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"I Think Too Much" – Culture, Trauma, and Expressions of Distress.

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Abstract
The 21st century has seen a dramatic increase in chronic non-infectious diseases, and medical anthropologists have noted a rise, particularly, in the area of mental health. Past studies have shown that a lack of cultural understanding of trauma narratives resulted in non- or mis-diagnosis which ultimately has negative repercussions. Culturally specific and appropriate understandings of trauma narratives are necessary for correct diagnosis and treatment. Diagnostic manuals, such as the DSM and ICD, rooted in Western culture thrive on their universal nature, however, they are exclusionary to non-Western societies ignoring cultural and spiritual elements that are embedded in understandings and treatment of trauma. This paper draws on the experiences and understandings of trauma from the perspective of South Africans who have non-Western cultural affiliations. Distress has its own language and expression according to culture. Cultural practices provide a safe haven from distress and help us to make sense of what we are experiencing enabling healing and closure in their processes. This paper draws from several in-depth semi-structured interviews, with South Africans from differing cultural backgrounds, conducted over the course of six months. The results of the study reflect that the structure of trauma narratives are heavily influenced by cultural concepts and contexts, illustrating that cultural awareness and appropriateness is important when engaging with trauma discourse. Through the ethnographic study of trauma narratives, anthropologists have an important role to play in the global mental health crisis. This paper, therefore, posits that cultural awareness of perspectives of trauma must be brought into curriculum, especially in the discipline of Psychology, in order to ensure that treatment, intervention, and prevention strategies are culturally aligned for success.

Keywords: trauma, culture, distress, cultural appropriateness, anthropology of distress, mental health.

Introduction

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 paper aims to examine the important of cultural narratives in understanding trauma and expressions of distress and the need for non-Western cosmologies to be included in psychology teaching practices.

In the 1600s, applications of the word trauma concerned medical bodily wounds (Kirmayer and Sartorius, 2007). Since then scholars and clinicians have used the concept of trauma across multiple disciplines, more so through a medical and psychological lens (Kirmayer and Sartorius, 2007). Medical understandings refer to direct bodily injury; for example, trauma to the head would indicate a wound on the head. Psychological trauma, however, is more complex and multifaceted because it is a response to physical and emotional trauma, unveiling an invisible nature to trauma (Lester, 2013). It not only involves the traumatic event itself but includes "the complex sets of responses to the event", including flashbacks, unusual sleep patterns, and hyper-arousal (Lester, 2013). There is a third understanding of the term, encompassing the physical and the psychological state which can be considered as a traumatic event which leads to traumatic stress (Edwards, 2005; Swain et al, 2017). 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". 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.

Traumatic events alter a person's world, changing the nature of their relationships, needing to reconstruct avenues of safety and security, and after a traumatic event, people are constantly pushed to their limits, both physically and psychologically (Lester, 2013).

Trauma has traditionally existed in the realm of psychology studies and therefore this paper uses terms associated with psychological discourse. 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 evolved since the first edition of the Diagnostic and Statistical Manual of Disorders (DSM) in 1952. Initially 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). Trauma was seen as an acute response that was reversible and, if the reaction did not fade, another diagnosis would be assigned (Andreasen, 2011). The DSM-II, published in 1968, completely omitted trauma and stress-related responses (Andreasen, 2011). 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 reversible, leading to the development of Post-Traumatic Stress Disorder (PTSD) (Friedman et al, 2011).

Cultural Understandings and Expressions of Trauma

It is important to address the impact that knowledge and knowledge production has on the validity of health. Western knowledge and Western knowledge production, due to colonisation and modernisation as well as the influence of the World Health Organisation and the United Nations, has been a model that influences and determines health, wellbeing, and healing across the world (Levine, 2012; Brown 2015). Traditional knowledge and alternative methods of healing that deviate from Western knowledge are often scrutinized and dismissed. Mental health, illness, and stress disorders, have traditionally been measured and studied according to the Western experience, as evidenced by the reliance on the DSMs, highlighting geopolitical forces which impact the validity of health in non-Western spaces (Tseng, 2006).

Whilst Western psychology enjoys dominance around the world, the acknowledgement of local and indigenous ways of knowing are often marginalised, disregarded, or 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). A relativistic approach to health and well-being is important and 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 (Farquhar, 2012). 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. Culture plays a vital role in health, especially in areas of mental health, because culture provides perspective on what is seen and understood as health problems and potential treatment options.

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. In some cultures, it is taboo to seek the help of a Western mental health practitioner. Anthropological studies have shown that there are often culturally specific ways of understanding and dealing with phenomena that cause mental stress. Evans-Pritchard's research amongst the Azande illustrates that if a person experiences a strong mental stressor it may be believed to be a result of an act of witchcraft, which can only be confirmed by an oracle and treated by a diviner (Peters-Golden, 2006: 14). Amongst the amaXhosa, in South Africa, mental illness is believed to be a result of the supernatural, whether it be bewitchment brought on by jealousy, or related to ancestors who have withdrawn their protection, and treatment must therefore be supernatural (Campbell et al, 2017). A similar argument can be made in other cultures where mental illness may be seen as a sign of lack of poor faith and intervention would be on a religious level (Reid et al., 2009; Caplan, 2019). 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).

Culture provides meaning to one's life through the social, economic, religious, and cognitive structures (Anderson et al, 2003). Thus, 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 IV includes a cultural glossary and cultural factors to consider when assessing patients. Culture-specific sickness has evolved in its classification 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 Syndrome (CBS) (Yap, 1967; cited in Tseng, 2006). CBS is a collection of signs and symptoms which encompass particular behavioural and cognitive manifestations, as a result of specific social factors, in specific cultures (Sahoo et al, 2021). CBS in non-Western societies have been studied extensively but have often been seen as fixed illnesses through time and not recognising development and change as a result of modernisation and globalisation (Kaiser and Weaver, 2019:590). Anorexia Nervosa, for example, has been perceived 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, 1996; Sepulveda and Calado, 2012). CBS's, however, have been critiqued as problematic in nature due to their being exoticized and limited to a specific culture. Nichter's (1981) idioms of distress aimed to remove this exoticisation and provide some sense of fluidity as several of these (CBS) 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 recognition that the DSM needed to have cultural diversity and not only depict a Western narrative, creating a space that encouraged cultural diversity within a prominent diagnostic tool (Thornton, 2017). The recognition of CBS in the DSM speaks to the geopolitics of knowledge production. CBSs are now recognised by the world because it is recognised by the West. This is problematic because these CBSs have existed long before the DSM gave them validity, thus highlighting the power the 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 the International Classification of Diseases (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 and in 2001, Tseng recommended subgrouping based on how culture affects psychopathology (Tseng, 2006). A common issue that arose with CBS is that it was culture-specific and could not be universal, resulting in the inclusion of a glossary of Cultural Concepts of Distress (APA, 2013). 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) explored cases for the cultural shaping of emotions and emotional regulation, which often correlates with trauma-related symptomology and found that cultural understandings 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 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.

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. Western psychological models often focuses on the individual and the body while African psychological models of health draw on the social, physical, and spiritual realm with the community playing a vital role in health and mental wellbeing (Goduka, 2012; Baloyi and Ramose, 2016). Therefore, the Western explanatory model does not account for African experiences and 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 reality views three interrelated world which consist of the macro-cosmos (the Divine), the meso-cosmos (spirits, witches, and sorcerers), and the micro-cosmos (everyday practical, social and collective life) (van Dyk, 2001; Nobles et al, 2016).

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) 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). Noluthando, who lived with her aunt in Pretoria, grew up with an absent father who late in his life tried to mend their relationship and to which Noluthando refused and her father subsequently passed away. In her adult life, has had unsuccessful romantic relationships which her aunt attributes to her father's "unfinished business with her" (Nobles et al, 2016). Noluthando sought help from two white psychologists but found them unaccommodating because they were unable to understand her cultural and spiritual beliefs and associated her experiences with factors that are a direct cause in her life, ignoring the external cultural factors such as ancestors (Nobles et al, 2016). 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. 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. For example, a psychotic disorder, like schizophrenia, can be viewed differently from an African perspective. These same set of symptoms, according to the amaZulu perspective can be interpreted as *"the calling*" (*ukuthwasa*) to become a traditional healer. A Western lens would view symptoms in line with a psychotic 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). The awareness of worldviews and cultural factors promote accurate diagnosis and healing. Cheetham (1980) stated that 60% of black South Africans are misdiagnosed with schizophrenia due to their mental health care practitioner not being aware of or ignoring cultural factors. Nwoye (2002) 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' 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) 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) argues that this may have led to the desensitised manner in which South Africans relate to crime and violence, and subsequently trauma exposures.

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 Literature that is available is often situated in line with DSM and ICD understandings, thus do not accurately represent how South African ethnic groups deal with trauma because of its normalised nature. This speaks to the problematised nature that South Africans are dealing with difficult and extremely stressful situations with resilience as a coping mechanism. South African war veterans of the South African Border War[1] of 1974 and 1988 cope with war trauma, and trauma memories with "mental toughness" and 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 (Gibson, 2010).

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 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.

Methods

This paper draws from data generated from a Masters research study which sought to answer the question, "How does culture affect people's behaviour and perceptions of trauma?". South Africa is a multicultural society and the authors personal experiences reflected that Western diagnostic understandings of trauma did not match with their relative cultural understandings. Thus, the key objectives of the study were to explore cultural understandings of trauma, and how trauma is navigated from a cultural perspective. Data generation occurred over a period of eight months from March to October 2021 for both qualitative and quantitative data, via web-based and face-to-face interactions. Quantitative data was collected through the dissemination of an online questionnaire with 72 responses received. Goodman et al's (1998) The Stressful Life Events Screening Questionnaire (SLESQ) was applied, with a trigger warning, to assess 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 experienced across their life course. The SLESQ also highlighted common trends of types of stressful events and traumatic exposure to certain groups. The study used both semi-structured and unstructured phenomenological interviews with 11 key informants. The use of these interviews allowed for a smooth flow of conversation where participants could be prompted to delve deeper into their experiences and engage with their memories throughout their life thus generating detailed trauma narratives for each participant. It was important that participants be given the space to explore their experiences and understandings of their trauma and engage with what it meant to them and how this has evolved over their life course. Table 1 provides key informant information. In addition to these methods of data collection, online observation on Facebook groups were included. These are public groups (the information can be seen by anyone) which the researcher was a member of, however, prior to the observations for research commencing the researcher requested permission

[1] Also known as the Bush War and the Namibian War of Independence.

from the groups administrators and made her presence as a researcher known to the group members and contacted people whose posts she wanted to use for data for permission.

Table 1: Key Informant Information

Participant[2]	Age	Gender	Race/Ethnicity	Acute Trauma	Chronic Trauma
Tara	39	Female	White	-	Prison, domestic abuse
Sally	27	Female	White	Criminal	Child abuse, sexual abuse, medical trauma
Chrystal	25	Female	White	Sexual assault	Political violence, academic
Aamira	36	Female	Indian	-	Academic, witnessing domestic abuse (as a child)
Shuaib	52	Male	Indian	Gunshot, sexual assault	Child abuse, sexual abuse
Brooke	26	Female	White	-	Child abuse, multiple sexual assaults
Kollie	33	Male	Zulu	Criminal	Academic
Kudzai	31	Male	Shona	Death of parents	Sexual assault
Fatima	47	Female	Indian	-	Emotional abuse
Akhona	37	Female	Zulu	-	Sexual assault
Mira	25	Female	Indian	-	Witnessing domestic abuse (as a child).

Stratified and snowball sampling was applied to aid in a cross-cultural comparison, with a set of inclusion and exclusion criteria. The sample was stratified by age, ethnicity, and culture which was important to reflect South Africa's diverse cultural population. This ensured that the data generated about trauma narratives was diverse. Snowball sampling allowed for research participants to identify and recommend potential participants who were from a vulnerable and difficult to reach population (Acharya et al., 2013).

The inclusion 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, had been hospitalized for psychiatric care, and attempted suicide one year prior to the study did not qualify.

Expressions of Trauma

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

[2] Pseudonyms have been used.

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 the manner in which participants expressed distress had a cultural element to it.

Traumatic stress is an experience that is present in all cultures, but one cannot dismiss cultural influences, expressions and understandings. 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) noted 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. Social norms are important in understanding how a society or culture responds to phenomena and cultural languages of distress (verbal or non-verbal) exist to illustrate suffering (van Rooyen and Nqweni, 2012; Bova et al, 2017). 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. 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. Good and Hinton (2016) recognize the importance of culture in illness vocabularies and the impact this can have on ethno-psychology and ethno-physiology. Traumatic events are interpreted and acted upon based on cultural and societal understandings, and this plays a vital role in recovery (Jones, 2015; Hinton and Good, 2016). 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.

Through the use of various modes of expression, distress and post-trauma narratives can be better understood. This paper indicates that participants 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*" (Akhona). Furthermore, mental health illnesses, such as depression, are seen as "*white people problems*" (Aamira). 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). This study found 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. 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. Akhona was asked if she struggled with anxiety or anxious thoughts to which she said she did not. However, throughout the 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.

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 (for example, snakes are a sign of deception), 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.

Distress can be experienced and communicated in different ways, depending on the socio-cultural norms a person subscribes to. Mental healthcare practitioners need to be aware of these expressions of trauma if they are to have successful treatment and be cognisant that some communities require the involvement of the supernatural in their treatment. Trauma informed approaches need to be cognisant and accepting of culturally-informed understandings of trauma and can, therefore, be effective in treatment and healing. Trauma informed approaches must resist retraumatising individuals by being culturally ignorant and forcing narratives that are not aligned with an individual's belief system and thus inadvertently blaming or guilting a patient for their situation. It is important for therapists to consider the complex nature and impact of trauma on an individual's well-being and how culture shapes their ability to cope. Respect for belief systems other than Western psychological models must be strengthened first through shifts in curriculum, as well as mindfulness in practice, of how culture affects a person's perception and understanding of trauma and safety. This needs to take place when mental health practitioners are students, at a university level, whereby cultural understandings of trauma are explored in the lecture halls and students are encouraged to think about their own cultural understandings of trauma and mental health in relation to the Western psychological models they are being instructed in. Anthropology departments exist in almost all university settings and a collaboration between Psychology and Anthropology departments can create a rich curriculum that is culturally contextual and sensitive to the needs of the local population, but also provide future practitioners with the tools to navigate diverse cultural ways of knowing and been that they will come across in practice. Expanding curriculum to include cultural perspectives of trauma and healing must be included to broaden the spectrum and credibility of knowledge that is non-Western in nature and to ensure that treatment practice is culturally diverse and appropriate.

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. 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.

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. The use of metaphors and idioms allow for distress to be conveyed to various cultural groups without any stigma attached to their experiences. 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.

Disclosure statement

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