, but the supernatural too. This

includes the notion of magical causation, which refers to illnesses (in this case anger) inflicted by others- either in the natural or supernatural world. This can be inflicted through the human employment of witchcraft (Straker, 1994). The study by Crawford and Lipsedge (2004) concur with these findings. They found that, among isiZulu-speaking people, both mental and physical illness can be classified in terms of their understood aetiologies, including sorcery and the ancestors.

In light of these findings, it is also important to note that these meaning frameworks are not necessarily specific to Black people, or those of an African culture, and there may be similarities across cultures. Trauma survivors from various contexts and cultural groups develop explanations for trauma that draw on patriarchal assumptions, the use of violence as a means for men to gain control over women, self-blame, and alcohol and substance abuse. For example, Miller, Handley, Markman and Miller (2010) note that self-blame is a well-documented response to trauma such as sexual assault. Their study with young Caucasian women revealed self-blame to be prevalent among survivors of sexual assault. In addition, a study by Eng, Li, Mulsow & Fischer (2010) on a sample of 1,707 married Cambodian women found that men use violence in their relationships to control their spouses, and this is permitted by a patriarchal culture that sanctions violence when there are perceived transgressions.

As discussed in Chapter 2, Kleinman argued that how people explain their distress is influenced by the socio-cultural context in which they live. In this study, it appears that the culture of violence, the culture of patriarchy and the culture of blame that is prevalent in the African sociocultural context has influenced participants' understanding of the traumatic event that they experienced. Substance abuse and a traditional African worldview was also

considered, but to a lesser degree. The influence of these factors therefore needs to be considered and addressed in a trauma intervention with Black Africans in KwaZulu-Natal. However, as discussed, these factors are not necessarily idiosyncratic to Black Africans or the African culture, but may also be found in other contexts. This possibly suggests that the socio-cultural contexts in which people live are characterised by similarities and differences between cultures.

5.3 What symptoms of PTSD do the participants experience?

As argued in chapter 2, there has been a lot of debate in recent years about the use of the PTSD diagnostic criteria in non-Western cultures. Some authors (De Jong & Joop, 2002) argue that such cannot be applied to individuals from a non-Western culture, while others (Friedman and Marsella, 1999) argue that many aspects of PTSD are universal, but that there may be culturally influenced differences in the expression of traumatic stress. Results of the current study revealed that, in relation to the second research question, participants did experience and explain some of the symptoms of PTSD, and participants also experienced other consequences as a result of their traumatic event.

The result of the study shows that participants predominantly experienced symptoms of intrusive recollection, and these reports correlated with criterion B (intrusive recollection) of the PTSD diagnostic criteria. They reported that they constantly thought about the event, saw images of the event and had dreams about it. Participants described some psychological distress and physiological reactions at exposure to internal or external reminders of the traumatic event. They reported that when they thought or dreamed about what happened, they experienced symptoms such as crying, body aches, heart difficulties, hot flushes and trembling.

In addition, it is important to note that there was also an emphasis on somatic reactions to reminders about the event. Re-experiencing of the trauma was often accompanied by physical symptoms such as pain, sweating and trembling. This correlated with the study by Matkin, Nickles, Demos and Demos (1996), with Cambodian and Vietnamese refugees, who found that psychological symptoms are often expressed through physical complaints, such as body pain and impaired vision.

The current study also found that participants experienced symptoms of avoidance/numbing, and these reports correlated with criterion C (avoidant/numbing) of the PTSD diagnostic criteria. Participants reported that they avoided thoughts and conversations associated with the trauma, as well as activities, places and people with links to the event. Some participants isolated themselves (from people's conversation, activities or places) in an effort to avoid reminders about the event in the hope that they would forget about what had happened, or to lessen the pain. They reported a reduced interest in activities, and some avoided people and social gatherings- either because they did not want others to see that there was something wrong, or because they were afraid that if they went out, they might be put through a similar experience. Participants also reported numbing symptoms in which they did not experience the intensity of emotion that they used to. This restricted range of affect included not having any empathy anymore, and not feeling any sadness.

Participants reported symptoms of hyperarousal which correlated with criterion D (hyperarousal) of the PTSD diagnostic criteria. They reported that they were easily angered (often for no good reason), had difficulty concentrating and often fell asleep, and were forgetful and easily startled.

With regard to PTSD symptoms, results of the Davidson Trauma Scale showed that in comparison with avoidance/numbing and hyper arousal symptoms, intrusive symptoms were prevalent at a higher ratio, meaning that these symptoms are the ones that the participants experienced most frequently and most severely. Avoidance/numbing symptoms were prevalent at the lowest ratio when compared to intrusion and hyper arousal symptoms, meaning that these were the symptoms experienced least frequently and least severely. Hyperarousal symptoms, when compared to intrusion and avoidance/numbing symptoms, were experienced mainly in the medium range of severity and frequency, with some participants experiencing the symptoms in the low or high ranges.

The above results support previous research with Sudanese refugees in Uganda and torture survivors in Malawi (Kaminer & Eagle, 2010), and the study with Kalahari bushmen (McCall and Resick, (2003). These studies found that the re-experiencing and hyperarousal symptoms of PTSD were common in these samples, but the prevalence of avoidance symptoms was low. As discussed in chapter 2, avoidance/numbing symptoms are culturally influenced, and therefore PTSD is more common in cultures where avoidant behaviours (assessed by Criterion C) are common methods of dealing with distress. However, in collectivist African cultures where the individual is bound up with family and community, avoidance becomes a less likely method of coping, and thereby the prevalence of PTSD will be low (McCall & Resick, 2003). When participants in this study were asked about how they coped with the traumatic event, some replied that they drew from social support sources and visited with friends and family in order to get advice and support.

In the present study, avoidance symptoms were reportedly experienced least frequently and least severely (possibly because of the use of social support). However, many participants

reported the use of alcohol to help deal with the intrusive recollections, and help them forget what had happened, or to numb the pain they felt when thinking about the event. Thus, the use of alcohol as a coping strategy is a form of avoidance which is not clearly indicated by Criterion C. Criterion C looks at efforts to avoid thoughts, people and places associated with the event, but it does not specify what these efforts might be.

When asked about avoidance in the Davidson Trauma Scale, participants' replies related to avoiding people, places or activities. Participants might thus not have recognised alcohol use as an avoidance mechanism. For instance, Participant 1 said that she did not make efforts to avoid thoughts or reminders of the event, as she felt it could not be done, yet she also said that she used drinking to cope with what had happened. Thus, the prevalence of avoidance may be higher if the criterion clearly indicated different methods of avoidance.

With regard to trauma exposure and alcohol use, various authors (Kaysen et al., 2007; Montoya, Covarrubias, Patek, & Graves, 2003; Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009; Yeater, Austin, Green, & Smith, 2010) argue that alcohol use is a result of PTSD symptoms. Drinking is used as a way to cope with the symptoms, and thereby individuals with PTSD may be self-medicating to minimise or avoid distress associated with the trauma. The study by Taft et al. (2009) found that African American women who experience interpersonal violence are more likely to use and abuse various substances (including alcohol) in order to minimise thoughts and anxieties related to the event. However, there is little research on the racial and cultural differences with regard to PTSD and substance or alcohol use (Montoya et al., 2003).

Friedman and Marcella (1999) argue that many aspects of PTSD are universal, but we must remain open to the possibility that there may be cultural differences in the expression of traumatic stress. Hinton and Lewis-Fernández (2010) also postulated that there are several types of idioms (ways in which distress is expressed) and these idioms may vary across cultures. Idioms of distress are those specific ways in which people of a sociocultural group express distress. From the results discussed above, it is clear that the way in which these individuals expressed their traumatic distress included a psychological (constantly thinking) and somatic (body aches, heart difficulties, hot flushes and trembling, high blood pressure) aspects, as well as acting out behaviour (drinking alcohol). These results correlate with PTSD criteria and indicate that many of these symptoms expressed by the research participants are not idiosyncratic to Black people or to African culture, and may be more universal. However, these also appear to be cultural differences in the participants' expression of traumatic stress.

As already mentioned, alcohol is a widely used method of coping with trauma and avoiding associated distress. Many of the symptoms described also correlate with the widely used PTSD diagnostic criteria, for example, recurring distressing thoughts, experiencing bad dreams, avoiding reminders about the event, difficulty concentrating and anger outbursts. Thus, although there appear to be similarities across cultures, it is still important to listen to each individual's idiom of distress. This idiom may contain similarities with other cultures, or may contain differences. Kleinman's theory posited that our understanding and expression of illness is influenced by meaning systems and social positions that we use. It is important to listen to patient's narrative and how they are expressing their understanding of the traumatic event and their symptoms. Participants in this study used terms such as 'constantly thinking' to describe intrusive thoughts and 'seeing images' to describe flashbacks. Patients may not use the Western 'technical' terms to describe what is happening. For instance, individuals

may use terms such as 'body shakes' to describe the anxiety or fear they feel when reminded about the event. As Kleinman said, it is important that practitioners understand the patients explanatory model and this can be lost if the focus is on technicalities and obtaining a diagnosis.

Another important finding of the study was that, in addition to reporting symptoms of PTSD, participants also reported other consequences which they experienced as a result of their trauma. Participants reported that they did not have work, food or a place to stay as a result of what had happened to them. For instance, one participant quit her job because she was scared, another did not have food because the provider was killed, and another had nowhere to live, as she had to move out of the abusive situation. One participant was unhappy that she was not able to go for virginity testing anymore, as she had wanted to remain a virgin until she married. Participants also reported that as a result of their experience, they were having relationship problems, or lacked desire for sexual activity. In addition, participants reported that they had become more fearful of being raped, of being alone (in case the assault or rape happened again), and some reported that they feared men and mistrusted them. Some believed that if they entered another relationship or even went on a date, they might be abused or raped again.

Some of the rape victims reported that the most severe and distressing consequence for them was that they had contracted HIV as a result. The study by Pettifor, Measham, Rees and Padian (2004) supports these results in their finding that women's lack of sexual power was associated with increased risk of HIV infection. Although the women in this study did not give details as to what happened during their rape, it may have been seen as culturally

inappropriate for them to ask the rapist to use a condom for fear of further violence, or because of the notion of male sexual entitlement.

In summary, results of this study have shown that participants' experience of the consequences of their traumatic event was not limited only to PTSD related symptoms, but also included some socioculturally influenced consequences. Therefore, even though some aspects of PTSD (such as intrusive thoughts and hyperarousal) may be universal and experienced in many cultures, idioms of distress may still contain differences. As discussed in the literature review, trauma from an African perspective is seen as affecting the whole person and the community, and not just the individual (as in the Western view). For the Black individuals in this study, consequences experienced as a result of the trauma included a more holistic experience, in which the personal, social, and cultural aspects of the individual were influenced.

The way in which they experienced and responded to the traumatic event, did not only include a list of PTSD symptoms, but included aspects such as being without work, food or a place to stay. Participants were experiencing relationship problems, and were fearful of a re-occurrence of the trauma. Unfortunately, as a result of the sociocultural context of these individuals (such as the culture of violence, patriarchy and poverty), fears and experiences are realistic. Participants live in a context and community where poverty and unemployment affects most community members, and where exposure to potentially traumatic events is an unavoidable aspect of daily life (Kaminer & Eagle, 2010). As mentioned before, this sociocultural context may not be idiosyncratic to Black Africans, but its consequences on this population group still need to be considered.

As a result, in designing a culturally sensitive treatment intervention, the context of the individual needs to be taken into account, and one cannot just look at dealing with PTSD symptoms. As this study revealed, participants experienced PTSD symptoms that may be similar in other cultures, but, as I outlined, idioms of distress may also differ. For participants in this study, their idiom of distress included not only PTSD symptoms, but included being jobless, not having food or a place to stay and not being able to follow the cultural practise of virginity testing. Thus, as expressed by Kaminer and Eagle (2010), local expression of traumatic stress may require different interventions when compared to the mainstream ones.

5.4 What interventions do the participants think will be helpful?

As outlined in chapter 2, evidence based research has shown that the best treatment for a client is one that is tailored to the needs and sociocultural context of the individual (Bernal et al., 2009). Literature on culturally adapted interventions is varied and some authors emphasise the creation of new therapies (Smith et al., 2011), while others argue that all aspects of Western models are not necessarily inappropriate, and therefore propose implementing traditional evidence-based treatments with slight changes (Ford, 2008; Smith et al., 2011). Results of the current study revealed that, in relation to the third research question, participants' sociocultural context did appear to influence the type of treatment intervention they wanted, but their expressed needs also showed that they required aspects of Western treatment interventions. From this study, it appears that there are similarities across cultures in individual's experience of traumatic stress, and therefore treatment modalities developed in other- including 'Western' cultures- may have value.

The result of this study showed that some participants felt that they would like a job to provide for their needs. It must be remembered that participants of this study are based on a

sociocultural context of poverty, and this is influential in determining what needs are most important to them. For individuals in poverty, the need to provide food for themselves and their families is more pressing than emotional needs.

Good support from the police was also mentioned by participants, and the importance of following proper legal processes. Participants expressed a need for psycho-education around HIV and trauma related symptoms- not only for themselves, but for their families as well, to help them understand what the individual was going through. Psycho-education has shown to be an essential element of a culturally adapted trauma intervention (Hinton et al., 2004; Kirmayer et al., 2010).

Most participants received counselling or debriefing after their traumatic experience, and many found it helpful. Despite this, many participants did not initially identify that they would like to receive counselling, as their immediate needs (such as medicine for HIV, a job and food) were of a more pressing concern. However, when asked if they would like to receive counselling, they all said that they would. Many of the participants stated that they would like someone to talk to. There was a clear emphasis by most participants on wanting the counsellor to help with their problems and give them advice on what to do. Although participants did not specifically state what these 'problems' were, most identified their intrusive thoughts, lack of income, alcohol use, and interpersonal problems to be problem areas.

Kirmayer et al, (2010) argues that Western based counselling approaches, such as cognitive behaviour therapy (CBT) and trauma focussed psychotherapeutic intervention, are useful. Although these approaches are developed in other cultures, results of this study indicate

similarities in an individual's experience of PTSD, and thus these approaches may have value in other contexts. These approaches work by changing modes of interpreting and responding to trauma cues, reducing catastrophising thoughts and emphasising adaptive coping. Many participants identified that the PTSD symptoms that they were experiencing were difficult to deal with, and therefore it is essential to address these in a culturally adapted intervention. Culturally adapted aspects of CBT that deal with the symptoms of intrusive thoughts, avoidance and hyper-arousal, and teach healthy coping mechanisms are thus likely to be helpful. Studies (Hinton et al., 2004; Otto & Hinton, 2006) support the importance of culturally adapted CBT, which include intervention methods such as psychoeducation, relaxation training and cognitive restructuring.

The results of this study also place emphasis on the need for a problem solving component to help the individual deal with consequences that they were experiencing, and thus the inclusion of problem solving skills would be essential in a culturally adapted treatment approach. Problem solving therapy (PST) is a structured psychological treatment that includes teaching a client how to solve any problems that they may come across, using a step-by-step method (Malouff, Thorsteinsson, & Schutte, 2007). This approach would not only help trauma victims to effectively deal with the consequences that they have experienced as a result of their trauma, but the approach would also give them the skills to solve other problems in their lives.

Another participant said that she would like a traditional ceremony which bonded her to her ancestors for blessing and protection. Thus, an African worldview which allows for indigenous healing systems, such as rituals in dealing with traumatic events, their causes and consequences must be available for inclusion. This point supports the argument of Eagle

(Eagle, 1998b, 2004) that Western and traditional African systems can be integrated: for instance, a traditional healer may be consulted to perform protection rituals, but a counsellor seen for helping to deal with traumatic stress symptoms such as anxiety.

The findings thus far show that participants might benefit from Western based interventions, such as psychoeducation, to help normalise symptoms, provide the opportunity to talk through what happened, assistance with PTSD symptoms and with problem solving. However, they also require help with more practical aspects such as finding a job, support from the police and a traditional ceremony. This reinforces the argument that Western models can be useful, but as this study has shown, sociocultural context does influence individual's idiom of distress, and thus there needs to be adaptations to make it more culturally appropriate.

Participants were almost split evenly when deciding whether they would like individual or group counselling. Participants who preferred individual counselling felt that it was more private, and thus they felt they had more liberty to talk about any issue without having to listen to the opinions of others, and felt the counsellor was able to render specific individual assistance. Participants who preferred the option of group counselling emphasised that this approach was best because listening to those who had been through similar experiences helped them to know that they were not alone, and one might learn from others how to deal with these experiences. The group members were able to support one another. This concurs with the discussion of Nicholson and Kay (1999b) who argue that the most significant healing factor of support groups is mutual aid and normalization by members, and the all-important goal is the improvement of coping skills gained through this communal aid and sharing. Their study found culture-specific group treatment of traumatised Cambodian

women beneficial, and emphasised the importance of a social support network in which the traumatised women developed and maintained a helping network where they found support from those who shared a common culture and experiences.

5.5 What implication does this have for a culturally-sensitive model of intervention?

As discussed in the previous sections, there appear to be similarities and differences in individuals' experience and expression of traumatic stress across cultures. Thus, Western models are not necessarily inappropriate, and it could be beneficial to implement traditional evidence-based treatments with slight changes (Ford, 2008; Smith et al., 2011). However, in adapting and implementing an approach with Western principles, the sociocultural context and culturally influenced idioms of distress need to be taken into consideration. This includes not only the way in which the intervention is done, but the model also needs to address issues arising out of the sociocultural context of the participants.

As outlined in chapter 2, Bernal and Saez-Santiago developed an ecological validity model for culturally sensitive interventions (Bernal et al., 2009; Bernal & Sáez-Santiago, 2006; Griner & Smith, 2006b; Smith et al., 2011) They identify eight elements that focus on content and methods, and must be incorporated into treatment. Meta-analysis done by Smith, Rodriguez and Bernal (2011) and Griner and Smith (2006a) found that the most effective treatments are those with a wider scope of cultural adaptations, and that an average of four out of the eight components was described by authors in adapting mental health interventions. Based on the results of this study, I will outline possible adaptations that can be made to a trauma intervention in order to make it more culturally sensitive to Black Africans in KwaZulu-Natal:

1. Language - some participants also expressed that they would like the counselling to be done in their own language, while some said that English would be acceptable. Therefore, it seems that a culturally adapted intervention could be conducted in the victims' home language.

2. Persons - most participants wanted caregivers to provide the intervention, while others mentioned a psychologist or counsellor. Participants also described the qualities they would like the person to have, such as being understanding, mature and experienced, non-judgemental, and a facilitator. Thus, it seems that victims would prefer the person who administers the intervention to be someone who is already part of the community and familiar to them, and who possesses certain qualities.

3. Content – in determining the content of an intervention, it is important to consider the individual and their context. The content of the intervention must not only address PTSD symptoms and specific idioms of distress, but also contextual issues. Results from this study show that sociocultural constructs such as violence, patriarchy, blame and poverty that are prevalent in the African context (and other contexts, too) have influenced participants' understanding and experience of their traumatic event. Thus, these need to be addressed in the culturally adapted trauma intervention. Issues that arise out of this context are realistic and based on the individual's experience in their context. For instance, considering the culture of violence that pervades South African society, participants' fear that the trauma may re-occur is realistic, and needs to be addressed as such. Thus, when addressing these fears in the intervention, they ought to be treated as real and not imagined. For example, if the individual has to go through a dangerous area to access transport, help them to problem solve

as to how they may be able to protect themselves more effectively, e.g., only walk with a group of friends.

4. Concepts – as mentioned, principles of Western approaches such as CBT and PST might be valuable in addressing some of the consequences that individuals experience as a result of their traumatic event. However, when adapting existing models to sociocultural contexts, it is important, as Smith, Rodriguez and Bernal (2011) argue, to be careful to retain the original mechanisms of behavioural change or symptom reduction. However, the way in which the client’s problem is conceptualized and communicated should also be congruent to their context and culture. (Hinton et al., 2004; Otto & Hinton, 2006) explain that culturally sensitive CBT uses culturally appropriate visualizations and metaphors, culturally relevant examples to assist with the communication of central concepts, addresses fear networks (including culturally related fears) and culturally specific symptom interpretations. For example, when working with intrusive thoughts, CBT principles of cognitive restructuring can be used to address this, but it is important to use the idioms of distress expressed by the participants (e.g. “constantly thinking”) to illustrate and address this concept. When discussing physical reactions to the event as part of psychoeducation, use the idioms of distress of the participants to convey symptoms they may experience in response to reminders about the trauma, e.g.; “body shakes.”

5. Goals – when considering the goal of an intervention, not only from a theoretical perspective, but also from an individual, it is important to address issues arising out of the individual’s context. For example, a trauma victim may believe that she must conduct a ritual in order to receive forgiveness or protection from the ancestors. In a culturally adapted intervention, the counsellor must be open to integrating this into treatment goals and acquire

the help of whoever is needed to provide this intervention. The goals of the intervention also need to consider the socio-contextual issues, and therefore consider not only aspects such as PTSD symptoms, but must also consider that individual may be without work, food, a place to stay, or they may experience relationship problems which also need intervention.

6. Methods – as already outlined, this research has shown that there is a need for a Western based approach, adapted to this specific cultural context. In addition to using CBT and PST principles to address aspects such as PTSD symptoms of intrusive thoughts, or psychoeducation about PTSD reactions, these principles need to be adapted to the sociocultural context. Culturally adapted interventions must also consider other methods needed to reach goals, such as integrating traditional African methods or problem solving to deal with joblessness, and teaching healthy coping skills to deal with maladaptive alcohol use.

7. Context of the intervention or services – as already discussed, broader sociocultural issues also need to be considered in the intervention. It is important that the intervention is not only designed for the client's context, but also delivered in their community. Most participants felt that the best place for the intervention would be the 1000 Hills Community Centre, as many of them habitually resorted there to obtain food or medicine. Some participants wanted it to be a place that was not in the area where they lived, and not with people they knew. This could possibly be because of fears related to blame or confidentiality.

CHAPTER 5 PART 2: RECOMMENDATIONS AND CONCLUSION

5.6 Recommendations for a culturally adapted trauma intervention

Based on the findings of this study, the following recommendations are made:

As discussed above, Western based interventions have a place in treating individuals from different cultures. However, it is important that this intervention have a strong theoretical foundation before cultural adaptations are made. From the results of this study and reviewed literature, it appears that there is a need to test a CBT based intervention in a controlled study. A CBT based controlled study, conducted on Black Africans in KwaZulu-Natal would be beneficial in determining the effect of such an approach on this population. While a controlled study is necessary to test a CBT model, this formative qualitative data on participants' experience of trauma and what may be helpful, suggests that CBT techniques may be helpful. Consequently, the following suggestions are made for a culturally adapted intervention.

Firstly, a culturally adapted trauma intervention for Black Africans in KwaZulu-Natal must include basic trauma intervention aspects such as establishing whether the person is safe, and providing a safe and supportive environment. Individuals must be given the opportunity to tell their story about what happened to them and what they are experiencing as a result. As discussed, many participants expressed the need to talk to someone.

The intervention could possibly include various CBT based techniques to address the problems and symptoms experienced by the participants. For example:

- Cognitive restructuring techniques might be used to address self-blame, irrational fears, internalised stigma and intrusive thoughts. Cognitive restructuring targets a person's distorted automatic thoughts, dysfunctional schemas and maladaptive assumptions associated with the trauma. Distorted automatic thoughts reflect underlying assumptions about how things "should and must" be, and deep seated schemas about the nature of self and others. People with PTSD tend to see everyone as dangerous, unpredictable and

malevolent, and themselves as weak and incompetent. The goal of cognitive restructuring is to give the person a more balanced view, in which the world is safe, within limits, events are generally predictable and controllable, and that the person can cope in most situations, but there is acknowledgement of reality that negative events do happen (Leahy, Holland, & McGinn, 2011).

- Teaching healthy coping mechanisms to deal with PTSD symptoms is essential. For example, relaxation techniques such as deep breathing can be taught to individuals to help with underlying anxiety.
- Individuals also need to be taught healthy coping mechanisms to address maladaptive coping mechanisms, such as alcohol abuse. Activity scheduling is one process that might help to facilitate this. Activity scheduling (also known as behavioural activation) might be useful in addressing avoidance strategies used by participants. The goal is to schedule positive and rewarding activities which can help individuals engage in activities that will reduce avoidance behaviours, such as isolating themselves from people and places. Individuals with PTSD often become hyper vigilant in assessing their environment for trauma related cues, which leads to avoidance responses. Activity scheduling helps to target these responses and assists people in engaging in behaviours that help them to accomplish goals. Individuals are also helped in this process to engage in behaviours that may be associated with the traumatic experience (Mulick & Naugle, 2010).
- Assertiveness training could also be done in order to help individuals with relationship problems. Assertiveness training helps individuals stand up for themselves by teaching appropriate strategies to express their opinions, desires and needs. This can be empowering for women who feel that they have no control in their lives.
- Psychoeducation is also important. Psychoeducation includes basic information about common reactions to trauma and coping skills on how to reduce distress. Through

providing this information, victims may find their reactions less disturbing as they realise that their symptoms are normal. It may give them the basic tools to cope with the event and may assist with help seeking- if information on help available is given (Wessely et al., 2008).

Teaching individuals problem solving skills is also essential. Results showed that there was a definite emphasis on wanting "advice" on how to solve problems. Problem solving could be useful in dealing with not only PTSD symptoms, but also other consequences of the traumatic experience, e.g. joblessness. As previously explained, problem solving therapy is a structured psychological treatment that includes teaching a client how to solve any problems that they may come across, using a step-by-step method (Malouff et al., 2007). This approach would thus help to empower the individual to manage the problem that they are experiencing, instead of relying on the advice of others.

Once the theoretical foundation has been established, each component of the intervention needs to be re-designed to adapt to the culturally based way of communicating distress. In doing this, communication of core concepts must include culturally appropriate visualizations, examples and metaphors. Additionally, this culturally adapted intervention for Black Africans in KwaZulu-Natal also needs to employ a more holistic approach that looks at the physical, spiritual, psychological and sociocultural consequences of trauma. Sociocultural issues also need to be addressed in the intervention, and counsellors need to be open to integrating traditional practises into treatment plans. Examples of this include:

- Psychoeducation could be presented in a manner that addressed the individual's idioms of distress, for instance, using the terms "body shakes," when describing the physical

consequences that the individual may experience in response to the trauma. Including the family in this process is also essential. Family members who have an understanding of the experience that the victim is going through are better able to provide a supportive environment. In addition, as a result of the perception in many communities that sexual violence is normal, it is also essential to provide information around the defining characteristics of rape and domestic violence so that victims are able to get the help that they need.

- Cognitive restructuring might also be adapted with the sociocultural context in mind. When addressing fears, it must be remembered that these are often realistic, and thus the individual does not only need help in changing how they think about the fear, but possibly some problem solving skills on how to deal with it. For instance, because of violence in the community, it is dangerous to walk around alone, and thus the individual might need to get someone to walk with them. Intrusive thoughts might also be addressed through the use of humming or singing groups, as suggested by caregivers during the feedback session. Caregivers also mentioned that many of the trauma victims that they work with struggle with issues around internalised and externalised stigma, and thus it is important to address these beliefs when adapting CBT techniques such as cognitive restructuring.
- Caregivers in the feedback session also suggested that keeping busy with sewing, gardening and craft work would help. These kinds of activities might be useful to include in behavioural activation and when considering coping skills. At the same time, making goods would allow for a means of income, and thereby contribute to their financial independence. Jewkes (2002) argues that men may lash out at women if they are not able to support them financially. Thus, helping victims gain financial independence is essential.

- Considering the culture of patriarchy, assertiveness training could also be difficult. Individuals may be exposed to more violence if they question their partners, and therefore strategies to deal with this need to be put in place.
- Individuals may also want a traditional healer to perform a ceremony, and thus this may be a solution arrived at during problem solving. Counsellors need to be respectful of other methods of intervention, and be open to integrating it into treatment.

Counsellors need to be trained to administer the intervention to both individuals and groups. As discussed, although group intervention is beneficial, as it provides a source of support and normalises the experience, it is essential that the counsellors can also provide individual intervention. Victims of traumatic events may not always be able or willing to attend groups, and the community caregivers who provide the intervention may encounter individuals who need assistance during their routine home visits. Thus, it is essential that they have the skills to intervene no matter what the setting.

Many of the communities in South Africa are under-resourced and very little professional psychological help is available. When it is available, it is usually very expensive. In these scarce resource contexts, it is useful to adopt a model of integrating mental health into primary health care as a way to allow greater access to mental health care. This approach entails tasks shifting, where general health practitioners such as nurses or non-professional community based workers are trained to deliver mental health care (Petersen, 2010).

With regards to this intervention, home-based caregivers or lay counsellors from the community can be trained to administer the intervention. As a result, it is also important to consider who will administer the intervention when designing and adapting it. Concepts must

be clear and easy to understand, and must be presented in such a way that a caregiver or counsellor with basic counselling skills can be trained to administer the intervention.

In addition to training, counsellors also need to receive on-going supervision and support to address any issues that may arise during their work. This includes not only issues related to the victims, but also to themselves and their emotional and psychological state. A weekly support group may be beneficial, as it allows volunteers to share their experiences and discuss any challenges. Although the group may initially require mental health specialists to fill this role of facilitator, it may eventually be taken on by experienced group members.

Contextual issues such as gender inequality and biases, alcohol use, poverty and the levels of violence also need to be addressed at a community level. These factors influence not only the community members' exposure to traumatic events, but also how they respond to them. Unless these sociocultural structures are re-examined and addressed, the possibility of change within the community and individuals is less probable. As a result, there is a need for prevention interventions at a community level which aim to reduce the issues that lead to traumatic events such as interpersonal violence.

In achieving this goal, it is essential to educate community members about the rights of women and interpersonal violence in order to address some of the sociocultural issues related to blame and male dominance. It is also not only important to raise awareness around problems such as interpersonal violence, but in the process also establish norms that make it culturally unacceptable. Job creation initiatives will not only help to reduce poverty, but will allow men to experience a sense of control over their lives, and help them attain their ideals of 'successful' manhood. Recreational activities at community centres are also essential to

give individuals constructive ways to spend their time, and may help to reduce alcohol use. An emphasis on the use of social support within the community will also help with a reduction in the use of avoidance coping, and emphasise positive coping mechanisms. The South African Police Service and the Community Police Forum also need to be more active in addressing the criminal activity in certain areas. However, in all these processes it is crucial that all community stakeholders are involved in the development and implementation of programmes.

These issues also need to be considered at a policy level. Patriarchal societal structures have created gender imbalances and discrimination not only at a community level, but influenced society as a whole. Efforts to address these imbalances could include the petition for women to hold more positions of power within communities, and advancement for the equality of sexes- not only in society, but also in relationships.

Better implementation and development of the Victim Empowerment Programme is also essential. Community-based programmes and interventions that are appropriate for various communities need to be developed and implemented. Community health workers or counsellors need to be trained in appropriate trauma intervention methods, and supervision and support need to be provided.

5.7 Limitations of the research

- The present study was a qualitative study with 11 participants. It was conducted on a small sample of Black women in KwaZulu-Natal, who live in a poor community and were mainly isiZulu-speaking. The generalizability of the result is therefore limited and cannot be applied to any population of Black individuals.

- The information was also collected through semi-structured interviews and a screening measure, through the self-report of participants. This could have affected the reliability and validity of the information, as participants may have interpreted the same questions differently, thereby affecting the answers which they gave.
- Most of the interviews were also not conducted by the researcher, and as a result answers given by the participants were often accepted by the interviewer without probing for further information. This would have influenced the ‘richness’ of the interview text analysed.
- Many of the participants had been through a Western-based counselling or debriefing process and this may have influenced participants’ responses in favour of these approaches. Different responses may have been received from those who had not had this opportunity if they had been interviewed.

5.8 Recommendations for future research

- As this study showed, individuals from different cultures may have differences and similarities in their idioms of distress. However, current PTSD assessment procedures are based on Western idioms, and although not necessarily entirely inappropriate considering possible similarities between cultures, research needs to be conducted in order to create more culturally appropriate assessments.
- Research also needs to be conducted to make the PTSD diagnostic criteria more culturally applicable. Specifiers and examples given in the criteria do not correlate with the possibly different idioms of distress used by individuals of other cultures, including Black Africans in KwaZulu-Natal. As a result, more extensive qualitative and quantitative research needs to be conducted with various cultural groups in order to determine culturally relevant idioms of distress. In this process, researchers will be able to determine

which aspects of the PTSD diagnostic criteria need to be adapted or changed in order to be more culturally applicable.

- Smith, Rodriguez and Bernal (2011) in their review found that mental health services adapted to specific cultural groups were more effective than those provided to clients from a variety of cultural backgrounds. This study included Black Africans in KwaZulu-Natal. However, within this population there is a variety of different African cultures with different beliefs, practises and languages. Although there are similarities, research needs to be conducted with each specific cultural group in order to determine what is needed in a culturally adapted trauma intervention for each group.
- Research in this area also needs to be with larger sample sizes in order to ensure generalizability. It would be important to study a much wider and heterogeneous sample of trauma survivors, including participants of both genders and those who have sought traditional methods of treatment.
- Research into these issues also allows for the development, implementation and support of policy recommendations.

5.9 Conclusion

The aim of this study was to understand what sociocultural factors need to be considered when adapting a trauma intervention model to the South African context, specifically to the Black Africans in KwaZulu-Natal. To achieve this aim, semi-structured interviews were conducted in order to determine how Black Africans in KwaZulu-Natal understand the traumatic event they experienced, what consequences it had for them and what treatment intervention they required. Kleinman's explanatory model of illness was used as the theoretical framework in order to inform the questions asked, and analysis of the emergent data. Kleinman argues that explanatory models are culturally constructed, and thus how we

understand and experience illness, and expectations for treatment will be influenced by our social and cultural context (Kleinman et al., 1978).

The results of this study have illustrated this theory by demonstrating how the participants' sociocultural context has influenced their understanding and experience of their traumatic event, and what intervention they require. This highlights the connection between an individual and his or her culture. The results have shown that the culture of violence, the culture of patriarchy and the culture of blame that is prevalent in the African sociocultural context has influenced participants' understanding of the traumatic event that they experienced. Some participants also attributed their experience to the use of drugs and alcohol, and a traditional African worldview. Participants interviewed also live in a poor community and experience poverty, and as a result engage in daily activities that put them at risk for violence. Some lost their jobs as a result of the trauma, and felt that their most important need was employment in order to provide for their families. However, as noted in the discussion, it is also important to consider that the discussed sociocultural context and meaning frameworks of these participants is not necessarily unique to Black Africans in KwaZulu-Natal. Trauma survivors from other cultures and contexts also develop explanations for trauma that draw on sociocultural concepts such as patriarchy, blame and male dominance.

Results on consequence of the trauma also revealed participants experienced universal PTSD symptoms of intrusion, avoidance/numbing and hyperarousal, but their expression of this distress may be culturally influenced. In other words, there may be similarities between cultures in PTSD symptoms experienced, but there may also be differences among cultures, e.g. the use of different terminology such as 'constantly thinking'. In addition to this,

participants experienced other consequences, such as being without a job, home or food, and some experienced relationship problems and are fearful of a re-occurrence of the trauma. Unfortunately, as a result of the sociocultural context of these individuals (such as the culture of violence, patriarchy, and poverty), fears and experiences are realistic.

When it came to an intervention, participants felt that they needed a job, psychoeducation, support from the police, and were split between the option of group or individual counselling. The results showed that participants might benefit from aspects of Western based interventions to deal with specific symptoms and consequences, but these need to be adapted to suit the sociocultural context of the individual. In addition to PTSD symptoms, the sociocultural context thereby brings to light other issues that need to be addressed, such as poverty, the African worldview and traditions, the culture of blame, the culture of violence and patriarchy. It is thus important to have an intervention that holistically addresses the individual, and thus the physical, spiritual, psychological and sociocultural aspects of trauma.

Consequently, in designing a culturally sensitive treatment intervention, Western models are not necessarily inappropriate, and it could be beneficial to implement traditional evidence-based treatments with slight changes. Thus, an intervention should not only address trauma through Western approaches, but the sociocultural context and culturally influenced idioms of distress need to be taken into account. Consequences such as joblessness, interpersonal conflict and alcohol use also cannot be ignored. Based on the results of this study, recommendations were made for a culturally adapted intervention for Black Africans in KwaZulu-Natal. Principles and mechanisms of changes of Western approaches such as CBT and PST may provide a useful theoretical grounding for the intervention. CBT based techniques such as cognitive restructuring, activity scheduling, assertiveness training and

psychoeducation might be used to address problems and symptoms experienced by the participants. Problem solving therapy may also have a useful place in this regard. The approach should also be open and flexible to integrate traditional African interventions into the treatment approach. These Western approaches could be adapted to suit the individual's needs and context. Hence the way in which the theoretical concepts are conceptualised, communicated and administered should be congruent with the victim's sociocultural context and idioms of distress.

In addition, in the scarce resource context of many South African communities, a task shifting approach could be useful in order to allow more trauma victims access to mental health care. Existing community based mental health workers can be trained to administer the intervention, and thus it needs to be designed with this in mind. The study did show that participants felt that they would like the intervention in their own language, with a counsellor with whom they were familiar, and for this to be conducted in their own community. Moreover, in providing the intervention, these people also need on-going supervision and support.

Addressing sociocultural issues such as violence, alcohol use, blame and patriarchy cannot only happen at an individual level, but community based preventative interventions are also essential in this regard. Thus, there is a need for prevention interventions at a community and policy level which aim to address the issues. In this regard, it is essential to involve all community stakeholders in raising awareness around the problems, and in challenging social norms, in job creation and recreation initiatives, and in establishing and reinforcing the importance and use of social support.

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APPENDIX 1
LETTER TO GATEKEEPERS



**Faculty of Humanities, Development and Social Sciences
Department of Psychology**

Understanding social and cultural aspects of trauma in Black Africans in KwaZulu-Natal

Dear Center Coordinator,

RE: Permission to interview victims seen at this center

Study Information Sheet

The Research Study

My name is Vanessa Wright and I am a Counselling Psychology Masters student at the University of KwaZulu-Natal. As part of my Masters course I am conducting a study for my final research dissertation. I am undertaking a research study aimed at understanding social and cultural aspects of trauma in Black Africans in KwaZulu-Natal.

What are we trying to learn?

In this research I am trying to understand how people who went through traumatic experience understand the experience they went through, what they thought of the counselling that they got, and what psychosocial interventions they think would be most useful.

Why is it important?

This study is important because insights gained from this study can help to develop more culturally and contextually appropriate treatment interventions for people who go through traumatic experiences. Thus counsellors could help victims of traumatic events in a more beneficial and effective way.

Who will be involved and how long will it last?

Victims of traumatic events who were seen for debriefing or counselling at this center will participate in the study. Participants will need to be Black individual who have been exposed to traumatic events, more than one month ago. I require a sample of 10 victims. Participants will be interviewed once.

What will be required of participants who participate in the study?

Participants will be asked to answer a number of questions about their thoughts on the traumatic experience that they went through, the helpfulness of the counselling that they received, and what kind of psychosocial intervention they think would have been most helpful. They will also be asked questions about any symptoms you may be experiencing as a result of their experience. The interview will last an hour at the longest and will be recorded on an audio recorder. The interview will be conducted in English or isiZulu, depending on which the participants are most comfortable with. The participants will receive R100 for participating in this study.

Is there any disadvantage from participating in this study?

Since the focus of the study is participants' thoughts about the traumatic experience that they went through, there is a possibility that they may feel upset or distressed as a result of taking part in this study. If this is the case, they will be referred to a counselling center where they can get psychological help.

What if I change my mind later?

Participation is completely voluntary, so participants are free to withdraw at any stage from participating in the study and their decision will not disadvantage them in any way.

Who will see the information that we collected?

All information will be kept completely confidential and the participants' identity will be anonymous. In my final dissertation no research material will be used that identifies the participants in any way. After the data has been analysed, it will be kept for five years in a safe and secure place in order to abide by the regulations of the University. Thereafter the tapes will be destroyed and the transcripts will be shredded. The data will only be seen by the researchers and supervisor.

What I require from you?

The participation of this center and its victims will be highly appreciated. In order for this study to take place, I would like to request written permission for the researcher to conduct this research at this center. If you want more information on the study or have any questions, please contact me or my supervisor:

Researcher:

Vanessa Wright

E-mail: vanessawright@telkomsa.net

Cell: 084 431 2505

Supervisor:

Prof. Inge Petersen

E-mail: PETERSENI@ukzn.ac.za

APPENDIX 2
STUDY INFORMATION AND INFORMED CONSENT
(English and isiZulu)



UNIVERSITY OF
KWAZULU-NATAL

Faculty of Humanities, Development and Social Sciences
Department of Psychology

Understanding social and cultural aspects of trauma in Black Africans in KwaZulu-Natal

Study Information Sheet

The Research Study

My name is Vanessa Wright and I am a Counselling Psychology Masters student at the University of KwaZulu-Natal. As part of my Masters course, I am conducting a study for my final research dissertation. I am asking you to participate in a research study aimed at understanding social and cultural aspects of trauma in Black people in KwaZulu-Natal.

What are we trying to learn?

In this research I am trying to understand how people who went through traumatic experience understand the experience they went through, what they thought of the counselling that they got, and what psychosocial interventions they think would be most useful.

Why is it important?

This study is important because insights gained from this study can help to develop more culturally and contextually appropriate psychosocial interventions for people who go through traumatic experiences. Thus counsellors could help victims of traumatic events in a more beneficial and effective way.

Who will be involved and how long will it last?

Victims of traumatic events who were seen for debriefing or counselling at the 1000 Hills Community Centre will participate in the study. Participants will be interviewed once.

What will it mean if you participate in the study?

If you agree to participate in this study you will be asked to answer a number of questions about your thoughts on the traumatic experience that you went through, the helpfulness of the treatment that you received, and what kind of treatment you think would have been most helpful. You will also be asked questions about any symptoms you may be experiencing as a result of your experience. The interview will last approximately an hour and will be recorded on an audio recorder. The interview will be conducted in the language that you are comfortable with (either English or an African language). You will receive R100 as a thank you for participating in the study.

Is there any disadvantage from participating in this study?

Since the focus of the study is your thoughts about the traumatic experience that you went through, there is a possibility that you may feel upset or distressed as a result of taking part in this study. If this is the case, you will be referred to a counselling center where you can get psychological help.

What if I change my mind later?

Participation is completely voluntary so you are free to withdraw at any stage from participating in the study and your decision will not disadvantage you in any way.

Who will see the information that we collected?

All information will be kept completely confidential and your identity will be anonymous. In my final dissertation no research material will be used in which you may be identifiable. After the data has been analysed, it will be kept for five years in a safe and secure place in order to abide by the regulations of the University. Thereafter the tapes will be destroyed and the transcripts will be shredded. The data will only be seen by the researchers and supervisor.

Who to contact if you want to know more, or if you have a problem at any time?

Your participation will be highly appreciated, so if you want more information on the study before deciding whether or not to participate, or if you participate and later need help or have questions, please contact me or my supervisor:

Researcher:

Vanessa Wright

E-mail: vanessawright@telkomsa.net

Cell: 084 431 2505

Supervisor:

Prof. Inge Petersen

E-mail: PETERSENI@ukzn.ac.za

If you wish to obtain information on your rights as a participant, please contact Ms Phumelele Ximba, Research Office, UKZN, on 031 260 3587.

Consent to Enroll

I, _____ agree to participate in the research study on understanding socio-cultural aspects of trauma in Black people in KwaZulu-Natal, in order to understand culturally and contextually appropriate ways for treating trauma-related disorders and distress. I have received and understood the study information sheet. I have discussed the advantages and disadvantages of participating in the study and I agree to participate in the interviews as stated in the information sheet.

I know I can leave the research study at any time without prejudice and be referred for psychological help if need be.

Signature: _____

Name: _____

Date: _____

Witness 1

Signature: _____

Name: _____

Date: _____

Witness 2

Signature: _____

Name: _____

Date: _____

You may keep the information sheet. The signed consent form will remain in our study files.



Faculty of Humanities, Development and Social Sciences

Department of Psychology

Incwadi Lemininingwane

Igama lami ngingu-Vanessa Wright. Ngenza izifundo ze-Masters Psychology eNyuvesi yaKwaZulu-Natal. Ngenza ucwaningo oluyingxenywe lohlelo lwezifundo zami. Ngicela ube yingxenywe yocwaningo oluhlose ukwazi kabanzi nge-trauma (isimo sokwethuka) kubantu abangama-Afrika.

Yini esifuna ukuyazi?

Lolu cwaningo luzama ukuthola ukuthi abantu abadlula ezimweni ezishaqisayo noma ezithusayo bazibuka kanjani, nokuthi bathini ngokwelulekwa abakutholile kanye nokuthi iziphi izindlela zosizo lokomqondo abacabanga ukuthi ziyabasebenzela.

Yikuphi okubalulekile

Lolucwaningo lubalulekile ngoba luzosiza ekwakheni izindlela zosizo lokomqondo ezihambisanayo nabantu kanye nenhlalo abaphansi kwayo. Ngalokho-ke abeluleki bangasiza kangcono nangempumelelo labo abadlule ezimweni ezethusayo.

Ubani ongaba yingxenywe, kuzothatha isikhathi esingakanani?

Abantu abedlule ezimweni ezethusayo babonwa ngabeluleki e-Crises Centre bangaba yingxenywe lalolucwaningo. Kuzoba khona imibuzo ezothatha imizuzu engu-45 kuya kwihora kuphela.

Kusho ukuthini ukuba yingxenywe yalolucwaningo?

Uma uba yingxenywe yalolu cwaningo uzocelwa ukuphendula imibuzo ethile mayelana nalokho okwenzakala kuwe, nokuthi ukwelulekwa owakuthola kwakusiza kangakanani, nokuthi yiluphi usizo ocabanga ukuthi lwalungakusebenzela kangcono. Uzobuzwa ngezinto

ezenzeka kuwe ngemva kwesehlakalo. Imibuzo izothatha ihora elilodwa futhi izoqoshwa. Imibuzo izoba ngolimi oluthandayo. Uma uba yingxenye yalolu cwaningo uzonikwa imali engango-R100 ukukubonga.

Ngabe bukhona ubungozi bokuba yingxenye lalolu cwaningo?

Njengoba lolu cwaningo luthinta isigameko esethusayo owaba naso, lokhu kungenzeka kuholele ekutheni uzizwe ukhathazekile futhi uphansi. Uma loku kwenzeka, uzothunyelwa endaweni lapho uzothola ukwelulekwa nokusizwa ngokomqondo mahhala.

Uma ngishintsha umqondo?

Ukuba kulolu cwaningo akuphoqelekile futhi ungashiya noma yinini uma ufisa, akukho okubi okuyokwenzeka.

Ubani ozobona lolulwazi oluzothathwa?

Lonke ulwazi luzoba yimfihlo futhi igama lakho angeke lidalulwe. Ekugcineni kokushici angeke lusetshenziswe ulwazi olungenza waziwe. Lulolwazi luzogcinwa iminyaka emihlanu, njengomthetho weNyuvesi. Emva kwalokho luzobe selulahlwa. Abantu abazobona lolu lwazi abacwaningi kanye nomengameli wocwaningo kuphela.

Ungathintana nobani ukwazi kabanzi ngalolu cwaningo?

Siyokuthokozela kakhulu ukuba ukubamba kwakho iqhaza kulolucwaningo. Uma ufuna eminye imininingwane ngaphambi kokuba ube yingxenye, ungathintana nami noma nomphathi wami:

Vanessa Wright

E-mail: vanessawright@telkomsa.net

Cell: 084 431 2505

Umphathi

Prof. Inge Petersen

E-mail: PETERSENI@ukzn.ac.za

Uma ufuna ulwazi ngamalungelo akho , ungathintana no Ms Phumelele Ximba, Research Office, UKZN, ku 031 260 3587

Incwadi yemvume (Consent form)

Mina,ngiyavuma ukuba yingxenye yalolu cwaningo olumayelana nokuqonda kabanzi nge-trauma (isimo esiithusayo) kubantu abangama-Afrika ukuze sithole izindlela zokusiza ezihambisana nesikompilo kanye nenhlalo yabo. Sengifundile futhi ngaqonda kahle ukuthi ucwaningo lumayelana nani. Sengitsheliwe ngobuhle nangobungozi bokuba yingxenye yocwaningo futhi ngiyavuma ukuba yingxenye yalo njengoba kubhaliwe encwadini yemininingwane.

Ngiyazi ukuthi ngingama ukuba yingxenye lalolucwaningo noma nini uma ngifuna futhi ngitho ukwelulekwa komqondo uma kudingeka.

Signature: _____

Date: _____

Witness 1

Name: _____

Signature: _____

Date: _____

Witness 2

Name: _____

Signature: _____

Date: _____

Ungayigcina incwadi yemininingwane ngakuwe. Incwadi yemvume izoza ngakithi.

APPENDIX 3
DAVIDSON TRAUMA SCALE

Davidson Trauma Scale

In the past week, how have you felt about the experience you went through? For each statement use a number from the scale provided to indicate how often you have had the symptom **and** how upset you have been by the symptoms.

	<u>FREQUENCY</u> 0= Not At All 1=Once only 2= 2-3 Times 3= 4-6 Times 4= Every Day	<u>SEVERITY</u> 0= Not At All Upsetting 1= A Bit Upsetting 2= Somewhat Upsetting 4= Very Upsetting 5= Extremely Upsetting
1. Have you ever had painful images, memories or thoughts of the event?	0 1 2 3 4	0 1 2 3 4 5
2. Have you ever had worrying dreams of the event?	0 1 2 3 4	0 1 2 3 4 5
3. Have you ever felt as though the event was recurring? Was it as if you were reliving it?	0 1 2 3 4	0 1 2 3 4 5
4. Have you been upset by something that reminded you of the past event?	0 1 2 3 4	0 1 2 3 4 5
5. Have you been physically upset by reminders of the event? (This includes sweating, trembling, racing heart, shortness of breath, nausea, or diarrhoea).	0 1 2 3 4	0 1 2 3 4 5
6. Have you been avoiding any thoughts or feelings about the event?	0 1 2 3 4	0 1 2 3 4 5
7. Have you been avoiding doing things or going into situations that remind you of the event?	0 1 2 3 4	0 1 2 3 4 5
8. Have you found yourself unable to recall important parts of the event?	0 1 2 3 4	0 1 2 3 4 5
9. Have you had difficulty enjoying things?	0 1 2 3 4	0 1 2 3 4 5
10. Have you felt distant or cut off from other people?	0 1 2 3 4	0 1 2 3 4 5
11. Have you been unable to have sad or loving feelings?	0 1 2 3 4	0 1 2 3 4 5
12. Have you found it hard to imagine having a long life span and fulfilling your goals?	0 1 2 3 4	0 1 2 3 4 5
13. Have you had trouble falling asleep or staying asleep?	0 1 2 3 4	0 1 2 3 4 5
14. Have you been irritable or had outburst of anger?	0 1 2 3 4	0 1 2 3 4 5
15. Have you had difficulty concentrating?	0 1 2 3 4	0 1 2 3 4 5
16. Have you felt on edge, been easily distracted, or had to stay "on guard"?	0 1 2 3 4	0 1 2 3 4 5
17. Have you been jumpy or easily startled?	0 1 2 3 4	0 1 2 3 4 5

APPENDIX 4
INTERVIEW SCHEDULE

Interview Schedule

1. Think back on the day when you had the traumatic experience that brought you to this center. Take a minute to reflect on the thoughts and feelings you had on that day and have had since the event.
 - (a) What do you think caused the experience that you went through?
 - (b) Why do you think it happened when it did?
 - (c) What do you think your experience did to you?
 - (d) How severe are the effects? Will the effects last for a long or a short time?
 - (e) What are the main problems that the experience has caused you?
 - (f) What are the main fears as a result of the experience?

2. Think about the way in which this the people in this center helped you deal with your traumatic experience.
 - (a) Did you find them helpful?
If yes, what was helpful? If no, what was not helpful?
 - (b) Besides the help that you got at the center, what else helped you cope with the experience?

3. If you could dream of the perfect way in which you might have been helped in your experience, what would it be like?
 - (a) What would be done?
 - (b) Would it be best done alone or with others in a group? Why?
 - (c) Where would it take place?
 - (d) Who would provide this help?
 - (e) What do you think some of the benefits of this help might be?
 - (f) What do you think some of the difficulties/obstacles to getting this help might be?

4. Is there any other comments or questions that you have?

APPENDIX 5
ETHICAL CLEARANCE LETTER