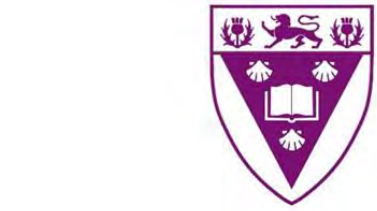

FACULTY OF HUMANITIES

IN

DEPARTMENT OF ANTHROPOLOGY

MASTER OF SOCIAL SCIENCE: BIG T'S AND SMALL T'S: AN EXPLORATIVE STUDY ON TRAUMA NARRATIVES IN SOUTH AFRICA

BY

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Declaration

I, Rinisa Naidoo, declare that this dissertation is my original work and all relevant information has been referenced and cited.

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Rinisa Naidoo

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Abstract

The 21st century has seen a dramatic increase in chronic non-infectious diseases, especially in the area of mental health. Medical anthropologists have seen a rise in the development of mental illnesses in both developed and developing nations. There is, however, little research conducted on trauma narratives that do not stem from political violence from an anthropological lens. South Africa has various understandings of trauma depending on the cultural context and it is crucial to examine these narratives as this provides vital information of the daily lived experiences of trauma survivors. Key themes draw on issues of trauma denialism, communicating distress, traumatic symptoms and the development of mental illnesses as a result of traumatic exposure.

The data was analysed through Goffman's (1959) *Presentation of Self in Everyday Life* illustrating various ways how survivors present themselves depending on the particular audience. This research employed both qualitative and quantitative research methods to gather a holistic understanding of trauma survivors. With the use of semi-structured interviews of Stressful Life Events Questionnaire coupled with observations of online support groups for trauma survivors, this research has provided rich ethnographic evidence of the impact that culture has on trauma narratives illustrating a clear normalcy of trauma present in South Africa.

Key words: *trauma, culture, trauma exposure, trauma narratives*

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Chapter 1: Introduction

1.1. Background and context

In the 21st century, there has been a dramatic increase in chronic non-infectious diseases, particularly in mental health. Mental health diseases have become a leading contributor to the global disease burden, however little progress has been made to acknowledge the aetiology of these mental illnesses. (Syme and Hagen, 2020:87). Kleinman (1980; 1982) has illustrated the importance and effect that culture has on the sickness experience, and this is particularly true in relation to trauma studies. Anthropological research on trauma has traditionally focused on the trauma narratives of wartime veterans and political crisis (see Chemtob, 1996; Kienzler, 2008; Tol et al., 2010; Moghimi, 2012; Reynolds, 2013). Although these are important narratives to have, it is equally important to document and illustrate the consequences of daily trauma experiences through a cultural lens. This study focuses on trauma narratives from a multicultural South African perspective illustrating the impact that culture can have on behaviour and perceptions of trauma.

1.2 Understanding the concept of trauma

The word trauma derives from the Greek word for wound. In the 1600s, understandings of the word trauma concerned medical bodily wounds (Kirmayer and Sartorius., 2007:31). Kirmayer et al. (2009:31) point out that both scholars and clinicians have used the concept of trauma across multiple disciplines. The two common understandings of trauma are through a medical lens and a psychological lens. Lester (2013:754-756) states that the medical understanding is referred to as a direct bodily injury; for example, trauma to the head would indicate that the individual needs medical attention to their head. On the other hand, psychological trauma is more complex and multifaceted because it is a response to physical and emotional trauma, unveiling an invisible nature to trauma. It not only involves the traumatic event itself but also includes "the complex sets of responses to the event" (Lester, 2013:756). This includes but is not limited to flashbacks, unusual sleep patterns and hyper-arousal. Edwards (2005:117) discusses a third understanding of the term, encompassing the physical and the psychological state which can be considered as a traumatic event. This study will use the psychological definition of trauma in response to traumatic events and agents. This is because there tends to be medical, emotional, and psychological aspects which encompass the multifaceted dimensions of trauma.

Trauma is accompanied by traumatic stress, which emerges from a traumatic event (Swain et al., 2017:1). Natural disasters, accidents, abuse, victimisation, and war are some events that

can be categorised as traumatic events. Furthermore, Galea et al. (2004:78) state that a traumatic event can result from experiences of terrorism, relocation, disasters, and violence that pose life-threatening harm or serious injury. Brown et al, (1998:154) define a traumatic event as "very stressful, often emotionally arousing situations that an individual directly experiences and that have immediate consequences for the individual's unfolding life".
Lester (2013:753) discusses that people are constantly pushed to their limits after a traumatic event, both physically and psychologically. Traumatic events tend to alter an individual's world. Regardless of the type of trauma, (whether physical, emotional, or psychological), the experience changes relationships with and between people, and avenues of safety and security need to be reconstructed (Lester, 2013:754).

Allarakha and Uttekar (2021) discussed three types of trauma; acute, chronic and complex, all of which create a disconnect from reality. Acute trauma refers to a singular, isolated traumatic event such as a car accident over a short period. Chronic trauma refers to a prolonged, repeated event that could have lasted a few years, such as domestic violence or child abuse (Allarakha and Uttekar, 2021). Chronic trauma also exposes multiple traumatic events throughout one's lifetime, such as exposure to domestic, emotional, and physical violence (Allarakha and Uttekar, 2021). If traumatic events are not treated, they can sometimes develop into Post Traumatic Stress Disorder (PTSD). Complex trauma engages with multiple forms of long-term trauma and can develop into Complex Post Traumatic Stress Disorder (cPTSD). Lester (2013:754:756) explains that traumatic experience is often the emotions that encompass the event that can leave a person feeling vulnerable and have a loss of agency or fear for one's existence. These emotions and experiences often create long-term consequences that attribute to memory, identity, and perception (Kirmayer et al., 2007:37).

Experiences of trauma affect all facets of an individual's life and how it is dealt with, understood, and treated are often a result of cultural influences. This dissertation is particularly interested in trauma narratives that exist as chronic and/ or acute trauma.

PTSD rates around the world vary. There are a few reasons for this; including cultural perceptions of post-trauma as well as the fact that not all trauma results in PTSD (see Kessler et al., 1995; Sareen et al., 2010; Stein et al., 2013). According to Sareen (2014:462), studies conducted in the United States of America (USA) and Canada indicate that 6-9% of the population have PTSD. This number drops within Australia as prevalence is estimated to be 1-2%. According to Peltzer and Pengpid (2018:360), South Africans are estimated to have a

lifetime prevalence of 2%. This is surprising because of the long-term violence that South Africa is infamous for, especially against women and children. Swain et al. (2017:1) stated that in countries known for having long-term violence, like South Africa, PTSD prevalence could rise to 10%. South Africa has a deep political and social history which are active components to the contemporary issues South Africans are currently facing, especially in relation to traumatic exposure and experiences. Interactions between mental health, mental illness, and wellbeing have direct correlations with understandings of trauma exposure and trauma narratives in South Africa. Political, criminal, physical, and gender-based violence are key categories that have led to South Africa's epidemic of violence and are argued to be a result of South Africa's colonial and apartheid history (see Magubane, 1996; Thompson, 2008; Reddy, 2015).

The culture of violence is so prominent in South Africa that it has been categorised as an epidemic. Reddy (2015:1) states that due to its colonial and political (apartheid) past, South Africa is a country that is driven by guilt, fear, and anger because of the accumulated injustices suffered. Thompson (2008) explores the deep political history of South Africa noting Khoisan (KhoiKhoi and San) presence on South African land in millennia BC (Before Christ) and expands onto the arrival of the Portuguese setters in 1487. The following century consisted of a variety of wars that forcefully removed indigenous people from their land, including the *amaXhosa* tribe and resided in indigenous land (Coovadia et al, 2009:818). In 1652, slaves were brought into the Cape region from West African countries, Mozambique and India to work on farms[1] (Coovadia et al., 2009:818). The Dutch settlers, however, were the first to officially colonise the land in 1652 which was then colonised by the British in 1795 (Thompson, 2008: xix). South African land was passed between the British and the Dutch until 1815 when South Africa was included in the British Empire (Pagel, 2021:4). British settlers arrived in the Cape Colony in 1820 (Thompson, 2008). Indians from India were brought to Natal, South Africa, to solely work on the sugar farm plantations in 1859 (Coovadia et al., 2009:818). Magubane (1996: xii) states that the clear motive of British colonisation had no intention of human freedom but instead was "to capture Transvaal and its newly found riches, regardless of the consequences" (Magubane, 1996: xxi). In Kimberly, famously known as the mining town in South Africa, mining began in 1870, and resultantly black workers were working in horrendous conditions in search of diamonds (Van der Merwe et al., 2010:185). These harsh working conditions left mine workers with diseases and even resulted in death.

[1] These slaves were the ancestors of the "coloured" i.e. non-white, population of the apartheid regime

Magubane (1996: xiv) states that the mining industry in South Africa began the road to white domination. In 1902, the British secured victory in the Anglo-Boer War, enforcing two Afrikaans and two British populations under one rule (Coovadia et al., 2009:818). South Africa had entered its Segregation era in 1910 and lasted until 1948. This was a period whereby racist assumptions and ideologies swept the world and within South Africa, this meant that the British were exploiting black South Africans and other people of colour (who were brought into the country) for cheap labour due to British beliefs of superiority; any form of resistance by labourers was met with violence (Thompson, 2008:155). The National Party had gained victory over the British in 1948 but this had marked the beginning of the Apartheid in South Africa (Chopra and Sanders, 2004:153-154).

Racial segregation was further intensified during the Apartheid era of 1948-1994 and built on many British ideologies (Chopra and Sanders, 2005:154; Thompson, 2008,190). Apartheid marked the era of legalised institutional racism marking white supremacy and one of the biggest crimes against humanity (see Magubane, 2008, Abdullah, 2015; Pagel, 2021:4). The institutional and dehumanising circumstances of the apartheid era have resulted in South African citizens with accumulated traumas of everyday experiences. Chopra and Sanders (2004:154) address the forced removal of 3.5 million people from 1960-1982 and an additional 700 000 people from areas that were now considered '*White only'* areas. The displacement further intensified as the government introduced the Homeland areas, which were areas that black citizens were forced to move into (Chopra and Sanders, 2004:154). The 1970s and 1980s marked a period of mass resistance in South Africa whereby violent and gruesome acts were inflicted on non-white citizens through the means of torture, detention, intimidation, and physical violence. The end of apartheid was in 1994, however, the South African apartheid state frequently denied inflicting acts of political violence on its black citizens (Pillay, 2008:149). The development of the Truth and Reconciliation Commission (TRC) was aimed to reveal and document abuses that were inflicted during the apartheid regime with the aim for closure for families who lost loved ones, and peace (Allen, 2001:22). Kaminer and Eagle (2010:10) document that the TRC reports revealed acts of abduction, torture, extensive physical violence, shooting and destruction of property. Pamela Reynolds's (2013) book, *War on Worcester*, documents the events unfolding at the TRC and provides vivid ethnographic detail from fourteen men who underwent acts of gruesome human rights violations. Notably, Reynolds (2013) describes the South African youth's fight for freedom and the government's retaliation, her book is vital to understanding the consequence of the apartheid regime as it

documents acts of torture that have been excluded from the TRC report. This has been infuriating for South Africans as actions during the apartheid regime were not accounted for, and the TRC provided amnesty for perpetrators of violence in exchange for information. This and previous colonial and apartheid instances have created patterns of lack of accountability that has become the norm in South Africa. Resultantly, families and mostly non-white populations in South Africa have built up levels of resentment and anger that has become generational. This is important to understand why South Africa is still a violent country and why particular types of violence are normalized in South African societies. The apartheid regime allowed for government-sponsored acts of violence as a reaction to dealing with problems. These notions echo in contemporary South Africa. Most recently, a nationwide student-driven protest tackling the spike of student fees across South African universities in the #FeesMustFall movement. The protest began peaceful but eventually became violent (Langa et al., 2017). This exposed South African youth to similar traumatic experiences that were endured by generations before them.

As seen above, traumatic exposure has become embedded in South African culture as violence is seen as ordinary. Although colonization and apartheid are no longer seen as dominant political issues in South Africa, the consequences are still rippling through society. The abolishment of Apartheid aided in limiting acts of political violence, however, acts of criminal, domestic, and sexual violence crimes rose since the end of apartheid (Kaminer et al, 2008:1589). Kaminer et al (2008:1589-1590) state that the political history and consequently disproportionate levels of socioeconomic inequalities have led to the epidemic of multiple types of violence that are still dominant in the country. Here one needs to recognize that the acts of violence in a country cannot be separated from the lasting effect of its consequences. Reverting back to the low PTSD rates in the country does not mean that South Africans are not suffering from post-trauma narratives but rather our experiences are not analysed through an appropriate cultural lens. Punamaki (1989:6) has pointed out the problematic nature that stress theories present the world as a “universal laboratory”, however. they do not examine the nature of the stressor. South Africa’s political history can be seen as a dominant indicator for high levels of stress exposure.

Trauma and PTSD have traditionally existed in the realm of psychology studies. Therefore, it is important to have a sense of and understanding of these terms from the discipline it originates from and is most popularly understood in relation to. The inclusion of trauma-related disorders has come a long way since the first edition of the Diagnostic and Statistical Manual of Disorders

(DSM) in 1952. In the first edition of the DSM, the inclusion of trauma narrative was weakly described as a “gross stress reaction” which was illustrated as an abnormal stressor and thus it documented the experiences and narratives of war veterans, survivors of rape, and Holocaust survivors (Friedman et al, 2011:738). Additionally, it was seen as an acute response that was reversible. Andreasen (2011:241) states that if the reaction did not fade, another diagnosis would be assigned. The DSM-II, which was published in 1968, had completely omitted trauma and stress-related responses (Andreasen, 2011:241-242). A wide range of academic literature includes a list of trauma and stress syndromes such as rape trauma syndrome, war trauma syndrome and child abuse syndrome (Friedman, 2011: 738). The removal of the gross stress reaction from the DSM-II highlighted a gap that was crucial to include in the DSM-III. This resultantly required a diagnosis for individuals who were suffering from post-trauma consequences that were not irreversible (Friedman et al.,2011:739) and led to the development of Post-Traumatic Stress Disorder (PTSD).

PTSD first entered the DSM-III in 1980. It is important to note that the DSM is a Western psychological diagnostic tool most commonly based on Western experiences and trained by Western thought (Tseng, 2006: 558). As early as 1996, Marsella et al (1996:116) argued that the DSM was an ethnocentrically biased concept and was problematic in its applicability to non-Western cultures. Marsella et al (1996: 116) and McBride (2003: 1) both argue that PTSD, from a Western perspective, is not inclusive of non-Western cultural experiences and explanations, specifically in terms of how health, illness, well-being, and normality are understood, as well as expressions of symptomatology. Markus and Kitayama (1991: 246) and later McBride (2003: 3) all argue that situational context is important in understanding an individual's relationship with trauma. What it means to be a person of worth, or to be ill or mentally ill, differs based on cultural perceptions of the self and society (Markus and Kitayama, 1991: 246; Marsella et al, 1996: 116; McBride, 2003: 3). According to scientists and practitioners, there were preconceived notions of what PTSD looked like (Elklit et al.,2014:1). The DSM-III defined PTSD as "the person that experienced an event that is outside the range of usual human experience, and that would be markedly distressing to anyone" (American Psychiatric Association (APA), 1980). Scientists, authors, and practitioners' ideas were based on traumatic events that occurred during wars and related to soldiers returning from war zones, particularly United States veterans of the Korean and Vietnam wars (Mollica, 2000:54; Breslau, 2004:113). Breslau (2004:113-116) elaborates that this fixed idea soon changed

during the 1990s, and PTSD developed into a cultural model to understand suffering from traumatic experiences, ranging from car accidents to any form of abuse to terrorist attacks.

The DSM-IV-TR[2] outlines three different ways that PTSD can emerge, in relation to the traumatic event, namely; acute[3], chronic[4] and delayed[5] (APA, 2000 cited in Edwards, 2005:118). Three key features for PTSD is re-experiencing, avoidance and heightened sympathetic arousal (Edwards, 2005:117). Edwards (2005: 118) further addresses that PTSD symptoms may present for a few weeks but can last for years for some individuals. According to the DSM-V, there are eight criteria used to assess PTSD based on the three ley features of re-experiencing, avoidance and heightened sympathetic arousal (Kimmel et al., 2020:3).

The International Classification of Disease (ICD) is a standard tool that is used worldwide to capture data on mortality and morbidity. The ICD is a World Health Organisation (WHO) project which aims to ensure that the data recorded is used for more than just health statistics. An imperative of the ICD is to provide decision support and guidelines for health (WHO, 2021). According to the IDC-11, PTSD is categorised as the experience of fear and horror. It additionally draws attention to reliving the traumatic memory, often resulting in avoidance and hypervigilance which is similar to the DSM (Alford, 2016:16)

The ICD-11 symptoms consist of three categories:

1. Re-experiencing symptoms. This includes nightmares and/or flashbacks;
2. Avoidance symptoms (avoidance of thoughts and memories as well as associations to trauma); and
3. Hyperarousal (hypervigilance).

With this, it is noticeable that both the DSM and the ICD share diagnostic categories. Alford (2016:17) argues that practitioners prefer the ICD-11 criteria for diagnosing PTSD over the DSM-V because of its ease of criteria. The criteria of symptoms for the DSM-V involve 20 symptoms that are grouped into clusters based on symptoms, while the IDC-11 has broken it up into three categories. Additionally, the DSM is based solely on American experiences while the ICD is based on global health.

[2] Text Revision
[3] Less than three months
[4] More than three months
[5] Present after 6 months

Kimmel et al. (2020:4) state that key PTSD symptoms were excluded from the DSM, largely somatic (bodily) symptoms, which are common symptoms in non-Western countries. For example, a common non-western cultural idiom is "*thinking too much*" (which will be explored in Chapter 2) across various cultures, which can be linked to stress and anxiety disorders and may contribute to a deeper psychological issue (see Hinton et al., 2015; Kaiser et al., 2015; Weaver, 2017; Backe et al., 2021). These symptoms come across as somatic symptoms that create a form of invalidity in many non-western cultures. The DSM-V stated that they assigned a Culture and Gender Work Group to assess cultural factors; however, they did not adjust criteria for non-Western countries. The table below illustrates the differences between the DSM-V and the ICD 10 and 11.

DSM-5		ICD-10	ICD-11
Trauma	Exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in one of four specified ways	Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone	Exposure to an extremely threatening or horrific event or series of events
Re-experiencing	The traumatic event is persistently re-experienced in one or more of five specified ways	Persistent remembering or 'reliving' the stressor in one or more of three ways	Re-experiencing the traumatic event or events in one or more of three ways
Avoidance	Avoidance of trauma-related stimuli after the trauma, in one or two ways	Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor)	Avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event(s)
Negative alterations in cognition and mood	Negative thoughts or feelings that began or worsened after the trauma, in two or more of seven ways	(a) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor[a]	Not a criterion
Altered arousal	Trauma-related arousal and reactivity that began or worsened after the trauma, in two or more of six specified ways	(b) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of five ways[a]	Persistent perceptions of heightened current threat, e.g. as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises
Duration	Symptoms last for more than 1 month	Onset follows the trauma with a latency period that may range from a few weeks to months	The symptoms persist for at least several weeks
Complex PTSD?	Not specified	Not specified	Severe and persistent: (a) problems in affect regulation; (b) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and (c) difficulties in sustaining relationships and in feeling close to others

DSM and ICD criteria for trauma Table 1 (Morganstein et al, 2021:186)

Anthropological research[6] into PTSD has focused on the socioeconomic effects on cultures and societies. This is especially true within African countries in which traumatic experiences are widespread as a result of colonisation, war, domestic violence, and livelihood insecurities, among other factors (King, 2002; Shultz, et al, 2011; Steinert et al., 2015; Bromet, et al., 2016). In relation to trauma studies, these factors create an increase in risk exposure that can be translated into traumatic stress. Traumatic stress is an experience that is present in all cultures, but one cannot dismiss cultural influences, expressions, and understandings. According to Gilligan (2009) and Jones (2015) trauma, and resulting PTSD, are influenced by social and cultural constructs. D'Andradre (1995:217) notes that "cultural representation affects perception, memory and reasoning" and that cultural models and social norms play a significant role in how trauma is experienced and dealt with. Bova et al (2017: 117) argue that social norms are important in understanding how a society or culture responds to phenomena and according to van Rooyen and Nqweni (2012: 57) cultural languages of distress (verbal and non-verbal) exist to illustrate suffering. These authors highlight that when this language is expressed in a context different from its origin it loses its meaning and, in some cases, can produce a whole new meaning. Hinton and Good (2016:23) recognised the importance of culture in illness vocabularies and the impact this can have on ethno-psychology and ethno-physiology. Jones (2015: 8) further stresses that traumatic events are interpreted and acted upon based on cultural and societal understandings, and this plays a vital role in a person's recovery (Hinton and Good, 2016:24).

The African worldview is a collective one. There is an interconnectedness that exists as all things are linked through a hierarchy. Mkhize et al (2016: 2) explain that there is a hierarchy of beings, with God at the top and which extends down to the ancestors. There are concepts of vitality, principles of cosmic unity and finally, and very importantly, a communal view of personhood (McBride, 2003:3). Anthropological ideas situated around personhood is understood as the ways in which social persons are created in different social context (Chekero and Morreira, 2020:36). Authors like Conklin and Morgan (1996) argue that western ideas surrounding personhood is based on individuality while authors like Menkiti (1984) and Comaroff and Comaroff (2001) argue that personhood derives from community. Southern African, and other non-white populations understandings of personhood are often connected with the social, spiritual, and physical worlds.

[6] It is important to note that medical anthropologists who write about PTSD have clinical backgrounds and are either psychiatrists or medical doctors, for example Allan Young and Arthur Kleinman.

The ancestors play an important role in health and well-being through their protection of family members. When misfortune befalls someone, for example loss of employment, or ill health, the ancestors are called on to assist. In some instances, as Marsella et al (1996: 150) and McBride (2003: 4) point out, the ancestors may be believed to be responsible for misfortune if they feel that they have been forgotten or maligned in some way. Mental health problems are not understood in an individualistic manner, and Mkhize et al (2016: 3) point out that successful treatment within an African context must be holistic and draw the ancestors, and any other culturally important facets, into the experience. Dinan et al (2004:738) explored the pervasive nature of violence in South African communities and the relation to PTSD, particularly in rural areas, where violence is seen as the norm rather than the exception. South Africa has a history of traumatic exposure and consists of an environment whereby trauma-inducing events thrive. Due to South Africa's political and violent past, trauma exposure is common thus creating a culture of trauma acceptance and denialism of trauma existence. Current trauma epidemics that are present in the South African landscape include high rates of physical, criminal, domestic violence, Gender Based Violence (GBV), and poverty. Kaminer and Eagle (2010:25) have highlighted patterns of premeditated and mediated trauma exposure across the South African population. This has created a pattern of ongoing exposure which increases one's daily vulnerability due to exposure. This is partly due to the political history of the apartheid regime that has left many citizens traumatized. Since the abolishment of apartheid, in 1994, South Africa still has high rates of traumatic exposure. -South Africa is infamously known for extreme levels of physical and sexual violence and high crime rates;

> *"The latest figures cover July to September. During this time, … the country recorded 5,876 murders. Of these, 1,334 happened at the homes of the victims, while 2,424 people were killed in public places and 444 at taverns, nightclubs and shebeens. Fifteen people were murdered on farms, plots or smallholdings." (Gifford, 2021)*

Additionally, Gifford (2021) added that more than 10 000 people were violated and sexually assaulted and 2000 reported kidnappings[7]. These statistics echo the dangerous environment that South Africans are constantly exposed to. Buiten and Naidoo (2016) frame the violent epidemic of South Africa, more specifically GBV as a result of colonisation and apartheid. Historically, South African men have been denied power due to South Africa's history and thus now enforce their power over women (Buiten and Naidoo 2016:538). Shane and Ellsberg

[7] Most linked to robbery, hijackings, and rape cases

(2002, cited in Meyiwa et al., 2017) address that females are victims of violence solely based on their gender and violence is inflicted by members in their family and within their cultures. Within South Africa, gender roles are drastically enforced, and masculinity is associated with dominance and power resulting in superiority (Meyiwa et al., 2017:8615). There have been countless cries for intervention regarding the alarming rate of GBV in South Africa. Despite the numerous initiatives that have been put in place since the Apartheid, the GBV rate is still detrimentally high (Dlamini, 2020:587). In 2018 South Africans called a #TotalShutdown because of the alarming rates of GBV and newly elected President Cyril Ramaphosa had responded with a Presidential summit with the aim to eliminate GBV in the country (Dlamini, 2020:587). Little was achieved and GBV movements such as the #AmINext and #SAShutdown movements occurred in 2019 following the brutal murder of Uyinene Mrwetyana, a 19-year-old University of Cape Town student (Pagel, 2021:1). Meyiwa et al., (2017:8615) further voice that physical, emotional, and sexual violence against women and children are seen as cultural norms and considered acceptable.

One would need to recognise that these statistics only reflect reported instances of criminal activity and does not account for incidents that go unreported. These numbers reflect a high rate of violence, it is increasingly likely that the violent activity, and thus trauma exposure, is far higher than statistics depict.

Due to the high rates of violence and historical past, South Africa is the perfect melting pot to examine the consequences of trauma exposure and narratives. Kaminer and Eagle (2010:4) describe South Africa as a 'natural laboratory' to study the effects of trauma because of its historical and contemporary events. South Africa presents a unique perspective as it allows society to see that despite the political and social changes that have been implemented since the end of the Apartheid regime, the consequences and causes of traumatic events should not be seen in isolation as they directly impact on another.

Mvimbi (2007) and Robbins (2004) (cited in Jones, 2015:8) argue that when individuals who are not accustomed to biomedical Western labelling were interviewed about their involvement and exposure to traumatic events, they did not display the typical symptoms of PTSD according to the DSM V account. Anthropological studies have looked at different explanatory models and cultural understandings for reactions to traumatic events and these are often labelled Idioms of Distress and Culture Bound Syndromes (CBS). These studies include Rosaldo's (2004) *Grief and a Headhunter's Rage*, Poss and Jezewski's (2002) *The Role and Meaning of Susto in*

Mexican Americans and DelVechio Good and Good's (2010) *Amuk in Java*. Nichter (1981:191) explained that "in any given culture, a variety of ways exist to express distress" and expressions are based on expressive modes that tend to be created within cultural boundaries. These lead to particular types of interaction between people and are associated with values, norms, generative themes, and issues of health that are culturally pervasive (Nichter, 1990:191). When biomedical labelling and criteria are removed one can see commonalities across cultures. For example, *Susto*, a CBS from Latin America, can be seen as a form of PTSD with cultural-specific labelling. Razzouk et al. (2011:16) define *susto* as "chronic somatic suffering stemming from emotional trauma or from witnessing traumatic experiences lived by others, who had become 'frightened". Common symptoms of *susto* are depression, anxiety, loss of appetite, restlessness, and disturbed sleep patterns (Razzouk et al., 2011:16). This CBS aligns with experiences of PTSD in Western cultures. There are several types of idioms of distress, however, this study will only draw on the psychological and somatic compliant and acting out behaviours.

Courtois and Ford (2015:3) acknowledge that people who have complex traumatic pasts are in constant survival mode, both psychologically and biologically. According to evolutionary biology, "trauma was an expected part of our environment of evolutionary adaptation; hence, we have adaptive mechanisms for coping with the threat of danger and the aftermath of violence", triggering the fight or flight response, and releasing catecholamine[8] (Kirmayer et al.,2007: 42). McCorroy (2007:7) argued that in individuals who have experienced long-term trauma, one's biology changes and impacts behaviour (Rigg, 2015). This means that the trauma has become so difficult to manage that it has fundamentally created structural and functional changes in one's brain and body (McCorroy, 2007:7). Normal stressful situations can elicit this response if an individual has experienced ongoing trauma as the psyche is in constant survival mode. This, coupled with South Africa's history explains the normative nature that is situated around traumatic experiences. Individuals are often unaware that they are in survival mode and that they have been traumatised. This means that trauma narratives have become embedded in the South African experience resulting in undiagnosed cases of trauma and PTSD.

1.3 Aims and Objectives

This research is situated around trauma narratives within South Africa providing ethnographic evidence of the everyday consequences of trauma and finding the underlying structure behind

[8] commonly known as adrenaline

people's perception of the world around them. This illustrates that understandings of trauma are culturally specific and adds to the limited existing medical anthropological research.

Question: *How does culture affect people's behaviour and perceptions of trauma?*

Objectives:

- Explore cultural understandings of trauma
- Explore if individuals with exposure to trauma experience behavioural changes in non-threatening situations;
- Investigate the relationship between trauma, stress and fear;
- Investigate the effect on relationships as a result of trauma; and
- Explore how trauma is navigated from a cultural perspective.

1.4 Chapter Outlines

This dissertation consists of ten chapters. Chapter one presents an introduction to my study and outlines the South African context as well as the criteria necessary for diagnostic manuals for mental illness diagnoses. Chapter two presents a literature review illustrating the need for trauma studies to be conducted within a South African cultural lens. Chapter three explains to the reader the methods used to execute this study and presents the theoretical frameworks that were used to analyse the data. Chapter four introduces readers to the eleven key participants of my study framing the trauma narratives. Chapter five addresses issues of denialism that trauma victims experience as well as languages, verbal and nonverbal, to communicate distress through a culturally appropriate language. Chapter six explores the development of mental illness as a result of traumatic experience and exposure. Chapter seven delves into symptoms that arise with traumatic experiences and the consequences that accompany it exploring detachment, hypervigilance and avoidance. Chapter eight provides readers with the crucial role that memory, and in turn dissociation, have in trauma narratives. Chapter nine uses Goffman's (1959) *Presentation of Self in Everyday Life* to analyse trauma narratives in a South African context. It explores how trauma survivors present particular versions of themselves to audiences indicating a performative nature. Chapter 10 provides the conclusion of this dissertation.

Chapter 2: Literature Review

2.1 Culture and Trauma

Culture plays a vital role in health, especially in areas of mental health, and this is because culture provides perspective on what is seen and understood as health problems and potential treatment options. This has been extensively studied by Kleinman (1978) who stated that medical systems should be seen as cultural systems. This would be beneficial as medical terminology would be translatable across various cultures (Kleinman, 1978:85). Trauma and resultant PTSD studies became widely popular due to war-related occurrences. The 9/11 terrorist attacks, in the USA, shifted trauma and PTSD understandings from war-related occurrences to lived experiences that could happen daily. As a result of that, recognition of trauma became a worldwide conversation in academic circles. The recognition of PTSD and stress-related disorders into the ICD and the DSM was widely popular. However, anthropologists and cultural psychologists critiqued the use of western diagnostic tools to examine non-western cultural experiences (see Marsella, 1996; Markus and Kitayama, 1991: McBride, 2003; Breslau, 2004; Tseng, 2006).

It is important that I address the impact that knowledge and knowledge production has on validity of health. Western knowledge and Western knowledge production has been a model that influences health, wellbeing, and healing across the world (Mbembe, 2015). One may argue that this is due to colonialism and the power that they possess. Traditional knowledge and alternative methods of healing that deviate from western knowledge is often scrutinize and dismissed. Akena (2012:600) argues that Western knowledge is seen as a monolithic worldview that tends to give hegemony to the West. Herbert Sprout argues that knowledge is socially determined by the purpose of society (Akena, 2012:602). Considering this, one needs to recognise that due to colonisation, western ideologies and forms of healing have dominated the world. In relation to mental health, illness, and stress disorders, this has been measured and studied according to the Western experience (Tseng, 2006). These claims are supported by the fact that diagnostic manuals are based on western experiences. This is highlighted as the two diagnostic manuals used to measure mental health and illness is based on American and British context. Western modes of knowledge production and developing alternative modes of knowledge production that is relevant to particular societies and in turn, are context bound (Mbembe, 2015:18). This highlights the geopolitical forces that impact validity of health in non-western spaces. Due to production of knowledge being centred in western spaces, there are patterns that are highlighted in the forthcoming literature review that only western

experiences are considered valid and in turn impact access to care. It is vital that experiences and effects of health, specifically mental health, is understood from multifaceted lens to create models for non-western experiences.

Knowledge production, on issues surrounding health, are strongly Western influenced. The authority of the World Health Organisation and the United Nations are placed in high esteem and the knowledge of these institutes often overrides existing health knowledge in non-western countries (Brown, 2015: 111). The Lancet is a highly reputed journal for publishing health related topics and is also rooted in Western ideologies (Brown, 2015: 111). The COVID-19 pandemic made it very clear how these Western institutes have global power in the realm of health and healthcare, as the WHO was at the forefront of providing guidance for how to combat the virus and the institution of lockdowns throughout the world. South Africa was one of many non-western countries that followed the rules and regulations of the WHO, and this impacted the nation on a cultural level as well. Non-western knowledge is overlooked in favour of 'evidence-based' western knowledge because they meet a set of criteria, which are also determined by western standards (Brown, 2015: 112; Levine, 2012: 2). Whilst Western psychology enjoys dominance around the world, the acknowledgement of local and indigenous ways of knowing is pushed to the margins and often discredited. Local perspectives and ways of knowing struggle to gain footing and achieve legitimacy unless they align with Western paradigms and protocols around knowledge production (Levine, 2012: 2). Farquhar (2012: 153) argues for the importance of a relativistic approach to health and well-being. Farquhar (2012: 153) argues that the rigid positivism of biomedicine and the political economy of health must be challenged and non-western, local, ways of knowing be acknowledged and incorporated into treatment and understandings of health and well-being. Baloyi and Ramose (2016) and Mkhize et al (2016) echo these sentiments in calling for the acknowledgement and inclusion of African worldviews into psychology for better diagnosis and treatment options. Baloyi and Ramose (2016) express that western psychological paradigms are not always effective treatment options for indigenous South Africans and should not take precedence over indigenous knowledge.

This literature review, therefore, explores the development of trauma studies, including PTSD, and the importance of cultural models to understand trauma narratives in order to promote healing.

2.2 Wars

There have been various studies that have been conducted based on war zones as it has allowed future studies to develop on trauma and PTSD (see Port et al, 2001; Johnson and Thompson, 2008; Kienzler, 2008; Thabet, 2009). During the period of the 1980's, research focused mainly on survivors from war-related trauma; this included both war veterans and citizens and explored the emotional and social implications which created crippling effects that were consuming their everyday lives (Lund et al, 1984; Taft et al., 1999; Mollica, 2002; Koenen et al., 2007). This paved the way for soldiers returning from war, and citizens living in war zones were the first to be studied extensively to develop trauma frameworks. Johnson and Thompson (2008:37) reflect the impact that war-related trauma has on soldiers and citizens, and often resulting in human right violations. This speaks to the vast amount of trauma and in turn, trauma exposure that citizens have in war zones have experienced. Harvard University's research team and the World Federation for Mental Health deployed a psychiatric unit to the largest Cambodian refugee camp on the Thai-Cambodian border in 1998. From the 993 people interviewed, the team discovered that these refugees had experienced a collective of 15 000 traumatic events; which included incidents or rape, imprisonment, and torture (Mollica, 2002:54). The sponsors and organisers of the camp had provided no access to mental health services to these refugees. This has not changed in recent years and correlates with a lack of mental health services in multiple refugee camps worldwide (see Gong-Guy et al., 1991; McKell et al., 2017; van der Wiel et al., 2021). Mollica (2002:54) draws one's attention to the fact that the impact of trauma on mental health can be seen as invisible; "put simply, it is easier to count dead bodies and lost limbs than shattered minds" (Mollica, 2000:54). It could be argued that trauma survivors do not seek assistance because of a lack of diagnosis, accessible services, stigma, and cultural understanding of traumatic events.

Countries in Africa have experienced multiple wars and disasters that have exposed citizens to trauma (see Prah, 2004; Buhaug and Rod, 2006; Peters and Richards, 2007; Coulter et al., 2008). One of the most infamous tragedies in African history is the Rwandan genocide. Decades after peace was restored, the impact of PTSD is still present in the lives of Rwandan citizens. King (2002) focused on the trauma, healing, and rehabilitation of people in Rwanda, post-genocide, illustrating the lifelong presence that PTSD has, as the individual accounts for the sensory memory of seeing, smelling, and hearing occurrences of death. Makumana (2004, cited in Edwards, 2005:126) acknowledges the experiences of rape survivors of the Rwandan genocide and their feeling of numbness and sensations of being "only half alive" (Edwards,

2005:126). Kessler et al. (2017:2) state that only a small percentage of people develop PTSD despite the vast majority of people exposed to traumatic events, like in South Africa and this, in turn, raises questions about a person's vulnerability towards PTSD.

2.3 Apartheid and TRC

The International Federation of Red Cross and Red Crescent Societies (1998, cited in Johnson and Thompson, 2008:37) have recorded human rights violations in over 150 countries. Most notably, the Apartheid regime in South Africa resulted in countless human rights violations. As seen in Chapter 1, the apartheid regime inflicted horrendous violence on citizens who resisted the apartheid regime and resulted in death, torture, intimidation, and various other acts of violence.

Cooppan (2012:47) states that violence is prominent to trauma narratives because of the apartheid regime. She explains that there the traumatic past created a shattering effect on individual's psyche, their group and self-identity and every experience that South Africans face has some form of trauma embedded in their lived experiences. The TRC aimed to document the violations that occurred during the apartheid regime. According to TRC reports (1998, cited in Ross, 2003: 328) by December 1997 21,298 statements, concerning 37,672 violations, had been reported. This illustrates a portion of violent acts that were endured during the regime as some may have not been reported. Reynolds (2013) and Byrne (2004) provide ethnographic evidence of acts of violence that were inflicted during the apartheid regime. As mentioned in chapter 1, the aim of the TRC was to give a voice to the previously marginalised voiceless, to address acts of violence that they had experienced during the Apartheid era and allowed for preparators to account for their actions in return for amnesty. This, however, was not the case. Reynold's (2013) book gives voices to fourteen men, who were previously voiceless, to describe their experiences. For example, Amos, one of Reynolds' (2013) key informants, noted that he was brutally tortured. Reynolds (2013:73) field notes document his narrative,

> *"you know that machine used in building- a jackhammer to drill concrete? This one had sharp iron points. They took off my trousers and they inserted the jackhammer into my anus. (He stops and drinks water.) Sorry. I apologise for the expression of my emotion. He switched on this [the machine and placed a] plastic tube over my face. I was screaming but I could not be heard. It seemed as if my intestines were coming out. I felt as though I was being disembowelled."*

Amos explains that their perpetrators were invited to the TRC commission hearings to present their cases and confess to their violent crimes but “never do” (Reynolds, 2013:73). Byrne’s (2004:248) informants highlighted their hopes of the TRC commissions describing that one of their hopes of the TRC hearings would be that perpetrators would come forward and address their acts of violence, in exchange for amnesty. Informants were hopeful that they would receive some insight on reasonings as to why such gruesome acts were inflicted upon them. They, however, did not but perpetrators still received amnesty despite the clear evidence that they were not telling the whole truth. This was evident as various perpetrators were contradicting one another (Byrne, 2004:248). The ethnographic research conducted by both Reynolds (2013) and Byrne (2004) illustrate that the goals set out by the TRC were not achieved and resultantly has left survivors infuriated by the lack of accountability by perpetrators and the government.

With this, one can understand the embedded nature of trauma that is experienced in South African culture and reiterates Cooppan (2012:47) notion that trauma is ingrained in the South African experience, despite the abolishment of apartheid. This shows that cultural models need to be implanted in order to deal with traumatic experiences in the contemporary world and specifically South Africa.

2.4 Cultural Understandings and Expressions of Trauma

Allan Young (1995:101-102) states, "[PTSD] can be real in a particular place and time, and not yet be true for all places and times". PTSD was conceptualised through a Western lens that was situated around war veterans. This understanding of PTSD is often individualistic and focuses on the trauma victim. In non-Western societies, however, trauma often isn't depicted that way; therefore, it usually does not fit a non-western culture.

Political violence is a common experience across the African continent resulting in traumatic experiences. Added to this is the everyday exposure to trauma, such as; sexual, domestic, physical violence, and child abuse. Exposure to chronic trauma can develop into PTSD, but it is often not diagnosed in many settings due to poor or lack of access to mental health care resources and differences in cultural understandings. In some cultures, it is taboo to seek the help of a mental health practitioner. There are often culturally specific ways of understanding and dealing with phenomena that cause mental stress. In some societies, for example the Azande, if a person experiences a strong mental stressor it may be believed to be a result of an act of witchcraft (Peters-Golden, 2006: 14). As such, this can only be confirmed through the use of an oracle and treated through a diviner. Campbell et al (2017:2) illustrate that amongst

the amaXhosa, in South Africa, mental illness is believed to be a result of bewitchment brought on by jealousy. This may or may not be related to ancestors being upset with a person, or family, and resultantly withdrawing their protection (Campbell et al, 2017: 3).

A similar argument can be made in other cultures where mental illness may be seen as a sign of lack of or poor faith and intervention would be on a religious level (Reid et al., 2009; Caplan, 2019). In non-western cultures there is often a lack of acknowledgement that mental illness exists and even believe that if your basic needs, (such as food and shelter) are met, then there is no reason to be sad or stressed. Alternatively some traumatic events may be seen as normal and as such the trauma is denied, and has been a generational cycle; for example, corporal punishment (Mayisela, 2020).

As stated, Western and non-Western experiences and understandings of trauma are different. Fernando (2008, cited in Alfred, 2016: 6) emphasises this in her work with Sri Lankans. In the year 2004, around Christmas, a tsunami hit the coasts of Sri Lanka, Thailand and India. She explained that when Sri Lankans spoke of traumatic experiences, that often develop into PTSD, key symptoms such as anxiety and depression were not present in their explanations but rather they focused on the social damage it caused as citizens were alienated from loved ones. According to Alford (2016:6) in order to understand the intensity of trauma and the impact that it has had on an individual, social relationships need to be evaluated. Western understandings of PTSD illustrate that individuals would fail in their social roles due to depression, isolation, withdrawal. A cultural relative understanding is necessary in this context in order to facilitate methods of healing. Mollica (2000:54) explains that particular traumatic experiences are more prevalent in some comorbid diseases than others, such as depression and PTSD. Trauma survivors are diagnosed with mental illness based on their traumatic experiences. This involves accounting of their experiences for a diagnosis; and while experiences differ from person to person, it is noted that open-ended questions are more challenging to answer depending on the intensity of the traumatic event such as rape and physical violence. Mollica (2000:55) explains that refugee psychiatric patients from Indochina, the mainland of Southeast Asia, found it easier to account for their experiences through the widely popular Hopkins Symptom Checklist developed by Parloff, Kelman, and Frank in 1954. Questions are situated around energy levels, difficulty sleeping and suicidal thoughts, which illustrates the suffering experienced by individuals who experience trauma. It is difficult to explain what they had experienced expressively, but acknowledgement of symptomology allows for open dialogue. Mollica (2000:55) illustrates that respondents could explain their symptoms without causing too much

emotional distress. This creates an understanding that diagnoses differ based on how trauma is expressed in that region. It is essential to acknowledge that shifting the way questions were asked allowed respondents to engage with possible diagnoses without Western labelling, allowing for trauma expressions.

Anderson et al (2003) remind us that culture provides meaning to one's life through the social, economic, religious, and cognitive structures. With this being said, it is important to recognise the role that culture has on sickness and diagnostic manuals in the area of mental health. Cultural psychiatrists and medical anthropologists have always been interested in the ways in which culture infiltrates and encompasses medical diagnoses, particularly in the area of mental health.

The DSM and the ICD are psychological diagnostic tools that are heavily influenced by western thought, as addressed in chapter 1. As illustrated in chapter 1, authors like Mcbride (2003) and Marsella et al (1996) problematise the western influence of the DSM. With the release of the DSM IV, it has included a cultural glossary and cultural factors to consider when assessing patients. Culture-specific sickness has evolved in its classification. Tseng (2006) notes the evolution from its first introduction to the Western world as 'peculiar psychiatric disorders' but due to the problematic Eurocentric nature of the name, it was reclassified as Culture bound syndromes (CBS) (Yap, 1967; cited in Tseng, 2006). A CBS is seen as a collection of signs and symptoms of a particular disease limited to several cultures by their behavioural and social factors (Prince, 1985:201). CBS in non-Western societies have been studied extensively but have often been seen as fixed illnesses through time and did not recognise the development and change that existed as a result of modernisation and globalisation (Kaiser and Weaver, 2019:590). Anorexia Nervosa, for example, is seen as a CBS of the West, but it is present outside Western countries. This is argued to be because Western culture has dominated the world, and in turn, the notion of thinness has progressed to other countries (Lee, 1985; Sepulveda and Calado, 2012). Hughes (1998) discusses CBS's problematic nature and their being exoticized and being limited to a specific culture. Nitcher's (1981) idioms of distress aimed to remove this exoticisation and provide some sense of fluidity as several of these illnesses are related to distress. CBS's were introduced into the DSM IV and described as, "locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM IV diagnostic category" (APA, 2000:898). The inclusion of the CBS created a form of recognition that the DSM needed to have cultural diversity and not only

depict a western narrative (Thornton, 2017:52). This created a space that encouraged cultural diversity within a prominent diagnostic tool. The DSM IV-TR included 25 CBS (APA, 2000). The recognition of CBS in the DSM again, speaks to the geopolitics of knowledge production. CBS are now recognised by the world because it is recognised by the West. This is problematic because these CBS have existed long before the DSM gave them validity, this highlights the power that DSM has.

It is necessary here to acknowledge the importance of cultural context because no one diagnostic manual can speak for the universal experience, despite the DSM and ICD being depicted as such.

The concept of idioms of distress has gained significant popularity amongst practitioners, academics, and mental health care providers. Nichter (1981:379) defined Idioms of Distress as "in any given culture, various ways exist to express distress". In 1977, Nichter (1981), researched the South Kanarese Havik Brahmin women of South India. Havik Brahmin culture is highly patriarchal. He explored the five ways these women expressed their distress due to cultural norms that would typically prevent them from doing so. Due to the extremely patriarchal society, women were unable to verbally express their distress which resulted them in doing so within cultural boundaries thus using nonverbal cues and behaviour (Nichter, 1981: 379). Nichter (1981:382) addressed that expressive modes were conducted through; firstly, commensality, weight loss fasting, or poison; secondly, purity in relation to obsession and ambivalence; thirdly, illness; fourthly, external forces of disorder such as the evil eye and spirit possession; and lastly devotion. These various expressive modes convey to others that there is distress.

In 1985, cultural psychiatrist RC Simons and anthropologist CC Hughes recommended grouping CBS's based on cultural factors (Tseng, 2006:557). In 2001 Tseng (2001) recommended subgrouping based on how culture affects psychopathology. A common issue that arose with CBS is that it was culture-specific and could not be universal. Thus resulting in the DSM-V including a glossary of Cultural Concepts of Distress (APA, 2013:834). Cultural concepts of distress include cultural syndromes, cultural idioms of distress, and cultural explanations of illness. The cultural concepts of distress which are drawn from different cultures, include nine common cultural syndromes that may serve as idioms of distress and also offer cultural explanations. The nine are *khyal attacks/cap, ataque de nervios* (attack of the nerves*), dhat* (semen loss), *kufungisisa* (thinking too much), *malady moun* (humanly caused illness)*, nervios* (nerves), *shenjing shuairuo* (weakness of the nervous system), *susto* (fright), and *taijin kyofusho* (interpersonal fear disorder). Symptomatology for trauma-related mental

illnesses has different explanations. Chiovenda et al. (2020:606) explored cases for the cultural shaping of emotions and emotional regulation, which often correlates with trauma-related symptomology. Chiovenda et al. (2020:606) address that that cultural understanding and societal expectations tend to guide the ways in which people interpret emotional expressions and give meaning to those expressions. They express that the Achnese people of Indonesia often explain distress is through the statement *jantung berdebar debar,* which translates to "my heart pounds" (Chiovenda et al., 2020:606). This is a more culturally appropriate way of communicating their symptoms compared to stating that there are nervous or anxious.

There has been a significant progression in trauma and trauma-related illness over the years between the DSM-III[9] and the DSM-V[10]. It became evident that cultural models need significant consideration when assessing trauma victims. The updated versions of the DSM allow more inclusivity, which ranges from criteria to cultural explanations and inclusions. Most notably, the "thinking too much" idiom has been present across cultures around the world such as Ghana (Avotri, 1997), Haiti (Kaiser et al., 2014) Cambodia (Hinton et al., 2015) and Zimbabwe (Patel et al., 1995). The "thinking too much" idiom is particularly interesting as it can present as various western syndromes and disorders depending on the way it is articulated; such as schizophrenia, anxiety disorders, PTSD, and depression. This means that Western trained practitioners, like practitioners in South Africa, may misunderstand the means of communication which can typically lead to misdiagnosis. This is a common occurrence within African countries and more specifically South Africa.

With this, it is important that one recognise the concept of employing an African perspective to psychological thinking within South Africa. African's and the West have different concepts of reality. The Western concept of health often focuses on the individual and the body while the African concept draws on the social, physical, and spiritual realm (Goduka, 2012:134). This attempts to show the inadequacies with the Western explanatory model as it does not account for African experiences. In Africa, the community plays a vital role in the lives of people and it is important in understanding health, and particularly mental health (Baloyi and Ramose 2016:19).

Western psychology and African psychology may view the same set of symptoms as a result of the different causes. One may argue that this is because African's see multiple realms of

[9] The DSM-III was published in 1980

[10] The DSM-V was published in 2013

reality which include humans, the spirit, and the Divine (Nobles et al, 2016:39). Nobles et al (2016:39), state that African reality views three interrelated categorized worlds which consist of the macro-cosmos, meso-cosmos and the microcosmos. The macro-cosmo consists of the highest entity which is God (van Dyk, 2001:60). The meso-cosmos consist of spirits, witches and sorcerers (van Dyk, 2001:61). The microcosmos consists of everyday practical, social and collective life (van Dyk, 2001:62).

Psychology began in the Western world and is based on Western cultural contexts (Allwood and Barry, 2006:243). Western psychology is dominant throughout the world and centres on "biological, cognitive, emotional, behavioural and interactive aspect of the human condition from a rational, logical and intellectual perspective" (Allwood and Barry: 2006:243). One may argue that this psychology is designed for Western lifestyles and cultures. According to Baloyi and Ramose (2016:13-14), Western psychology cannot entirely represent the African people because of the different ways that Africans and people of the West view the world.

The practice of psychology in South Africa is very Eurocentric and has, arguably, disregarded the socio-cultural and religious beliefs of Africans. Many Africans experience issues with their mental health and often seek counselling but one may argue that the Western approach is not appropriate and excludes African ideologies and beliefs. Buhrman (1987:262) argues for the importance of examining sociocultural and religious beliefs in the counselling process, as dismissing it or misunderstanding it can result in anti-healing. Western psychology does not consider the spiritual being in the analysis. An example which illustrates this is that of Noluthando, a 28-year-old single Sangoma and a Western-trained clinical psychologist (Nobles et al, 2016:48-49).

Noluthando lived with her aunt in Pretoria. They were in constant conflict because of Noluthando's relationship with her deceased father. Noluthando's father, who left Noluthando's mother for another woman when she was 2 years old, was trying to mend their relationship but Noluthando refused to see him. Noluthando has had unsuccessful romantic relationships and her aunt attributes it to her father's "unfinished business with her" (Nobles et al, 2016:49). Noluthando states that her three previous relationships ended because her ancestors were not happy with her choice of boyfriends. This has impacted her Doctor of Philosophy (PhD) work as she is having difficulty sleeping and paying attention (Nobles et al, 2016:49). According to Nobles et al (2016:49), Noluthando is expected to perform certain rituals and abstain from sex which she argues is the reason for her frustration and the demise

of her relationships. Noluthando had sought help from two white psychologists but found them unaccommodating because they were unable to understand her cultural and spiritual beliefs (Nobles et al, 2016: 50). They associated her experiences with factors that are a direct cause in her life, ignoring the external cultural factors such as ancestors. She then sought help from a black male psychologist who was able to relate to her spiritual and cultural beliefs. This black male psychologist recognized her beliefs and that her problems are due to her father's unhappy spirit (Nobles et al, 2016: 50). They have been able to work towards appropriate treatment options. This example highlights the dire need for cultural factors to be consider when approaching methods of healing.

Symptoms are viewed differently according to cultural context. One may argue that what can be seen as a psychotic disorder, such as schizophrenia, can be viewed differently from an African perspective. These same set of symptoms, according to the amaZulu perspective, for example, can be seen as *"the calling*" to become a traditional healer. A Western lens would view symptoms in line with a psychotic disorder, (mental disorder), while these symptoms from an African perspective, is rather seen as a result of conflict and broken social relationships which is impacting one's life (Sorsdahl et al, 2010:284). The awareness of worldviews and cultural factors promote accurate diagnosis and healing. Cheetham (1980, cited in Matoane, 2012:11) stated that 60% of black South Africans are misdiagnosed with schizophrenia due to their mental health care practitioner not being aware of cultural factors. Nwoye (2002, cited in Matoane, 2012:10) presented a cultural model for practitioners to deal with the loss of a loved one within an African context in relation to mourning. With this, one can see the vital importance of non-western understandings in order to promote healing and in turn deal with instances of trauma.

McBride (2003) explored the relationship between political, historical, social, and cultural factors with the resultant disruptions and distress faced by rural amaZulu people in KwaZulu-Natal. She argues that the Zulu worldview was centred around 'paths of distress' which are laden with traumatic meaning. The concept of 'paths of distress', argues McBride (2003: 3), aid in the understanding and explanation of how an event/s may trigger the creation of a path, which is important in relation to a person or people's history and/ or culture. Paths of distress connect events and experiences of trauma and suffering of which distress and disruption follow. In South Africa, traumatic experiences have historically been a collective experience. McBride (2003: 13) unpacks this by explaining that during political wars, (pre, colonial, and apartheid) the entire community was affected, not just a single person or a single family. Trauma

narratives were collective, but at the same time they were not adequately dealt with due to the disruption of social and cultural beliefs, for example the Witchcraft Suppression Act of 1895 in the Cape Colony and then the Witchcraft Suppression Act of 1957 applied throughout South Africa by the apartheid government. This effectively removed the ability of numerous ethnic groups to deal with traumatic experiences in culturally appropriate ways. Social networks were disrupted, cultural avenues of healing criminalised, and so McBride (2003: 14) argues that this may have led to the desensitised manner in which South Africans relate to crime and violence, and subsequently trauma exposures.

These collective tragedies are still being experienced today because of political mismanagement. From October 2015 to June 2016, South Africa faced one of the worst scandals since apartheid; 1711 psychiatric patients were transferred from various mental health care facilities that were previously managed by *Life Esidimeni* and put into the care of various non-governmental organisations (NGO's) in the Gauteng province (Durojaye and Agaba, 2018:161). Durojaye and Agaba (2018) elaborated that the NGO facilities were not prepared adequately to deal with the extreme inflow of patients. This has resulted in patients' suffering and in some cases death. It is estimated that 144 patients had died, 1418 had suffered various acts of trauma; from torture to starvation, and lastly, there are still 44 patients who are unaccounted for (Durojaye and Agaba, 2018; Hodal and Hammond, 2018; Janse van Rensburg et al., 2019). Hodal and Hammond (2018) addressed the tragedy and spoke with a deceased victim's sisters.

> “In September 2016, Phumzile Motshegwa received a call from an unknown number. The woman on the end of the line said Motshegwa's brother, Solly, was dead. His body was at a funeral parlour in Atteridgeville, a township in South Africa. Did she want to go and collect him? The address she gave was a disused butcher's shop. When Motshegwa arrived, a man hosing down blood-stained floors handed her a pair of rubber gloves.
>
> > "Do you know your brother?" he asked.
> > "Yes," she answered.
> > "Choose your brother, then."”

The mismanagement speaks to the normalised traumatic nature that is present in South Africa. Phumzile’s experience is not unique and many families are still searching for their lost loved ones who were placed in the government’s care. It could be argued that this occurred due to

the poor are often left forgotten and this could be a rippling effect of apartheid. As mentioned above, black poor South Africans were extensively marginalised and through the Homeland Areas acts, were displaced. The constant moving of patients around mirrors actions that occurred during the apartheid regime. This then can be understood as a normative traumatic experience that South Africans have become accustomed to.

Kirmayer et al. (2007:31) analyse trauma as a multifaceted event; which tends to affect ones social life as well as impact on their psychological and biological state. Dr Nadine Burke Harris is famously known for involving adverse childhood experiences and stress. In her TED[11] Talk[12], Harris (2015) puts forth the notion that the impact that childhood trauma has can alter a person's life and, in turn, their lifespan which the way in which they deal with conflict and stress. Often trauma, and PTSD, are seen as either mental health problems or social problems. Edwards (2005) adds to this and further argues that PTSD is a public health concern. As a paediatric doctor, Harris (2015) explains that she often received referrals for child patients that had the symptoms of Attention Deficit Hyperactivity Disorder (ADHD), however when she did the intake of history and a physical, she noticed that these children did not have ADHD but were exposed to immense trauma. Thus, ADHD, or rather, the display of ADHD like symptoms were a response to trauma exposure. ADHD is commonly attributed with the act of dissociating, however, dissociation (as it will be discussed further on) is a response to trauma exposure. Studies found that children who were exposed to, psychological, physical and emotional abuse, physical and emotional neglect, and exposure to caregiver's mental illness can result in substance dependence (see VanDeMark et al., 2005; Min et al., 2007; Mauritz et al., 2013; Ekinci and Kandemir, 2015). Edwards (2005:212) explains that behavioural, cognitive and emotional avoidance mechanisms exist to elevate the trauma's pain. Edwards (2005:213) elaborates on this and states that behavioural avoidance can be seen as avoiding the destination or situation where the event occurred, including any sensory memory.

Jones (2015) examined trauma symptoms within dreams, play, and culture's social construction and explains that a dream for someone who has experienced a traumatic event is a way to reflect and express their trauma through different ways, including metaphors and symbols. He contextualised that dreams present through the spiritual realm resonates and populations across ethnicities (Jones, 2015:4). A study conducted by Helminnen and Punamaki (2008) (cited in

[11] Technology Entertainment Design

[12] How Childhood Trauma Affects Health Across a Lifetime

Jones, 2015:6) focused on how children living in Gaza, Palestine, were able to communicate their feelings and comprehension of the trauma through dreams. These dreams served as indicators as to how these children were comprehending the trauma based on visual imagery and emotions felt (Jones, 2015:6). Similarly, Jones (2015:11) details the experience of Abui, a 10-year-old boy that has fled Sierra Leone, and how to play therapy detailed the experiences that Abui encountered in his village. This presented healthcare practitioners with the information necessary in order to help Abui deal with his traumatic expressions. This contextualised that the way in which individuals express distress do not have to align with western diagnostic tools and cultural and social understandings are important to deal with traumatic experiences.

The anthropological literature is extremely limited in understanding South African responses to trauma. This is because western understandings of trauma is often individualistic while South African experiences are more communal and related to personhood. Experiences that derive from non-white populations often impact family and the social world of individuals, as will be explored in Chapter 2.

Literature that is available is often situated in line with DSM and ICD understandings, thus do not accurately represent how South African populations deal with trauma because of its normalised nature. Kim et al (2019) present that cancer patients meet their diagnosis with resilience. This speaks to the problematised nature that South Africans are dealing with difficult and extremely stressful situations with resilience as a coping mechanism. Gibson (2010) contextualised that South African war veterans of the South African Border War[13] of 1974 and 1988 cope with war trauma, and trauma memories with "mental toughness." Gibson (2010:619) addressed that these veterans expressed that they struggled with mental distress as a result of the war but any expression of emotions and struggles did not align with notions of masculinities and were aligned with weakness.

Kim's (2020) dissertation work focuses on studying intergenerational trauma across three generations which began in the early 1990s with pregnant (South African) women. His longitudinal study focuses on stress and the impact of intergenerational trauma since the end of the apartheid era, focusing on stress among pregnant women. A participant explained that the neighbourhood violence and societal pressures added stress to her pregnancy as she feared weight gain, poverty, and the societal stigma of being a single mother. Kim (2020:4) explains

[13] Known as the Bush War and the Namibian War of Independence

that there are not adequate assessment tools to treat these women for stress-related problems resulting in intergenerational trauma, thus the study provides ethnographic information that could improve public health. Although the anthropological studies are limited, it is important to analyse the everyday lived experiences in order to eradicate the notion that trauma is the norm in South Africa and find adequate, culturally appropriate ways to deal with trauma related problems.

This study, therefore, aims to provide ethnographic information that could aid in public health exploring understandings from anthropological cultural perspectives. Currently, the majority of literature available is based in the discipline of psychology thus it is filling an anthropological gap.

Chapter 3: Methods

The previous chapter explored relevant literature and highlights the importance of anthropological trauma studies to be conducted from a non-political lens; i.e. from a socio-cultural lens. It aims to emphasize the dire need to explore how culture impacts individuals behaviour and perception in relation to traumatic experiences. This chapter delves into the research methods that were used to shape this study, providing context to the research site, design, and ethical and moral considerations that guided the research process. It, additionally, provides a reflective element that allows the reader to understand the processes that took place and the necessity for the methods provided.

This mixed-method exploratory study investigated the impact that culture has on behaviour and perceptions concerning traumatic experiences across one's life course. My unit of study examines people who identified as having traumatic experiences and who are currently residing in South Africa. I did not focus on a specific type of trauma, rather I examined trauma narratives through one's life course. This decision was made because overall trauma experiences can have an impact on behaviour and perception regardless of the type of trauma experienced.

This was a multi-sited study, which was coined famously by anthropologist George Marcus (1995). A multi-sited ethnographic study creates an environment that encourages a shift in traditional single-site anthropological research. This instead allows thick rich ethnographic data with a "circulation of cultural meanings, objects and identities in diffuse time-space" (Marcus, 1995: 96). This research study was conducted across multiple sites across South Africa; both face to face and through online platforms[14] and support groups. Participants were drawn from four South African provinces, namely Eastern Cape, Western Cape, Gauteng and KwaZulu Natal while survey respondents were drawn from all provinces in South Africa using online platforms to distribute the survey. A multi-sited study, like this, explores different understandings from separate communities, who are sometimes left voiceless in academic literature, such as online communities. The decision was made not to conduct research within an individual site as there are various trauma narratives, from different cultures, that need to be addressed. This, coupled with the Covid 19 pandemic, steered me in the direction of making use of multiple platforms to gather data across a wide sample size. South Africa is an extremely diverse country that consists of several cultures, ethnicities, and religions. It is important to acknowledge that in some cultures, there are particular behaviours and experiences that are

[14] Zoom and Whatsapp video calls

present that have been normalised, where they would be considered traumatic in other cultures. As a result of these behaviours being normalised, they are often dismissed and not seen as traumatic. Such cultural mindsets, which normalise traumatic experiences, may create a sense of invalidity of one's experiences. Here it is important to highlight that the shortcomings of a general or blanket approach to healing, dismissing the cultural context, creates barriers to mental health care and treatment.

3.1 Methods and Design

Data collection occurred over a period of eight months from March to October 2021 for both qualitative and quantitative data. Throughout this dissertation, participants who were interviewed will be referred to as participants and questionnaire informants will be referred to as respondents.

This study used stratified and snowball sampling which aided in a cross-cultural comparison. The sample was stratified by age, ethnicity, and culture. Snowball sampling involves potential research participants identifying and recommending potential participants for one's study (Acharya et al., 2013:333). This sampling strategy was useful as my target population is a high risk and difficult to access population. Snowball sampling was used as it provided access to a population that is considered hidden due to the sensitive nature that my research involves. This sampling strategy was useful as it provided me with a pool of diverse participants with various trauma narratives. Additionally, I had opted to use stratified sampling which involves the organisation of one's sample groups into 'strata,' which are subcategories that share common or similar characteristics (Acharya et al., 2013:331). The reason for using this sampling strategy is that the various ethnicities, age groups and cultures in South Africa have different understandings of what can and should be considered traumatic. As such, stratification was necessary in order to conduct a cross-cultural comparison. This method allowed for a diverse representation of the South African population.

This study had inclusion and exclusion criteria. For an individual to qualify to be interviewed for this study, they must have been diagnosed or identified as having a traumatic experience that impacts their overall behaviour and in turn perception; and at the time of data collection, they must have been working with a qualified mental health care provider and be over the age of 18. Exclusion criteria was necessary in order to protect potential participants from potential harm and minimise risks. The exclusion criteria excluded potential participants who displayed signs of suicide. Additionally, potential participants who had abused substances, been hospitalized for psychiatric care, and attempted suicide one year prior to the study did not

qualify. Research has indicated that academics, health care providers, and first responders are exposed to vicarious trauma (also known as secondary trauma) through working with trauma victims. I acknowledged the potential for harm to myself that may be experienced through the data collection and analysis processes. Considering this, I had opted to ensure I was working with a professional mental healthcare provider to protect my well-being, both through the data collection and analysis process.

Quantitative and qualitative data collection occurred via web-based and face-to-face interactions. Quantitative data was collected through the dissemination of an online questionnaire. This benefited my research as the questionnaire was widespread, cost-effective and research hidden populations through anonymous platforms. This research used Goodman et al's (1998) The Stressful Life Events Screening Questionnaire (SLESQ) to assess an individual's exposure to traumatic events. It is well known that the causes and consequences of traumatic events cannot be seen in isolation. With the exposure to long-term trauma, and the presence of constant trauma in a country like South Africa, a person may be constantly exposed to traumatic events without realizing it. A revised SLESQ is a self-assessment tool used to document an individual's exposure to traumatic events. From this, the type of trauma experienced, and the number of traumas experienced was identified and analysed according to their symptoms, experiences, and exposure. The benefit of this questionnaire is that it created a space which probed respondents to reflect across their life course. Interestingly, as these questionnaires were distributed both online and face to face, face-to-face respondents expressed that they were not aware of the level of trauma exposure that they had succumbed to across their life course. The beginning of the questionnaire provided respondents with a scale documenting the number of traumatic events that the respondent believes that they were exposed to. This, coupled with the proceeding questions allowed for the illustration of the frequency of traumatic exposure amongst South Africans. This also allowed me to gauge the respondent's understanding of their traumatic experiences. Participants were encouraged to fill out the questionnaire and they reflected that the questionnaire allowed them to understand their trauma narratives more holistically as they did not realize the intensity of their lived experiences. This form of data collection can be seen as a therapeutic measure for respondents and participants alike.

The questionnaire information was also useful to glean demographic and simple information from a wide range of participants. This allowed me to analyse data based on; race, culture and age, what was considered traumatic, and what was seen as a cultural norm. The questionnaire

was intended to be distributed on social media support groups[15] and forums[16] specifically for people with post-traumatic stress disorder to obtain a diverse pool of participants. Once the data collection process began an obstacle I faced was that admins on social media support groups were unhappy with my presence when I had disclosed the nature of my presence in the groups and my study. This was because these support groups were seen as a safe space and administrators did not want members to *"feel like they are being watched,"* as they were sharing personal information regarding their lives. This shifted the nature of the online support groups observed and directed me to public groups where members were aware and accepting of the nature of the study. I observed their posts and responses to posts which supported findings from my primary data sources; semi-structured interviews and the SLESQ. I had initially aimed to gather a minimum of 100 quantitative surveys, however, due to research obstacles, I had only managed to gather 72 survey responses. This did not hinder the research in any way as the data collected was rich and provided crucial information to the overall research objectives despite the initial slow response rate.

The quantitative SLESQ questionnaire was distributed both online on social media platforms, with trigger warnings, and face to face. On average, the questionnaire took 15-20 minutes to complete and allowed respondents to contact the researcher by email if they had any questions or would have liked to participate in an interview. The questionnaire was anonymous and was stratified by age, gender, and ethnicity. This allowed for a holistic understanding of different generational understandings of trauma and the validity of types of traumatic experiences by cultures. Additionally, it highlighted common trends of types of stressful events and traumatic exposure to certain groups. It is important to acknowledge that trauma experience does not discriminate based on gender, age, and ethnicity but some groups have a higher risk of exposure to others which makes them more vulnerable.

It could be argued that the reasoning behind the lack of responses on the questionnaire, despite the anonymity and online nature, was based on South African's lack of awareness situated around the nature of their traumatic experiences. The data gathered spoke volumes that due to the cultural norm of trauma in South Africa, people did not identify as trauma survivors. A key feature that had inspired this study was in relation to conversations with peers, colleagues, and loved one's around daily lived experiences. There were an alarming number of stories that had

[15] PTSD support group South Africa, Living with PTSD, Trauma and PTSD community
[16] Community care

emerged around the normalcy around traumatic experiences and the conscious and unconscious denialism that had been ingrained in cultures.

The study used both semi-structured and unstructured phenomenological interviews. Adams (2015:366) describes semi-structured interviews as an interview technique that involves the collaboration of open and closed-ended questions accompanied with how and why. Semi-structured interviews are the most frequent type of interviews used in qualitative research and are a great research method when conducting more than one interview (Neumann, 2014: 245; Bernard, 2006: 210). Phenomenological interviews can be described as an interview technique that involves participants engaging with their memory and focusing on aspects throughout their life (Granot et al., 2012:548.) Granot et al., (2012:548-549) highlight the importance this method has in drawing attention to power and politics situated around the social and organizational context of their life stories. The key aim of using these research methods was to allow for in-depth conversations, allowing me to get a comprehensive understanding of people's experiences. The recruitment of participants was challenging as potential participants did not meet the original criteria for the study, resulting in research delays. The sample group was shifted from PTSD to trauma narratives which widened the research sample. There was a shift in the initial research question due to participants not being diagnosed as having PTSD despite meeting the criteria but not having the resources to access diagnoses. This presented a new angle to the research as it shifted the original research plan and sample group. The research then moved to focus on participants with traumatic experiences that, they believe, impacts their everyday interactions. This did not change the central hypothesis of the study but instead highlighted the structural inequalities that are present in cultural groupings. I aimed to gather a minimum of 12 and a maximum of 20 in-depth qualitative interviews. The data collection began later than initially planned due to ethical clearance delays. This delayed the initial process but by June rich ethnographic data was in the process of being collected. I was able to work with 11 interview participants. The data I collected was richer than I originally expected and therefore do not believe that my research was compromised by the limited number of participants in the research sample.

The semi-structured interviews that I conducted with my participants was carried out in a series of conversations. The number of times that a participant was interviewed was dependent on the participant and the amount of information that needed to be uncovered. The series of interviews have been conducted both face to face and online, due to the Covid 19 pandemic. I made the decision to cap interviews at one hour in order to prevent fatigue and overstimulation for both

participant and researcher. My participants were discussing multiple types of trauma exposure and their lived experiences through these interviews, and this can unintentionally create triggers[17] and increase vulnerability in everyday life. The decision to cap interviews allowed participants to deal with fewer and specific trauma narratives at a time and reduced the risk of unintentional triggers. Once an interview reached its cap, I requested a second and, in some cases, the third interview with participants and they were informed of the area of trauma we would be delving into. Additionally, this allowed me to ensure that the necessary resources were accessible to participants, and both them and I were emotionally and physically prepared for the interview.

Participants selected the interview space and time and were encouraged to decide on their own pseudonyms as they were providing such vivid detail that it was important that my participants felt as included as possible in the process. Interviews were recorded and transcribed in English. There were instances whereby participants expressed their experiences in their home language and translated the meaning of this into English. It was important that I received the translation from my participants themselves as I did not want an interpretation of the conversation by someone else, which may have resulted in data being lost in translation. I have experienced this problem when, in 2019, I worked as a junior researcher collecting data with a team of researchers in Tanzania. There were two teams; a South African team collecting data and a Tanzanian team who served as translators on the project. During the research process, we became aware that the Tanzanian team were translating research questions and responses based on their interpretation of the question and the participant's response rather than providing a direct translation of the questions posed and answers given. A situation like this is a problem in the sense that data may be compromised and meaning lost, and I did not want to run this risk.

3.2 Challenges faced in the research

I entered the research field under the impression that the interviews would only be triggering for my participants. I believed that I had immersed myself in the field, through reading literature and prepared myself to engage with the needs of my participants. I, however, did not adequately prepare for the emotional obstacles that I, the researcher, would face. This created challenges and triggers for me. It also became apparent as participants guided me through experiences across their life course that most had somewhat become detached from their trauma

[17] Something that impacts one's emotional and mental state significantly, in a negative way

narrative. Interestingly, my participants conveyed their more extreme experiences rather nonchalantly, and I was often exposed to vivid gruesome depictions of trauma and had to remain composed and objective during our conversations. There was an emotional and physical toll that my research took on me and the constant exposure to trauma narratives resulted in me becoming angry on behalf of my participants because of what they had experienced. This was especially so when incidents of childhood trauma were narrated. I constantly had to reposition my mindset to remain in a space allowing for objectivity while being compassionate. These emotions resurfaced again during the periods of data analysis which meant that I, as a researcher, had to negotiate appropriate time periods for analysis to protect my own mental health. Surprisingly, participants who had one dominant trauma narrative (often acute trauma) had more difficulty conveying their experiences. I argue that this is because they are less accustomed to trauma compared to those who experience multiple traumas.

Another challenge faced in the research was the wide range of ages that were present in the sample. As I was conversing with people of different ethnicities and ages, I found that the participants who were 40 years and older would struggle to convey their experiences as one participant stated *"this is odd, you are younger than my daughter and I would never tell her any of this."* This statement allowed me to recognize some of the reasoning behind the hesitation of participants who were older than me, especially when engaging with participants of similar ethnicities. Considering this, I was able to phrase my questions in a more specific way that directed the participant to the primary aspect of the question to enhance the quality of research and strengthen rapport with participants.

3.3 Data Collection and Analysis

Data was collected and analysed simultaneously. Grounded Theory was a useful tool for my data analysis and this was because I was able to compare data coming into existing data, and these comparisons resulted in the formation of relevant themes for discussion. Grounded Theory, first proposed by Glaser and Strauss (1967), is important for exploratory research that has a particular focus (Glaser and Strauss, 1967: 1). The 'grounded' approach places emphasis on the importance of empirical fieldwork, and the need to link explanations very closely to what happens in practical situations in the real world (Glaser and Strauss, 1967: 4). An important of using Grounded Theory as a method is that the researcher "embarks on a voyage of discovery" which allows empirical data to flow without the rigid confines of pre-existing theoretical frameworks, which ensures an open-minded approach to data collection (Glaser and Strauss, 1967:6). Through the exploratory nature of the study, the data highlighted common

themes, such as understandings of masculinity, that needed to be addressed by other participants. This allowed for the development of themes, coupled with probing allowed for rich ethnographic data. Additional forms of data collection were through diaries, reflections and field notes.

There is limited research conducted on trauma from an anthropological perspective that is not focused on political crises; therefore, it was difficult to base the research around an existing theoretical framework at the outset. Grounded theory allows for various viewpoints drawing specific attention to the participant and respondent in relation to the situation at hand (Ralph et al., 2015:2). Grounded theory additionally prevents researchers biases from guiding the research and developing their hypothesis in relation to the data that is gathered (Glaser and Strauss;1967:6). For this reason, grounded theory with symbolic interactionism was used as it allows for the generation of theory from the data collected as opposed to being guided by existing theoretical frameworks that may not be suitable for the study that would pre-empt the findings (Glaser and Straus, 1967:4). The theoretical basis for grounded theory derives from symbolic interactionism, which examines human group life and human conduct in relation to the world around them (Blumer, 1969; Straus and Corbin, 1990). Symbolic interactionism is useful in looking at how people make sense of their world and involves the physical (behavioural) and psychological (emotional and personality-related) (Glaser and Straus, 1967: 2). This aids in understanding whether or not culture has an effect on behaviour and perception within trauma parameters. People are active agents in their lives, this means that they are aware of social forces that implement their lives (Straus and Corbin, 1990). Handberg et al (2015:1023) discuss that symbolic interactionism is built on three assumptions;

1. "people strive and act toward what represents meaning for them,
2. meaning arises out of social interaction,
3. meaning is being dealt with and modified through the interpretive process."

These three assumptions allow the data to speak for itself and analyse at the interactions that allow for an understanding that speaks to the findings. Symbolic interactionism views individuals as products of their environment. The main features of symbolic interactionism are the self, the world and the social action (Charon, 1995). The self is first constructed through social interactions with immediate kin and so self-identity develops because of these interactions (Charon, 1995). The world in social interactionist theory refers to the world of

symbols however not all objects are symbols. Objects become symbols when meaning is attached to them.

Through the symbolic interaction experience, it became evident that participants and respondents portray a particular version of themselves to certain audiences. This resulted in my using Goffman's (1959) *Presentation of Self of Everyday Life* to provide a lens to understand human interaction. Goffman (1959) analysis individuals as they are presenting a particular role to the desired audience, based on the audience particular aspects of their behaviour will be demonstrated. Goffman's (1959) *Presentation of Self in Everyday Life* was coupled with Role Conflict theory as participants and respondents negotiated their role in particular situations. These theories will be engaged with in more detail in the analysis chapter.

3.4 Ethical and Moral considerations

At the outset of the project, I ensured that I was aware of the ethical concerns surrounding my research topic due to its sensitive nature. The experience of trauma and its subsequent effects can be debilitating and as such, I approached this research with the utmost respect and empathy for my participants' sensitive situations.

I examined Rhodes University's ethical guidelines and firmly upheld them. The latest Rhodes University Ethical Standards Committee (RUESC) handbook (2014) and Anthropology Southern Africa guidelines state that researchers are expected to explain all information pertaining to the research; such as the reason for the study, the period of data collection, and the necessary people who would have access to the relevant information. I adhered to these guidelines and through the use of an informed consent document, I explained my participants' rights and made it clear that their participation and engagement in the study was completely voluntary. Each of my participants was provided with a copy of the informed consent. I made it a point to emphasise that should a participant choose, for any reason, to withdraw from the study, no data collected from them during the data collection process would be used. No participants withdrew from the study. I acknowledged that I was dealing with the sensitive nature of trauma which may lead to my participants feeling vulnerable due to their experiences. Taking this into consideration I chose participants from existing social networks who have access to a mental health care professional to provide emotional and physical support. I am aware that I have a responsibility to my participants and the discipline of Anthropology. Additionally, I provided my participants with mental health care resources such as the South African Depression and Anxiety Group (SADAG) Mental health care line. Considering that a particular trauma was not examined through the research process and that each participant was

addressing different trauma narratives, I provided individual participants with resources that were specific to their trauma narratives[18]. This was done to ensure that my participants would have access to resources even if their private mental health care professional was unavailable. The criterion for this study was intended to protect participants, who were advised to withdraw from the study if there was a negative impact on their mental health.

3.5 Risks and benefits

Considering the high-risk nature of this study, a few precautionary measures were put in place. Primarily the most noticeable risk would be to potential participants themselves. Due to the sensitive nature that this study dealt with, there was always a possibility of triggering a participant. For this reason, I chose to draw participants from existing social networks and who have access to a mental health care provider for emotional, psychological, and physical support. A perceived economic risk was that participants required more psychological assistance, therefore I directed participants to free mental health resources. An additional perceived risk may have included the detailed private information which was provided by my participants, in which case an informed consent document, pseudonyms, and safeguarding of information reduced the risk of any participant being publicly outed.

There is a therapeutic element that came with my research that benefited participants. Participants had expressed that discussing trauma narratives aided in healing and created validity within their trauma narratives. Additionally, participants experienced a boost in self-esteem as they felt important enough to be part of the study. My research benefits the South African community at large as it provides a cultural understanding of how trauma is represented without Western Biomedical labelling. This would provide a more local context to deal with everyday traumas and allow for better diagnoses and subsequently for better treatment and healing.

[18] Cipla 24hr Mental Health Helpline, Families South Africa (Famsa), People Opposed to Woman Abuse (Powa), Suicide Crisis Line, SADAG Mental Health Line, Tears Foundation etc.

Chapter 4: Who Am I and What Are My Traumas?

4.1 Introduction to Participants and Their Traumas

This chapter provides an insight into the lives of my research participants and provides a brief overview of their trauma exposure, experiences, and narratives. The data gleaned through the research process examines the complexities that encompass trauma narratives in South Africa. It is important to note that during the course of data collection it became clear that people of colour[19] in South Africa share explanations and understandings of trauma. This is why specific cultures are not always referred to, explanations are not always culturally specific, and therefore the term 'South African culture' is used. A reason for this shared understanding and explanations of experiences may be rooted in the shared experience of colonisation and apartheid, however, delving into this is beyond the scope of this dissertation.

Table 2: Overview of Participant Information.

Participant	Acute	Chronic
Tara		Prison, domestic
Sally	Criminal	Child abuse, sexual abuse, medical trauma
Chrystal	Sexual assault	Political violence, academic
Aamira		Academic, witnessing domestic abuse
Shuaib	Shot, sexual assault	Child abuse,
Brooke		Child abuse, multiple sexual assaults
Kollie	Criminal	Academic
Kudzai	Death of his parents	Sexual assault
Fatima		Emotional abuse
Akhona		Sexual assault

[19] This includes black Africans, Indians, and Coloureds.

Mira		Witnessing domestic abuse

4.1.1 Tara

Tara is a thirty-nine-year-old divorced white woman from the Eastern Cape, South Africa. She has recently been released from prison after serving a seven, out of ten, year sentence for committing a white-collar crime, specifically fraud. Tara has an older brother and a twin sister. Growing up, Tara felt a lot of self-pressure as she was not as academically gifted as her siblings. She described herself as lazy but wanted to make her parents proud of her in the same regard. She is the only one of her siblings who did not receive a formal university education and pursued a Technicon qualification in office management. At the time of her incarceration, Tara had a partner, Trent, and a son who was a toddler. Trent has no formal tertiary education. Tara and Trent had gotten together when Tara was twenty-two. As the relationship progressed and Tara furthered her career, Trent pressured Tara into moving into their own space with specific criteria; i.e. he stressed that they needed a shower and garage or carport. Tara had explained, "*with the new job and pay increase came new expectations."* Trent can be described as someone who is very reliant on others, Tara highlighted that he did not learn how to use a computer, and he expected Tara to provide for him and their family. Despite his high expectations for a home, he expected Tara to be the one to find an apartment and all the subsequent responsibilities fell on Tara. Soon after they began living together, Trent stopped contributing to household necessities and only paid for his car instalments, alcohol, and social life. The stealing (fraud) began because of these lifestyle choices. Trent would ask Tara to pay his share of the bills saying that he would pay her back. This, however, did not happen, leading to a shortfall in money each month which would then be filled with the money Tara took from her workplace. Her trauma experiences are often navigated around adulthood experiences and are mainly informed by her time in prison and its aftermath. Tara has struggled with anxiety from her high school years, which was exacerbated in the lead up to her prison sentence and continues today.

4.1.2 Sally

Sally is a twenty-seven-year-old white Mozambiquan and South African woman. She and her family have constantly moved houses for most of her life. Sally said that she had been to sixteen different schools by the time she had matriculated and had lived in twenty-four different homes. Sally has always struggled to make friends and maintain those friendships; expressing that she "*was the new weird kid who would sit and eat her lunch next to a tree because it is the only*

one who understands me." This illustrates Sally's relationships with human beings and she prefers connecting with nature and keeping her distance from new people as many people have betrayed her, including family and friends.

Sally has experienced various traumas, which can be considered complex trauma because of the disconnect of those traumas to one another. Sally grew up in an emotionally and physically abusive household. Her maternal grandfather was an alcoholic who physically abused her grandmother, mother, and uncles. This created a rippled effect of traumatic experiences in the family, which has become a generational cycle. Sally's mother physically and emotionally abused Sally throughout her childhood and continues to gaslight[20] Sally. Sally has had a string of abusive boyfriends, both emotionally and sexually, who, in various ways, have further confirmed her distrust in men. These are repercussions to the generations of abuse in her family as Sally, her mother, and grandfather have trouble controlling their temper. Sally's mother and grandfather would often lash out in acts of physical abuse during outbursts.

Throughout Sally's life, she has struggled with her mental health and mental illnesses. She was first diagnosed with a panic disorder in 2018 when she was 24 but remembers experiences of panic attacks as early as high school. It was not, however, diagnosed or given an appropriate name and instead, it was seen as a symptom of puberty. She has a wide range of other illnesses in addition to her panic disorder, which includes, but are not limited to, generalised anxiety disorder and depression. Sally became pregnant in 2020 and delivered a healthy baby boy in 2021. This pregnancy was difficult for Sally, and she developed both prenatal and postnatal depression, which exacerbated her existing depression and general anxiety disorder. These experiences have added multiple layers to Sally's perception of the world.

4.1.3 Chrystal

Chrystal is a twenty-five-year-old white Zimbabwean South African woman who currently resides in South Africa. Chrystal spent her childhood and schooling life in Zimbabwe and moved to South Africa for university. She had witnessed and experienced the effects of the political violence in Zimbabwe first-hand as her family had owned a farm. She explains that due to the political situation in Zimbabwe she was aware that havoc could implode at any time. As a result, this created a form of unconscious anxiety within Chrystal. Chrystal disclosed that she does not have many recollections from her childhood, which could be explained through

[20] emotional abuse that makes one question their beliefs and perception of reality.

the lens of dissociation[21]. Chrystal enrolled at Rhodes University in South Africa for her tertiary education and has continued with her Post Graduate studies there. During the final year of her undergraduate studies, Chrystal was sexually assaulted by one of her classmates. She did not disclose the nature of the events, but it has been detrimental to her life and relationships in general. During her Honours year Chrystal, in dealing with her trauma exposure and narrative, bore the post-trauma consequences more or less on her own. Her perpetrator was still enrolled at the university, pursuing his Honours degree, and she had indirect contact with him as he was always in similar places; despite her no-contact order. Chrystal did not choose to lay formal charges against her rapist but had the issues dealt with through the university and a no-contact order was put into place. This essentially meant that Chrystal's rapist was not allowed to be in the spaces that she was in, at the same time. He was given specific guidelines to follow and times to refrain from being in certain buildings when Chrystal was. Chrystal's rapist violated the no-contact order on numerous occasions, which resulted in the university excluding him for as long as Chrystal would be a student at Rhodes University. This single event created an acute trauma narrative in her life and has affected her social behaviour and perception of the world.

4.1.4 Aamira

Aamira is a thirty-six-year-old Muslim South African woman of Indian descent, who was raised by her mother and maternal grandparents. Aamira's trauma narratives are situated around witnessing gender-based domestic and physical violence, in her childhood home and grandparents home, respectively. Aamira's mother divorced Aamira's father when Aamira was approximately three and a half years old. This was because Aamira's mother feared the abuse would extend to her children. As a child, Aamira suffered from asthma which was described as seasonal asthma triggered by high-stress levels. Aamira does not believe that these were panic attacks; and, she has not suffered an asthma attack in many years, in fact, since she was nine-years old, the same year her father was no longer present in their lives. Aamira noted that whilst she did not experience physical discipline at home, she witnessed her older brothers being beaten for being naughty or disobeying her grandparents or mother. Corporal punishment was normalised during her childhood years so this was not seen as anything out of the ordinary. Aamira considers most of her life as uneventful. She attended a former Model C school and then the University of KwaZulu-Natal. Her post-graduate years have been fraught with self-doubt and imposter syndrome. This was partly due to one of her lecturers constantly criticising

[21] See chapter 8

or having negative things to say about her work. Aamira has struggled to make friends and is not very trusting of people due to incidents from her childhood. She said that she has a constant belief that people will let her down at some point, will stop caring about her, or do not actually care about her and are just pretending to in order to be nice. Aamira was diagnosed with major depressive disorder and general anxiety disorder in 2016, and with Attention Deficit Hyperactivity Disorder (ADHD) in 2018. She is currently on medication for these illnesses.

4.1.5 Shuaib

Shuaib is a fifty-two-year-old Muslim South African man of Indian descent who has experienced complex trauma. He has three sisters and spent much of his childhood with female cousins. He shuffled between his grandmother's and parents homes. From Sunday to Thursday, he and his siblings lived with his maternal grandmother; and spent the weekend with his parents. His grandmother's house was filled with strong women and the household consisted of his grandparents, aunty and his female cousins. His grandfather, however, was a traditional Indian man who went to work at five o'clock in the morning and returned home in the evening. He bathed and ate, but no one had seen him outside of that and there was no quality time spent with the family. His paternal uncle's wife and four children also lived in the home. Shuaib pointed out that due to his grandfather being absent, he was the only male in the household most of the time, and there were different expectations of him because he was male.

Shuaib has experienced a string of, mostly, unrelated traumatic events that have contributed significantly to his mental health issues that have developed into mental illnesses. Shuaib's traumatic narratives fit under the definitions of child abuse, domestic violence and medical trauma resulting from sexual abuse. Surprisingly, Shuaib does not consider his traumatic childhood experiences as child abuse because the people responsible were his caregivers (family). He has been in long term therapy and has been diagnosed with PTSD, and stated he has *"a little bit of anxiety and depression."* His mental illnesses have been diagnosed as severely chronic as he has mental health benefits that are not deducted from his normal medical aid.

Acute traumas are not foreign to Shuaib; as an adult, he was shot due to a road rage incident and was sexually assaulted when seeking medical assistance for sexual problems impacting his marriage.

Shuaib is currently a married man and has one son. He reflectively analyses many of his experiences through periods of reflection and therapy. He has come to terms with and understands that the forms of punishment he experienced as a child were more than necessary

or normal. This has created a complex relationship with those around him, however, with therapy and a life coach he has been able to navigate the world and discuss his brutal experiences.

4.1.6 Brooke

Brooke is a twenty-six-year-old white queer South African woman who grew up in a single-parent household headed by her mother. She has never met her father and is an only child. She describes her childhood as wildly chaotic and abusive. "*She [her mother] was not physically abusive per se…"* but Brooke proceeds to recount that her mother would chase her around the house during anger episodes whereby Brooke did fear for her life. Brooke recalls her mother physically hitting her once but does not have any memories from her early childhood. She is aware that her maternal grandmother abused her mother and there seems to be a generational cycle of abuse. Brooke reached out to teachers and extended family members from an early age, describing the events at home, but they invalidated her feelings stating her mother was just stressed. This has had a severe effect on Brooke as she struggles to trust the people around her, and as an adult strives for ultra-independence. For several years, Brooke has seen various mental health care professionals to combat her complex trauma. She has been diagnosed with cPTSD, depression, and general anxiety disorder. She has pressured speech, which is speaking at a fast pace whereby people struggle to follow the conversation (Cassidy et al.1998:187). The pressured speech stems from her anxiety disorder and there is little trust between her and her mother. Her mother does not believe in mental illness and has accused Brooke several times of being on drugs due to her pressured speech.

Brooke conveyed that her mother had isolated her from a young age, and she had no support system. She describes herself as a social chameleon who adapts to those around her; and believes that this is one of the reasons why she has excelled in the service industry. In 2014, however, she returned to Grahamstown in the Eastern Cape, from Johannesburg, and her peers, family, and friends could not comprehend her angry mindset. During her time in Johannesburg, she had been emotionally and physically abused by her then boyfriend and raped by him. She had left that relationship and returned to Grahamstown extremely angry with the world. She wanted to protect people because no one had protected her.

Brooke has faced several mental health illnesses and physical sicknesses due to her traumatic experiences. She has complex PTSD which is accompanied by general anxiety disorder and

depression. Due to the physical injuries, she has a temporomandibular[22] disorder and cervical dystonia[23].

4.1.7 Kollie

Kollie is a 33-year-old black Zulu gay man who has experienced several acute and chronic traumas in his life. He grew up in KwaZulu-Natal and has lived in Johannesburg, Gauteng, where he was victim to multiple acute traumas, often situated around robberies and car hijackings. Kollie was most recently victim to a hijacking when he was in KwaZulu-Natal conducting research for his PhD. Additionally, he has been in a romantic relationship whereby his partner threatened his life. It is essential to acknowledge that Kollie does not consider this an abusive relationship because, as he explained, the nature of the threats was not long term. Once he had noticed the behaviour, Kollie left the relationship and did not turn back. Kollie acknowledges that he has encountered a variety of acute traumatic instances, and, unlike my other participants, there is no one major incident that was present in his life that had traumatised him.

Kollie's trauma narratives also include issues around masculinities, (perceived and experienced). He does not conform to the notion of a typical Zulu man and has had negative experiences in relation to that. Kollie is currently a PhD scholar and resides in a small town in the Eastern Cape.

4.1.8 Kudzai

Kudzai is a 31 year-old Shona Zimbabwean man who currently resides in South Africa, for the past ten years. He attended boarding school in Zimbabwe, but his permanent residence was with his mother until her demise during his third year of university. As a young child, his father and sister both passed away from Human Immunodeficiency Virus (HIV) related illnesses. As a result of this, his mother raised him as a single parent but often received help from those around her. Kudzai was molested and raped by his caretaker as a child, and a previous girlfriend would hit him when she was intoxicated. Despite fitting the description and definition of domestic violence, Kudzai does not perceive it as such. Kudzai was brought up in a traditional Shona household with traditional patriarchal gender expectations. This has resulted in some negative behaviour, such as suppressing his emotions, which he is still in the process of unlearning. Masculinities, as a toxic experience, became apparent during our conversations.

[22] Disorder of the jaw muscles that results in chronic facial pain

[23] Involuntary movement of the neck muscles resulting in chronic pain

His mother had passed away when he was 23, which is when he believes his depression began. This, coupled with the passing of his father and sister, is the dominant trauma narrative in Kudzai's life. He considers the sexual assault and intimate partner violence as "*bad but nothing compares to losing my parents*."

4.1.9 Fatima

Fatima is a forty-seven-year-old South African Indian Muslim woman who grew up in a conservative Muslim community in Durban, KwaZulu-Natal. Her household consisted of her parents and her grandmother. She struggles to comprehend many of her experiences and seeks validation of her own experiences. As a teenager, straight after her matric year, her household was burgled while their family was in the home. She suffered injuries that resulted in a visible face scar but her family "*swept it under the rug."* Fatima conveys that this is a common trend in many Indian, but more specifically Muslim, households; if one is not bringing honour to one's family it should not be discussed. She emphasizes this by painting a picture of the concerns of the social consequences that the family may have faced when her father was imprisoned during her preteen years. She believes that "G*od draws a veil over your sins and protected you.*"

Fatima expressed that her father was wrongfully imprisoned during her preteen years. She did not disclose the nature of the event that led to his imprisonment. She considers this instance as traumatic but, more notably, she emphasizes the importance her family put on "*what would people think?*" This is a narrative that is common in Indian households and she has carried with her throughout her life and continues to struggle with it today.

Fatima has been married three times; twice to the same man. During the first year of her first marriage, she gave birth to a stillborn baby girl, and her son was born in the second year of that marriage. Her son is now 24 years old, and her first husband gained custody of him when he was a child. Fatima struggled with the pressures of what was expected of her as a woman and admits that she only got married and had children because that was the expectation. Fatima initially had no desire to get married and wanted to continue with tertiary education after high school. Indian-Muslim culture in South Africa dictates that young girls should be married young and they do not need to further their education since they will be housewives and mothers. Husbands are the providers and only they need to work.

She is the oldest of four children, and she bared the brunt of what occurred and struggles with issues of abandonment. She confesses that this created a ripple effect in her adult relationships;

in both of her marriages and her relationship with her son. She states that she was not able to easily navigate her life much after her father's imprisonment, she felt abandoned throughout her life, and struggles to bond, even as an adult, with her son. She describes the nature of their relationship as disconnected and superficial.

4.1.10 Mira

Mira is a twenty-five-year-old South African woman of Indian descent who grew up with separated parents who resided in the same household in Johannesburg, South Africa. She describes her upbringing as emotionally turbulent because of the domestic violence present in the household. She has three siblings all of whom have complex understandings of their childhoods as nothing was stable "*but we didn't know any better."* Mira is the only one of her siblings who has actively dealt with their childhood with a mental health care professional. She has seen various mental health care professions since she was eleven. Initially, her family were supportive about the treatment but not long term as "*nothing was wrong with her."* Mira currently sees her mental health care professional without her family's knowledge. Mira was diagnosed with dyslexia at the age of seven and struggles with imposter syndrome while being a postgraduate student at Rhodes University. Additionally, due to Mira's trauma narratives she has been diagnosed with PTSD, major depressive and generalised anxiety disorder, and has active panic attacks that are elevated during periods of high stress. She is currently not on any medication for her mental health disorders as previous medications made her feel like a *"shell of a human."*

4.1.11 Akhona

Akhona is a thirty-seven-year-old Xhosa South African woman currently residing in the Eastern Cape. She has two sons and currently lives with her boyfriend. Both her parents have passed away and Akhona struggles with her sense of identity. She had a very sheltered upbringing and remembers her family being very strict. Akhona's was raped as a teenager which resulted in a pregnancy. At the time, she did not understand the nature of her rape and was unaware of how a child is conceived. As a result, she was too far along with the pregnancy before realising she was pregnant. Akhona deeply struggled with the interview and providing her trauma narratives. Recalling past traumatic events became more difficult than she initially realised and struggled to finish the interview as she was too emotional. However, she did still want to be involved in the study. Additionally, Akhona does not adhere to western cultural models and instead explains experiences through the lens of her own culture. This means that she does not identify with western diagnostic labelling but does believe she, "*thinks too much"*

which is a cultural idiom of anxious thoughts. This provides insight into the ways in which Akhona understands the world.

4.2 Big T's and Small t's

Galea et al. (2004:78) state that a traumatic event can result from experiences of terrorism, relocation, disasters, and violence that pose life-threatening harm or serious injury. Understanding of the term differed from participant to participant, which was clear through the analysis of my data. Still, it is essential to point out that the general theme is that trauma is a life-altering event that causes some distress in an individual's life and sometimes in the lives of those around them. Interestingly, common understandings of trauma events are significant disastrous events that create havoc in some shape or form. During a conversation with my first participant, Sally, she disclosed that she is not aware if she fits the criteria for the study. This is because she explained that she has many "*small traumas compared to big traumas."* This was particularly interesting because she had gauged and lessened her experiences based on public perception of an experience. Traumatic events that were more private seemed to be labelled as small traumas to Sally. As the conversations grew and the rapport was strengthened, it was evident to me that her trauma narratives would typically not be considered small traumas but big traumas. This provided great insight into the way in which participants and respondents can understand their trauma narratives. Going forth in interviews, I had explained Sally's description of small traumas and big traumas (which was later called "small t's and BIG T's" to my research participants; participants resonated with this understanding. Participants presented me with their small t's and BIG t's. There was a common notion that small t's are ingrained in an individual's life which seems to create more ambiguity. These are often common normalised behaviours that, in some societies and cultures, are passed on from generation to generation; therefore, they are not considered traumatic because of their commonality. Participants describe BIG T's as events that were deemed "traumatic" by society[24] and this created validity in the experience. Participants had explained to me what they considered their BIG T and thus I have labelled that their dominant trauma narrative. Considering this, when referring to small traumas, I am not dismissing the severity of the event/s but rather the understanding of the trauma concerning the bigger picture.

Trauma narratives were an important aspect of this study as they provided insight into which traumatic experiences have shaped individuals life. Most notable, the primary understanding

[24] Such as sexual assault

that has been gathered is the intensity of the trauma has been creating various forms of denialism ways in which trauma narratives can be expressed. Chapter five presents readers with understandings of trauma narratives based on sociocultural experiences and expressions of trauma.

Chapter 5: Denialism and Expressions of Trauma

Chapter five begins by exploring the understandings of denialism that my participants have in relation to their traumatic experiences. This chapter explores the cultural understandings of trauma indicating emphasising reasons of why denialism tends to exist. This is an important introduction to the trauma narratives that my participants have shared with me, and this provides insight into their perception of the seriousness of their trauma narratives. These understandings filter into trauma narratives that are explored throughout the dissertation. Secondly, the chapter delves into various expressions of ways in which participants and respondents communicate forms of distress in verbal and non-verbal cues through the use of metaphors and idioms. This allows us, as readers, to recognise the various modes of communicating and in turn how trauma survivors present themselves in everyday living.

Dye (2018:381) states that trauma does not discriminate based on gender, age, ethnicity or religion. It is evident, however, that there are prominent trauma narratives based on age, ethnicity, gender, and cultures as some are more likely to be exposed to specific trauma types based on the above subcategories. These subcategories heavily influence one's perception of the world and can impact lived experiences. Culture, and evidently gender, are key factors that can influence the intensity of traumatic experiences. This can directly feed into participants understandings of what they consider "BIG T's and small t's." Through discussions with participants, it became apparent that denialism, (in various forms), was a strong presence and culture had a pivotal role in this.

5.1 Denialism

Understandings of the term trauma differed from participant to participant, but it is essential to point out that the general understanding was that trauma is a life-altering event that causes some distress in an individual's life and sometimes in the lives around them. Interestingly, the most common understanding of trauma events, as explained by my participants was that they are significant disastrous events that create havoc in some shape or form in a person's life.

South Africa's multicultural landscape and the deep political and social history of violence has led to some forms of trauma being seen as more intense, legitimate, and more valid than others; i.e. BIG T's and small t's. Through the research process, it became evident that cultural factors such as trust and mistrust in the system, social relations, stigma, services offered, and stereotyping have a large impact on how one acknowledges their trauma (Jenkins, 2017:26). A key theme in this research is that most participants have the acknowledgement of their BIG T's which they tend to walk on eggshells with, as they are fully aware of the social perception of

the traumatic events. Small t's are those incidents that are considered as the small, unfortunate, occurrences that happen in people's everyday life. This too is traumatic, however, most participants were not actively aware of the trauma but through the data collection, it became evident that the "small t's" impact their daily behaviour and perception. These small traumas tend to be cultural norms in their lives, because of this there seems to be a sense of denialism around whether the experience was traumatic or can be labelled as such.

Denialism is multifaceted in the face of traumatic experiences. Throughout the research process, it was evident that there are various forms of denialism.

1. Denial that the trauma ever existed - I do not have trauma because it is a common experience in my culture;
2. Denial of the intensity of the trauma - What happened was not that bad;
3. Denial that they have caused trauma - I was the only victim of trauma and did not traumatise anyone.

The three kinds of trauma denialism listed above are common responses gathered from participants and observations through support groups. The complex nature that encompasses trauma narratives allows for the overlapping of the three types of trauma; i.e. acute, chronic and complex.

The first form of trauma denialism centres around denial that the trauma existed. This is explored through various ways illustrating the complex nature that trauma denialism has on trauma victims. Societal understandings differ on what is considered trauma based on a variety of factors including who the abuser is. The following section explores this narrative of trauma through the lens that trauma did not exist based on cultural understandings of experiences.

In Indian and Black households, it was found that corporal punishment was a normal part of everyday life. My participants expressed that "*hidings*" were normal when children were naughty, disrespectful, and disobedient. If your parents or caregivers hit you, it was because of one of these reasons, "*it had to be because you did something wrong, otherwise why would your parent hit you without reason?*" (Aamira). This was the same experience that my participants' parents had growing up, and their parents before them. The abuse is generational and has been normalised in this way. As such, parents and caregivers (kin and non-kin alike) are not viewed as abusers, and these experiences are not framed as traumatic, but rather as a part of the discipline process. This was also regardless of how severe the punishment was. A traumatic event or experience for these participants was something that happened outside of

the norm. My white participants, on the other hand, specifically Sally and Brooke shared that they understood that their families were abusive and did not share the narrative of discipline. This speaks to the normative abusive nature that non-white populations were constantly exposed to throughout their life course.

Shuaib, for example, is now aware that he has had traumatic experiences; however, he does not consider himself a victim of child abuse. This is because his caregivers (kin) were the perpetrators of this violence against him, but he does not believe that one's family can abuse them. Shuaib is aware that the physical abuse he experienced was extensive and sometimes unprovoked. He explains that usually in parenting styles, there is a *"good cop and a bad cop"*, and that in most households if the father is disciplining the child, the mother will console the child after. This was not his experience. He recalls a vivid memory of an act of punishment but not the reason for him being punished. He draws the picture of a young Shuaib who had known the repercussions of any misbehaviour, regardless of the extent. He explains that his caregivers had tied his hands and ankles together behind his back with a sock and left his naked body bare and awaiting the actual physical punishment. In most Indian households, the waiting period to be punished, which was often fraught with tension and fear-laden anticipation was as agonising as the actual punishment, however, this was not the case for Shuaib. This gruesome punishment involved the rubbing of chillies on his genitalia. The threatening and rubbing of chillies in one's mouth is a common form of punishment in South African Indian households. Chillies are seen as a staple item in Indian kitchens and are often grown in the garden. Indian grandmothers are known to grow tiny chillies that are nicknamed '*devil chillies'* because of their potency. Children are aware of the burning sensation that is felt in the mouth due to the type of spicy foods that Indian populations consume, therefore the fear is inflicted. Chillies would also be used to stop a child from sucking their thumb by rubbing the thumb with a chillie which would then burn the child's mouth when they sucked on it. The child would associate this horrible feeling with having their thumb in their mouth and would stop the habit. Being part of the South African Indian population, I must note that the rubbing of chillies on one's genitalia is excessive even in strict households. Shuaib described the feeling as fiercely burning to the point whereby a tied-up, young, Shuaib was rubbing his naked body on the carpet in an attempt to remove some of the chillie extracts from his genitalia which resulted in major bruising. This and other forms of punishment has resulted in Shuaib's genitalia being so severely injured that it required surgery in his adult life. Other family members, including his sister and cousins, were warned not to assist Shuaib during the punishment processes, as this will teach him a

lesson. His sister and cousins, who were all female, feared that if they aided him in any way they would suffer the same fate. This form of punishment is a unique response as no other participant or respondent have expressed that they endured similar fates.

Additionally, Shuaib's understanding of his traumatic experiences is unique. He is aware of the abnormality that comes with his experiences but even with extensive years of therapy he still struggles with labelling his experiences as traumatic. 6% of survey respondents address that they were not victims of child abuse but responded yes to the question,

> *"When you were a child, did a parent, caregiver or another person ever slap you repeatedly, beat you, or otherwise attack or harm you, without the intent of discipline?"*

Although the percentage is significantly small, it is important to acknowledge the level of awareness that respondents have of experiences that they endured during their childhood. Discussions and proceeding questionnaire questions with Shuaib and respondents suggest that they have a blended notion that family members cannot abuse you because they are one's caregivers and that these are normal experiences therefore not considered traumatic.

Unfortunately, Shuaib experiences denialism regarding his medical trauma as a result of sexual abuse. This narrative does not align with the three forms of denialism presented but it is important to recognise as it indicates the complexities that encompass traumatic experiences. The first form of denialism presented above deals with denial of trauma existing because it is a cultural norm. Shuaib, however, struggles with labelling his sexual trauma as traumatic because he had paid for 'treatment'; this therefore speaks to a sub form of denialism as he struggles to label it traumatic because of the monetary aspect. This speaks to cultural understandings that are often centred around women's experiences with sexual assault. Shuaib alludes to aspects of victim-blaming as he voluntary sought medical help. Victim-blaming is a traditional response to female survivors of sexual assault. Shuaib may fear that society in general may direct the fault on him. As an adult, Shuaib had surgery on his genitalia due to the countless years of abuse; because of the trauma and the surgery he was struggling to perform sexually as a married man. His urologist recommended a clinic that specialised in sexual health and performance in Johannesburg. The doctor performed a full physical on Shuaib and prescribed three different rounds of medication, none of which achieved the desired results. The professional biomedical doctors wanted to eliminate the possibility that Shuaib was not attracted to females. The doctors explained that they would bring in what they called 'surrogates' who would perform a series of tests. There were two surrogates, a male and a

female, and he was informed that they would perform the necessary tests to ensure he was attracted to women. Shuaib expressed that he did not fully understand the extent and procedures of the role of the surrogates but had faith in his practitioners. These surrogates required Shuaib to touch, feel, and explore their bodies and vice versa. During the 'testing' aspect, practitioners were observing Shuaib's sexual reactions to both surrogates. A reluctant Shuaib describes this ordeal as nauseating. He views it as traumatic, however, did not want to label it as anything such as abuse because he felt that he sought help for his sexual problems and paid for it. This speaks to the complex nature that encompasses traumatic experiences. Shuaib's sexual abuse does not fit the three forms of denialism outline but speaks to the grey nature of traumatic experiences.

Kudzai has a similar experience of the first type of denialism. Kudzai explained that in Zimbabwe, it is the norm for there to be helpers in one's home to assist with basic household tasks and child care in exchange housing and their school fees being paid. Kudzai was molested as a seven-year-old child by a helper in his home. Kudzai's mother used to work at a school and one of the students, a fifteen-year-old girl, would assist in childcare and household chores in exchange for her school fees being paid. She lived in Kudzai's home for a year and sexually groomed[25] seven-year-old Kudzai. The helper had gained the trust of Kudzai and he was unaware of the physical act of sex at the time. Kudzai had not reported this to an elder or another caregiver because it was seen as their secret, which is a key feature in grooming. He trusted this girl and had a bond with her; he described them as having a very strong bond and she was one of the closest people to him. Kudzai voices that he is aware of several males in Zimbabwe that were sexually abused by their helper. This tends to be a taboo topic to discuss but a cultural norm. As he grew older, he realised that he had had sexual intercourse at a young age but become embarrassed of discussing the nature of events. He is aware of the commonality of the sexual abuse in Zimbabwe amongst boys but prefers not to engage with the topic; this alludes to complex understandings of denialism. This is a frequent understanding that victims of child abuse and sexual abuse (as children) experience. A survey respondent states,

> *"I didn't know what he (perpetrator) was doing was sex. I knew I didn't like it but I only realised it during my teenage years, I don't know how I made him think I liked it. He was always so nice to me"*

[25] Sexual grooming involves building an emotional relationship with the attempt to gain their trust and have a sexual relationship (Gillespie, 2002:411)

This survey response suggests that there is still some elements of guilt, blame, and denialism that she is demonstrating. This is because she feels that she had done something to elicit the sexual relationship, despite her being a child. These collective responses, although representing a small percentage of my data; speak to a community that struggles to negotiate their understandings of sexual abuse because of conflicting factors.

A secondary understanding of trauma denialism amongst, Kudzai and Shuaib is that societal understandings have expressed that men should enjoy all forms of sexual activity, regardless of factors. These create conflicting understandings of whether these sexual advances should be appreciated or not. This means that Kudzai and Shuaib find trouble negotiating understandings as they were unwanted advances. This could speak to elements that emerge from their understanding of masculinities (which will be explored in chapter 6).

The second common denial of trauma is the intensity of the trauma experienced. In society, people are often aware of the struggles that individuals face. Classical understandings of trauma narratives were often depicted as unimaginable events that are out of the ordinary such as soldiers returning from war zones. Since the inclusion of PTSD in the DSM-III the perception of trauma has arguably changed in many populations. Most individuals in my study, however, do not perceive their trauma as intense. It is evident that they are aware that they have traumatic experiences and sometimes PTSD but more importantly express that it is a common experience and others have it worse. There seems to be an overlapping nature between types of denialism experienced. In terms of the denial of and the intensity of trauma, my participants and respondents express narratives that they are aware that they are traumatised but argue that the situation could have been more detrimental. A survey respondent expressed that they have not experienced domestic violence because;

"*it is not real domestic violence because he hasn't hit me yet, it could be worse."*

This illustrates the misunderstandings that come with domestic violence and this form of denialism. Domestic violence, like other forms of abuse, is multi-layered and is not exclusively defined by physical violence. The interesting aspect of this response is that the woman has conveyed the invalidity of the experience yet is aware that it is traumatic, but the trauma is lessened and its intensity reduced. This also affects the validity of one's experience. This further reveals the denialism that victims of abuse experience. This response suggests that the woman is aware of more detrimental consequences to domestic violence that include physical violence. It is implied that she has experienced and/or witnessed domestic violence resulting

in physical abuse therefore she is grateful for the lack of physical abuse. 40% of survey respondents, who are mostly women, have stated that they have been victims or witnessed domestic violence in their lifetime. In many cultural settings, abuse and trauma are so prevalent that it is seen as the norm. Mira and Aamira have both witnessed domestic violence throughout their childhood, but this was seen as a norm in Indian culture therefore it is not considered traumatic. The belief was that everyone's family experienced it, and domestic violence was only considered serious if someone ended up in the hospital or the community and/ or police became involved. Through the domestic violent upbringing, there were evident traumatic experiences that Mira categorises as traumatic; she labels these her BIG T's which often resulted in the community getting involved. However, the everyday lived experiences, (for example, shouting and small acts of violence), she did not see as traumatic because it wasn't always life-threatening in the same way, i.e. small t's. The turbulent aspect of her lived experiences illustrated that if no one had landed up in the hospital it *"wasn't that bad of a night."* For example, she explains that the violent activity often occurred late evenings this was because her father would return home from work late. She explained that repeated behaviour was of her father coming home late at night beating her mother. Mira and her siblings often watched helplessly trying to defuse the situation. She further articulates that she had trouble sleeping until her father came home terrified of what could occur. Mira only comprehended the intensity of her small t's during therapy during her university years. This is because she had witnessed drastic acts of violence and anger as a child on a regular basis. She briefly explains that during a "*rage episode"* her father set his car on fire. She did not want to engage in the details of this BIG T. This trauma narrative illustrates the denial of the intensity of the daily trauma experienced. Mira has revealed that as an adult she struggles with generalised anxiety disorder. Through many years of professional psychological help, it has become evident to Mira that these small t's in her everyday childhood experience results in her current anxiety.

> *"There was no calm, I was always waiting for the other shoe to drop and this still happens today."*

By reducing the perceived intensity of a traumatic event, this enabled respondents and participants to move on with everyday life and activities. This form of denialism may thus be a coping mechanism for trauma exposure. The idea or belief that something that happens is normal and occurs in all homes ensures that the events are not dwelled on too much, rendering them inconsequential. As an adult, Mira has begun to renegotiate the nature of her traumatic experiences. She, as well as several key participants, resonated with Sally's description of BIG

T’s and small t’s. This speaks to the nature of denialism that can be present in those who have witnessed and been victims of multiple trauma. It is important to recognise that the complex nature that encompasses trauma is not as transparent as one would naturally like to believe.

The third form of trauma denialism is where the person believes that they were the only victim of trauma and in turn, did not traumatise others in the process. Frequently, victims of trauma unconsciously and consciously traumatise those around them. This feeds into the complexities that come with traumatic experiences and in turn denialism.

For example, Fatima had experienced hardships in her marriages and resultantly struggles with the emotional abuse she endured. It became apparent that she severely struggles with the emotional abuse to the extent that it consumed a period of her life. She failed, however, to recognise the trauma she transferred onto her child. Fatima had given birth to a stillborn baby girl during the first year of her first marriage and gave birth to her son during the second year of her first marriage. Her family and husband had supported her after the passing of her daughter, but it was initial support and not long term. As a Muslim, Mehraby (2003:1-2) states that "all suffering, life, death, joy and happiness are derived from Allah and that Allah is the one who gives us strength to survive." Belief systems such as these are expected to aid in the grieving process, and while it is pointed out that the grieving process may not end in one's lifetime but the outward grief process, Islamically, is not to last more than three days. This explains the immediate reactions and community support that Fatima had received. She had not sought out additional professional help regarding her grief and this has arguably had an impact on her motherly bond with her second child. She stated that she felt a disconnect from her son and this did not change as he got older. This had a direct impact on her parenting and relationship with her son. After she and her first husband divorced, her husband gained custody of their son. Fatima had expressed that this was, to some extent, a relief, as she had never wanted to be a mother. Motherhood seemed like the next rite of passage in married life and the expectation from her husband, family, and the community. Fatima recognised that her son is aware of and feels the disconnect between them as he prefers, and has a better relationship with, his father. After her divorce from her first husband, she felt free and could pursue ventures that interest her. She describes herself as "*selfish*" as she wanted to do something for herself. She had always been someone's daughter, wife, and mother and wanted to gain a sense of independence. This further separated and soiled her relationship with her son. Her son is now twenty-four years old and seeking professional help to repair the damage caused by the relationship with his mother. Fatima does not disclose the nature of events that occurred

between her and her son; however, she was able to identify, through professional help, that she "*could possibly*" have a role in his trauma narrative although she does not wholly believe this. This supports the third form of denialism whereby traumatised people can traumatise those around them but do not acknowledge it.

Additionally, Mira and her nuclear family have experienced various forms of trauma as a result of her father. Mira disclosed that her father had witnessed his father (her grandfather) abuse his mother and siblings throughout his (grandfather) life. As a result, Mira's father had similar experiences to Mira, however, the outcome was different. He saw the abuse towards his mother and this, in turn, affected his behaviour and perception of domestic violence. He believed that the abuse toward women was acceptable, however, he finds it unacceptable to physically abuse children, due to his own experiences. With this, one can see that despite Mira's father witnessing years of abuse, he was not aware of the trauma that he was inflicting on his family as they witness the abuse. This speaks to conflicting understandings of how Mira's father understands trauma. Due to the normative nature of domestic violence in Indian communities, he found this behaviour widely acceptable and not abusive. Mira's father, however, endured acts of physical violence and therefore understood that it should not be inflicted on children. This narrative provides insight as Mira father believes that abuse, and in turn the resultant trauma, can only be physical. Through his understanding, he was physically abused as a child but his children did not suffer any form of trauma as he physical did not abuse them. This is considered within the third form of denialism has Mira's father is under the impression he is not traumatising his children because he is not physically abusing them

Observations from support groups echo sentiments presented by Mira and Fatima. Members of these groups frequently express that their parents and other loved ones cannot seem to recognise the trauma that was inflicted on them which they have, in turn, inflicted on others. For example, a thread of posts by a black South African woman explains that her mother was both a victim and perpetrator of domestic violence. This resulted in her mother frequently being in and out of prison. The poster explains that her mother cannot recognise the harm that she inflicted on the poster and her siblings and has a "*one-minded*" view of the nature of events that have occurred. The woman explained that she struggles with aspects of her turbulent traumatic childhood and struggles to communicate this with her mother because her mother has a "*distorted*" view of how things occurred. Other members rushed to share similar experiences supporting her narrative as well as others resonating with caregivers failing to recognise their role in trauma narratives.

There is a relatively new term that has been commonly used across social media platforms, namely; trauma bombing[26]. Trauma bombing describes an act of unconsciously discussing traumatic events in a normalised manner to others. This creates a form of secondary traumatic stress to people around them. Long-term trauma victims have become so accustomed to their lived traumatic experiences that they are sometimes unaware of the intensity of their situation as well as the effect this can have on other individuals. I argue that this is a form of trauma denialism, as individuals can create secondary trauma through expressing their own trauma narratives. At some point in the conversations, my participants reflected that they have been guilty of this, and this is mainly because they denied the intensity or existence of their trauma experiences. My discussions with participants have thus provoked a form of reflection as they have not viewed their trauma collectively prior to this interview. Most notably, Kollie illustrated that through a reflective process, he is now aware that he has unconsciously trauma bombed others. Kollie has previously worked in spaces related to social issues; namely, student support services at the university he was enrolled in, and in non-profit organisations that focused on advocacy situated around gender-based violence. There were detailed experiences that involved homophobia, rape, and violence. This had become a norm to Kollie who had, to some degree, become detached from the situation in order to engage with the matters at hand. Kollie explains that he would regularly deliver talks to audiences without providing context or trigger warnings prior to presenting the trauma narrative. Kollie has now become aware of how normalised it was, but through reflection, he expresses that in some way he was trying to make sense of those sensitive topics. He further explains that when he had left his previous job, he had to train community workers in police stations about sensitive matters that they were likely to encounter and the way to handle them and he says;

> *"Trauma was just a secondary thing, I guess I was trauma bombing without even knowing it. I was bleeding on other people."*

Kollie engaged with sensitive material in an opened manner because of the familiarity of topics. This is not uncommon for those who are constantly exposed to trauma narratives. In their line of work, Kollie and Aamira have experienced vicarious trauma[27]. Jenkins and Baird (2002:423) defines vicarious trauma as "reactions to the emotional demands on therapists and social network members from exposure to trauma survivors' terrifying, horrifying, and shocking

[26] Also known as emotional offloading
[27] Secondary trauma

images; strong, chaotic affect; and intrusive traumatic memories." Kollie is not a therapist but worked in areas of advocacy and student support in university academic settings. Aamira is currently working in a university academic setting and has expressed the common nature of trauma bombing in an academic setting. Aamira, like Kollie, has conveyed that she has unwittingly trauma-bombed individuals but has also been trauma bombed due to her line of work. Aamira's job description entails marking, lecturing and offering academic support to students, however, the emotional support that is required is not clearly outlined or even evident in the job description of an academic. Through further investigation, there is an invisible expectation from academic staff to support students emotionally despite there being formal services that cater to this, such as the university's counselling centre. Due to the regular experiences that these academics go through it is reasonable to understand how one can experience secondary trauma through these unprovoked circumstances. Aamira expressed that she and a colleague would regularly have students come to them about a seemingly academic problem but would be trauma-bombed by the student who would blurt out a traumatic experience that they have had. Usually, the experience that is brought up has had a direct impact on the student's academics, however, student's do not usually come to speak about the cause of an academic problem, but rather to seek an extension for a deadline or a resubmission for an assignment. Aamira says that in this regard, even the student does not expect to trauma-bomb. The person on the receiving end is often left feeling helpless, powerless, frustrated, angry and traumatised through association. Aamira said that she enrolled in a lay counsellors course offered by her institution so that she could be better prepared for such incidents. Other participants alluded to notions of trauma bombing during times of distress, exploring that it was could be seen as a cry for help. Observations indicate that trauma bombing, which is also described as "*word vomit*" help individuals make sense of the world and the incidents that are occurring around them. Again, this form of trauma unveils a notion of trauma denialism, whereby individuals are often trying to make sense of the world, and therefore, are sometimes oblivious to the traumatic nature surrounding the event. Trauma bombing is a term that became popular recently through social media platforms but previously was more colloquially known as "word vomit."

With this, one can recognise the vast ways in which trauma survivors negotiate their experiences in order to make sense of the lived reality. Denialism, overall, speaks of the failure of recognising the culture of trauma present in everyday experiences and provided insight into how individuals view themselves and traumas that have been normalised through different

cultures. The proceeding section explores various expressions of distress through metaphors and idioms. Data collected offered perspective that individuals, often from non-white populations, prefer to use non-verbal and non-medical terminology to convey feelings of distress; which is commonly done through the use of metaphors and idioms.

5.2 Metaphors and idioms

Traumatic stress is an experience that is present in all cultures, but one cannot dismiss cultural influences, expressions and understandings. According to Gilligan (2009) and Jones (2015) trauma and its resulting PTSD are influenced by social and cultural constructs. Mvimbi (2007) and Robbins (2004) (see Jones, 2015:8) have argued that when individuals who are not accustomed to biomedical labelling were interviewed about their involvement and exposure to traumatic events, they did not display typical symptoms of PTSD according to the DSM-V but rather used language that was socio-culturally appropriate. This section focuses on highlighting the cultural understandings of trauma-based on language of distress (both verbal and non-verbal) and taboos, the importance of navigating trauma from a cultural perspective and highlighting various ways in which South African's express distress and trauma narratives.

D'Andradre (1995:217) notes that "cultural representation affects perception, memory and reasoning" and that cultural models and social norms play a significant role in how trauma is experienced and dealt with. Bova et al (2017: 117) argues that social norms are important in understanding how a society or culture responds to phenomena and according to van Rooyen and Nqweni (2012: 57) cultural languages of distress (verbal or non-verbal) exist to illustrate suffering. These authors highlight that when this language is expressed in a context different than its origin it loses its meaning and, in some cases, can produce a new and different meaning. Good and Hinton (2016:23) recognize the importance of culture in illness vocabularies and the impact this can have on ethno-psychology and ethno-physiology. Jones (2015: 8) stresses traumatic events are interpreted and acted upon based on cultural and societal understandings, and this plays a vital role in recovery (Hinton and Good, 2016:24). One can see that cultural contexts have a vital role in the validity of trauma narratives and the ways that they are presented. Cultural models provide insight into cultural contexts. South Africa has many western influences therefore western perspectives can be beneficial to parts of the population, however, there is a dire need for a cultural model that is appropriate for the multicultural landscape.

Chentsova-Dutton and Maercker (2019:1) state that PTSD prevalence rates and symptoms are dependent on cultural factors. This is because each culture addresses trauma and its understandings differently. This creates an impact on exposure, risks, and beliefs situated around traumatic events. If one is able to distinguish the reason for particular traumas, it allows researchers and practitioners to create and implement strategies that enable healing in society. There is limited research that has been conducted examining trauma without the influence and lens of the western perspective of trauma.

The ways in which some South Africans express discomfort and signs of distress differ from the Western narratives; typical signs of distress are presented in the DSM V and the ICD-11. Chentsova Dutton and Maercker (2019:3) address that non-western signs of distress could be illustrated through psychological, social, and spiritual understandings which can be conveyed through stories, metaphors, and explanatory models. Through the use of various modes of expression, distress and post-trauma narratives can be better understood. My research has indicated that my participants and respondents who have endured and acknowledged significant trauma in their lives have difficulty expressing themselves in language that is culturally appropriate to their families, loved ones, and communities. This is because they have come to understand their experiences as traumatic through a western lens, often as a result of therapy sessions with mental health practitioners. Their families, especially those who do not put much value in western ideas of mental health and illness, do not see the experience in the same way due to their own cultural perceptions that have been normalised and internalised. Trying to set down emotional and psychological boundaries, for example for black and Indian people, is difficult because parents often feel entitled to input in all aspects of their children's lives. A common issue is that black and Indian parents also do not understand how their child can claim to be depressed because they believe that as long as your basic needs are met you should be happy. Oftentimes, parents will bring up stories about their own childhood and tell their children that they should be happy because they (the parent) did not have "*such luxuries and nice things, like meat regularly, a TV of your own to watch because they were lucky if they even had a radio growing up or sometimes the community only had one radio that they shared*". Furthermore, mental health illnesses, such as depression, are seen as "*white people problems*". People of colour expressed that their parents and grandparents would often say that they did not have the luxury of being able to be depressed because they were so focused on survival.

Anthropological research has provided pivotal cultural understandings of illness narratives in relation to mental illness; famously this has been done through studies on Idioms of distress and resilience (see Nichter, 1981; Rechtman, 2000; Kim et al., 2019). My research indicated that individuals have filtered their language and expressions of trauma consequences depending on the audience. This entails using language that creates a validity of their experience to a culturally specific audience. For example, all participants expressed that they have some form of anxiety present in their life and 88% of survey respondents supported this claim. However, in many non-white populations stating that one is suffering from mental distress is a taboo topic; this is because mainstream media has situated mental health struggles as disorders that are dangerous and extreme; both to themselves and those around them. Participants and respondents have conveyed that they explain their anxious thoughts and the repercussions as *"thinking too much*." Thinking too much is an idiom of distress that is widely present amongst various cultures (see Yarris, 2014; Hinton et al, 2015; Kaiser et al, 2015; Weaver, 2017; Mendenhall et al., 2019; Backe et al., 2021). Notions of "thinking too much" can be understood as overthinking and have elements of intrusive thoughts. This is a common experience that is experienced across populations around the world (see Yarris, 2014; Hinton et al, 2015; Kaiser et al, 2015; Weaver, 2017; Mendenhall et al., 2019; Backe et al., 2021). Cultures across the world have culture-specific language for the term but boil down to thinking about occurrences too often. The thinking too much idiom is an appropriate way to communicate distress as it does not require a diagnosis and can be understood through several generations. Participants and respondents, especially those below the age of 35, have expressed that they convey their mental distress in culturally and socially appropriate ways; such as explaining their distress in language, metaphors, and stories that resonate with the person they are speaking with. A black female survey respondent explained that she is aware that mental illness is not accepted in South African Black cultures, therefore she is cognizant of the language she uses when discussing her hardships with her loved ones. She communicated that instead of stating that she struggles with anxiety, she says that she "*thinks too much."* This expression is easy to comprehend and has been echoed with other participants and through my observations on social media platforms. Members of support groups on social media platforms have explained that they are aware of the hardships that their parents' and grandparents' generation endured due to South Africa's apartheid past, therefore it is difficult for their generation to understand anxious feelings as South Africa is seen as a more inclusive country compared to their life course.

Primarily it is important to know that the DSM and the ICD are diagnostic manuals that are written through a Western cultural model. These are extremely beneficial diagnostic manuals

that have shaped several understandings of mental health struggles and experiences; they can, however, be exclusionary to non-western populations. I had engaged with Akhona asking if she struggled with anxiety or anxious thoughts to which she said she did not. However, throughout our interviews, there was a common theme of her "*thinking too much*" that resulted in disruptions in her day. She had explained that she and her sons struggle with "*thinking too much*" about the past and what the future entails. This suggests that she struggles with anxious thoughts and aspects of anxiety but prefers a different label that is not situated according to Western biomedical labelling. Tara expressed similar sentiment around experiences of her childhood and of her time in prison. She explained that when she was younger she used to overthink many aspects of her life and her social behaviour and later realized that she struggled with anxiety. Despite her recognising her anxiety and having received a western biomedical diagnosis validating that she has an anxiety disorder; she continuously used the term "*thinking too much."* This was present during her time in prison and the consequences that her son endured due to her actions. She explains that during her time in prison there was not much to do besides think;

> *"It allowed me to look at my actions. I always knew what I was doing was wrong and just waiting to get caught."*

She explained that she spent most of her time thinking about her son, wondering about the impact that it had on him and if he was coping with the ordeal. She alluded that during this time, her anxiety was elevated as she was unaware of the consequences of her actions to those around her;

> *" I spent a lot of time thinking about them"*

A key feature displayed through narratives with participants, respondents and through observations is the notion of thinking too much. Participants addressed that loved ones believe that they *"think too much*.," this results in other behaviour that adds to additional stress.

Children expressions of distress often differ from those of adults. Children tend to make sense of the world through play. Kollie expressed that his uncle had passed away from a "*freak accident*" when Kollie was a child. The unexpected death led to overt expressions of grief being demonstrated by family members. He acknowledged that due to the unexpected nature of the passing of his uncle the emotions felt by those around him were quite raw. He explained that he was around eight years old at the time and thus was able to comprehend and notice behaviours of loved one displaying their grieve. He recalls that after the funeral he, his friends and cousins would *"play funeral"* and now realises it is because he was trying to make sense

of the situation. He explains that they would mimic the dramatic expressions of grieve and thus could make sense of the death. As a result of that, he was better prepared when another family member passed on years later. With this, one can recognise the importance that play had in Kollie understanding of death. Tara son, used play to express his concerns about his mother leaving for prison. Tara explained that she had a few months before she was going to be serving her prison sentence. Tara had used this time to prepare her young son for her departure and opted to seek the assistance of a mental health care practitioner. Her son was constantly listening to what his mother was informing him but did not voice concerns about it initially. Through the therapy sessions, the mental health care practitioner opted to use play therapy while she and Tara conversed with Tara's son. Shortly, they realised that Tara's son had many concerns regarding Tara's imprisonment; like whether she will have a bed, if he can visit and why he could not live with her in prison. These questions were communicated through play therapy and Tara believes that this was the only way he was able to voice his concerns. Observations on social media groups have illustrated the positive use of play for children conveying distress.

Sleep is a crucial part of everyday functioning and sleep disruptions can be one's body conveying distress. Participants and respondents have addressed problems in sleep patterns during high periods of stress. This tends to be a nonverbal cue to my research participants and respondents that their body is communicating that they are under extreme amounts of distress. There is a general notion that participants and respondents either sleep too much or not enough. The key factor here is that there is a disruption in the usual sleep schedule. Participants, namely Tara and Kudzai, explain that during high periods of distress they are up for hours until their body is desperate for sleep, and sleeps for hours. Observations have indicated that loved ones often notice sleep patterns as an indicator of distress. Akhona explained that she pays particular attention to her sons sleeping behaviour,

"If they sleep too much, there is a problem, if they not sleeping something is wrong."

These disruptions in sleep patterns can be an indicator for loved ones as they are non-verbal cues that are easily translated in many cultures. Sleep disruptions are not only indicators of distress in one's life but dreams seem to provide a sense of reflection for participants and respondents. These allow for forms of communication and analysis of one's life. Disruptions in sleep patterns are symptoms present in the western diagnostic manuals, but this is often examined through a negative light, and dreams may be ignored or translated through a western lens; e.g. through a Freudian lens which has no bearing on non-western populations. This is

especially so in the case of a number of African societies. For example, the amaZulu and amaXhosa believe in the existence of ancestors and that ancestors use dreams to communicate with their living descendants. A western psychological lens would overlook this and focus on symbology that is irrelevant in the required cultural context. In many non-western cultures, dreams can be a form of reexperiencing and, more importantly, allowing for communication from spiritual entities and a source of reflection. Dreams provide a source of introspection and can be used to interpret things in daily life. People of colour, particularly black South Africans, (of different ethnic backgrounds), view dreams as important and as indicators of how people are feeling if they are pre-occupied and/ or stressed. Dreams are spiritual. Dreams are not phenomena that are ignored. South African Indians expressed that dreams may be signs or warnings of something that may be about to happen, a warning of someone untrustworthy in your life (the example of dreaming of snakes came up here), or a way to see loved one's who have passed on. Participants, respondents and observations, reflected that during periods of struggle, post-trauma, signs of hope were presented through dreams. This was through communication with loved ones that had passed, ancestors, and religious deities. Active members of support groups regularly post their dreams on social media platforms, looking for different interpretations from other members. One user posted,

> *"I am curious to hear you guys interpretation of a recurring dream I keep having. Every night I have an extremely detailed dream that I am at work, which is a stressful environment. The dream lasts forever and at the end of my day, I am being reviewed by a panel of "people," which includes my boss, Jesus, and my dead father. My boss's review is always that I need to do better. But Jesus and my father keep telling me that I am doing okay and that I should leave. I really need the money and am in no place to leave but I dread work every day and now wake up exhausted, like I had just had a full day of work."*

Members of support groups are extremely interactive and constantly offer support in various ways. Responses included that "*God communicates best through dreams,"* "*maybe you should start applying elsewhere, this is affecting your mental health,"* "*sounds like a toxic work environment that you NEED to escape."* The user admitted that she was not aware of how much strain her job was putting on her until she had this dream. This suggests that this recurring dream provided some perspective that conveyed her work distress that she was constantly experiencing. Fatima expressed that her dreams are her unconscious communicating what she already knows. When she had faced struggles in both her marriages, she had dreams about her

passed loved ones telling her that it was okay if she wanted to get divorced. This provided her with a source of comfort as she was anxious about getting divorced. Here one can notice that various forms of distress can be understood through dreams.

Elements of distress may also come from the body itself. Psychosomatic pain can be described as pain that manifests due to psychological, mental, or emotional factors (Alfven, 1997:8). The factors of pain can be described as the body indicating it needs help in relation to stress. A respondent described an element of psychosomatic pain in her ankle when she is stressed. She explains that her ankle tends to swell when she is "*bearing a heavy load*." A common pain that is translated across cultures is headaches. These are described in various ways but most commonly as migraines. Akhona explained that she gets a piercing pain at the tip of her head sometimes creating impairments to her vision. Tara expressed that she has been having migraines for as long as she can remember and there is no biomedical explanation. She explains that it is constant, but during periods of extreme stress, they worsen. Akhona and Tara's experiences are similar despite not using the same language, and this can be seen as a nonverbal form of stress.

Sally has expressed that she conveys her distress using metaphors. Singh (2017:133) states that metaphors are culturally ingrained and tend to reflect social pain. She conveyed that metaphors became an easy way to communicate her feelings and anxious feelings without feelings *"crazy*." These metaphors are constantly changing depending on the social situation and specific time in her life; she explained that sometimes more than one metaphor is necessary to depict her feelings and surroundings. Currently, the metaphor that most accurately represent her is a pressure cooker, which represents her anger outbursts. She has explained that she struggles to appropriately, and in a timely manner, present her anger. She voices that elements of life will anger her and she will try to not let it bother her, however, it begins to build up inside of her like the pressure would in a pressure cooker. When Sally was pregnant she faced several biomedical challenges surrounding her pregnancy and post-birth. She explained that a metaphor that currently represents her life is;

"So, I feel like a snail with a really big shell on its back, a heavy shell. But I am a slug."

Interestingly, the major difference between a snail and a slug is that a slug does not have a shell. This metaphor suggests that the hardships that Sally is facing, and carrying on her back, is invisible to the outside world; conveying that she is tackling her struggles alone. This metaphor unveils several layers of distress; such as lack of support system and the pain that she

is experiencing; both physically and emotionally. She revealed that she has fears around motherhood and wants to be a good mother to her son, as well as a good partner to her spouse. These worries can stem from the lack of support she received as a child as she was often left to fend for herself, especially in times of sickness. The use of metaphors to convey stress was a common experience that was elicited from data across platforms. This suggests that participants are seeking informal casual ways to portray their struggles with loved ones in a manner that they might understand.

Chentsova-Dutton and Maercker (2019:1-2) explain that responses to trauma are multifaceted and complex, and these differ depending on the cultural context. The DSM and ICD have been a great diagnostic tool that has aimed at universalizing diagnoses situated around trauma and trauma disorders (Bird, 2002; Roberts et al., 2004). This has been established through examining common symptoms around trauma. The aim is to provide validity and create a baseline for practitioners. The DSM and ICD are Western-based manuals that draw on the Western experience, and although useful it sometimes does not reflect the realities that are present in multicultural landscapes like South Africa. Tseng (2006) reminds us that all human behaviour is culturally patterned and shaped by local beliefs and conditioning therefore it is necessary to have the appropriate diagnostic tools and language that is fitting to those cultures.

The following chapter explores the development of mental illnesses as a result of the traumatic experiences that survivors have endured. It delves into understandings of their lived everyday experiences with their mental illness and the impact that their trauma narrative has on lived experiences.

Chapter 6: Development of Mental Illness as a Result of Trauma

A wide range of literature has focused on the rise of mental illness due to traumatic experiences such as depression, anxiety, and personality disorders (Cummings et al., 2012; Dye, 2018). Subsequently, there is a growing body of literature that focuses on the long-term effects that trauma has on individuals (see Steele et al. 2002; Scharf, 2007; Dye, 2018). Through discussion with my research participants, it emerged that those participants who have suffered long term trauma, especially those who suffered childhood trauma, have succumbed to mental illnesses in their adult life. This section, therefore, focuses on mental illnesses that have developed because of traumatic experiences.

Exposure to childhood trauma impacts the psychological developmental process (Dye, 2018:382), which tends to affect one's physical and mental health. As mentioned above, long term exposure to childhood trauma alters the biological evolutionary adaptive mechanisms put in place, triggering the fight/ flight response (Kelly et al., 2011:26). It has been argued that their biology has changed for individuals who have experienced long-term trauma. This means that the trauma has become so difficult to manage that it has fundamentally created structural and functional changes in one's brain and body (McCorroy, 2007:7). This can often result in the development of mental illnesses. Most notably, the most common mental illnesses that have developed as a result of childhood trauma are anxiety and depression disorders. Seven of my key participants have explained that they have been diagnosed with these. Hypervigilance is another common occurrence that will be addressed in more detail in chapter 7.

Participants explained that forming and maintaining relationships as children were problematic and this has reflected into adulthood. This was for a number of reasons, most notably was because of the lack of a support system during periods of distress. Sally, Mira, Shuaib, Brooke, and Aamira all expressed that they had trouble forming and maintaining relationships because of the experiences that they had as children. This was either due to a lack of support system or purposefully having been ignored as a child. Sally, Brooke, and Aamira all have families who invalidated their experiences during childhood. For example, Sally struggles with seeking help for her anxiety and depression especially during times of illness. She explains that because she lived in Mozambique she contracted malaria on four different occasions and had tick bite fever due to the climate. Her parents believed that she was over emotional and dramatic and did not comfort their child during sickness episodes. She recalls, at the age of 12, having a severe case of malaria. She explains that as a result, she began having visual hallucinations as a symptom. At the time, she was left home alone as her parents were on holiday in a different country. She

reached out to them expressing her need for them to return home, they, however, did not believe the severity of the matter as Sally was known for being "*dramatic.*" Sally expresses that she has been alone most of her life and lacked a support system. She explains that her family were not present; emotionally and physically. Additionally, she was constantly betrayed by her friends and boyfriends. These experiences, coupled with her intrusive anxious thoughts and her resultant mental illnesses have left her feeling helpless in times of need.

Aamira's family would actively downplay the severity of asthma attacks and she would be told that it was not bad enough to go to the hospital to get treated. Aamira says the reason for this is likely because even if her mother had taken her to the hospital[28], the waiting time would have been 5 – 6 hours before even seeing a doctor to receive the obvious diagnosis of an asthma attack and the need to be nebulised. She would have to get to the point of almost not being able to draw breath before being taken to the hospital. While she doesn't feel angry about what happened, Aamira does say that she internalised the experience to mean that she had to deal with her problems on her own and not to seek help. Making friends has always been difficult as well and this is related to feelings of inadequacy that stemmed from childhood relationships. Divorce in the Muslim community was not a common thing in the 1980s and Aamira's family was stigmatised as a result, specifically by the Muslim community they lived amongst. Aamira said that Muslim girls at her school would befriend her on one day and unfriend her a few days later. This would be a continuous cycle throughout primary school. Aamira's grandmother insisted that Aamira had to be friends with Muslim children, no matter what, because she believed that non-Muslim friends would lead her astray. She would tell Aamira that she needed to try harder. Aamira would try her best to please the Muslim girls in her class so that she could play with them during lunch breaks. These experiences have led to mistrust of people as an adult, and the need to people please.

Brooke lacks trust in people (regardless of the closeness of the relationship) because of the constant betrayal she has experienced from her loved ones. Brooke grew up in a single-parent household and is unaware of who her father was. Brooke recalls that her first real relationship (a friendship) outside of her family was when she was around eight years old. She had developed a deep friendship with a female friend in school and felt secure. Her mother, however, has been a constant problem in the demise of many of her relationships. Brooke's mother began an affair with Brooke's best friend's father, who was married. Brooke describes

[28] This was a provincial hospital that had to solely cater for the entire township of Chatsworth, which had a population of roughly 100 000 people at the time.

her mother as a narcissist; however, her mother has not received any professional mental health care during her life course thus has not received a diagnosis. Brooke's mother does not believe in professional mental health care and invalidates mental illnesses within her own family. Brooke's needs[29] were constantly ignored as a child, and young adult and her mother only focused on her own personal interests. Her mother was aware of how vital Brooke's friendship was to her; however, she put her physical needs first. This created a source of conflict between Brooke and her mother as they, (her mother and her friend's father), would have sex in her home. This put a strain on Brooke's relationship with her friend as she felt she was deceiving her, especially when they would visit each other's homes. This created a form of constant hyperawareness in Brooke as she came to the realisation that everyone may not be who they say they are. This further developed into an anxiety disorder as she grew older. This, coupled with the years of abuse and intrusive thoughts, eventually led to a major depressive disorder that Brooke still struggles with today. Unfortunately, Brooke's trauma experiences followed her into her adulthood. She expresses that her "*severe trauma*", i.e. BIG T, was post-2015. She had dropped out of university, in the Eastern Cape, and moved to Johannesburg, Gauteng, where she told me with little to no emotion that she *"was almost killed about six times by my boyfriend."* She explains that during her time in Johannesburg she was raped and physically beaten a number of times by her then-boyfriend.

Shuaib has been diagnosed with PTSD, generalised anxiety, and depressive disorders. The multiple accounts of unrelated traumas that Shuaib recalls, by definition, constitute cPTSD. Shuaib has not specifically been diagnosed with cPTSD, however, the extent of his traumatic experiences places him in this category by definition. For individuals who have experienced long-term trauma, many of their mental illnesses are seen as part of their personality and character traits because they have been present for long periods. As a result of the extensive years of abuse, Brooke has been diagnosed with cPTSD. Due to the turbulent life course, she has developed a range of mental illnesses and physical illnesses. Most notably, her anxiety and depression have directly impacted her social behaviour. Shuaib highlights that his anxiety has always been present in his life; however, it was just not diagnosed or labelled. He saw his generalised anxiety as a characteristic of his personality rather than a disorder that needed a diagnosis. As a father, his son began expressing forms of distress whereby Shuaib and his wife sought medical intervention; ultimately, their son was diagnosed with an anxiety disorder. This allowed for a period of reflection for Shuaib as he questioned his own experiences, and his

[29] Psychical and emotion

feelings mirrored those of this son. He pondered if his son had shared the same forms of punishment and upbringing as Shuaib had, what obstacles would he face today. Shuaib acknowledges and validates his son's experiences, but this allowed for a moment of reflection as he felt more secure and released of some of the self-stigma he felt towards his diagnosis. One can understand this thinking because he has been exposed to various traumas. Shuaib's exposure to traumatic experiences has created a form of hypervigilance in his daily activities, impacting his behaviour and perception.

Children who have experienced childhood trauma and were present in instances of interpersonal violence display forms of anxiety and anxiety disorders in normal everyday circumstances. There may be an instance when children experience parentification[30], and they are left to parent their parent and/ or their siblings. Additionally, this is a common trend depicted through my online observations. As adults these children, for example, Brooke and Mira, do not unlearn these behaviours and believe it is their duty and responsibility to be the caregiver in almost all situations and relationships. This results in creating patterns of unhealthy behaviours that are detrimental to the individual. Brooke had admittedly stated that she is guilty of this trait and often seeks it out in social and romantic relationships. She believes that this is where she is seen as valuable and needs to take care of those around her. She explains that the first time she learnt that she is not responsible for those around her was in therapy when she was 14;

> *"it was only at the age of 14 when I did seek help from a school counsellor told me after a session that "you do realise that you don't control people, you can't get them to behave a certain way, you can't change the mood of anything, and you're not responsible…"*
>
> *I was like, this seems like a trick…really?"*

She admits that she is still trying to grasp this concept and learn this today. Brooke sheepishly states that she has spent most of her life fawning[31] in almost all situations, believing she is a social chameleon. Fawning is a trauma response that is commonly learnt at a young age due to constant upheaval. She explains that the fawning behaviour, combined with the sexual and physical abuse as an adult, resulted in many people taking advantage of her. Fawning is a common trauma response and can also be understood as people-pleasing in order to reduce

[30] The acts of children having to play the role of a parent to their parents or siblings
[31] People pleasing in order to avoid conflict

conflict or potential conflict. Mira, Aamira, and Sally are also guilty of this. Sally explains that she is so accustomed to people abandoning her that she will people please her way through social and romantic relationship even though she is aware that they are unhealthy relationships. She explains that her best friend, at the time, would constantly make sexual advances on Sally's boyfriends and often have sex with them. Sally's friend would eventually confess the ordeal and pressure Sally into forgiving her as they "*were such great friends."* Sally admits that she forgave her as she tried to avoid conflict and people-pleasing was easier than arguments.

Brooke struggles with avoidance behaviours and fixation which she attributes to the cPTSD. She avoids confrontation, relationships, and commitment to things. Brooke explains that she struggles to maintain romantic relationships as "*I always picture how I can fit into their life rather than how they can fit into mine."* This further illustrates the intensity of her statement expressing that she is a social chameleon. She declares that the longest romantic relationship she has had was when she was in high school that lasted a year and a half but that mirrored the relationship that she had with her mother and her childhood trauma.

> *"He was not present, emotionally distanced and manipulative and he took me for a pus"*

With this, one can recognise the role that mental illness plays in trauma's survivor's perception of the world. This tends to create a rippling effect into the way in which they approach relationships and the impact this can have on support systems.

My research has highlighted a strong theme of toxic masculinity amongst male participants and respondents. Salter (2019) explains that toxic masculinity refers to traditionally masculine traits that have transferred harm to society and men themselves. Three of my ten key informants were men of colour and displayed some degree of toxic masculinity because of their upbringing. Of the survey data, 35% identified as male and of this, eighteen men stated that they had been victims of interpersonal violence. Only two respondents had reported it to the police; and the outcomes are unknown to me. Qualitative data reflected a strong indication that forms of abuse, especially those whereby women were the perpetrators and men the victims, were unreported due to stigma.

Common experiences from male participants and respondents were around the expectation of men to suppress emotion, regardless of the event or situation, to keep quiet about interpersonal violence if they were the victim (of a woman), and silence in relation to sexual assault. Shuaib describes that is in South African Indian households, it is unacceptable and even taboo for male

individuals to discuss and express emotions. This conditioning begins from childhood and is ingrained throughout one's lifespan. This further invalidates mental illness diagnosis, which prevents a method of healing. These expectations existed because as men, it is believed that they must not show any emotion other than anger and that being a victim of domestic violence means that you are weak and pitiful. Sexual assault was also trivialised. Males who have had sexual experiences young as a result of being groomed, and who have been sexually assaulted are made fun of if they complain about it. The general expectation is that as a man they should enjoy the interest that a woman shows them and they should enjoy the experience. This is echoed on online forums when posts are made, for example, about schoolboys being molested by their female teachers. Responses are generally in the area that the boy is lucky that he got to have sex with his 'hot' teacher, and some comment that they wished they had teachers like that when they were in high school. It is not usual for messages of support to show up. The reality of the nature of the violation of body and personhood is generally ignored for men. Whilst women are victim-blamed in cases of sexual assault, men are belittled.

As addressed previously, Kudzai was molested as a child and was unaware of concepts of sex. As he grew older[32] and became aware of sex, he realised that he had lost his virginity before his friends and was embarrassed to tell his friends of his past sexual experiences. Kudzai had not disclosed the nature of his relationship with his caretaker outside of his current relationship of three years before the interview.

> *"No one besides (girlfriend) knows. I am a black Shona man you don't complain about getting sex."*

Kudzai is aware that the nature of the relationship was an abuse of power, and he was taken advantage of; however, there is a particular expectation for men in society. The traditional gender expectation men often involve men being the breadwinners in families, showing no emotion, and displaying strength, both physically and mentally (Wikström, 2019:28). A shift in this narrative creates an image of a weak man. The National Sexual Violence Resource Centre(2021) states that men are conditioned not to identify as victims as this demonstrates weakness. This correlates with Kudzai experiences.

Additionally, Kudzai identifies his primary traumatic experience is through the loss of his parents. His father passed away due to HIV complications when he was a child and his mother

[32] During his teenage years

to cervical cancer when he was 23. With the loss of his parents, he was told to suppress his emotions. With the passing of his father, family relatives conveyed that he needed to be strong for his mother as she was having a difficult time with her husband's death and instructed him not to cry as "*men do not cry*." This created a lasting effect on how Kudzai expressed emotions. His mother's passing was extremely difficult for Kudzai and resulted in depression. Kudzai mother was HIV positive and had cancer.

> *"She had been sick for a long time, but she first fell sick when I was writing my final exams."*

Kudzai expresses come conflicting emotions during this period. Kudzai was under immense pressure as it was his final O-levels[33] exams, and he was writing Mathematics paper two. Kudzai usually performed well in mathematics, but he still felt the pressure as he did not test well, and his mother was aware of this. During this examination period, his mother had collapsed, and Kudzai believes that this is due to worrying about his examinations. Family members informed him that she had collapsed but he was not aware that she was hospitalised as he was in boarding school. He had discovered that his mother was in the hospital two weeks later, after his final examination paper. His cousin-sister arrived to fetch him from boarding school, which was unusual as his mother usually sends bus fare. His cousin told him about the hospitalisation for the first time during this trip. She had been ill for six years before her passing.

Kudzai expressed that the fifteen-minute drive from the graveyard back to his mother's house was the longest drive he has experienced in his life. It is important to note that Kudzai is used to long-distance travelling. He has constantly travelled from Zimbabwe to Johannesburg, South Africa, by bus, which is an approximately a seventeen-hour bus trip. This emphasises the hardships and emotions felt during the fifteen-minute commute. During the commute, relatives tried to communicate with him, but he explained that he could hear them but was completely "*zoned out*". This can be understood as a form of dissociation in order to process and cope with traumatic events. Once he had reached his childhood home, his uncle voiced his concern over Kudzai, and this led to Kudzai first display of public emotion since being a child. Kudzai reflects that during this period of letting emotions in, he has not been the same since, and it

[33] This is equivalent to South African grade 10 and 11 exams

opened a wave of emotions that he had long suppressed. He currently struggles with depression and believes that it began during this period in his life.

Shuaib, like Kudzai, struggled with forms of toxic masculinity as well. He was accustomed to the strong men narrative that is displayed in society. As mentioned, Shuaib grew up in a strong female-dominated household; however, he was expected to be stronger than those around him despite being one of the youngest. His caregivers had indoctrinated him with gender roles and expectations, but not exactly the traditional types. Surprisingly, they had taught him that women are the superior gender and they should be treated this way which is not the norm in many patriarchal societies. They did, however, teach him that men should be providers for families, boys/men do not cry or express emotion (outside of anger), and boys/men should take responsibility for everything. For example, it was ingrained in him that if a girl/woman close to him was in trouble or in distress, it was his duty to take on her burdens and claim to be responsible for the situation even if he had nothing to do with it. He does reveal that currently, he struggles with understanding if this gendered narrative is right or wrong. This is due to the numerous beatings and other forms of punishment that he received as a child because of something that would happen to his sister or female cousins;

> *"For example, if we (cousins, sister and himself) were playing outside and one of them (the girls) fell and bruised their knee, I would get punished for it."*

He explains that his caregivers interpreted the situation as either he was chasing them that resulted in them falling, or most notably, it was his responsibility to ensure that everyone was safe and had not fallen. He would have been severely punished for these actions in both of these instances. Through a reflective process, he explains that he has no ill feelings towards his cousins or sister but has difficulty negotiating the reasons for the punishment as he somewhat understands the role of being male in these situations. This strengthens the understanding of toxic masculinity displayed in households that can shape one's perception of the world.

Kollie has demonstrated the same narrative as other men in this sample group depicting that men do not cry. A standard narrative displayed to Kollie throughout his early childhood was that these emotions were reserved for women and not men. Kollie recalls an expression that he had heard from his paternal grandmother, which was,

> *“Indoda ayikhali, idla umhlathi.”*

Kollie translated this expression as *"a man does not cry; he grinds his teeth*". In other words, it can be understood to people that men need to acknowledge their emotions (tears) internally and not externally, meaning that a man has to bear the burden of his emotions silently. Currently, as a man in his thirties, Kollie can express and understand emotion a lot better than when he was a child and teenager. During his university years, he had many black male friends who were highly expressive of their emotions and even felt comfortable crying in front of others. They often pointed out to Kollie that he was "*weird*" as he did not display any form of emotion. He does point out that his friends displaying emotions did not influence how he expresses himself today, but personal growth and unlearning that black men don't cry has helped him navigate self-perception.

There is, however, still forms of toxic masculinity that are still present in Kollie's life today. This stems from childhood (grade 5) where there were various forms of bullying. Kollie now sees it as a way of making sense of his sexuality. He often played with girls in his classes and not boys. This further encouraged bullying from his peers. Strategically, Kollie found a form of protection as he was academically strong, which allowed for leadership benefits that created a protection force. He reiterates that the bullying was physical and verbal. He often expressed concern to his caregivers that peers had physically hit him at school, and he was instructed to hit them back. These ideas originated from the expectations placed on the male gender. This resulted in Kollie withdrawing socially from a lot of physical situations. He explains that he would want to play with the girls and engage in stereotypically feminine activities; however there was an expectation as a boy to play on the field with the other boys. This created forms of hesitancy within his social behaviour as he was aware that if he played with the girls, which is what he wanted, he would be teased or attract unnecessary attention. Additionally, if he decided to play with the boys on the field, he would be teased as well as he was not athletic like his male peers. This created a form of anxiety within Kollie, and he believed that if he withdrew socially, it would eliminate the teasing and internal struggle.

Kollie has escaped the social sporting interaction since his school years; however, once in a while, he reflectively states that he is transported back to those times of hesitancy due to everyday occurrences. Kollie grew up in the township, and his family still lives in the area. He explains that in the township, daily, boys play soccer in the street. Due to the conflict, he faced during his school years, Kollie still struggles with kicking the ball back to people playing soccer.

"The soccer stuff still traumatises me till this day."

He has this internal notion that if he kicks the ball back to the group of boys playing, they will ridicule him as he "cannot kick a ball,"

> *"I just carry on walking. So now the thing is, if you do that in the township, especially if you're boy is like, you're disrespectful, just kick it back. But the thing is, the first few times I tried, it showed that I can't play soccer. So again, what happens, you become ridiculed. It's like you should have just let it go, like this embarrassing. So for me, it was that thing (kicking a ball) that would scare me. So if I saw people playing on the road and my calculation told me the ball might just be kicked in my direction, and there's another street I can use I will use another street just to avoid that possibility. And it happened to me like two weeks ago, kids were playing in the field. It was in my complex and I was walking from the gate to my flat and they kicked the ball in my direction my body said kick it back to them but my brain said no, carry on walking. Okay, carry on walking, and I realise I still carry that from primary or early High School, but I will not kick a ball."*

This illustrates how childhood experiences, even something that can be interpreted as minor, directly impact perception. Kollie's understanding of kicking a ball is fuelled by the masculine narrative of being a man's expectations.

Through these three key informants, the nature of toxic masculinity is indisputable that is present in cultures across South Africa. These three men of Shona, Zulu, and Indian-Muslim ethnicities demonstrate the common theme that boys are not allowed to cry and further perpetuate the belief that men are expected to display masculine toxic traits in society to be considered a man. This has created a false perception of the ways in which they are expected to present themselves in the world and in turn has had a direct impact on their behaviour and perception.

Chapter 7: Traumatic symptoms

South Africa has a long history of traumatic exposure. Political, criminal, and interpersonal violence, as well as accidental injury, are all contributing factors to why South Africa has a high number of traumatized individuals. It is not surprising that 73.8% of South African citizens are potentially exposed to one traumatic event in their lifetime (van Zyl et al. 2017:235). Since the abolishment of apartheid, in 1994, South Africa still has high rates of traumatic exposure.–South Africa is infamously known for extreme levels of physical and sexual violence and high crime rates. Due to the high rates of violence and historical past, South Africa is the perfect melting pot to examine the consequences of trauma exposure and narratives. Kaminer and Eagle (2010:4) describe South Africa as a 'natural laboratory' to study the effects of trauma because of its history and contemporary events. This chapter explores the traumatic symptoms that are experiences due to exposure and experiences. These experiences highlight the relationships between trauma stress and fear as well as the how individuals experience behavioural changes as a result of trauma endured. South Africa presents a unique perspective as it allows society to see that despite the political and social changes that have been implemented since the end of the Apartheid regime, the consequences and causes of traumatic events should not be seen in isolation as they directly impact on another which creates heighten traumatic symptoms. My participants and respondents trauma narratives may not directly stem from South Africa's political past but instead the way they navigate their world is a consequence of it. With this, one can recognise elements of detachment, hypervigilance and avoidance present in the way in which they tackle post trauma experiences.

7.1 Detachment

As mentioned in chapter 1, South Africa's prevalence rate for PTSD is at 2% which is lower than most developing countries, however, one may argue that this low rate is not because individuals are not suffering the consequences of traumatic events but rather, they are unable to access resources to achieve the desired help. Additionally, it could be argued that many mental health resources are situated around the Western gaze and diagnostic manuals are exclusionary to South African cultures as they do not possess the same language and understandings of trauma narratives. The rich ethnographic and survey data collected throughout this study, reveals that many citizens are aware that they have experienced trauma and have undergone extraordinary stress but do not classify nor identify themselves as victims of trauma but rather it is something that has "*happened to me [them]*." Survey data, however, reflected that of the 72 respondents only 4 respondents (which is 2.88%) have only experienced

one form of trauma. This includes both direct[34] and indirect[35] trauma, highlighting the epidemic of violence and trauma narratives present in South Africa.

Anthropologists have examined various ways to explore sickness and distress by removing the Western biomedical labelling allowing for more culturally appropriate approaches to healing (see Foster, 1976; Nichter, 1981; Fabrega, 1989; Sorsdahl et al., 2010). Chentsova-Dutton and Maercker (2019:2) emphasize the importance of using cultural models to minimize complexity in trauma and trauma-related studies. They draw one's attention to the fact that trauma survivors often tend to filter their experiences based on a few factors, namely;

1. The symptoms that are directly linked to the traumatic experience;
2. What causes the most pain;
3. Which experiences are believed to be the most difficult or meaningful;
4. What is socially and culturally appropriate to discuss;
5. Which would create the most support from others.

Chentsova-Dutton and Maercker (2019:2) highlight that these five factors are general ways in which trauma victims engage in conversation that can describe their experience, but limiting factors are due to cultural taboos and limitations. Participants tended to filter their experiences as they were discussing their trauma narratives. As mentioned, South Africa has a tendency of normalcy regarding violence (interpersonal; criminal, and political), however, narratives surrounding interpersonal violence were more discrete than political and criminal. Eight of my key participants openly recounted experiences that surrounded criminal activity while interpersonal violence was discussed with more scepticism. Culture has a role in this. Through my observations and discussions with participants, there are behaviours that are indirectly learnt through socialisation and social behaviour regarding taboo topics. For example, whilst there is a normalcy of domestic violence in Indian households in South Africa, there is also a hushed nature as they are considered private matters. This stems from culture as there is a dominant mindset amongst South Africa Indians as to "*what will people think?"* George (2018) provided a global cultural test examining emotions that motivate individuals across cultures emphasising patterns of guilt, shame, and fear. George (2018) presents that South Africa as a whole is collectively driven by guilt behaviours, however, the South African Indian population is driven by shame. George's (2018) study specifically looks at grouping populations according

[34] Physically suffered the trauma

[35] Witnessing the trauma but did not suffer any injuries

to guilt, shame and fear. This does not mean that there is a blanket cultural understanding for a multicultural landscape but rather that these patterns are common amongst diverse populations. These are similar patterns that are displayed in Indian populations across the globe, which arguably originate from cultures in India itself. George (2018) work provides confirmation that South African Indians are deeply concerned around public perception and public image is important. Discussions with participants of the Indian population have resonated with "*what will people think"*, a mindset which tends to reason why domestic violence is so prominent and hidden in Indian cultures. This is because individuals do not what to bring shame to their families and loved ones (including their abuser), thus remaining silent about such violent matters.

Similar cultural patterns are illustrated in black cultures in South Africa surrounding domestic and sexual violence amongst family members. Observations speak directly to this; and is illustrated through a thread of cries for help of black women seeking support to confront their family members about sexual abuse. None of my key participants spoke to this issue.

81% of survey respondents addressed issues surrounding criminal activity. Of the 58 people who encountered criminal activity, 28 people stated that they were left unharmed without serious injuries, despite the preparator having a weapon. Most of these encounters involve acts of intimidating the victims by shoving and pointing the weapon. A survey respondent paints a picture of two instances that involved criminal activity.

> *"the first incident, they hijacked my uncle outside the house, when we tried to assist they pointed the gun at us. They then got into my uncle's car and got away.*
>
> *The 2nd incident, I was home alone and heard them breaking down the front door. I locked myself in my bedroom. They also cut the phone lines and I didn't have my cell phone with me. They ransacked the house and in the process of trying to open the garage activated the alarm. This scared them off. They managed to steal my car as well. The private security reacted and there was a shoot-out, when my car was retrieved there was blood in the car, but the perpetrators got away."*

She explains that no one in her family was harmed; however, this vignette speaks to the complexities which ingrain traumatic narratives. The wording suggests a sense of helplessness and an entrenched form of hypervigilance present as the respondent expresses that she was home alone. Additionally, the vignette provides context to the detachment of the incident. She witnessed a shoot-out, and paints a picture of the incident, however, her focal point is that the

"perpetrators got away." This speaks to the normalcy of violence resulting to life threatening circumstances that are commonly portrayed in South Africa. The incident described in both events are considered traumatic yet the respondent is primarily concerned that the perpetrators had gotten away, speaking to the commonness of events like this. With this, From the examples and experiences described above, one can identify that traumatic exposure to criminal activity is normalised in South Africa.

Most of Kollie's dominant trauma narratives are situated around criminal activity. Kollie is an academic researcher and was recently collecting data in Durban. During data collection, he was hijacked. He and his research participant were walking down a valley-like area, often overlooked by bystanders. They had found a shady isolated area to conduct the interview. Kollie was not familiar with the area or with the locals. A man walks up to them, Kollie assumed he was a local, and pointed a gun at them demanding the car keys;

> "*They want the car keys so now I'm struggling, struggling with my pockets trying to find the keys. Then as the guy (the participant) was trying to stand up, they fire a shot. So okay, it's a real gun and he (participant) sits down because I think he wanted to fight with them. Okay, so we sit down then they walk off I think then they realised to stop us from running after them, they took our clothes. I don't know whether they wanted them or was just to stop us from going after. So they took my shoes, was like some sneakers And then took, took the pants I was wearing."*

Kollie explains that no one was physically harmed during the ordeal and the police eventually retrieved the car. He believes that they weren't trying to harm them, and the gunshot was a warning shot. This correlates with a lot of criminal activity that survey respondents voiced. Acts of intimidation were used more than acts of physical violence. Kollie explanation and understanding of the ordeal can speak to an aspect of denialism leading to detachment. Kollie is aware of the multiple ways that the traumatic event could have played out, but he is explaining that the perpetrators were not trying to harm them speaks to the detached nature as the experience could have been worse. The detachment is a coping strategy in this case in order to make sense of the trauma.

A similar trend of intimidation was used during a house burglary when Sally was a child. She explains that four-armed perpetrators broke into the home by unscrewing the air conditioning box attached to the wall from the outside. They had climbed moved into her room, picked her

out of her bed, and carried under her arms, like *a "child with a dirty diaper"*, to her parents room demanding they open the safe, point a gun at her. The perpetrators had gotten away with the contents of the safe and the family was physically unharmed but encountered psychological injuries.

As mentioned briefly above, there is a sense of detachment that is accompanied with victims of criminal violence. There is the notion it is me/us versus them (perpetrators), as presented with the survey respondent regarding the shootout. However, this drastically differs with victims of interpersonal violence (mostly with intimate partners or kin). Denial presents as the reasoning for this, which was explored in chapter 5, however more notably, there is a frequent hushed nature implying partial responsibility or presenting loved ones in a negative light. I briefly mentioned in chapter 4 that Chrystal was raped by a classmate. Chrystal and her rapist shared mutual friends, however, she actively chose not to inform her friends of the rape as she did not want them to feel partially responsible as they were present at the end of year celebration.

Through these ethnographic descriptions, one is able to see the various level of filtering that occurs when discussing traumatic events. Criminal activities are easier to discuss as there is a sense of normality in South Africa compared to violence amongst kin. There is a sense of detachment present amongst the perpetrators of criminal violence. This can be understood as a coping strategy in order to deal with the nature of the event. Additionally, criminal activities are often centred around theft and there are polarised communities here; both have self-interest[36]. This can be understood through us versus them, which creates a sense of detachment from the people involved and the event.

This is different for violence between kin. Violence of any kind which occurs within family relations is complex because there is a community and/or family interest present compared to self-interest. George's (2018) culture driven work focuses on two key elements that drive South African cultures; shame and guilt. Both of these can be key factors as to why the hushed nature of violence amongst loved ones exists. Culture and cultural ideas are extremely fluid and consist of multiple knowledge systems, especially in South Africa (Kirmayer and Sartorius, 2007:823). Mira accounts for her traumatic experiences during her upbring and now recognises a sense of detachment. She explains that due to the violence present in her home, she struggled

[36] The victim self interest is safety and the perpetrator interest is to get what they want

to make sense of the situations constantly arising. She explains that as a teenager she became more and more aware of the toll that the violence had on her mental health and resulted in her socially withdrawing. She has a vivid memory of sitting with her large group of friends during her lunch breaks at school but not conversing with anyone. It explains that because the friend group was so large, it was easy to "*go unnoticed*." Her loved ones assumed that this behaviour was a symptom of puberty and did not force any interactions. Mira explains that during that time, she was trying to deal with her mental health struggles and in order to cope with that, became detached from the social world. Culturally, Mira was taught that family matters are dealt with in the family thus she did not seek emotional support from her friends as this may have brought shame to her family; reiterating the notion of "*what will they say*." The understandings presented above illustrate that detachment is a symptom that accompanies post trauma experiences that allow trauma survivors to make sense of their traumatic experience.

7.2 Hypervigilance

This section explores hypervigilance, a form of mood alteration, as a key post trauma symptom, which is highlighted in the DSM-V, ICD-10 and 11. These manuals, although attempting to depict the universal experience, is extremely relative to the Western lens. South Africa, like other colonised countries, has a heavy western influence therefore the manuals are appropriate to parts of the population. Due to the multicultural landscape, however, the language and lens do not fit the country as a whole. Typically, post-trauma symptoms are experienced in direct relation to the trauma itself; however, it is apparent that these are experienced on a daily basis and are exacerbated by stress, which will be addressed shortly. All eleven key participants believe they have experienced trauma, and this has created a shift in behaviour and perception, through various forms of hypervigilance, detachment and avoidance. This mirrors the information that was gleaned from the stressful life events questionnaire. The questionnaire analysed stressful experiences across one's lifespan and analysed the data through the lens of trauma. My quantitative data reflected that these individuals have been victims of multiple traumas across their lifespan but due to the cultural understandings, taboos, and language it is not seen as traumatic.

This created a form of acute post-trauma symptoms, particularly hypervigilance, amongst my respondents and key participants. Through my discussions with them, it is noticeable that because of the acute nature of the post-trauma symptoms and the regularity of these crimes in South Africa they do not consider it as traumatic compared to other traumas experienced, like

interpersonal violence. The epidemic of criminal activity has instilled the narrative that it is a citizens responsibility to ensure that they do not invite criminal violence or activities. This has created a societal sense of hypervigilance across the country. All participants explained that they have some sort of safety measure put in place in their homes protecting themselves from intruders, i.e. alarm systems, access to weapons in case of emergency, and burglar bars. The symptoms and behaviours here often correspond with typical PTSD symptoms and are organised around the crime itself. There tends to be constant fear around safety, and this is displayed through hypervigilance, a form of mood alteration. Through every observation and conversation with fellow South African's, hypervigilance in relation to safety is displayed through everyday behaviour, it has somewhat become second nature and somewhat routine. This can be explained by walking fast in the evening, alarm systems and ensuring homes and cars are actually locked. Hypervigilance is a core symptom of any trauma experience. With traumas that are situated around criminal activity, hypervigilance is often coupled with avoidance. For example, a coloured Christian respondent stated that their house was burgled during Easter while she and her family were at church. She is aware that the neighbourhood she and her family live in is not the safest and crime rates have increased. Due to the burglary, she became more fearful in all aspects of her life. She was afraid to leave her home but simultaneously afraid to be inside it in case they came back. This created a form of hypervigilance in her everyday activity, she began to self-blame and explained that it was because she didn't close the curtains early enough and her children would leave their bicycles outside. The self-blame behaviour occurred for two weeks before she and her husband decided to move so she could have peace of mind. This experience addresses the hypervigilance and re-experiencing symptoms that are accompanied by acute traumas. These symptoms disappeared once she and her family moved homes into a new neighbourhood.

Hypervigilance as a result of criminal acts tend to be more clean cut in their explanations. This is different when it comes to interpersonal violence. 58% of survey respondents have been victim to interpersonal violence. Surprisingly, 18 of the 42 respondents identify as male and this number is extremely high, (almost 50%), compared to general statistics which reflective relatively low numbers of male interpersonal violence. This speaks to the number of reported incidents that male survivors have endured. This could be linked directly to ideas of masculinity that were previously discussed. There are several studies that have been conducted on survivors of interpersonal violence and the majority of these involve female participants. This does not mean that men are not victims of interpersonal violence but rather that they are less likely to

come forth. The anonymity provided by the survey may have resulted in the creation of a safe space for males to be open about their experiences without fear of negative responses. Of my eleven key participants, three are male and came forward with experiences of interpersonal violence. My male participants spoke of their male loved ones and their (male participants) experiences with interpersonal violence displaying acts of intimidation, emotional, and physical violence. This suggests that there are more male victims of interpersonal violence than literature depicts. During my conversation with Kudzai, he admitted that he knows of several men who were molested when they were boys, but it is socially not appropriate to disclose this because it directly impacts one's "*manhood*." In post-trauma experiences of interpersonal violence, there tends to be a gendered dynamic in the ways in which trauma is processed and the trauma responses that are elicited. Kaminer and Eagle (2010:9) state that gender is a factor in the types of violence and traumas one is exposed to and that women and men are more likely to be victims to particular crimes as they are at higher risk, such as sexual violence, domestic violence and criminal violence. Literature often reports that women are more often victims of domestic violence and sexual violence while men are more at risk for criminal. Hypervigilance through these crimes differs for men and women. Male participants and respondents explain that they are the most fearful in areas that have high rates of violence and criminal activity. Male participants expressed that they are constantly looking over their should to assess if there if any potential danger lurking. Additionally, male participants and respondents state that they do have a weapon of some sort near their bed in case of danger that occurs during the night. These are consciously playing on the minds of men as they are aware of the potential dangers that come with living in South Africa. This suggests that males' levels of awareness spike in areas that are associated with danger and unknown perpetrators. This, however, differs for female participants and respondents as they are more conscious of violence coming from loved ones and individuals that they know and are constantly around. Participants and respondents express knowing loved ones are more likely to inflict violence upon them create heightened hypervigilance in everyday life. Mira expressed that she has witnessed men in her life, who she often trusted and let her guard down around, "*flip their switch*" and inflict acts of horror. She recalls a particular event whereby she and her long-term boyfriend were having an argument and he lost his temper. This resulted in physical violence on his part, and this was not a behaviour she had witnessed before; despite knowing him for several years. She explained that this triggered a level of awareness in herself that no one can be trusted and exacerbated her hypervigilance. She struggles with trusting men and often do not let them into her home alone, in fear of past events reoccurring. She states that she is aware that "it is a bit crazy but its

difficult to let my guard down." She explains that this has created a ripple effect into her romantic relationships.

Through discussions with my research participants and data collected from my research respondents, several of them have experienced interpersonal violence through relationships that they were currently in, both social and romantic. There seem to be very few respondents, 12% who have been the victim of interpersonal violence by a stranger. Considering this, I will be examining the post-trauma responses in relation to chronic traumas as it should not be seen as an isolated event. These examples and discussions involve a particular use of power that tend to isolate individuals, who therefore struggle to receive help due to the language, threats, and social norms involved.

A frequent trauma response and emotion elicited from victims of interpersonal violence is fear (Badour et al., 2011:401). The fear translates to forms of hypervigilance. This is because of the constant upheaval that is present in one's life. This, coupled with common symptoms of post-trauma of avoidance and mood arousal are depicted in ways that are typically not analysed through western diagnostic manuals. My data reflects that trauma survivors do not recognise the term hypervigilance because the language and cultural understanding are not familiar to them. They also see it as being a normal part of a South African's life. Often models of healing are produced through Western cultural models. Many non-white populations in South Africa do not identify with those models as their upbringings were more central to addressing their emotions through feelings of distress. Chentsova-Dutton and Maercker (2019:2) address that non-western populations use filters when conveying their traumatic experiences. More specifically, they draw their attention to symptoms that may result directly from the traumatic experience. This can serve as problematic as individuals may not realise that post-trauma feelings of distress may stem from the trauma itself. Mira explains that growing up she was not aware of what anxiety attacks were and how they accumulate through various experiences. The constant emotional turbulence that was present in her life resulted in forms of hypervigilance that resulted in anxiety. In other words, her anxiety would build from various causes, and she explains,

> *"the anxiety build-up could last weeks, sometimes even months before I had an attack. I always thought that I was super paranoid growing up because I was always waiting for shit to pop. Now, through tons of help from my psychologist I am able to realise that those feelings are an indication that the anxiety is building."*

Mira explains that she is constantly analysing every room that she enters. Most recently, she recalls visiting a friend and unconsciously began scanning the room for exists in case of an emergency. She further explains that a cat had entered through a window, startling Mira which resulted in her bolting off her seat to the nearest exist. In that moment, she realised how extreme her trauma experiences are on her everyday living, even in environments she feels safe.

I argue that because of the common cultural experience around silencing taboo topics, individuals have not learnt to articulate this feeling without repercussions; social and physical. For example, Akhona does not resonate with western biomedical labelling as she was never exposed to it. She, however, did state that there are times whereby she "*thinks too much*" about events like her trauma narratives. She is aware of the criminal dangers in her neighbourhood and actively makes decisions that would not put her in danger. She explains that she thinks about criminal activity often and it can make her paranoid, especially in the evenings. This notion can be translated into hypervigilance. Akhona explains that she ensure that she does not return home too late to ensure that she is not inviting danger into her life. This speaks to levels of conscious and unconscious planning that aids in hypervigilant thinking. This indicated that participants were unaware of the term hypervigilance but resonated with "*thinking too much."*

Hypervigilance is presented in various ways and is not just situated around the trauma narrative but rather through everyday experiences. Through my discussions with research participants explained that they do not necessarily identify with experiencing hypervigilance, but it became evident that it existed and was experienced through the conversations that we had. For example, eight of my eleven key participants communicated that they have disruptions of sleep patterns, anxiety and paranoia but it is not overtly situated around the trauma narrative. They voiced that once there is the slightest distress in their life, these are common traits that are displayed and experienced, but they do not believe that it is directly linked to the trauma narrative. One needs to acknowledge the biological mechanism that is present in victims of long-term trauma. The body often struggles to distinguish if there is a life-threatening situation or an everyday disruption. This is linked to the constant upheaval that existed in their lives, and their flight or fight response is triggered.

Mira's upbringing has instances of domestic violence present in the household. She lived in constant fear of what would occur every night as her father would physically abuse her mother when he got home from work, usually after 22:00. This resulted in her having a form of hypervigilance that she was unaware of prior to professional mental health care help. Presently

Mira is 25 years old and abuse has not occurred in ten years. She, however, has daily disrupted sleep patterns and occurrences of paranoia. She has been diagnosed with PTSD due to the traumas experienced. Triggers do not need to be present for these responses to be activated. This correlates with the similar experiences of Tara. Due to time in prison, she was constantly aware of her surroundings and this created a form of hypervigilance as she was aware of her surroundings at all times. This form of hypervigilance is still present today. She expressed that when life becomes 'stressful' she struggles to sleep and can be up for days before her body gives in and sleeps continuously. Tara admits that due to her criminal past, she tries to avoid any situation whereby the blame can be shifted on her, because she believes that;

"I am the perfect target"

Tara explains that in her previous job, prior to her arrest, she was stealing money from her work as she was in charge of "cashing up." She has taken full accountability of her actions and is aware that what she did was wrong but admits she needed the money. In her current job, Tara chooses to cash up in front of a security camera so that blame cannot be pinned on her if something goes wrong. These ethnographic experiences do not link directly to their trauma narratives but there is link to stress, disruptions and awareness in relation to past experiences. Due to the chronic type of trauma exposure, it is noticeable that participants may not recognize their hypervigilance but patterns in their behaviour are a clear indicator that they are hypervigilant. This is especially so when they are under stress, which is similar to stress undergone through their traumatic experience.

One can see that the common symptoms that are experienced post trauma, especially for chronic and complex traumatic narratives are not necessarily linear, which is often what is depicted in literature. Here one can see a complex response to everyday life and there tends to be an amalgamation of symptoms that are not directly linked to the trauma. For example, through my discussions with my participants, they are aware that they avoid many situations and engage in avoidance behaviours and behavioural distractions to cope with traumatic stress. Discussions have indicated that they are not always consciously aware of this until a period of reflection and sometimes through professional help. Common avoidance behaviours and behavioural distractions that have been displayed through this study are the use recreational drug, binge drinking, smoking.

7.3 Avoidance

Edwards (2005:212) explains that behavioural, cognitive, and emotional avoidance mechanisms exist to elevate the pain that accompanies trauma. Edwards (2005:213) elaborates on this and states that behavioural avoidance can be seen as avoiding the destination or situation where the event occurred, including any sensory memory. Additionally, behavioural distractions such as excessive cleaning fall under behavioural avoidance mechanisms. Cognitive avoidance refers to thoughts and imagery unrelated to the trauma, such as sexual fantasies or planning a retaliation concerning the event (Edwards, 2015:2013). Lastly, emotional avoidance refers to instances that can distract the individual from the trauma by shifting to alcohol and drugs as an avoidance mechanism. This study addresses various issues surrounding avoidance in relation to trauma narratives.

Survey respondents all admit that they engage in some form of avoidance behaviours or behavioural distractions in some aspect of their life and these behaviours are depicted in various forms. A common behavioural distraction that my respondents (43%) and participants (7) admit to is smoking. Participants and respondents describe smoking as an instant stress-reliever and lets their thoughts move away from what is bothering them. Brooke and Tara stated that they smoke excessive amounts when triggered around situations of their trauma narrative. Chrystal explains that it creates a destressing feeling and a break away from ritualised activities. Additionally, she adds that smoking is a stress relief during periods of anxiety and it provides her hands with an activity. Aamira explains that smoking allows her brain to release stress and in essence calm down. Smoking is an avoidance behaviour because it removes the person from the situation that is causing them distress and focuses their mind on something else.

Drinking and recreational drug use is another avoidance behaviour as well as a distraction. Survey responses indicate that during stressful times, especially after a traumatic incident, their use of recreational drug use increases as well as their drinking habitats. This accounts for 68% of respondents. Participants provided rich ethnographic details of patterns that they engage in when triggered due to the trauma or stress which is either indirectly or subtly related to trauma and the feelings that accompany it. Kudzai admits that he realised that his drinking habits dramatically increase when he is reminded of things that are situated around his trauma narratives. This helps to keep him distracted and he can avoid his feelings. This correlates with similar notions and habits which Mira has. Mira admits that she has always kept herself busy, to the point of overworking, which prevents her from paying too much attention to the repercussions of her trauma narratives. The Covid-19 pandemic created a stillness in the world

and this created havoc in Mira's life. The lack of activity and fast rushed pace of life required Mira to deliberate her thoughts which created a mental break in her mental health. This resulted in a negative behavioural distraction of binge drinking as it served as a sort of comfort and distraction. Brooke articulated that she partakes in other behavioural distractions when triggered by events. These forms of triggers that Brooke is speaking of last longer than an acute trauma response. She explains that she becomes hypersexual and has been from a very young age (see Schwartz and Galperin, 2002; Reid et al., 2009; Ciocca et al., 2021). Hypersexuality is a well-known avoidance behavioural response, however, something that was significant to address was Brooke's ideation of sexual activities as a child. She informed me that,

> *"For as long as I can remember I knew what sex was. My mother was having sex everywhere, including the kitchen, with random men."*

Brooke's mother was not her only exposure to sexual acts. She explained that her two gay godfathers would sunbathe naked near the pool and therefore she didn't comprehend that exposure to sexual acts was for only for adults. She further articulated that as a child she would have rape fantasies and is not aware of the reasoning why. She expresses this was the first form of hypersexuality that she experienced. Now as an adult, Brooke explains that she uses sex as a distraction when she is triggered of any kind and through extreme amounts of stress. This creates an escape for Brooke in order to cope.

Examining trauma through a cultural lens means that understandings and depictions of the aftermath of trauma are extremely relativistic rather than universal. This has created similar patterns of responses to trauma across cultures but it has been presented in different ways. For example, according to the DSM and the ICD common effects of post-trauma involve re-experiencing and avoidance. Through the western biomedical lens, this is often depicted as re-experiencing the trauma and avoiding triggers that encompass the traumatic event. In Chrystal's situation, she does not discuss the trauma in any detail but speaks of instances before and after the rape. She remembers what happened but prefers not to engage with the details. Chrystal explains that in order to cope with the traumatic event she prefers to avoid voluntary discussions situated around gender-based violence. This is seen as a response to the traumatic event. Chrystal has actively found avenues, such as avoidance, enables her being in control of the level of exposure she has to trauma triggers. For her own safety and mental health, she had reported the incident to the university and obtained a no-contact order in order to be in control of the level of exposure she has to her perpetrator. This means that her perpetrator is not allowed

to voluntarily enter spaces that he is aware Chrystal is in. She states that she chose not to lay criminal charges against him because;

> *"I did not want to do the court thing, I didn't want to have to relive it again by telling what happened."*

This can be seen as a typical symptom and response that fits her diagnosis of PTSD. Through my discussions with my research participants, five of the eleven key participants (all who are people of colour) do not fit the universal criteria as their symptoms and experiences are more blended with cultural understandings. Chrystal's reasoning exposes structural problems with the legal system as this adds to her trauma narrative. Chrystal voluntarily chose not to engage with criminal charges as she felt that reliving the nature of the event would create more harm than good for her. A few (11%) survey respondents have chosen not to lay criminal charges, like Chrystal. Six of my key participants have been victims to acts of sexual abuse, but only Brooke had reported her rape. This could speak to the culture of silence that needs to be addressed in South Africa, and likely worldwide. Chrystal's reasoning of not laying criminal charges may be the reasoning for many other victims of sexual assaults as silence may be an easier response to trauma compared to justice, as justice is not always served. Here one can recognise that silence is a driving force that is present in relation to trauma. It can be seen that this is because little is actually done for survivors of trauma therefore silent is easier to cope with.

Most avoidant and behavioural distractions are situated around negative behaviour, however, this is not always the case. In some cases, avoidant and behavioural distractions can involve everyday activities. My data shows that there is a clear pattern of participants seeking to have some sort of control in their lives. This is displayed in various ways but a distinct theme is through the organisation of everyday life. Mira expressed that a common behavioural distraction of her is the cleaning. She explains,

> *"my workspace around me is always a mess but in some way it is organised chaos. When my brain breaks, my workspace needs to be organised"*

Mira articulated that her brain breaking is a way of her communicating that there had been a mental break and disruption. This suggests that she is expressing immense stress and it has caused emotional and physical barriers. She voiced that cleaning provides a sense of control and two components, her mental state and physical state, cannot both be in distress as it exacerbates feelings of anxiousness resulting in Mira not functioning. Trauma survivors,

especially those of chronic and long-term trauma, often struggle with aspects of control. A common theme that has transpired through the data collection process is survivors trying to maintain control of things in their daily lives. By focusing on what can be controlled, one is able to avoid issues around trauma experiences.

This is done in various ways but will be categorised as rituals and routines as this is how they have manifested. Turner (1973:1100) defines rituals as a "stereotypical sequence of activities involving gestures, words and objects, performed in a sequestered place and designed to influence preternatural entities or forces on behalf of the actors' goals and interests." Shuaib performs what he calls "a hygiene ritual" every week, this includes having his feet soaked, nails buffed and exfoliated. A part of this hygiene ritual is body waxing. This ritual stems from Shuaib's experiences when he was younger, under his family's care. It is important for him to do this weekly activity which seems to provide a source of comfort for Shuaib. These experiences also speak to a sense of control needed in order to function and it can be seen as a source of comfort for one's mental well-being. Routines and rituals may also be a negative thing, especially when they are linked to hypervigilance. Aamira has spoken to issues surrounding control as well. She explains,

> *"I have been pedantic about dirt and germs in my home. This was something that manifested more after my mother got sick and I lost any sense of control over my own life. I was living to keep others going and to ensure that everything worked properly in the home and that my mother was getting better. There was no time, or energy to focus on myself. This ended up manifesting in controlling my physical space around me. I would demand that if anyone entered my room, they had to take their shoes off to go to a certain part of the room because that was where I prayed and I did not want any dirt there. I did not sit on furniture in the house with clothes that I had worn outside because I felt that they were dirty. This was exacerbated when I moved into my own home. I would come home from work and immediately take a shower, my dirty clothes went into a hamper, and jeans that I would reuse were placed on a chair. I would not walk with my socks on the floor and I would not walk barefoot on the floor. I had a little mat by my bed, and I would not step on it with shoes. In my bathroom, the floor mat covered most of the floor space and I would not use my shoes in there either, because in my mind when I showered and stepped out onto the mat I would be dirtying my feet if I had walked on it with shoes on. I had home clothes and work clothes and they would remain separate. I would be physically uncomfortable when I had a visitor, who would sit on*

my couch and as soon as they left I would wipe the surface of my couch down to disinfect, and even go as far as to change the bathroom mat if they used the toilet."

Avoidance and behavioural distractions are often present because individuals do not want to face their trauma narrative, or it creates a form of comfort. A survey respondent presents a unique avoidance behaviour that literature does not depict. I am aware that their behaviour is an outlier, but it contributes to existing limited literature. The anonymous survey respondent explained that they try to avoid strenuous aerobic exercise such as running. This is because the physical activity that often mirrors the feelings that are embodied when they have a panic attack. Resultantly, it creates a trigger for them and even after the physical activity they experience the same emotions that they would post-panic attack.

With this chapter, one can recognise that participants and respondents identify with similar aspects that are presented in the DSM-V and the ICD11; such as avoidance and hypervigilance. Often participants were not exposed to these words thus initially unable to identify with them. It became evident through our conversations that elements of detachment, hypervigilance and avoidance was present in their post-trauma narratives but used cultural appropriate words to discuss their emotions; such as thinking too much. One can recognise the importance of the DSM-V and ICD-11 to have more be more mindful regarding their approach to diagnostic methods as language serves a vital part in understanding trauma through the lens of the survivor. The next section explores the role that dissociation, which is also a common response to trauma, and memory have in trauma narratives.

Chapter 8: Memory

Dissociation and memory play vital roles in post-trauma experiences, this is because memory provides insight into the experience that was endured by trauma survivors. There are different types of memory that tends to be focal points in trauma narratives. This chapter will provide an outline of dissociation as acts of dissociation feed into memories and how they are experienced. This chapter highlights the constant relationship that exists between trauma, stress and fear.

Dissociation is described as, "mental states characterized by disruption in conscious awareness" (Scaer,2014:72). This influences memory, behaviour, attitude, and personhood. Rhoades (2006:22) addresses that dissociation creates a split or break from cognitive, emotional, and physical processes from the body. In turn, this impacts the mental connection in both the inner and outer world (Rhoades, 2006:22). Dissociation, pioneered by Janet (1894) in the nineteenth century, has been extensively studied for several years . Key factors that have been heavily researched are; a sense of altered perception, a disconnect with time and memory, and forms of detachment. Psychologists and psychiatrists have identified forms of dissociation through fugue states, hysteria and dissociative identity disorder[37] (Scaer, 2014:72). Media and popular culture have commonly documented cases of dissociation as disorders but often dismiss acts of dissociation in everyday occurrence. Although these are important they are critical to psychological studies. From an anthropological perspective this dissertation examines four types of dissociation, in everyday occurrences, that are linked to trauma narratives, namely; emotional, perceptual, physical and memory. These types of dissociation feed into memories and will be explored through memories expressed.

There are many different understandings of why dissociation occurs, but a key component of why dissociative states begin is often linked to anxiety. Scaer (2014:72) states that psychiatrists conclude that in instances whereby anxious feelings are detrimentally high, individuals begin to dissociate and parts of one's personality begins to split or 'dissociate' from one another in order to protect the individual from anxiety (see Abdollahi, 2011, Scaer, 2014; Schimmenti, 2016). In other words, when feelings of stress and anxiety become high a person may mentally break down and become non-functional. This in turn means that dissociative states serve as a biological involuntary coping mechanism (Rhoades, 2006:22; Scaer, 2014:72). It is important

[37] Formerly and commonly known as multiple personality disorder

to understand that these are not dissociative disorders but acts of dissociation that is present daily. This can be commonly understood as “spacing out.”

Dissociation varies depending on the individual and the four types of dissociation can overlap one another. Foremost, it is important to understand how these types of dissociative states are linked to trauma and trauma narratives; both directly and indirectly. Dissociation will be addressed in relation to understandings of memory as dissociation is present through different memory types.

Memory related dissociation is common amongst all trauma types. There have been revolutionary research that have made strides in trauma research in the last two decades (see Kihlstrom, 2006; Payne et al, 2004; Hamburger, 2020). Memory has a vital place in trauma narratives as it examines the complexities that makeup memory systems. Traumatic memory differs from normal memory. Schacter (1987) (cited in van der Kolk and Fisler, 1995:508) acknowledges that traumatic memories are “encoded” differently compared to regular everyday events and normal memory. Van der Kolk (2014:210) brilliantly explains the way in which memories are encoded in one’s brain, that they are dependent on feelings and emotions felt during a particular time and are translated based on “schemas or maps” (Van der Kolk, 2014:210). Narratives that fall out of the design scheme are highlighted in one’s brain and subsequently create a memory. Traumatic memories are engraved slightly differently due to biology. Once the body is under potential threat our bodies release adrenaline and the secretion of adrenaline enables the memory to be encoded; the greater the perceived threat the more adrenaline is released which means that the memory is stronger and more memorable (see van der Kolk and Fisler, 1995; Van der Kolk, 2003; Kirmayer et al, 2007; Kelly et al, 2011; Scaer, 2014; Van der Kolk, 2014). Van der Kolk (2014 stipulates that this is only partially true. He clarifies that once the body experiences “inescapable shock” the sympathetic nervous system becomes overwhelmed and breaks down (Van der Kolk, 2014: 210). This can create fragmented memories or a lack of awareness of memories.

The National Institute for the Clinical Application of Behavioural Medicine (2017) addresses four types of memory;

1. Semantic memory- general knowledge;
2. Episodic memory-the memory of the event or experience (what/ who and where);
3. Emotional memory- emotions felt during the event (anxiety and shame);
4. Procedural memory- how to perform a common task without thinking.

Semantic memory is memories that encode general knowledge and skills (Kirmayer, 1996:7). This type of memory has little impact on trauma unless there is a traumatic brain injury (TBI). TBI's are not the focus of this dissertation, therefore, I will be not exploring semantic memory in relation to traumatic memories. Procedural memories are also not impacted through traumatic experiences. This chapter will focus on episodic and emotional memories as key theme arose from my data in relation to traumatic experiences.

8.1 Episodic memory

Cohen-Mansfield et al. (2010:564) illustrate the understandings of autobiographical memories, which is a subfield of episodic memories. This category of memory provides a personal narrative of how one identifies themselves. This further address that episodic memory directly impacts themselves and their surroundings both socially and their self-function. Cohen-Mansfield (2010:565) demonstrates that these types of memories influence one's belief systems and values about themselves and the world. This correlates with behaviour and perception due to the traumatic events experienced. Formative events are instances that create a form of "vividness" (Cohen-Manfield et al., 2010:565); this constructs a personal narrative that tends to include what, where, and who, and creates a sense of personhood. Episodic memories provide individuals with which core aspects of their lives that they tend to vividly remember and construct personal and social narratives from. These memories are often situated throughout childhood and adolescence as this is where one begins the understanding of identity. This can create a self and world view for people. For example, Sally's memories of her childhood are not pleasant. The research has presented various forms of trauma narratives, often beginning during childhood, however, only three participants blatantly express unpleasant childhoods. She recalls several instances whereby she was put down by her family and this has created a negative self-image of herself and she is in constant need of acceptance, which has a direct impact on behaviour. During her childhood, the blame was shifted on her for acts that were not her fault or act that were beyond her control, and this has created a constant loop and fragmented nature that she is to blame for everything. This has had a ripple effect on her relationships. Through observations on social media platforms and support groups, this is a pattern that many trauma survivors identify with. The memories created during their formative years have dramatically shaped this understanding of the world and themselves. Similar notions were articulated by Brooke, and she believes that it is her responsibility to fix and help those around her and this has detrimental impacts on her mental health and self-image

if she fails. Mira self-understandings correlate with those of Brooke and Sally. Mira expresses that some memories are incredibly vivid;

> "*I was about ten to twelve at the time. It was the morning, just before seven o clock. There was quite a bit of hostile energy in the air. My parents weren't talking to each other, which was the norm. Every morning before work my sister would have a slice of toast with Rama (margarine) on it. She had asked my grandmother where the Rama was, my grandmother said there was only Flora. My father stormed from down the passage demanding that she (the sister) tells her mother to buy the Rama. This resulted in a heated argument between my father and sister. I remember exactly the tone of voice that was used, I remember what my sister was wearing and remember that it was over something so stupid*"

Through further discussions with Mira she explains that arguments, like the one addressed above, were common in her household and more often than not resulted in domestic violence. Resultantly, she tends so avoid any source of conflict that she can. Brooke and Sally shared similar sentiments; all of who witnessed abuse as children. Mira explains that she avoids conflict through masking. Hodge (2021:115) explains that masking is a technique whereby individuals suppress their emotions and socially camouflage into settings.

Masking is a process that is typically displayed by females. None of the male participants in my study displayed or conveyed that they masked behaviours in any way. This is likely seen as a personality trait, learnt through socialisation that is demonstrated by only females in this study. My observations have further supported this as common personality traits that men often possess are situated around anger and emotional outbursts. I argue that the way in which children are socialized and conditioned impacts the behaviour around trauma. Male children who experience traumatic events are often expected to display the socially acceptable gender expectation of a man, which is to be strong both physically and emotionally. The physical condition of strengthening can be seen through the typical violent nature that men generally possess while women tend to try to remove the conflict from the situation and begin masking. This provides us with striking evidence that episodic memories can have a direct impact on behaviour and perception; whether consciously or unconsciously.

I reiterate that autobiographical memories allow for personal accounts of experiences, this means that siblings or other trauma survivors can account for the experience in a completely different way. This tells us that episodic memories do not reflect reality accurately, but rather

present perceptions of reality based on each individual. Through my discussions and observations, it has been clear that siblings who have experienced multiple traumas, in the same setting, may have different accounts of it. For example, one sibling's memories may be situated around the emotions felt during that time and therefore experience involuntary or voluntary triggers while the other sibling may have experienced some form of dissociation which altered and shaped their memory of the same event. Both siblings may be able to state the core features of the episodic memory, which is; what the memory is, who was there and where it was. However, because of the personal narrative they both could have experienced dissociation through the same event. For example, Mira has a brother who is around the same age as her, they resided in the same house and were the youngest in the family. Mira explains that their understandings of their childhood are vastly different. The pair of siblings both can recall acts of domestic violence and the unpleasantries that came with it, however, Mira has vivid emotional and episodic memories around this however, her brother does not remember the finer details. Research participants with siblings have articulated similar sentiments, especially those with childhood trauma as well as acts of domestic violence in their homes.

Cohen-Mansfield et al. (2010:565) discuss first memories and the social relations that they have on the child's life. Healthcare practitioners have pointed out that children process events very differently from adults and this ultimately impacts memory. Most often, first memories involve primary caregivers and the child and the types of interactions they encounter. Due to the caregiver and child interactions, these memories can unconsciously influence how individuals create relationships and social interactions, as they get older (Cohen-Mansfield et al., 2010:565). These create various self-understanding and understandings between caregiver and child. Often there are cases whereby long-term victims of trauma are unaware that they were traumatized because they have blocked out memories and this happens through instances of dissociated or complete amnesia of particular events. This is due to the psychological protection that one's brain provides in order to deal with the traumatic event as explained above. Strikingly, conversations with my research participants reflected those seven out of the eleven key participants' first memories are traumatic memories. Discussions around memory have led to conclusions that first memories that are not traumatic are often situated around post-pubescent years and in rare cases adulthood. This is concerning as participants with traumatic childhoods do not remember large parts of their life. Chrystal recalls a recent conversation that she had with her mother regarding aspects of her childhood. Chrystal grew up chaotic political landscape of Zimbabwe in the late 1990s and early 2000s. Her family were looking through

family pictures of when Chrystal and her sister when young children and came across pictures with suitcases lined up in the corridor. Through a conversation with her mother she had realised that these suitcases where there in case of an emergency and they would have to evacuate their home due to political violence. Chrystal voices that this should have been part of her first memories but has no recollection of it all it. This speaks to a dissociative nature that may have occurred in relation to trauma exposure of political violence.

Amongst my research participants, there has been a considerable amount of concern regarding the lack of memory of particular events. Shuaib conveyed that now, in his adult years, he is currently working with his health care professional to unpack the repressed memories and try to regain parts of his young life. This causes some concern as through my conversations with Shuaib he has provided abundant detail of accounts of abuse during his childhood and adolescent years. This leaves one to ponder the extent of the abuse endured if he is still currently retrieving repressed memories. On the other hand, Brooke drew my attention to rape fantasies that she began having as a child which surrounds her first memories. She deliberates if the rape fantasies could be flashbacks as she has partial amnesia of large parts of her childhood. This notion seems to resonate with several members of the online support group community. Many active members ponder whether their dreams and flashbacks are real events or not; linking further to experiences of dissociation.

8.2 Emotional

The second type of memory relevant to traumatic events is emotional memories. This field of memory focuses on the emotions felt during the traumatic event. Common emotions elicited were around fear, anxiety and shame. Emotions experienced is a core aspect of post-trauma experiences as when one is exposed to a trigger, one generally experiences the feelings situated around the trauma rather than the trauma itself. Scaer (2014:74-75) discusses notions of memory, specifically emotional, and occurrences of distortion based on perceptual and physical alterations of the trauma narrative and the physical place. For example, Kudzai articulated that the drive home after his mother's funeral was the longest drive of his life, despite it only being a fifteen-minute commute.

Through my research and the acute trauma narratives that I have gathered, there is a pattern of emotional and perceptual dissociation in relation to theft crimes[38]. As illustrated in chapter 7, a young Sally and her family was the victim of a house burglary when she was a child and she

[38] Hijacking, burglary, muggings, etc.

was used as a pawn of intimidation for her parents to open the safe. As Sally recounted this experience, she narrated it as she saw herself in this scenario, vividly, but through the third person. This is a form of perceptual dissociation, and she described a feeling of numbness. Through this understanding, it can be linked directly to one's fight and flight response eliciting a freeze reaction. This type of dissociation is common in many settings especially in cases of rape in adulthood. Through my research, all participants who have been victims of rape or sexual assault (seven key participants) have experienced some form of dissociation. Dissociation amongst adult rape victims is a common symptom and can be displayed in various ways but most notably through perceptual dissociation and memory-related dissociation. Nothling (2015:1) addresses that victims of interpersonal violence experience higher levels of dissociation compared to victims of natural disasters and grief. My data supports this statement additionally, victims of interpersonal violence and sexual violence experience dissociation more commonly than victims of criminal activity. Six out of my eleven key participants have been victims of sexual violence or rape, and each of them recounts some form of dissociation. Akhona was raped when she was a teenager during an outing with friends. She explains that she was invited out with her friend, her boyfriend and one of his friends. She reveals that she was unaware of what sex was at the time and didn't understand what was occurring. She described a third person dissociation and agonisingly waiting for it to be over. There is a clear pattern that individuals who endured sexual violence or rape post-pubescence experienced perceptual and emotional dissociation. This correlated with data that was collected through the survey. Four (5.5%) survey respondents shared similar forms of perceptual dissociation and experiences of the third person.

A key feature in trauma narratives and PTSD are situated around emotions felt during the traumatic event. There can be two types of triggers; internal and external. Internal triggers often refer to feelings, memories, perceptions and flashbacks while external trigger are situated around people, places and things (Malmo and Laidlaw, 2010:26). Life and social changes can be a form of an external trigger.

There are various reasons why triggers occur and there are instances whereby one is not aware that they are triggered due to the subtle responses that they experience. Scaer (2014:74) discusses the notion that somatic memories may serve as indicators that elicit panic, flashbacks and dissociative symptoms. Droga (1997:174) defines somatic memories as "memories that are anchored in bodily sensations, considering both developmental aspects and implications for psychoanalytic treatment." This definition highlights that our body often remembers what the

brain forgets which makes it difficult to understand the actual trigger. Somatic memories are difficult to navigate as they can stem from both external and internal triggers. For example, for a childhood trauma survivor their childhood home may serve as an external trigger when they return. This is something that has been expressed by Mira and, to an extent Shuaib. Additionally, feelings of unsafety and a high source of conflict may serve as an internal trigger. Through observations and extensive discussion with my participants, this seems to be a common thread that they struggled to articulate with ease. This is because the understandings of somatic memories are not always transparent. A key feature for individuals that experienced trauma during their childhood is the feeling of being helpless again. Discussions and observations have highlighted that when individuals are placed into physical spaces where they experienced multiple traumas, they revert to the child that they once were and eventually grew out of. Mira explains that she left her childhood home when she was eighteen for university but returns a few times a year to visit family. She has secretly and privately undergone extensive years of therapy to deal with the trauma she has witnessed and is actively trying to unlearn behaviours that she was conditioned to growing up. Mira, however, confesses that she has a source of conflict when returning home as she reverts back to the helpless child she was and unconsciously forgets the coping mechanisms she uses;

> *" I become small again. I know I shouldn't but the little things just bother me. When I lived at home I think I was so used to there being chaos in every corner and I didn't know better. Since I left for university, I have finally lived in a space where it felt safe. But now when I come home I remember things that I didn't even know where memories."*

Mira explains that when she was growing up a lot of the trauma that she witnessed, she believed was normal and didn't realise the extent of the trauma until she was in university. She articulated notions of somatic memories in relation to her childhood bedroom. Her bedroom, which was also the room that her mother would seek solace in during times of conflict with Mira's father, provokes somatic memories. She explained that the first time she came back home for an extended period of time during the December holidays (which is approximately three months) she endured excruciating stomach aches in the evenings. This can be considered a somatic memory. Her mind may have not actively remembered the trauma that was experienced and witnessed in that room, but her body does as most of the abuse was encountered during late evenings. This pain was a result of the unconscious anxiety and memories that she had been in that bedroom again.

Shuaib shares similar sentiments about his aunty. He explains that she was the executioner for many of the punishments that he endured and resultantly he has physically painful memories around her and thoughts of her. As a result of this, he experienced forms of perceptual dissociation around his emotional memories. This is experienced through the way he remembers events playing out and the emotions situated around it. For example, he explains that during torturous acts of violence he would dissociate and experience little to no emotion towards it as it would help the beating end sooner. This suggests that the dissociative state would produce an altered sense of time.

Van der Kolk (2014:211) has performed extensive studies on trauma and in turn memory. He explains that is one cannot exactly monitor what occurs in our brains when an organic traumatic event occurs but has been able to "reactivate" the trauma in a laboratory through Magnetic resonance imaging (MRI) machinery screening the brain. These studies have informed us that,

> "When memory traces of the original sounds, images, and sensations are reactivated, the frontal lobe shuts down, including, as we've seen, the region necessary to put feelings into words, the region that creates our sense of location in time, and the thalamus, which integrates the raw data of incoming sensations. At this point the emotional brain, which is not under conscious control and cannot communicate in words, takes over. The emotional brain (the limbic area and the brain stem) expresses its altered activation through changes in emotional arousal, body physiology, and muscular action. Under ordinary conditions, these two memory systems—rational and emotional— collaborate to produce an integrated response. But high arousal not only changes the balance between them but also disconnects other brain areas necessary for the proper storage and integration of incoming information, such as the hippocampus and the thalamus. As a result, the imprints of traumatic experiences are organized not as coherent logical narratives but in fragmented sensory and emotional traces: images, sounds, and physical sensations" (Van der Kolk, 2014:22).

This explains the impact that images, sounds and emotional sensations can have. This is highlighted through experiences felt by participants and the ways in which triggers can be involuntary. Three key narratives are apparent here, those of Kollie, Shuaib, and Mira. As mentioned in chapter 6, as a child Kollie was ridiculed by peers and other children for his inability to play soccer well and display heteronormative masculine characteristics, such as being sporty. Kollie recounted his feelings regarding kicking a soccer ball and the feelings of

anxiety and shame that are displayed, which returns even in adulthood. Through this, one can see the impact that emotional memory has and how it can transgress into adulthood.

Shuaib was transported back to the emotions he often felt as a child recently while simply browsing through Netflix. Shuaib explains that he was in search of a movie on a Saturday whereby he came across a movie that severely took him back to the helpless child he once was. He explains that he was unaware the severity of the abuse that was forthcoming in the film as he was drawn in by the title[39]. He describes the movie as a horror despite it not being advertised that way. The central plot surrounding the film explores the life of a young boy who is beaten to death by his mother. He paints a picture of the scene that drew him back to the typical days of his childhood. Shuaib explains that the young boy had slightly misbehaved, and his mother was outraged. The boy was dragged to the shed and tied up while the mother continuously beat the life out of his boy. The father is sitting inside the house hearing shrieking sounds come from his young son, he turns the volume on the television up to muzzle his son's cries for help. The scenes simultaneously shift between each other until the boy is left dead on the floor. Shuaib confesses that this was an extremely difficult scene to watch he but could not draw his eyes away from the screen. He explains that he instantly felt the emotions that he used to feel as a child, lying on the floor helpless;

> *" I couldn't believe something like this was in a movie, it was like I was watching what could have happened to me. I guess I was lucky."*

Mira's trauma narrative is slightly different from those of Shuaib and Kollie, but share similar emotional memory of particular events in their life. As an adult, Mira's father was shot and was transported to a public South African hospital. It is quite evident that public health services in South Africa are understaffed and overworked. This meant that there was little to no staff present once they had reached the hospital. Mira explains that there were about 20 other people hovering around with several visible injuries that needed medical attention but no staff or adequate resources to assist in the situation. She explains that she and her sister were patiently waiting to receive communication from the doctors outside the emergency room, not in the designated waiting room due to the circumstances surrounding the shooting. She presented with a form of dissociation from her emotions. She confessed that she was numb through the whole incident.

[39] Shuaib cannot remember the title of the film

“ I don’t really remember feeling anything. I thought he was going to die and had no emotion towards it. My sister and I kept making jokes. I know now that it was a coping mechanism. I guess I dissociated in some way through the whole day.”

She recalls several other patients wounds and injuries in vivid detail. She explains that there were copious amounts of blood around and everything was dirty. She confesses that the smell of blood still sticks with her presently, despite this incident occurring in 2018 which was three years ago. This has served as a challenging obstacle for Mira as initially, she could not comprehend why the sight of blood made her want to throw up. This has resulted in Mira switching from sanity pads to tampons as she became disgusted with her body because of the emotional memory that is engraved in her brain.

These trauma narratives provide one with a perspective that emotions around memories can be more detrimental and impactful than emotional sensations once experienced. One can recognise the crucial role that memories and dissociation have in post-trauma narratives. Discussions with participants and respondents have highlighted that despite healing from aspects of their trauma external and internal triggers still exist and result in post-trauma consequences and can result in relapse.

Chapter 9: Presentation of Self in Everyday Life

Goffman's (1959) *Presentation of Self* was influenced by William Shakespeare who once famously declared that "*All the world's a stage, and all the men and women merely players; they have their exits and their entrances, and one man in this time plays many parts*[40]*.*" Goffman (1959), inspired by Shakespeare's words, compared everyday social behaviour and interactions to theatrical performances. Goffman's (1959) attention to theatrical imagery unmasks the significance of face-to-face human interaction and the impact this can have on behaviour as all individuals are actors performing a role in the social world.

Goffman (1959) applies a "dramaturgical approach" to social behaviour. Goffman (1959) illustrates that every individual is an actor and performs roles to specific audiences. He illustrates the importance of face-to-face interactions which he considers a performance moulded by impressions (Goffman, 1959:17). There are two types of impressions that are vital to the dramaturgical approach which guides the actor's modes of behaviour. Goffman (1959:14) explains that impressions are dependent on the "expression that he [the actor] gives" which is often through verbal communication. Secondly, there is the "expression he [the actor] gives off" which is demonstrated through non-verbal symbols like body language. These verbal and non-verbal indicators provide insight into self-representation and concepts of awareness. These expressions are depicted through a performance. The two types of expressions may contradict each other which is also an element of the performance. Throughout this chapter, one will understand the impact that these expressive modes have on human interaction and social behaviour.

9.1 Conceptual concepts

Goffman (1959) provides various elements that can impact an individuals' everyday performance and here I will highlight a few conceptual concepts that are crucial to understanding in relation to his "dramaturgical approach."

Goffman (1959:17-18) considers all types of behaviour and interactions in relation to audiences, of any kind, as a performance. Performances occur and can create conscious or unconscious impressions to a given audience. Trauma survivors provide insight into conscious and unconscious depictions of traumatic sufferings; both visibly and invisibly. Drawing from my ethnographic chapters, my findings illustrate that my participants perform particular roles which are highly dependent on the cultural and social audience. Understandings of personhood

[40] As You Like It, Act II, Scene VII

can be seen through Goffman (1959) theoretical framework. Goffman (1959:44) expands on performance as "socialised, moulded, and modified to fit the understandings and expectations of the society in which it is presented." This unveils his explanation of what he deems a front. Fronts are the particular performances that actors demonstrate to audiences. He describes a front as "that part of the individual's performance which regularly functions in a general and fixed fashion to define the situation for those who observe the performance" (Goffman, 1959:32). As mentioned earlier, personhood in non-white populations are based on understandings of their role in their community. This can create conflicting issues as it steer indivudals into portraying different versions of themselves dependant on the audience.

Reverting to Goffman's (1959) imagery of theatre the Front is comprised of two elements; the setting (which is to be seen as the stage) and the personal front (which can be seen as the costumes in the idea of theatre). The setting refers to the scenic, geographical, and physical layout in which the social role is being displayed. Additionally, there is the personal front which illustrates how actors identify themselves; and can be seen through the individual's appearance and manner. This can be done through professional rankings, physical appearance and presentation, posture, speech patterns, as well as bodily gestures and expressions (Goffman, 1959:34). Setting, manner, and appearance are important factors in any performance as it illustrates to actors the role they are expected to portray and the impression the audience will receive (Goffman, 1959:35). Additionally, individuals may present with a social front. These social fronts consist of particular cultural and institutionalised norms and appropriate behaviour. This is crucial when conducting studies on trauma from a cultural lens. Findings have illustrated that participants perform a particular role that is reliant on the given audience.

Goffman (1959) draws on concepts such as idealisation and misrepresentation as elements that encompass performances in order to portray a particular image. Goffman's (1959) imagery of theatre discusses notions of regions that are vital to analysing my study in relation to this framework. Goffman (1959:109) believes that there are two main "regions" which illustrate social behaviour and in turn the performances that one chooses to portray. He explains that "a region may be defined as any place that is bounded to some degree by barriers to perception" (Goffman, 1959:109). There are two main regions that Goffman (1959) presents; namely the frontstage and backstage Notably, elements of the front stage are that the individual is consciously aware that they are being watched and therefore how they engage with the audience, i.e. other individuals. This is communicated through the setting, appearance and

manner of the performative role. The backstage is more informal, and although the actor is still performing a role he may behave in a more comfortable natural setting.

Through analysing the traumatic experiences it became evident that issues arose with the conflicting roles that individuals experience; especially in issues concerning masculinities. Role theory states that there are "a set of normative expectations that are presumed to define particular positions or statuses in social structure and their corresponding roles or behaviours in interaction with others" (Hunter, 2015:852). Different roles have different expectations which result in a particular behaviour. Ebbers and Wijnberg (2017:1345) address that role theory explore the expectations that rise due to assigned roles and one is expected to make decisions that fit that assigned role. Role conflict theory examines when individuals are unable to perform the tasks set by the assigned roles (Ebbers and Wijinberg, 2017:1345). Gordan et al., (2012:668) explain that when different roles have different demands they begin to compete with one another and may create conflict. Throughout this study, it has been evident role conflict arises from negative circumstances and create unwanted mental health problems, specially when dealing with ideas surrounding masculinities. Societies has dictated gender roles and expectations for men and in the contemporary times, these are evolving. Despite the evolutions, participants still struggle to negotiate between traditional and contemporary understandings. Through Goffman's notion of region, different roles and expectations are explored.

9.2 Frontstage

Cultural understandings play a central role in identity formation in many settings. Social scientists have constructed several meanings of the self in accordance with various lenses and disciplines (Öztürk, and Şar, 2016:1). Culture has been broadly defined in anthropology but it is the case of this discussion when I refer to cultural elements of South African culture, gender, and ethnic narratives are all contributing factors.

As explained above, the front stage region is an area whereby actors are aware that they are performing a particular role. Findings have illustrated that trauma survivors, like members of general society, are constantly performing a role to main a particular narrative. Trauma survivors in this study expressed that they performed to present a front that was normal and would not differentiate them from the people around them. Goffman (1959) discusses the notion of personal front which is depicted through physical appearance and social fronts which is illustrated through behaviour. Not surprisingly, trauma survivors of this study do not have a defining feature that conveys that they are a victim of trauma through their personal or social

fronts. Evidently, this is comprehendible as individuals do not want to unveil layers that can illustrate their vulnerability and impact impressions. The settings that are created and set out on the front stage aim to depict normalcy in particular social settings. The actor, in this case the trauma survivor, creates a front of normalcy to the audience. This is through the setting and the personal front in how they portray themselves. In some instances, the setting may be the workplace and a tidy workspace is kept because that is the expectation and the norm in that setting. In terms of non-verbal communication, for participants, this translated into smiling during friendly encounters with strangers or acquaintances, even when they did not want to. Trauma survivors tend to downplay any sense of differentness or uncomfortableness in the setting. Most of my participants have been diagnosed with general anxiety disorder and/ or depression, which may severely impact social interactions and settings. In most cases, however, they have been able to present and maintain a front that does not reflect what they are truly feeling internally. Sally is constantly worrying about her baby and wondering what in the world is going to harm him; when Mira enters a room she calculates which is the nearest exit in case of an emergency; and Brooke is constantly trying to figure out how she can fit into the lives of others. In my initial interaction with my participants, one would never assume these are thoughts that are constantly looming in their heads and addresses aspects of hypervigilance. An example of this can be taken from Aamira's experience as an academic. It may seem unusual for someone who has an anxiety disorder to be so comfortable in front of people, but Aamira admits that this is not the case. She is able to hide her anxiety quite well. Aamira says that lecturing is a performance and the lecture venue is the theatre. To prepare for her role she has watched her own lecturers during her time as a student and internalised what worked and what did not. Before a lecture, she goes through her PowerPoint slides and makes notes on the points that she wants to make that are not in the slides, such as examples for discussion, and in this sense she creates a script for herself that she is able to follow during the class. Whilst she does go 'off script' at times, depending on the responses by students, Aamira prepares for these instances as well by planning around possible student reactions so that she knows how to interreact. In this sense, Aamira says that she is able to maintain a façade, a front, before her students. Hypervigilance is an important part of the front stage performance and trauma survivors are constantly aware of what is going on around them, in order to behave appropriately. Mimicking is also another technique that is used whereby participants expressed reading the room so that they know how to react. This means paying careful attention to one's audience's tone of voice, facial features, and body language. Hypervigilance is important in mimicking. If a person is faced with an audience that is sad, they are able to mimic facial

expressions and body language. Aamira says that mimicking is a very important tool for her because, as a result of her general anxiety disorder, she sometimes feels like bursting out laughing in sad situations, but is able to prevent this by focusing on the act of mimicking. This means that my participants and other survivors of trauma often blend into society without a physical marking. There does, however, tend to be emotional factors that overshadow many aspects of their daily lives

There are also instances whereby trauma survivors have physical markings as a result of their trauma. Fatima and her family were victims of a house robbery when she was 18 that became violent. She was slashed across the face with a knife resulting in a laceration that has left a visible scar. This has resulted in a physical marking embodying her trauma narrative. Furthermore, physical markings are constant indicators of domestic violence. Participants who have been a witness and/or victims of physical violence portray perfectly constructed fronts in order to communicate their desired objective which often is that they are not victims of abuse. Goffman (1959:65) discusses the role of misrepresentation in performance, which can be performed through two forms. Firstly, this can be done by strategically constructing their performance to maintain an image of themselves and their abuser/s. This resultantly portrays a front to communicate a particular narrative. On the contrary, misrepresentation can be used to perform a false image to an audience that becomes their front. This second form of misrepresentation often aids the abuser in being seen as desirable to society. This is depicted in many ways and a key feature that my findings have illustrated is that abusers use a form of charm to allude to audiences. Participants communicated the carefully constructed ways that they misrepresented their partner/ loved ones to ensure a bruising was not questioned. Shuaib explained that after a gruesome beating by his aunt that left him with the inability to walk, they would prevent him from attending school until the bruising subsided. They had informed the school that Shuaib was severely ill resulting in him missing many days of school. This speaks to the levels of awareness that they possessed of the wrongdoing they have inflicted which resulted in misrepresenting the situation in a manner that was palatable to society. Victims of physical abuse often find ways to misrepresent or hide their bruises or scars, and present a front that appears normal. This could be through their physical appearance, for example by wearing clothes that covered bruises, presenting themselves as clumsy and even having a fall in public to cement the idea, and in some instances very common to domestic abuse survivors the use of make-up to cover up bruises. These fronts additional convey elements of hypervigilance as they are constantly aware of their surroundings and anticipating interactions of the foreseeable

future. The front that is portrayed to the audience aims to match the setting or a normal, trauma-free existence.

In some instances it may be argued that outright denial of the existence of trauma, as a mental block, would ensure that a good social front is presented. This can be seen in the case of male participants and respondents where social fronts have been presented to hide the existence of domestic or sexual assault. The data directed me to explore issues of role conflict in relation to conflicting masculine identities. Role conflict, in terms of socially approved and idealised masculine identities versus personal ideals of masculine identity, emerged in three ways. Firstly, in relation to Kudzai's narrative where men are expected to be strong and not publicly show emotions such as sadness or fear. In Kudzai's experience, he was conflicted around his immense sadness and sense of loss when his mother died, and the expectation of him to keep his emotions in. Kollie has also alluded to the notion that "*real men don't cry*" in his narratives. This was a common narrative not only with participants but with respondents and online observations. Many men feel the need to portray a front of what their audience, society, expect from them, and even their coping mechanisms to deal with the conflict are seen as socially acceptable for men, for example drinking alcohol. These fronts stems from heteronormative ideas of what is expected of a man. It became evident that showing emotions, outside of anger, were not fitting for men and portrayed weakness.

Secondly, Shuaib's conflict in masculine identity stems from the confusion he experienced as a child by the ideas and expectations of men and women created by his family. Shuaib has been taught that women are the superior gender. At the same time, he was taught that men are responsible for women's well-being and safety and as such he must protect the women in his life. This created a conflict in how Shuaib sees male and female roles because if one gender is superior, then why do they need to be protected by the inferior gender. This creates conflicting roles and results in various understandings of what is seen as the 'correct' role for a man or a woman. During our conversations, Shuaib spoke timidly when discussing relationships with women which suggests that he is still currently struggling with power dynamic. He does declare that he does not harbour ill feelings towards his female cousins and his sister as they were just young bystanders to the abuse. He does not recognise them having a role in his traumatic experiences. Shuaib, currently, is negotiating with these understandings of power dynamics in relation to gender. He is currently working with a mental health professional and a life coach to over his traumatic experiences.

Thirdly, Kollie's role conflict comes from the expectation, as a child, that he should play with boys and play 'boys' sports, like soccer, whereas Kollie wanted to play with the girls around him. He has stated that he was often presented with an internal struggle which developed into anxiety, as a result. So while he may not present this outwardly, he has an internal sense of upheaval that he has to deal with. Each of these conflicts have resulted in the performers having to find ways in which to navigate their conflict, and in most cases this comes out as putting up a front for their audiences.

Goffman (1959:17) discusses the important aspect that impressions have, and individuals have a direct influence on impressions and these are shaped by the manner in which individuals conduct themselves and their physical appearance. As mentioned in chapter 3, my participants were recruited through snowball sampling and social media platforms. Interestingly, when participants were recruited through social media platforms an impression was created, by me as the researcher, due to their online presence and profiles. Goffman (1959) *Presentation of Self in Everyday Life is* based on face-to-face interaction but online presence has provided society with a contemporary perspective that allows impressions through conscious decisions based on what is communicated through one's profile. Individuals can perfectly construct the Front they want to portray. Social media has allowed individuals in the 21st century to be in control of the image they portray as they choose what is communicated through their platforms, and in turn, have some choice in the narrative they want to paint. COVID-19 restrictions have also made it easier to keep up fronts, especially on social media, because physical social interactions have been drastically reduced.

Face to face interactions consists of other factors as other individuals are able to read non-verbal expressions which can mould the impression they have of you. In most cases, even though they were aware of the nature of the research and interview, my participants would express that they were not sure if anything or much of what they had to say would be useful. As the interview/s progressed and we became more comfortable with each other, this changed. I had shared a little bit of my own experiences when they were similar to my participants and they were comfortable enough to open up more. It can be argued then that this is because the front stage setting changed to be inclusive to my participants actual self. Goffman (1959:18) notes that the physical impression one gives off may contradict the emotional impression you may want to give off. This emphasises the importance of manner and appearance. For example, society has a preconceived perception regarding individuals with tattoos and piercings. Western Capitalistic spaces have long dictated and shaped what is considered appropriate attire

in the workspace, and physical markings do not fit that idea. This has resulted in individuals concealing physical expressions that they have in order to "make a good impression." This is according to Goffman's (1959) dramaturgical approach to construct a particular front. This was evident in the way participants had approached the interview process. My first interactions with Sally, like many other participants, were warm but with a guarded nature. This is comprehendible as participants were completely aware that I was "watching them" which provoked a particular performance and in turn role. Once I had built rapport with Sally then did I only discover her wide range of tattoos. This confirmed the Front that research participants were aiming to portray in order to create an impression despite engaging with sensitive material. Non-verbal communication, such as body language, established cues that indicated levels of comfort and distress. This was a particularly important aspect of the interview process, I, as the researcher, observed non-verbal cues that communicate discomfort and levels of stress. This was an important observation as it guided me into understanding the emotions that surrounded the topic. It is important to recognise that participants were not the only individuals portraying fronts, as I as the researcher was portraying a front as well. As much as participants were aware that I was "watching them" I was very cognizant that they were watching me as well. This resulted in my portraying a front as a researcher as well trying to maintain true to myself; this was done through my physical appearance and my body language. Levels of professionalism were demonstrated, and I was particularly conscious of the body language that I was giving off. I usually have difficulties with social interactions and maintaining eye contact, but I was aware that a lack of eye contact may imply a level of disinterest which was not the case. Therefore, I ensured strong eye contact was made. This was done to portray a favourable impression in the eyes of my participants. This was crucial because if an unfavourable impression was conveyed it would impact the data gathered. With this, I could recognise that both participants and myself were portraying fronts which can be seen as a performance.

Reverting back to the imagery and personal fronts, discussions have highlighted that participants aim to portray an image of "togetherness" in order for other individuals, and particular audiences, not to discover aspects of their distress. This in turn can be seen as a coping mechanism to deal with trauma narratives. My participants expressed wanting to be in control of their emotions and present a front that was 'together'. By controlling outward emotional signs they were able to dictate how people see them and perceive them. For those who do not want to come across as vulnerable, this would be, for example, to make sure that they did not cry in public, i.e. in front of their audience. This was especially so for male

participants and respondents, and some female participants. The front is held up to convey emotions of strength or even indifference at the situation in front of them. These fronts can also be played too well in that the performer hides emotion so well that their audience gets the wrong impression. Trauma survivors are very good at enacting fronts that make them seem strong and even invulnerable in settings. Trauma survivors, as my research notes, have a tendency to be the one that people turn to in times of need, for example the mother-type who looks after everyone; like Brooke, Mira, and Chrystal. In not wanting to seem emotional or vulnerable a trauma survivor may run the risk of coming across as cold and distant, which may then create tension between them and their audience. Aamira says that this is something that often happens with her when she is presented with stressful situations. Aamira recalls a particularly negative outcome to a situation, and she explains that, initially, she was shocked, hurt and felt a little betrayed, but she did not want the people around her, (her audience), to be burdened by her feelings and feel bad for her. As such, she pretended to be okay with what happened, went about her regular routine and seemed, to her audience, to brush it off. She had prepared for a plan B and a plan C. Recently, however, in conversation with a person who was part of the situation, Aamira expressed her anger and frustration at the result and Aamira's colleague, (who had been an audience member for a while), verbally and physically expressed relief at this because they believed, based on the front that Aamira had acted out, that Aamira did not care about the outcome. Here we can see what happens when the front is not aligned with the setting, and as such the audience.

There are particular fronts performed in order to portray that image and impression that one desires to give off. Understandings and themes of denialism unveiled forms of fronts that are portrayed. As mentioned in chapter 5 denialism is demonstrated in three ways;

1. Denial that the trauma ever existed- I do not have trauma because it is a common experience in my society;
2. Denial of the intensity of the trauma- What happened wasn't that bad;
3. Denial that they have caused trauma- I was the only victim of trauma and didn't traumatise anyone;

I argue that these forms of denialism are shaped by cultural understanding, therefore, resulting in particular fronts. These cultural understandings are informed by a variety of factors, such as ethnicity, South African culture, gender. These cultural understandings feed into one another and create complex narratives. Individuals of trauma often feel alienated in many aspects of their lives, especially in contexts whereby they have experienced their trauma narrative alone

or in muted spaces. Therefore, they may not want to recognise their trauma which results in denialism. It became apparent that trauma survivors do not want to stand out in the social aspect due to the trauma experience. They are seeking forms of normalcy in order to have a sense of belonging. Conversations with my participants illustrate their denialism. Strikingly, the conversation I had initially had with Sally that sparked the explanation of BIG T's and small t's spearheaded this theme. Sally's labelling of BIG T's and small t's illustrate that she did not want to be an outlier in society. The small t aspect alludes to trauma narratives that can be considered a normal experience while BIG T alludes to extreme cases. As mentioned before, participants were able to identify with the BIG T and small t understandings which further emphasise the cultural epidemic of trauma in South Africa. This is because in other cultural settings, what may be considered traumatic to one group may not be considered traumatic to another. The trauma culture present in South Africa has resulted in trauma survivors tackling their trauma with fronts portraying of resilience rather than their actual emotions. It is important to explore what lies beneath the front and how individuals engage with traumatic experiences through backstage analysis.

9.3 Backstage

I now shift into analysing behaviour through the lens of backstage performances. Goffman (1959:114) explains the backstage region is defined as "a place, relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course." Goffman (1959:115) articulates that "here the performer can relax; he can drop his front, forgo speaking his lines, and step out of character". In simpler terms, the backstage is an area of everyday life with those who are considered loved ones and are part of one's inner circle and in most cases, their support systems. Whilst the backstage area is a more relaxed setting, with like-minded and experienced people, some parts of a person's trauma may still be hidden even to those who are the closest to them.

Foremost, it is crucial to understand the role of the support system for trauma survivors. The backstage region includes other actors, i.e. support systems, access to the authentic self of the actor, and who can offer physical assistance and/or emotional support. They are aware of particular fronts that are portrayed and often understand the reasoning of those fronts. Participants explained that it is often loved ones that are aware of the "cracks" in the well-constructed image that actors have shaped, and often supported through the backstage area and through traumatic experiences. The backstage regions allow support systems to engage with actors without any pressure of being watched; this essentially looks at actors removing their

makeup and allowing aspects of vulnerability to be displayed and this encourages healing. The lack of a support system makes healing more difficult and may result in various kinds of altered behaviour. Participants who had expressed their trauma narratives from a young age have difficulty creating solid support systems. This is because those, which was often family, were not present and could not provide the support that was necessary at a young age resulting in cautious behaviour with those around them. This can be understood as a response to much of the trauma that they have endured as the ones who were expected to protect them did not. Initially, when conversations of support systems rose with participants, their immediate thought related to family; however, there is a pattern that families lacked the kind of support needed. This is comprehensible as families of trauma survivors may not acknowledge their role in the actors' trauma narrative, and therefore are unable to offer the kind of support that is necessary. The trend that has been analysed from participants is that friends play a crucial role in the support system. This is because actors allow friendship groups to see their authentic self and understand the trauma narrative from the perspective of the act. Within family relations, there may be instances where trauma narratives conflict which results in a lack of empathy and support. For example, Mira explained that there is a version of herself that her family are aware of, which is to true to an extent; however, she has emotionally grown since her childhood traumatic experiences. Her family have their own versions of her/and their childhood which blurs Mira's narrative in their eyes. Her friends, however, understand her perspective thus allowing her to be her current authentic self. She explains that her primary support system is that of her friends and not her family. Her friends are more aware of her mental health struggles and encourage aspects of healing that requires Mira to put herself first.

The back stage region involves preparing for front stage performances. This can happen in various ways that require the actor to rehearse and/or predict what may occur in frontstage regions. As mentioned before, Brooke explains that she excelled in the service industry because, as she describes herself, she is a social chameleon. Brooke is able to anticipate and rehearse interactions that occur in the front stage region which require her to elicit a particular performance. This suggests that she is constantly trying to manoeuvre her ways to camouflage and adapt in performative acts. The backstage regions provide a source of relaxation that allows for preparation for front stage performances. As mentioned, there are particular preparations that are required for Aamira's performance as a lecturer, the backstage region is a safe place in which she is able to engage with this matter. Additionally, Aamira has mentioned that some of her support systems fall within other academics. This creates a source of comfort as Aamira is

able to toss ideas around with members in her support system. i.e. other academics, which can strengthen her performance of lecturing.

A common theme that can be seen through the lens of backstage is understanding of trauma responses. As mentioned previously, the front portrays a particular representation of a person but the audience is unaware of the trauma that has shaped trauma survivors. Behaviours and attitudes that are often associated with personality (togetherness) are actually trauma responses and coping mechanisms in order to deal with the trauma narrative. Strikingly, the backstage provides insight to "fellow actors" who see a shift in the environment and are aware of hidden aspects from previous trauma narratives. Participants have addressed that there are a few close loved ones who are able to see their constant struggles; whether it be through verbal or nonverbal communication. For instance, those closest to Mira have witnessed that when she experiences high levels of anxiety her body releases some of the anxious feelings through her leg shaking. This has become a physical representation of her stress levels. Additionally, she strives for aspects of control through matters of tidiness[41]. Aamira displays similar antics as high periods of stress result in excruciating migraines and her trauma response circles around aspect of control in terms of cleanliness[42]. Here, backstage, the self is not presented as so well put together. The backstage is the place where trauma survivors meet their support systems, who know them more personally and so the trauma survivor can be their real selves without fear of reproach or feelings of inadequacy. This is where Mira does not have to hide the leg shake, she knows that the people close to her understand what the action represents, and do not make her feel 'odd' about it. With her backstage crew, Aamira is able to be pedantic about cleanliness and does not have to worry about being judged as 'weird' about her habits, when they become extreme. She also does not have to pretend that she is okay when she has migraines and is able to shut down in the presence of her backstage members.

There is a preconceived notion that in most settings, family members are seen as the individuals who would most likely witness backstage behaviour. Interestingly, this was not the case. Participants had explained that due to cultural understandings and expectations they struggled to be their authentic selves resulting in filtering their behaviour based on their audience. These expectations range from gender roles to keeping family matters private and stigma. For example, Shuaib, Mira, Aamira and Fatima's trauma narratives have a common thread of "*what will people think"* and these resonate within the South African Indian population. Additionally,

[41] Everything belongs in a particular place
[42] Free from dirt

male participants are constantly negotiating with conflicting ideas surrounding masculinities that shape their narratives. These become slightly more complex to heal from when loved ones are unaware of the conflicting expectations that culture has on their lived experience. Family members, thus, are likely to be front stage audience members as they do not always form part of their primary support system. Mira explains that she is currently seek assistance from a mental health care professional without her family's knowledge. This is because they do not understand the benefits of therapy and feel as though they are currently doing something wrong to exacerbate Mira's mental health; which is not the case. It is comprehendible that family members do not always comprise the pirmacy support system for survivors as family members have a role in trauma exposures and narratives. We can reflect here on Sally, Aamira, Shuaib, Mira, and Brooke's experiences growing up.

These factors that influence the way in which experiences are filtered, provide people with a sense of negotiating between roles. These social identities provide perspective on levels of comfort with engaging in a particular discourse. Interestingly, participants also consciously chose to keep particular information from individuals that fall into the backstage region. This is because family members may fall into a backstage region but are unaware of experiences. This aids in the discussion as to why actors tend to seek solace from friends over family members. For example, as mentioned, Chrystal was raped by a classmate. This occurred during her time at university and her family were not present. She was aware that they would have difficulties dealing with the horror that Chrystal went through thus Chrystal opted not to tell her family about her rape. She instead negotiates her experiences through her support system that is present within her university space, and this encourages healing in a productive element.

The backstage analyse provides vital insight into ways that actors prepare for upcoming performances as well and able to relax within backstage regions. Both regions, back and front stage are important to trauma narratives as actors are finally in control of aspects of their lives. Front stage performances allow actors that present themselves within a particular light and in most times can have an input in the impressions that are produced. The backstage region provides more comfort as they are aware they belong to communities that see their authentic selves thus creates a sense of belonging which they often look for.

Chapter 10: Conclusion

Mental health and well-being has become an important point of discussion in recent years. Rates of depression and anxiety disorders are rising, however, culturally appropriate understandings and methods of treatment are lacking. To reiterate, Syme and Hagen (2019: 87) argue that mental health diseases are a leading contributor to the global disease burden. Medical anthropologists have, through their research, shown the importance of the role which culture plays in health and well-being. The Western psychological narrative sees the mind and body as separate, which is not the case in many non-Western societies, like South Africa, where the mind, body, and spirit are all important to good health and well-being. Global institutions, such as WHO, are vividly aware of the problems that their countries face and trauma narratives have spearheaded their way into vital conversations that address contemporary challenges. This is because it is a lived everyday experience that grabs the attention of problems that pertain to particular countries and cultures that governments and institutions are interested in. There is a need for anthropological studies of trauma to examine social and cultural implications for trauma narratives in order to provide understanding for behaviour and survivors perception of the world. An ethnographic study of trauma narratives is an important addition to existing medical anthropology research as it has an impact on the global mental health crisis of cultural influences of trauma.

This study has explored various trauma narratives that exist in South Africa providing ethnographic consequences of the traumatic experiences. This dissertation offers a rich ethnographic description of the cultural influences of trauma narratives and the role that culture has on everyday behaviour and perception. Key themes that emerged from the data collected illustrated that the underlying structure of trauma narratives are heavily influenced by cultural concepts and understandings of post-trauma symptoms. Western diagnostic manuals such as the DSM and the ICD thrive on its universal nature, however, it is evident that it's focal point is on western experiences. As the world develops, westernisation has spread, however, these manuals and subsequent understandings and ways of treating of trauma is exclusionary to non-western societies. The multi-cultural landscape of South Africa cannot be ignored. The DSM and ICD do not acknowledge the cultural and spiritual elements which are key features in many cultures across the African continent, and more specifically South Africa. Key themes that arose is that expressions of trauma do not directly align with understandings presented in the DSM and the ICD. This is because languages of distress and expressions vary across landscapes. Similar attributes mirror symptoms that are presented in the Western manuals but

South Africans often do not have the same language, or culturally appropriate practitioners who are able to diagnose post-trauma experiences and symptoms. There is a need for more mental health practitioners and support avenues to be trained with more culturally relative frameworks in mind to promote healing.

The ethnographic descriptions provided in this dissertation document the real lived consequences of cultural influences in trauma narratives. The research has highlighted cultural understandings normalcy of trauma due to South Africa's political and social past. This has created a ripple effect on validity of trauma narratives. Due to the commonness of trauma exposure and traumatic events, trauma survivors struggle with labelling events as traumatic which results in various forms of denialism and often results in survivors using languages of distress that resonate within cultural spaces in order to convey their experiences. This is important to understand as they may not recognise or chose not to align with Western labelling due to the negative connotation associated with it. The use of metaphors and idioms allow for distress to be conveyed to various cultural groups without any stigma attached to their experiences. My research has presented that trauma survivors experience various forms of hypervigilance, detachment, and avoidance in order to cope with their traumatic experiences. This is important to document as it provides lived experiences and consequences of post-trauma narratives, especially in instances of long term trauma, additionally, this can have can be communicated through memory and forms of dissociations.

The theoretical analyses of this dissertation focus on Goffman (1959) *Presentation of Self in Everyday Life.* This analysis allows readers to see the performative nature that trauma survivors portray in order to maintain a front through a frontstage region. These fronts allow trauma survivors to fit into society often without advertising their trauma narrative. It is particularly interesting to see how survivors are able to manoeuvre their behaviour to depict the desired narrative. Additionally, it explores the role of the back region which allows a more relaxed nature. This allows trauma survivors to drop their front and find ways of healing. This is often done with the assistance of support systems as they tend to see one authentic self. This theoretical analysis provides insight into the carefully constructed nature that accompanies trauma survivors presentation due to their traumatic experiences and accompanied mental health struggles.

My study has illustrated the importance of gathering data first-hand from trauma survivors and understanding it through a sociocultural context. Through this lens, it provided underlying

structures that influence understandings of behaviour and perception due to culture. These are often dismissed when examining trauma narratives from solely a psychological perspective. Further research to ensure that voices are heard in relation to cultural understandings as this shapes the everyday experience.

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