CULTURALLY INFORMED CONCEPTIONS OF TRAUMATIC EXPERIENCE AND COPING STRATEGIES AMONG THE MOLE-DAGBON OF GHANA

By

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DECLARATION

I, Sandra Thompson (214053733), hereby declare that the dissertation for MA (Research) Psychology is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.

……. ……..

Sandra Thompson Date:

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ABSTRACT

Culture is important to an individual's understanding of traumatic events and the symptoms that ensue after such events. Cultural understandings also inform how individuals cope with the traumatic stress symptoms they experience. A great deal is known about the understanding of traumatic experiences and effective coping mechanisms used in Western cultures, but non-Western cultures are generally understudied.

Valuable lessons are learnt from conducting studies with understudied non-Western cultures. The research sought to explore and describe the culturally informed conceptions of traumatic experience and coping strategies in one such understudied population - the Mole-Dagbon of Ghana. The research used a qualitative exploratory descriptive interpretive methodology. Purposive nonprobability sampling was used to gain access to individuals who could comment on the knowledge objectives of the study. Data was collected using focus group discussions with cultural leaders, and semi-structured interviews with traumatized individuals. All interviews were audio-recorded, transcribed, translated and analyzed using interpretive phenomenological analysis. The findings indicated that traumatic experiences and the coping strategies are influenced by a number of cultural factors. Participants' understanding of traumatic experiences and symptoms relied heavily on normative traditional African cultural understandings, but explanations also utilized monotheistic (from Islam and Christianity) worldviews. It was also evident that not all explanations were purely spiritual and events and symptoms were also explained using a natural/scientific framework. Some aspects of this system indicated parallels with the Western cognitive understanding of traumatic stress symptoms. The

Mole-Dagbon did not focus naturally on explaining the events and symptoms and in the current sample such explanations were often deferred to authoritative individuals in the society (especially the soothsayers from the Traditional African Religion). However, there was an easy focus on coping with the symptoms after a traumatic event and in this last aspect there was a great degree of agreement between participants. A clear hierarchy of coping emerged with community and family social support being considered the most important aspect. Irrespective of religious affiliation, individuals also considered a visit to the soothsayer and completing prescribed rituals as important in the process. Even where an individual did not wish to include this practice from African Traditional Religion because of religious affiliation, they acknowledged the existence and effectiveness of these practices. Finally, it was thought important that a traumatized individual consult a religious leader for counselling (again irrespective of the actual religion). While there were elements of cognitive understanding and a recognition of counselling by religious leaders, Western based treatment modalities were not mentioned as options for the treatment of the symptoms of PTSD. Practitioners that come into contact with the Mole-Dagbon may need to use collaborative treatment strategies that respects and utilizes cultural treatment strategies for PTSD. One interesting element that needs further exploration is whether the cognitive understandings of the Mole-Dagbon can be used in a cognitive therapeutic paradigm. Even though these cognitive appraisals are present in explaining symptoms, there are no direct cultural remedies that rely on them.

Keywords: Culture, Traumatic event, Traumatic symptoms, Coping strategies, Mole-Dagbon, Ghana, posttraumatic stress disorder, cross-cultural psychology, cross-cultural psychiatry.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 CHAPTER OVERVIEW

This chapter introduces the contextual background for this dissertation, which explores and describes the trauma related cultural understandings of the Mole-Dagbon. The chapter delineates the significance of the study, gives relevant background to the Ghanaian and Northern Ghanaian context, and provides definitions of concepts incorporated in the study. The contextual information is used to frame the research problem and consequent research aim and objectives. The chapter concludes with a brief description of the methodology and summary of what is to follow.

1.2 INTRODUCTION

Trauma arising from natural or man-made events is experienced in every culture (Markert, 2011; Wilson & So-kum, 2007). This is true in terms of both senses of the word. 'Trauma' can refer to 'traumatic exposure' to the events that traumatise individuals or it could refer to the 'traumatic stress' symptoms experienced after a potentially traumatising event (Carlson & Dalenberg, 2000; van Horn, 2011). The experience of these events and symptoms are subject to cultural understandings that may lead to differences in culturally informed coping strategies (Terranova, 2011; van Rooyen & Nqweni, 2012).

Traumatic exposure has been defined diagnostically by the American Psychiatric Association (APA) (2013), as exposure to actual or threatened death, serious injury, or

sexual violence, in one (or more) of the following ways: directly experiencing the traumatic event, witnessing in person the event or learning that the traumatic event occurred to a close family member or friend. In cases of actual or threatened death of a family member or friend, the event must have been violent or accidental.

The APA (2013) definition was used to frame traumatic exposure in this study, but van Rooyen and Nqweni (2012), and Terranova (2011), have also recently argued that culturally and individually informed conceptions of traumatic events are important in considering what constitutes traumatic exposure. Certain events such as the sudden death of a loved one, sustaining a sudden and permanent injury (e.g. maiming leading to amputation) and witnessing the death of another person, could be instances which would be traumatising to people of all cultures because of the universal threat element involved (Bernacchio, Burker & Buse, 2013; van Rooyen & Nqweni, 2012). However, this does not mean that the specific attributions for an event will universally be the same. Taking cognisance of the Ghanaian belief system (the researcher is Ghanaian) for example: the death of a child at an early age can be attributed to the acts of God, the gods of the land, or the ancestors. This specific attribution is likely to distinguish Ghanaian culture from others. In terms of understanding traumatic experience from a cultural context, it is therefore important to understand how people from a specific culture view traumatic events. This may be important for a variety of reasons, but in terms of the researcher's purpose, such cultural understandings were significant because they were thought to be central in illuminating the cultural understanding of the symptoms that ensue after traumatic events.

Usually these symptoms include experiences such as intrusive remembering, avoidance of internal and external stimuli, changes in mood and cognition, persistent or recurrent experiences of feeling detached from the self, and changes in arousal and reactivity (APA, 2013). A mother that loses a child and subscribes to Ghanaian beliefs may exhibit symptoms of fear and intrusive unwanted thoughts of being visited by the gods of the land or ancestors. Anecdotal evidence in the experience of the author indicates that the origin of this fear and unwanted thoughts may be attributed (by the mother) to the failure to perform the rituals due to the gods after the exposure. This example of universal traumatic stress features that are experienced differently by individuals from different cultures is analogous to that which has been found in other studies (Alarcón, 2009; Markert, 2011; Mollica, Caspi-Yavin, Lavelle, Tor, Yang,Chan, Pham, Ryan & De Marneffe, 1996; Wilson, 2005). How people understand symptoms from a cultural perspective and their individual viewpoint is important in its own right, but it may also leads to a greater understanding of how they cope with the symptoms and reconstruct their lives after traumatic events.

Pathways to health after trauma is strongly influenced by cultural means (Bernacchio, Burker & Buse, 2013; de Jong & Reis, 2010; Frie, 2011; Terranova, 2011; Wilson, 2005). People (possibly from a more Westernised perspective) who are familiar and comfortable with the services provided by mental health professionals may ascertain that stress is the major factor, and resort to Western clinical practices for the resolution of their symptoms (Tang, 2007). On the other hand, individuals that hold more traditional cultural beliefs may consult soothsayers or spiritualists because they may attribute

symptoms to the acts of gods, ancestors and witchcraft (de Jong & Reis, 2010; Tang, 2007; Zur, 1996). In the latter example, victims will engage in rituals to limit or get rid of the symptoms and to help them feel re-oriented and render life predictable once more (de Jong & Rei, 2010; Graham, 2005).

The general perception that Western origins of understanding and modes of adaptation to traumatic stress are superior to those from non-Western origins unfortunately still prevails (Marsella, 2010; Terranova, 2011). This perspective has led to the situation where very little consideration has been given to ways of coping and adaptation in many non-Western cultures. Cultural background and the accompanying belief system play a significant role in how an individual adapts. For instance, in interdependent cultures, the support provided by family members (both nuclear and extended), friends and community members are salient sources of support to mitigate traumatic stress symptoms and therefore enable individuals to cope better (Carlson & Dalenberg, 2000; Kitayama, 2002; Hofstede, 2001; Terranova, 2011; Wilson, 2005). While social support is also a well-known positive prognostic indicator in independent Western cultures (Brewin, Andrews, & Valentine, 2000), it is likely that the use of social support is more salient in many non-Western cultures (Herbert & Forman, 2010; Nickerson, Lidell, Maccallum, Steel, Silove & Bryant, 2014). There are many other relevant examples here, but it is likely that a greater understanding of how coping works in non-Western cultures may illuminate valuable lessons in terms of the overall traumatic stress picture (Van Rooyen & Nqweni, 2012). In the opinion of the researcher valuable lessons learnt from Western perspectives can be challenged, scrutinized and augmented by including more varied perspectives.

Culturally focused research into traumatic stress is therefore important as there may be universal features and principles that are important across cultures, but it is also quite evident that cultural and individual factors will play a role in how people understand the events, their symptoms and then how they choose to deal with those symptoms (Terranova, 2011; Van Rooyen & Nqweni, 2012).

1.3 THE GHANAIN KNOWLEDGE GAP

In Ghana, there is limited literature concerning traumatic events, the understanding of symptoms and associated coping and healing mechanisms whereas in the rest of the world, it has been studied extensively (e.g, Alarcon, 2009; Markert, 2011; Marsella, 2010; Wilson, 2005). A literature search by the author found one published trauma study and a thesis by Agbenorku, Johnson, Nyador and Agbenorku (2010) and Terranova (2011) respectively. The first study investigated physical traumatic injuries among printing press workers in Kumasi, Ghana. Whereas the later study explored the relationship between Posttraumatic Stress Disorder (PTSD) and comorbid depression in citizens currently living in Ghana. Neither study focused on cultural elements. This indicates that there is limited literature on the topic in the country. The significance of this study thus seeks to contribute to the general knowledge base around traumatic stress, but also close a knowledge gap in the specific case of Ghana.

1.4 GHANAIAN CONTEXT

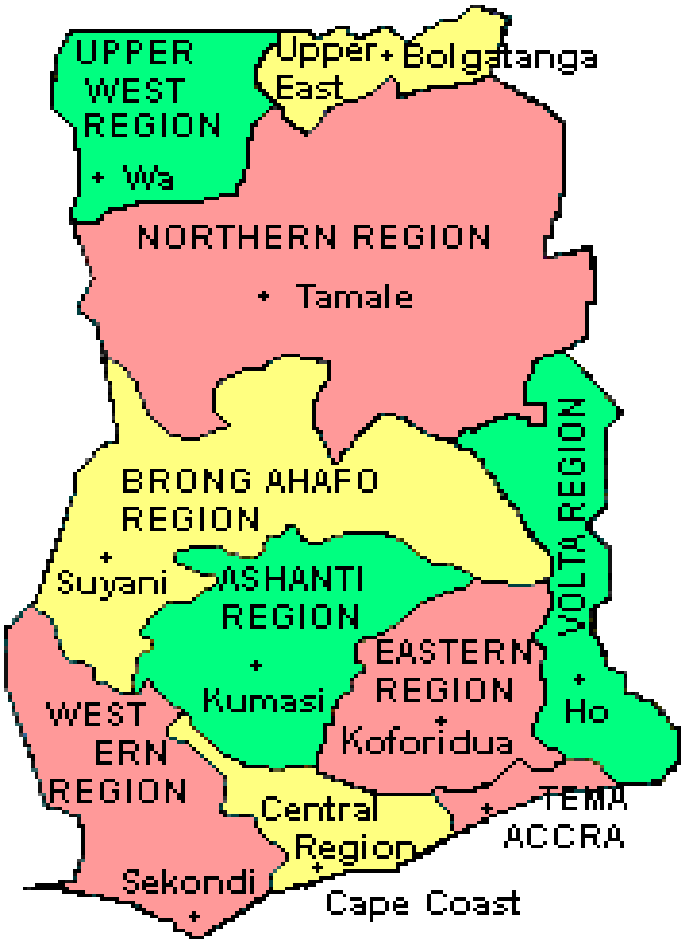
Ghana is located in the Western part of Africa. The country covers a total land size of 238,535 square kilometers with a total number of 27 million people (51% female and 49% male) (Ghana Statistical Service, 2010). The country is made up of a number of

ethnic groups. The major ones being the Ga, Akan, Ewe and Dagbani. The country is divided into ten administrative regions. Each of these regions is occupied by people from all over the country. However, in each region, there is a predominant ethnic group (e.g. Greater Accra - Ga, Ashanti – Ashanti, Volta – Ewe and Northern Ghana - Dagbani).

The region of interest to this study is the Northern – Dagbon region. This part of Ghana comprises the Northern, Upper West and Upper East administrative regions which are occupied by a number of different ethnic groups (Figure 1). The predominant groups (Konkomba, Nanumba, Dagomba, Mamprusi, Gonja and Mossi) are collectively referred to as the Mole-Dagbon. The dominant religion in the area is Islam followed by African Traditional Religion and Christianity (Awedoba, 2006). As illustrated by the pink section in figure 1 below the area is relatively extensive and the Mole-Dagbon constitutes a large population group.

Figure 1: The map of Ghana indicating the different regions.

www.ghanaweb.com/GhanaHome Page/geography/maps.php).



The Mole-Dagbon are also known as “the great warriors” and have suffered several natural and human induced events which are potentially traumatic for its members. For instance, the recurrent ethnic conflict between the Konkomba and the Nanumba (which has its roots in disputes around chieftaincy and land ownership) has led to several deaths and thousands of internally displaced persons (Refugee Review Tribunal, 2010). The ongoing

conflict between the Abudu and Andani also led to the death of the Ya-Na Yakubu Andani (the over lord of the Mole-Dagbon) while the one between the Kusasi and the Mamprusi has also led to deaths, injuries and destruction of property such as farms and houses.

In addition to these conflicts, there are natural disasters in this region that contributes to traumatic experiences. This include the spillage from the Bagre Dam in Burkina Faso which flooded the Black Volta in Ghana and destroyed houses, farm lands and livestock (Graphic Online, 2014). In spite of these and many other potentially traumatic events in Northern Ghana, no known or published study has been carried out in the area.

In terms of interventions provided by the state during and after these events, the researcher's knowledge is based on information from popular media. Often such media reports on government provision of practical assistance such as military intervention, physical rescue efforts, temporary settlement for displaced individuals and the provision of food and other relief items. Very little is reported to have been done to address the psychological challenges that may ensue after such events. The lack of reporting as well as the lack of literature to be found on issues around traumatic exposure creates the idea that no serious efforts are being made to understand the psychological state of the people after exposure to these traumatic events. There is quite clearly an academic as well as clear real life need to explore the traumatic experience of the Mole-Dagbon living in the area.

This study therefore seeks to explore and describe attributions for traumatic events among the Mole-Dagbon in Ghana, the conceptions of symptoms and the consequent

coping strategies. The information obtained will generate understanding and insight that could be used to eventually inform culturally appropriate intervention strategies.

1.5 DEFINITIONS

Definition helps to avoid ambiguity in terms of the understanding of terms/concepts. The key concepts have therefore been defined in terms of how they were understood and investigated in the study.

1.5.1 Culture

Culture has been defined in a variety of ways. It can refer to groups of people on the basis of ethnicity, gender, religion, social class, and even sexual orientation (Saltapidas & Ponsford, 2008). Culture is commonly defined in mental health research as "the unique behavior patterns and lifestyle shared by a group of people that distinguish it from other groups" (Okello, 2006; Marsella, 2010; Marsella & Christopher, 2004). The major themes that run through these two and other definitions of culture include reference to groups of people, ethnicity, unique behaviour patterns and social orientation. In spite of such commonalities, van Rooyen and Nqweni, (2012) argue that culture and related terms are often used in a contradictory and confusing manner. This confusion may be compounded by the fact that people also do not necessarily behave mainly in terms of their culture of origin but may blend cultural values or simply react from their personalised internal disposition or personality. This means that when examining cultural factors that shape reactions to traumatic events in individuals, it is important to keep in mind that there may be other (non-cultural) influences on these reactions (Herbert & Forman, 2010). Although there may be commonly accepted narratives around specific aspects of traumatic

experience, the individual may still incorporate these in distinctive ways (van Rooyen & Nqweni, 2012). The fact that individuals may incorporate cultural elements in personalised ways have been kept in mind in the design (focus groups and individual interviews) and execution of the current study.

'Culture' in this study was basically based on the shared beliefs and values of what can be termed an ethnic group. In addition to cultural practices and belief systems, ethnic groups often share a common geographical and historical ancestry, as is the case of the Mole-Dagbon. Because the study investigated both the normative cultural understandings of trauma related experiences as well as individuals' own experiences, it was possible to see how individuals incorporated 'culture' into their understanding. While a full description is given later in this document, it was quite evident that individuals used elements in their own way and often used elements from a variety of cultural traditions rather than a single one. The overall experience highlighted for the researcher the importance of understanding the formal cultural beliefs of a group in terms of traumatic events, but also that it is equally important to consider individuals' own views.

1.5.2 Traumatic Exposure

Traumatic exposure is defined as coming directly or indirectly in contact with an event that can lead to traumatic stress (Wilson, 2005). The DSM-5 outlines events that could be traumatic (see Appendix A). These events can be simple or complex in nature and depending on how the person perceives the encountered event, may lead to traumatic stress symptoms (Clark & Ehlers, 2004; Ehlers & Clark, 2000; González-Prendes & Resko, 2012; Wilson 2005). The person might be involved in the event, observe as it

happens to others or hear that a family member or close friend has experienced it. From the outset this definition was used to frame 'traumatic exposure' in terms of sampling and discussions. However the researcher did have cognisance of the fact that events other than these could be considered 'traumatic' by the Mole-Dagbon.

In the end the DSM tradition conceptualization of traumatic exposure was proven to be quite narrow. Although respondents experienced events (e.g. death of a loved one) that would be considered traumatic according to the DSM, there were other events (e.g. the loss of farm produce) which did not fit the DSM conception, but were considered quite traumatic by the Mole-Dagbon. A common example used to explain their understanding about traumatic exposure involved the loss of farm produce which affects an individual in an extreme manner. This was apparent in both the focus groups and individual interviews and is more fully elaborated on in the results and discussion section.

1.5.3 Traumatic Symptoms

Various symptoms can develop after a traumatic event (Nutt, Stein & Zohar, 2009; APA, 2013). Among these symptoms are extreme fear, helplessness, flashbacks, recurrent distressing dreams related to the traumatic event and inability to recall important aspect of the event (Halligan, Michael, Clark & Ehlers, 2003; APA, 2013). These symptoms are expected after traumatic exposure (see Appendix A). Some authors have cautioned that the DSM-5 coverage may not be globally adequate and that individuals from understudied cultures may present with symptoms that are not included in the current DSM-5 (Hinton & Lewis-Fernández, 2011; van Rooyen & Nqweni, 2012). Because of this, symptoms are defined as any experiences (these experiences can inter alia be behavioural, cognitive or

emotional) not present before the traumatic event that requires coping from the individual. The DSM-5 PTSD symptom criteria were considered as possible expressions, but symptoms were not limited to this set of criteria.

Traumatic symptoms in this study is therefore defined as any behaviour that differed from the individual's usual way of behaving before the exposure. Although individuals mostly exhibited expected symptoms, there were instances where symptoms (explored fully in results and discussion section) did not align with the DSM-5. These unexpected behaviours were considered and explored since they required coping.

1.5.4 Coping Strategies

Coping strategies are the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimise stressful events (Taylor, 1998). This study considered anything the respondent did to alleviate their symptoms as an act of coping. As expected by a variety of authors, individual's internal predisposition, personal experiences and cultural values played a role in the strategy he or she adopted to deal with the symptoms of traumatic event (Bernacchio, Burker & Buse, 2013; Koenig 2005). It was therefore recognised that the strategy a person adopts could either be personally or culturally informed.

Coping strategies in this study were therefore considered to be those culturally and individually informed practices adopted to deal with the symptoms after a traumatic exposure. Respondents resorted to a blend of social support, soothsayers, counselling and

rituals as means of coping. This is more fully explored in the results and discussion chapter.

1.6 PROBLEM STATEMENT

While there is recognition from theory and literature that culture will influence traumatic experience and coping, there was very little known about this interaction among the Mole-Dagbon in Ghana. The Mole-Dagbon therefore constituted an understudied (and potentially traumatised) group about whom there exists little literature to inform potential intervention strategies. There was therefore a need to explore and describe how traumatic events and symptoms are culturally understood among the Mole-Dagbon and how these understandings may inform the coping strategies that individuals employ to deal with the symptoms after traumatic events.

1.7 RESEARCH AIMS

1.7.1 Overall Research Aim

The study aimed to explore and describe cultural constructions of traumatic events, their symptoms and the consequent coping strategies among the Mole-Dagbon of Ghana in order to come to an initial understanding that may inform future culturally appropriate psychosocial interventions. This overall aim was reached by completing the following individual objectives.

1.8 RESEARCH OBJECTIVES

The objectives of this study were:

- To explore and describe the culturally informed conceptions for traumatic events among the Mole-Dagbon in Ghana,
- To explore and describe the culturally informed conceptions of post traumatic symptoms among the Mole-Dagbons of Ghana,
- To explore and describe the incorporation and nature of culturally informed coping strategies adopted by Mole-Dagbon individuals to deal with the symptoms of traumatic events.

These objectives were reached by using a qualitative methodology that is discussed in more detail in chapter three. A brief description is offered here to illustrate how some of the concepts dealt with above were realised.

1.9 BRIEF DESCRIPTION OF METHODOLOGY

Focus group discussions and individual interviews were used to gather the data for the study. The purpose of this method was to give a general (normative) worldview of the culture as well as describe individuals' personalised conceptualizing of traumatic experiences. This is in line with the definition of culture offered earlier. Individual respondents were people who were referred for clinical assistance after exposure to any event considered traumatic as per the definition provided above and focus groups were provided with a vignette for discussion that aligned with the definition.

The process of data collection was quite illuminating in terms of a number of factors. Very early on the very patriarchal nature of the Mole-Dagbon came to light and influenced how focus groups ran. This blindsided the researcher despite her being a Ghanaian! This

necessitated changes in the methodology. Fortunately (after discussion with the relevant ethics committee member) this change did not necessitate formal ethical clearance is discussed more extensively in the methodology chapter. After analysis it also became clear that certain elements of the design were very much influenced by a Western way of thinking. The logical progression from understanding traumatic events to understanding symptoms that leads to coping was not necessarily the logic of the Mole-Dagbon and illustrated to the researcher that methodology itself needs to be carefully considered in studies that purport to take culture seriously.

1.10 SUMMARY AND OUTLINE OF THE REST OF THE DISSERTATION

Traumatic experience and coping with the psychological sequelae may be a universal phenomenon but the conception of the traumatic experiences and means of coping likely vary across cultures. To understand these occurrences in any particular culture, both the normative cultural values and individuals' experiences need to be investigated. The study therefore employed a qualitative descriptive method to investigate these occurrences in the largest group of Northern Ghana - the Mole-Dagbon. The Mole-Dagbon have been affected by significant traumatic exposures of various forms. This chapter briefly explored this background and relevant definitions in order to frame the study. Additionally, the major guiding objectives and methodological features employed were described.

1.11 CHAPTER OUTLINE

Chapter 2 follows and presents the major theoretical concepts that guided the study. Ehlers and Clark's (2000) cognitive model for the maintenance and development of PTSD will be explored and discussed as it forms the conceptual basis for understanding and traumatic experiences and the consequent coping strategies in the research study. The final part of this chapter will explore the existing literature relevant to the study.

Chapter 3 will focus on the research methodology used for the study. The design elements, sampling, strategy used to ensure trustworthiness and ethical considerations for the study will be described.

In Chapter 4, discussions on the obtained results from the study is presented. The chapter gives a detailed account on the themes and subthemes emerging from the data analysis. The findings in this chapter are discussed with reference to the reviewed literature.

Finally, Chapter 5 provides the conclusion on the study along with discussion of limitations and recommendations for future studies.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 CHAPTER OVERVIEW

This chapter will start with a discussion on a theoretical framework that has been used to explain the development and maintenance of traumatic experiences and the coping strategies adopted to deal with them. This cognitive framework by Ehlers and Clark (2000) is extensive and nuanced with comprehensive detail, and the rendition presented here only highlights examples of how the theory works in maintaining the behaviours and symptoms of PTSD. These highlighted aspects were influential in the study design and led to the focus on the cultural understanding and interpretation of events and symptoms. The chapter concludes with a review of literature pertinent to the study and a framing of the research problem.

2.2 THEORETICAL FRAMEWORK

The major theory relevant to this study is Cognitive Behavioural Theory (CBT), which proposes amongst others that an individual's cognitions play a primary role in the development and maintenance of emotional and behavioural responses to life situations (González-Prendes & Resko, 2012). Ehlers and Clark's (2000) model presents an application of general CBT principles to understand individuals' processing of traumatic events and symptoms and to explain the perpetuation of traumatic stress symptoms (Edwards, 2005; Van Rooyen & Nqweni, 2012, Weisæth, 1998).

2.2.1 Application of Cognitive Behavioural Theory (Ehlers and Clark′s Model)

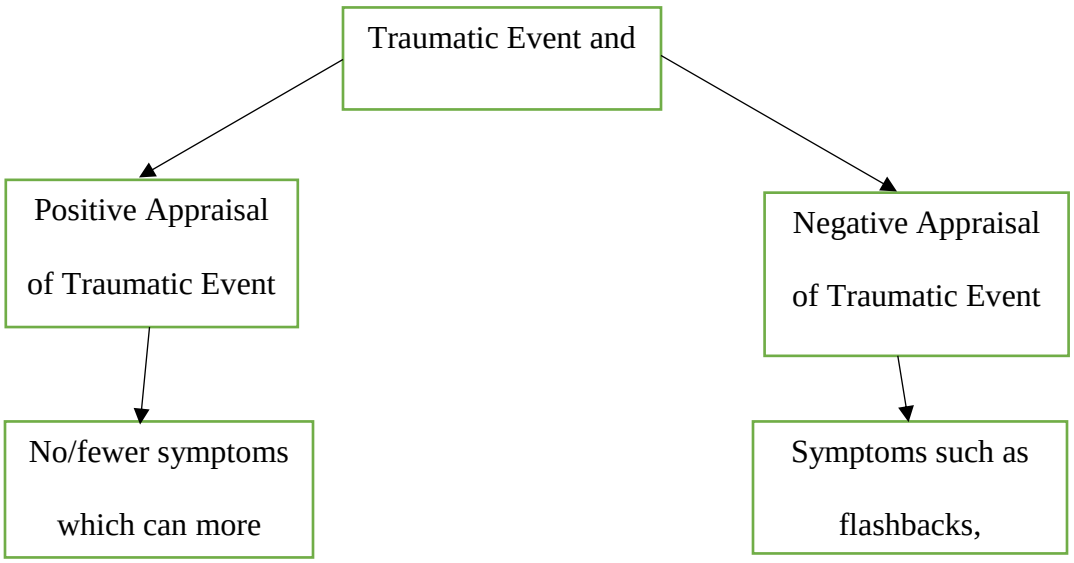
A core feature of this model is that traumatic stress symptoms are perpetuated by an irrational sense of current threat. Several types of appraisal of the traumatic event and symptoms contribute to this perpetuating sense of current threat (Ehlers and Clark, 2000). These appraisals and the coping process will be illustrated using a scenario of a woman who lost her daughter in a car accident (the same as used in the vignette – Appendix H).

2.2.2 Appraisal of the Traumatic Event

Some individuals perceive traumatic events in ways that are (for example) not characterised by future consequences (i.e. they see danger as time-bound and not persistent), but others' perceptions about the same event have negative implications for the future (Ehlers and Clark, 2000). The perceptions or meanings held by the latter group are usually more negative because they contribute to a sense of ongoing current threat that perpetuates traumatic stress symptoms. The associated cognitions can be related to external threat (e.g. the world is a dangerous place) or, very commonly, internal threat (e.g. the view that the survivor has been irreparably damaged) (Ehlers & Clark, 2000). For instance, the woman in our example may overgeneralise the threat presented by the accident and therefore perceive a range of normal activities as more dangerous than they really are. She may also exaggerate the probability of further disastrous events in general or take the fact that the trauma happened to her as evidence for appraisals such as "I must be cursed", "I attract disaster" or "bad things always happen to me". From Ehlers and Clark's (2000) view, if the woman interprets the event as purely accidental her PTSD

symptoms may be more transient because it does not perpetuate the sense of current threat. These examples present cognitions related to external threat. If she attributes the event's occurrence to her neglecting to pick her child up from school, the accompanying guilt can create a sense of continuous internal threat (Ehlers & Clark, 2000; Foa, Steketee & Rothbaum, 1989). The thoughts the woman has about the impending internal or external threat, the emotion she attaches to the threat and the actions she takes to manage the threat can either increase or decrease symptoms. In many cases the sense of current threat created by event conceptions leads to avoidance which on its part has an important role to play in the perpetuation of symptoms (Ehlers and Clark, 2000).

Figure 2: Hypothesised/Cognitive Appraisal model of Traumatic Event (adapted from Ehlers & Clark, 2000).



The model above illustrates the influence of positive and negative event appraisals on traumatic stress symptoms. The formulation above creates the idea that understandings of the event will be a primary concern of anyone after a traumatic event. However, in the current sample the Mole-Dagbon were relatively unconcerned about understanding the events. While there were mechanisms to create understanding, the focus was elsewhere. This highlights the difficulty in transporting theoretical frameworks across cultures. While Ehlers and Clark's (2000) model was useful in conceptualisation of the study, the results suggests the Mole-Dagbon may need a more culturally contextualised theory of their own.

2.2.3 Appraisal of Traumatic Symptoms

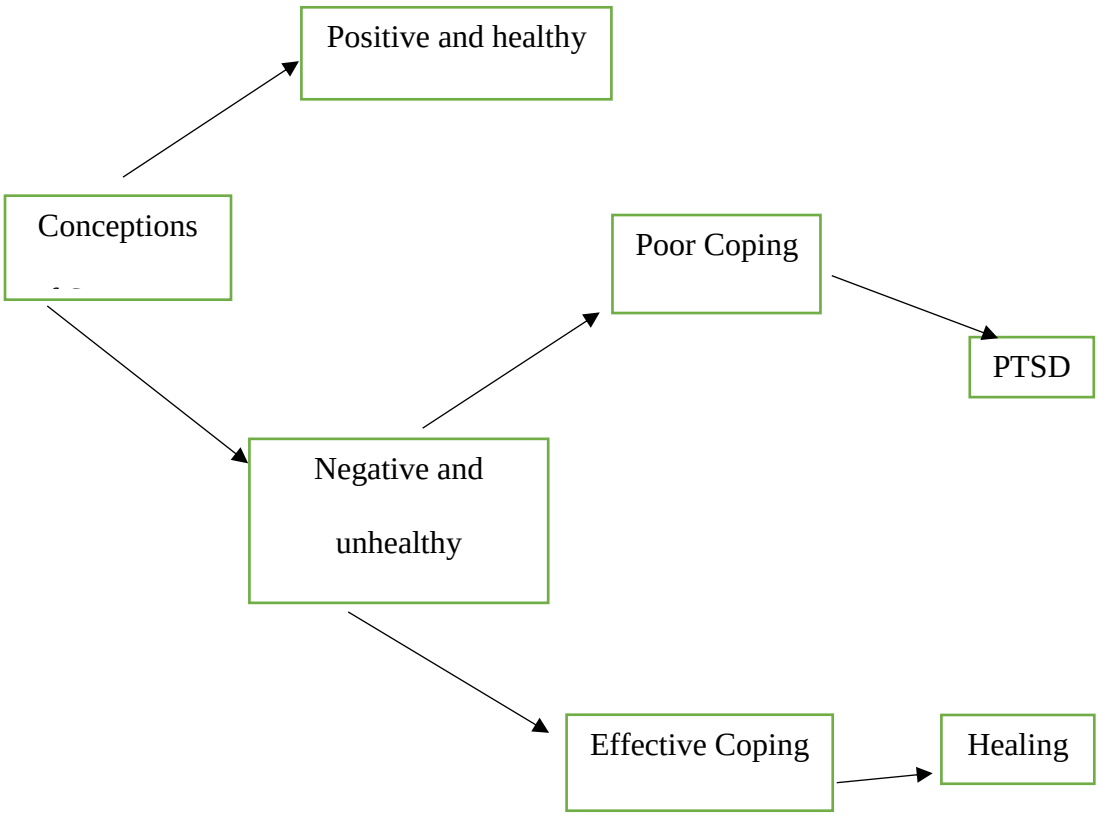
Several responses (fear, flashbacks, dreams of an intrusive nature, lack of concentration and mood swings, nightmares) develop after a traumatic event. The overly negative conceptions of these symptoms may also contribute to their own perpetuation (Ehlers & Clark, 2000). If the woman who lost her daughter experiences flashbacks and nightmares with negative appraisals such as "I'm going mad", "I'll never get over this" or "the gods are punishing me" it will contribute to a continued sense of current threat. This continued sense will perpetuate physical and psychological consequences (such as increased fear, anger and guilt) (Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Halligan, Michael, Clark & Ehlers, 2003). Negative and threat bearing appraisal of symptoms will therefore affect the healing process of the individual because it creates a continuous sense of current threat.

Cognitive appraisal of traumatic symptoms was not a natural focus of the Mole-Dagbon in the current sample. There was a greater focus in general on symptoms than on

events, but the Mole-Dagbon seemed to focus more on the emotional quality of symptoms than on cognitively understanding them. Despite this, some very cognitive explanations for symptoms did emerge. These do not necessarily align perfectly with cognitive models, they do demonstrate that there may be aspects of cognitive theory which would resonate with existing understandings of the Mole-Dagbon.

2.2.4 Coping Process

Figure 3: The effect of coping with symptoms



The above figure (Figure 3) depicts potential coping pathways of a traumatised individual. Symptoms will be positively or negative evaluated. Negative evaluations in particular will require coping. If the coping strategy is effective, it is likely to lead to healing. On the other hand, poor or ineffective coping may lead to PTSD. It has been argued above (section 2.2.3) that irrational (threat perpetuating) appraisals will contribute to continued traumatic stress symptomology. It therefore makes sense that some of the coping strategies involved may involve cognitive attempts to deal with the experience of threat.

The woman for instance can come to terms with the fact that the incident could happen to anyone (and that it does not mean that she is cursed) and that it is unlikely to reoccur (opposed to it being a perpetual possibility in a threatening world). These kinds of conceptions will lead to a decrease in the sense of threat and traumatic stress symptoms. When this kind of cognitive reprogramming happens in a therapeutic context, it is often referred to as cognitive reprocessing, but it can also happen naturally as a person engages their thoughts in conversation with a source of social support (van Rooyen, 2016a).

Another coping angle worth considering is exposure. Exposure is one of the most well documented healthy coping strategies that will lead to the prevention and curing of PTSD (van Rooyen, 2016a). It has the potential to decrease the reactive symptoms the woman will have in response to threatening internal (thoughts) and external (people, places and things) stimuli. This process may work through habituation, but exposure to stimuli that are considered threatening also means that a person is presented with the opportunity and necessity to change the negative appraisals they have about events and the consequent

symptoms (van Rooyen, 2016b). Such a change in negative appraisals will contribute to a decrease in the sense of current threat and traumatic stress symptoms.

Not all possible avenues of positive adaptation are explored here, but of specific relevance to this study is the fact that cultural sources are used to come to understandings that decrease a sense of current threat. There may also be culturally informed coping strategies that may not be considered helpful in terms of what is known about traumatic stress. Culturally informed strategies that enhance avoidance may (for example) not be that helpful (van Rooyen & Nqweni, 2012).

Ehlers and Clark's (2000) model is a well-accepted explanatory model and is used extensively across the world. In South Africa it has been applied a number of times to studies of a cross cultural nature (De Villiers, 2013; Edwards, 2005; Van Rooyen & Nqweni, 2012). It does however focus on processes within the individual. These internal processes may of course be influenced by culture, but the researcher has also argued above that not all coping strategies will be due to cultural influence and only certain cultural coping strategies may be incorporated.

Aspects of coping adopted from an individuals' culture and personal beliefs are vividly demonstrated in the results and discussions. Coping with the symptoms after a traumatic event was a very natural focus for the Mole-Dagbon in the current sample

2.3 LITERATURE REVIEW

An extensive literature search by the author yielded very little information in relation to traumatic experiences in Ghana. However, a number of international studies about culture and traumatic experiences and the strategies adopted to deal with the symptoms are discussed below.

2.3.1 Traumatic experiences around the world

Traumatic experience is a pressing global concern (Agbenorku, Johnson, Nyador & Agbenorku, 2010; Alarcon, 2009; Ehlers & Clark, 2000; Markert, 2011; Marsella, 2010; Terranova, 2011; Wilson, 2005). This concern has created impetus to understand the experiences that accompany these events by studying the cultural and individual elements involved in dealing with traumatic experiences.

2.3.2 Traumatic experiences and Culture

Some literature in this regard have been discussed in the introductory chapter of this dissertation. The following points are important considerations in the current study.

Firstly, exposure to traumatic events is perceived to be a universal phenomenon (Markert, 2011; Wilson & So-kum, 2007). The understanding of these events and the meaning assigned to them is however, culture dependent. Thus individuals' cultural orientation may impact significantly on how they interpret traumatic events. Eagle (2005), asserts that regardless of the varying explanatory system, traumatised clients often search for meaning after encountering a traumatic event. This meaning is usually interpreted in a cultural dimension which is relevant to the clients understanding of the event. Marsella, (2010) indicated that in conjunction with global cognitive processes, specific cultural

elements exert a significant impact in the individuals' conceptualisation of traumatic events. These conceptualisations lead to the symptoms and consequent coping strategies that an individual will employ.

Secondly, although PTSD is a common cross-culturally experienced phenomenon, the forms it takes and the way symptoms are expressed, is culture dependent (De Villiers, 2013; Rhoades, 2006; Yehuda & McFarlane, 1997). Culture also influences how individuals understand and interpret traumatic symptoms (Alarcón, 2009; Markert, 2011; Mollica et al., 1996; Wilson, 2005). People from different cultural background may understand the symptoms differently and that which is considered healthy in one culture is likely to be regarded as unhealthy in another (Marsella, 2010; Okello, 2006; van Duijl, Kleijn & de Jong, 2014; Wilson & So-kum, 2007). . While Ehlers and Clark (2000) and general cognitive theory propose certain common processes and elements that maintain PTSD, unique cultural understandings of symptoms are also important (Herbert & Forman, 2010; Wilson, 2005). Such interpretations will also lead to unique ways of coping.

To a great degree coping strategies are a function of interpretation of the symptoms, which in turn is embedded in culture (Bernacchio, Burker & Buse, 2013; de Jong & Reis, 2010; Frie, 2011; Terranova, 2011; Wilson, 2005). In effect, culture plays a very significant role in what constitutes traumatic event, the interpretation given to it, the ensuing symptoms as well as the coping strategies adopted to deal with symptoms thereafter. Two concepts that may be particularly important in cultural studies are social support and religious/spiritual coping strategies.

2.3.3 Coping with traumatic experiences

2.3.3.1 Social support

A great deal of literature exists about the usefulness of social support networks for survivors of traumatic events. A study on the presence of family and friends as a form of social support after a traumatic exposure revealed that lack of a sense of belonging and comfort from family and friends aggravated traumatic symptoms and led to short-term adjustment problems and worse coping with difficult life experiences (Manne, Duhamel & Redd, 2000). Dirkzwager, Bramsen and van der Ploeg (2003), also established a relationship between social support and symptoms of PTSD among former peace keeping soldiers, which indicated that the presence of social support limited PTSD symptoms severity. Community bonding and support has been indicated by Hussain and Bhushan (2011) as one of the cultural resources that promote healthy coping with traumatic stress. Thompson, Kaslow, Kingree, Rashid, Puett, Jacobs and Matthew (2000) further noted that greater psychological distress resulted from less social support in a sample of 138 trauma exposed African American women. A more recent study has shown the essential role of social support after traumatic exposure. Johnson, Williams and Pickard's (2016) study on Trauma, Religion and Social support among African American women clearly outlined the impact of social support on coping. Their results indicated that the availability of social support contributed to dealing with the symptoms after exposure to traumatic event. There seems to be clear evidence for the positive role of social support in minimising PTSD symptoms. Such support likely works in conjunction with other factors such as religious/spiritual coping which may especially be culturally salient.

2.3.3.2 Religious/Spiritual coping strategies

Religion and spirituality are culturally salient and useful means of coping (Marsella 2010; Terranova, 2011; Wilson, 2005). Individuals usually use religion and spirituality as tools that offer them comfort, practical support and a way of making sense of traumatic event (Eisenbruch, 1991; Herbert & Forman, 2010; Terheggen, Stroebe & Kleber, 2001). Koenig (2005) has shown that coping skills and healing is facilitated among those who suffer diverse forms of trauma when spiritual interventions are introduced. Similarly, Kennedy, Devis and Taylor (1998) found that spirituality contributed to the restoration of wellbeing of victims of traumatic events. It seems clear that the religious/spiritual aspects of culture of a community provides the individual with some guidelines in terms of adaptive strategies to help deal with their traumatic experience (Marsella, 2010; Wilson, 2005). Social and personal meanings that are often informed by spiritual and religious norms and there is the need to comprehend these social and personal meanings in order to make sense of how individuals cope naturally (Terranova, 2011; Wilson, 2005). Rando (1985) showed that many cultures also utilise religious rituals in solidifying and communicating these meanings which help people to cope with their traumatic experiences.

According to Rando (1985), a ritual "is a set of actions or steps performed by an individual or group that are done in such a way as to symbolically represent thoughts, feelings, or behaviours". Rituals are embedded in cultural experiences and religious ideology (Paylo, Darby, Kinch & Kress, 2014). In this regard, Paylo et al. (2014) have shown how adolescents who have been traumatised could rely on creative rituals to help them reorient their cognitive and emotional selves to the outside world. They advanced

that external termination rituals may be vital in reorienting the cognitive and emotional orientation. In a conversation with a Vietnam veteran, Wilson (2005) noted that those symptoms which otherwise would be considered psychotic in a Western culture, were actually related to ritualised experiences required to ensure effective coping after experiencing a traumatic event. In addition to providing specific acts for the alleviation of symptoms, religion also provides frameworks for understanding the world.

Western religious theology based on Christianity gives the understanding that, there is a pre-determined cause for every event and this pre-determination is outside of human control (Hyman & Yares, 2002). That is, the forces of evil and good are instrumental in manipulating our destiny. Horrific happenings could be attributed to the doing of either God or the devil (Hyman & Yares, 2002). Hyman and Yares (2002) have defined spiritual based coping using this kind of understanding as "the dependence on God for the meaning of events and the integration of these events into people's lives in order to minimise traumatic effects". Although Western based thought is used as an example here, it makes sense that other religious traditions will have their own explanatory frameworks.

Finally, religion remains a potent aspect for many individuals that protects them psychologically in times of death and serious illness (Ridge, Williams, Anderson & Elford, 2008). Chapple, Swift and Ziebland (2011) examined the role spirituality plays in an individual's life after the traumatic death of a significant other. They observed that a large number of people resorted to religion or spirituality to help them to face such traumas.

2.3.4 The Ghanaian Literature

There has not been any studies specifically on traumatic experiences, coping and culture in Ghana (and more specifically in the Northern, Mole-Dagbon part). Agbenorku, Johnson, Nyador & Agbenorku, (2010) reported on the physical traumatic injuries on printing press workers in Kumasi, Ghana after an industrial accident. They indicated that the most common recorded types of these injuries included superficial lacerations caused by the printing machines. Awedoba (2006) focused on the socio-economic patterns of the people who inhabit the Northern half of Ghana. His study included a detailed description of the background of various ethnic groups, the languages spoken and the distinctive social customs. Understanding Islam of the Dagbani speaking people was the focus of Twumasi (1996). He traced the history of ancient and modern Ghana in the development of Islam. The only directly related study in Ghana was conducted by Terranova (2011) and focused on PTSD and comorbid depression in Ghanaian citizens. Her study indicated high exposure rates, low prevalence rates of both disorders and that comorbidity was likely. This study did not include any cultural considerations.

There is recognition from theory and literature that culture influences traumatic experience and coping, but very little is known about this interaction among Ghanaians (and nothing as it specifically relates to the Mole-Dagbon). The ethnic group which formed the focus of this study is an under studied (and potentially traumatised) group about whom there exists little literature to inform potential intervention strategies. There is therefore a need to explore and describe how traumatic events, symptoms and the consequent coping strategies are culturally understood among the Mole-Dagbon of Ghana

and how these understandings inform the coping strategies that individuals employ to deal with the symptoms after traumatic events.

On the basis of the above literature, the study was therefore aimed at investigating the nature of the understanding of traumatic experiences (both in terms of events and symptoms) and the coping strategies of the Mole-Dagbon. While the findings were specifically relevant to the region, it also contributed to the general understanding of culture's influence on traumatic experiences.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 CHAPTER OVERVIEW

This chapter discusses the research methodology used in this study. The primary aim of the study was to find out how an understudied group of people (the Mole-Dagbon of Ghana) conceptualise traumatic events and symptoms and how they cope with the symptoms. The information was obtained from knowledgeable participants that could comment on normative cultural understandings (via focus groups with community leaders) or relate their personal experiences (via individual interviews with those who have experienced potentially traumatising events). A qualitative approach based on post-positivistic principles that apply an exploratory descriptive interpretive methodology was used to investigate the issues in question. These elements, the sampling, the strategies used to ensure trustworthiness and certain ethical considerations are described in more detail below.

3.2 DESIGN ELEMENTS

3.2.1 Post-positivist Research Approach

The underlying perspective of the study is post-positivistic. Reality for the post-positivist can never be completely known and attempts to measure reality are limited by human perception and comprehension (de Vos, Strydom, Fouche & Delport, 2011). Much of reality is constructed by the individual experiencing the reality and can only be known

with the use of multiple subjective methods. This also means that there are multiple valid realities, some which the researcher as an observer may be unaware of. The reality of the Mole-Dagbon in terms of the study objectives were solicited with the use of subjective (qualitative) procedures. From the outset the researcher anticipated that the Mole-Dagbon reality may be quite different to the normative Western perspective. However, during the process it became apparent that there were elements of the Mole-Dagbon reality that overlaps with existing understandings from other perspectives (i.e. the Western perspective). These understandings were of course not excluded in the analysis, but did demonstrate the complexity of reality that is presupposed by the post-positivist paradigm. Some Western perspectives were also brought into the process by the inclusion of explanatory frameworks based on these perspectives (Ehlers and Clark's (2000) cognitive theory of PTSD). Even though the overall approach was one that takes the subjective experience of the Mole Dagbon seriously, it cannot be ignored that the influence of a Western perspective impacted the manner in which questions were constructed. The researcher had a specific interest in the way in which the Mole-Dagbon understood traumatic events because of the salience that such understandings have in cognitive theories that originate from a Western background. However, this idea of attributing meaning to events seemed somewhat foreign to the Mole-Dagbon who naturally thought more about the alleviation of distress than the reasons for events. The researcher was cognisant of the combination of perspectives and the complicated heuristic dynamics inherent in an interpretive strategy.

3.2.2 Interpretive Approach

The interpretive approach is related to post-positivism in that it emphasises the subjective understanding and meaning individuals ascribe to their actions and the reactions of others (Babbie & Mouton, 2001). While these meanings are of primary importance, the interpretive researcher also acknowledged that these meanings were subjected to the knowledge of the researcher. This knowledge of the researcher formed an interpretive paradigm through which sense was made of the phenomenological information that was presented. The existing framing principles are acknowledged in terms of the study by the definitions, literature and theoretical framework presented earlier in this write up. The core concepts that were studied (traumatic exposure, symptoms and coping strategies) are well explained and defined. While such framing aided in fieldwork and analysis (and increases the dependability of the study), the researcher carefully considered the possible biases (which would reduce credibility). To reduce the potential for bias, regular meetings and discussions between the researcher, an independent coder (a visiting research intern completing a cross-cultural research internship) and supervisors were held in order to highlight potential sources of personal bias in the coding and interpreting of results.

3.2.3 Qualitative, Descriptive and Exploratory Approach

The lenses of both the post-positivism and interpretive approaches are qualitative, descriptive and exploratory in nature and thus fit the study, which had an exploratory and descriptive goal. The research problem suggested that we did not know what the cultural understandings and coping strategies of the Mole-Dagbon entailed. A descriptive, exploratory and qualitative approach was therefore more appropriate at that stage.

A qualitative approach enabled the researcher to gain an understanding of traumatic exposure, its symptoms and coping methods from the respondents' perspectives (cf. Babbie & Mouton, 2010). Emphasising the individual's experiences and respecting the way in which respondents verbally described their experience was important because the cultural expression of traumatic experience has not been sufficiently studied among this particular group in Ghana. As an initial attempt at starting to create an understanding, the study was also quite clearly exploratory in nature and because no causal conclusions can be drawn from the results, it was also descriptive.

3.3 SAMPLING

3.3.1 Sampling Location

The population for the study were residents of Tamale (in Northern Ghana) and its immediate surrounds. The location was chosen because it was reasonably accessible and familiar to the Ghanaian members of the research team (the co-supervisor had conducted fieldwork in the area before). Additionally the research team had contacts that were valuable as referral assets in terms of possible adverse reactions from participants. The population of this study is mostly Mole-Dagbon and were subjected to a number of natural and human induced disasters which had the potential to lead to traumatic experiences. The general traumatic context of the region has briefly been described in chapter 1, and brief descriptions of the individual experiences are provided below.

3.3.2 Sampling Strategy

Non-probability purposive sampling techniques were adopted to recruit individuals for the study. The technique ensured that the participants used were suitable for the study. The Ghanaian research team visited the chief's palace to inform the chief of the traditional area and obtained his permission to conduct the study in the area under his chieftainship. The co-supervisor has successfully solicited such permissions in the past and his knowledge of the area made this procedure much easier. The chief was also acknowledged in the identification of community leaders, traditional elders (custodians of culture) and religious leaders for the focus groups. Individual survivors were identified through contact with Dr. Abasini at the University of Development Studies (UDS), Tamale and members of the focus group discussion. In all cases the gatekeeper (Dr Abasini or focus group participants) was asked to approach a potential individual interviewee with an information letter to obtain their verbal consent for the researcher to approach them.

Potential participants were approached by the researcher telephonically and in person (after the gatekeeper had the initial discussion with the individual) to describe the nature of and requirements for the study (a brief script in this regard is provided as Appendix D). Where the individual accepted to take part, the interview was scheduled and conducted at a convenient and confidential space/environment in the individual's home. Before the interview commenced, the participant was given the opportunity to ask questions and grant consent for the interview to take place.

The eventual participants were individuals who were reasonably able to comment on 'official' Mole Dagbon culture (for the focus groups) or Mole Dagbon individuals who had

experienced a traumatic event as defined for the study (for the individual interviews). These individuals could speak at least one of the languages (Dagbani, Hausa, English and Akan) in which the interviews were to be conducted. However, almost all the participants were able to communicate in English and they opted to use the English medium throughout the interviews. The participants comprised of adults (18 years and above). There were more females (29) than males (24). Even though this was not overtly intended, it lead to a somewhat stratified sample that approximates the Ghanaian population which has more females (51%) than males (49%) according to the 2010 census by the Statistical Service of Ghana. This natural stratification is positive in terms of the credibility of the data gathering process.

The data collection strategy (described below) utilised focus groups and individual interviews. The focus group participants comprised of opinion leaders and influential members of the community. Four focus groups (18 males and 22 females) with 10 members each were used for the study. Since men in the Mole-Dagbon community are generally in leadership, the males consisted of cultural leaders and influential members of the community whereas the females consisted of participants who were well informed about the Mole-Dagbon culture and not necessarily cultural leaders.

It was always the intent to include both male and female cultural leaders, but it came to light at the commencement of the study that the Mole-Dagbon culture is very patriarchal in nature. Women are not permitted to be leaders. This meant that the leaders originally identified by the chief (and specifically the sub-chief) assisted in identifying women who were well informed about the Mole-Dagbon culture. This selection created an obvious

sampling bias to include individuals that would possibly toe the proverbial line in terms of cultural understanding. As this was the intent of sampling it was not a major drawback. Additionally, the sub chief suggested to the research team to organise a separate female focus group as the females would be reluctant to share their ideas in the presence of the men. This became quite evident in the first two focus group (mixed sex) discussion. The females only acted as observers and listeners until the researcher actively facilitated to the process of encouraging them to voice their views. But even then expressions were not comfortable. Even the sub-chief's reassurances that their expression would be respected did not alleviate the obvious discomfort of voicing their opinions freely in that kind of setting. The female only group worked better and enabled the females to comfortably express their views and understanding relating to the questions asked. The table below indicates the group composition of the four focus groups.

Table 1: Participants for Focus Group

Groups	Males	Females
1	4	6
2	4	6
3	-	10
4	10	-

The educational level of the focus group participants ranged from informal schooling to teacher's training level of education. The occupational background of (5) participants

were not known. The rest included farmers (N = 16), teachers (N = 2) and unemployed individuals (N = 17). The farmers and teachers are mostly men since the culture is patriarchal in nature. The women are labelled as unemployed simply because their labour (household) chores do not generate a direct income, but this division of labour is of course not unknown in patriarchal societies. These activities are what the people of the Mole-Dagbon usually engage in in the region and at least at a rudimentary level the selection of leaders in this regard did not completely remove the sample from the kinds of daily activities that most Mole-Dagbon would engage in. This was fortunate, but due to the purposive nature of sampling also completely unintended. In the researcher's view these participants commented openly on the questions asked and gave an accountable global view of the cultural belief system of the area.

The sampling of the individual participants have been described above. The table below illustrates the nature of their gender and individual exposure to potentially traumatic events.

Table 2: Participants for Individual Interview

Participants	Gender	Nature of Exposure
1	Male	Death of Father
2	Male	Loss of farm produce
3	Female	Attacked by armed robbers
4	Male	Death of wife
5	Female	Death of husband
6	Female	Death of husband
7	Female	Involved in car accident
8	Male	Death of an intimate friend
9	Female	Fire outbreak
10	Male	Death of wife
11	Female	Death of brother
12	Female	Death of husband
13	Male	Involved in car accident

Participants for the individual interviews were made up of adults (an age of 18 affords legal adult status under Ghanaian law) who had experienced at least one traumatic event. All the deaths experienced by participants were traumatic (either witnessed, violent or unexpected) in nature. None of the individual respondents were receiving treatment at the time of the research interview. Their treatment had been concluded more than three

months prior to the interviews. A total number of 13 participants (7 Males and 6 Females) were interviewed about their personal experiences.

3.4 DATA COLLECTION

The data collection procedure started on 21 January 2016 and ended on 10 March 2016. Prior to the data collection, research assistants were given a two-day intensive training course on interviewing skills and related issues by the co-supervisor in Ghana. As part of their training they conducted a number of mock interviews and their first three interviews with participants were closely supervised by the researcher and the co-supervisor to ensure research fidelity and ethical interviewing skills.

All focus group discussions were facilitated by the researcher with the use of a semi-structured interview protocol (see Appendix H). Participants in the focus groups were asked questions that were culturally related and they were not required to give personal experiences. The purpose was to elicit the formal cultural understandings of the Mole Dagbon rather than their personal experiences. Because the individuals in the focus groups were not to draw on personal experiences, they were provided with the vignette to illustrate the kind of experiences and symptoms that the researcher was interested in. In hindsight one of the drawbacks of the vignette was that it included a sudden death experience. While this fits the traumatic death criterion, it also meant that coping responses were also related to normal bereavement processes. This provided valuable insight into relevant cultural processes, but in future research it may be prudent to provide two vignettes (one without a death) as a discussion point to see whether coping would be markedly different in the two descriptions.

Individual interviews were conducted by the researcher and the research assistants. The individual interviews followed a similar semi-structured schedule (Appendices G) to the focus groups, but the intent was to solicit individuals' subjective experiences rather than the 'official' Mole-Dagbon position. An interview would start by eliciting an individual's symptoms in a broad sense and participants were asked to describe what was different for them after the event. Subsequent to the symptoms being clear, their understanding of their own symptoms was explored. Finally, participants were also asked to comment on their understanding of the normative responses that were generated from the focus group information. This last element was added to get a more comprehensive idea of the individual's incorporation of cultural elements.

While the focus was very definitely on their own subjective experiences of specific events, participants quite naturally spoke about other events. Although questioning and probing focused on personal experiences, these understandings of other events were also taken into account. The meanings attributed to events were still those of the participants, but participants also spoke about their understandings of traumatic events in general rather than sticking to their own experiences. This may make the information less immediate, but it does mean that the researcher had wider access to the general rules and principles which the individual respondents relied upon to make sense of traumatic events.

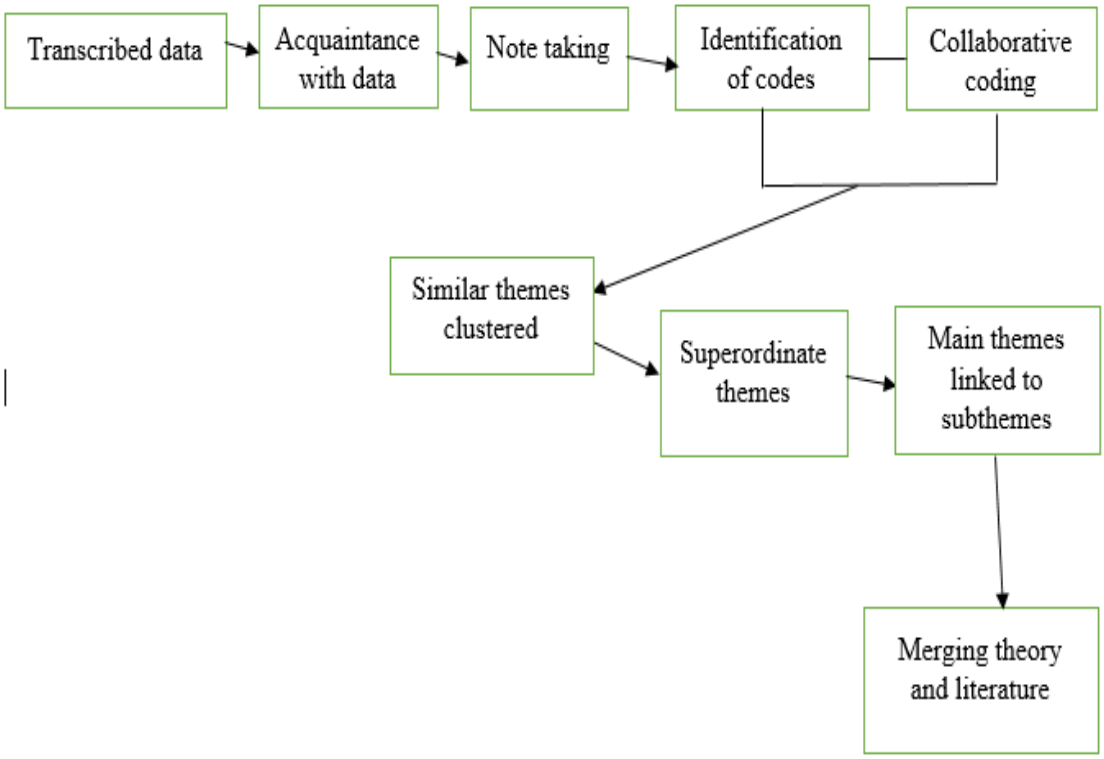
All the participants were compensated five Ghanaian Cedis (GHC) (roughly equivalent to twenty South African Rands). This amount was judged (by the Ghanaian co-supervisor) to be sufficient to cover any incidental costs well. While this amount was substantial in terms of the local economy, participants were not aware they would be

receiving any compensation. It would therefore not have influenced their willingness to take part or their responses.

3.5 ANALYSIS OF DATA

Interpretative phenomenological analysis (IPA) was employed to analyse the data. The data was organized into a manageable and significant units which facilitated easy identification of patterns and illustrated how the participants interpreted their experiences from their view point (Gavin, 2008 & Neuman, 2006). The diagram below indicates the IPA stages used for the analysis process followed by a detailed description.

Figure 4: Stages of data analysis (Adapted from Okello, 2006)



The stages above represents how the data was systematically analysed (for both focus groups and individual interviews) employing the specified steps required by IPA. These stages enabled the researcher to explore the respondents' insight on the researched topic (Langdridge, 2007). In the first stage, the audio recorded data was transcribed word for word (from each individual) by the researcher. The transcribed data was then reviewed by the co-supervisor to ensure accuracy of the process.

The researcher and the co-supervisor separately became familiarised with all the data from both the focus group discussion and the individual interviews by reading and re-reading the transcripts. Attention was paid to the individual experiences of understanding

traumatic experiences and the coping means before analysis over cases took place. In the case of the focus groups this was more difficult as the focus groups' phenomenology was of course that of a group rather than an individual. This initial strategy ensured that the phenomenology of each participant was well understood by the researcher.

Notes that were salient (reflecting initial thoughts, insight, biases and perception) were made about the each participant's/focus group's responses. A list of themes that supported the respondents' understanding of traumatic experiences were identified from the notes and written in the left margin of the transcripts. Different themes were classified and built around the salient responses. At this stage, the researcher employed collaborative coding with a second main (independent) coder who followed the same steps defined for the analysis. The researcher and the independent coder frequently met to come to an understanding of the generated codes. This process was also closely facilitated by the main supervisor. The procedure limited the influence of unknown bias and increased confirmability of the study.

After the researcher and the independent coder iteratively analysed and discussed the data, connections across the emerged themes were clustered. The aim at this stage was to develop bridging concepts and to identify superordinate categories that suggest a hierarchical relationship between them (Biggerstaff & Thompson, 2008). A main theme was constructed and all subthemes linked to the main theme in a meaningful way. A detailed description of themes and subthemes and the overall structure is presented in the next chapter.

3.6 STRATEGIES USED TO ENSURE TRUSTWORTHINESS

Trustworthiness is a framework for ensuring rigour in qualitative research (Shenton, 2004). The researcher carefully considered the four criteria (credibility, transferability, dependability and confirmability) to confirm trustworthiness in obtaining information from participants.

Credibility refers to whether a true picture of the phenomenon under study is being presented (Shenton, 2004) (internal validity in terms of quantitative research). Shenton (2004) indicates that narrow sampling (one site) may decrease credibility and that stratification of the sample enhances credibility. Participants were sampled from one site (i.e. where they had their treatment) but they are from different geographical locations in the Mole-Dagbon community and were naturally stratified according to gender. Method triangulation (individual interviews and focus groups) and peer scrutiny through regular research team meetings (Shenton, 2004) were other strategies employed in this regard.

Transferability refers to the transportability of qualitative findings (Krefting, 1991) (generalisability in terms of quantitative research). The findings of this study will be more applicable to the rural areas in the Northern part of Ghana. However, if practitioners believe that the context of data collection is similar to their own, it means that the findings can more easily be transported to the new setting. In order to come to this judgement, the researcher considered any contextual factors (e.g. the sampling procedure and eventual sample) impinging on the eventual findings (Shenton, 2004). Additionally the better the research context is described, the easier it becomes for a reader to decide whether the findings are applicable in their context and therefore the final product took cognisance of

clearly describing any relevant contextual factors. This process was facilitated by regular team meetings and discussion sessions.

Dependability refers to whether similar results would be obtained if the work was repeated in the same context, with the same methods and with the same participants (Shenton, 2004). A classic dependability ensuring mechanism (Shenton, 2004) (overlapping focus groups and individual interviews) was employed in the study. Additionally, a detailed description of the minutiae of the data methodology and data collection procedure is also provided (described above) as part of the outputs of the study – something which ensures that a project can be duplicated should it be deemed necessary (Shenton, 2004).

Confirmability refers to ensuring that findings emerged from the data and not the researchers own subjective view (Shenton, 2004) (objective in quantitative research). The researcher remained cognisant of possible biases through reflective notes and open discussions with her supervisors and the research team. Additionally the second coder also provided a backdrop against which possible biases could be highlighted during analysis.

3.7 ETHICAL CONSIDERATIONS

Permission to conduct the study was obtained from the Health Sciences Faculty Postgraduate Studies Committee (FPGSC), the NMMU Research Ethics Committee (Human) (RECH) and University of Ghana, Legon (UG). At UG, ethical clearance was obtained from the Ethical Committee of the Social Sciences Faculty (with the assistance of the co-supervisor). Informed consent was required from prospective participants before

the data collection was conducted (Appendices D and E). The nature of the study was explained to participants in their home language as well as in English as almost all the participants had some level of education and could express themselves well in the English language. Those who agreed to take part signed and thumb printed the informed consent form. The study took the form of interviews and focus group discussions which (as procedures) did not involve inherent risk or harm to participants. However, since the content was about a traumatic experience the researcher preempted a possibility of an interviewee experiencing anxiety or distress (similar to any research that explores highly personal material). Members of the research team were adequately trained to handle such cases. All members of the Ghanaian research team are registered as Psychologists (Dr Charles Brenya Wiafe-Akenten), training to be psychologists (the two research assistants), or have specific training in counselling (the researcher and Dr. Edward Abasini). Containment only needed to be provided in one instance (an individual interview). Counselling was offered to almost all individual participants before and after each interview by Dr Abasini of the University of Development Studies (UDS), Tamale. Dr Abasini was also a gatekeeper and individual participants (individual interview) had contact with him as a service provider previously.

In addition to the above, participants were not identified by names and confidentiality was ensured by linking transcript data to informed consent recordings/documents via reference numbers. In terms of the participants of the focus group: individuals were asked not to share their personal experiences, but also did sign a confidentiality agreement in order to ensure confidentiality between participants. No

individual will be identified in any research report and identification from textual information is unlikely as their respective responses is aggregated in themes.

3.8 CONCLUSION

This chapter provided an overview of the methodology used in conducting the research. A qualitative approach based on post-positivistic principles that apply an exploratory descriptive interpretive methodology was used to investigate the issues in question. The sampling procedure, participants, means of collecting data and the steps in Interpretive Phenomenological Approach used to analyse the data collected was presented. A detailed description of the various strategies in ensuring trustworthiness was also presented. The chapter then ended with the ethical considerations and the procedure used in the research. The following chapter presents the results and discussion of the study.

CHAPTER 4

RESULTS AND DISCUSSION

4.1 CHAPTER OVERVIEW

This chapter focuses on the major themes and sub themes arising from both the focus group (cultural leaders) discussions and individual interviews. The findings are generally in line with previous research that indicates that a number of social and psychological issues (including those that are culture specific) consistently shape the understanding of traumatic experiences and their sequelae (Marsella, 2010; Okello, 2006; van Duijl, Kleijn, de Jong, 2014; Wilson & So-kum, 2007). While the focus in this chapter is often on the content of what was said, process or experiential features are noted where they were relevant. One noticeable example is that the focus groups and individuals often answered with content related to coping with the traumatic experience rather than their understanding of the experience. This aspect is reflected on more extensively later in this chapter. This write up describes and discusses the culturally normed and individuals' personal conceptions of traumatic events, symptoms and coping strategies. Special attention is given to the intricacies of how Mole-Dagbon individuals have incorporated or not-incorporated cultural values in shaping their understandings of traumatic events.

4.1.2 Focus Group Conceptions of Traumatic Events

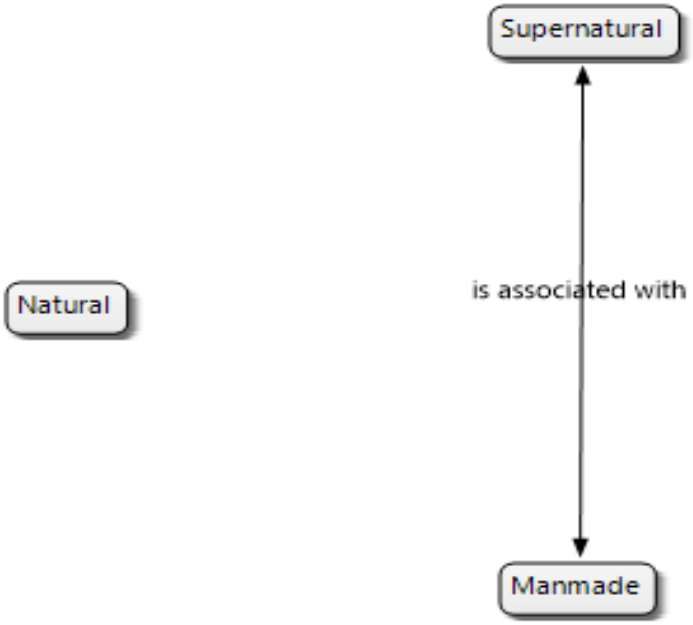
Respondents were a bit hesitant in answering questions relating to the cause of traumatic events. They indicated that the primary individual that determines the cause of

traumatic events and symptoms is a soothsayer. Therefore, it seemed that most of their responses in terms of causality consisted of information that they had received from soothsayers after the occurrence of a traumatic event. The overall sense of the researcher was that the soothsayer's voice was very strong within the focus groups (even though the individuals were not physically present) when it came to causality. The reluctance on commenting on causality, may have contributed to focus group respondents' answering with the means of coping rather than commenting on the actual cause. A question to the first focus group ("Why do you think these events (e.g. death of a loved one occur?") was (for example) answered with the following statement:

> "When traumatic event happens to someone in Dagbani it is a serious issue. We will go and greet the person. The person will be going through pain that is why we are there to greet the person and make the person calm".

This kind of coping response to a question about causality was common with most of the respondents and in the researcher's view, may be due to causality deference to the soothsayer. Although this trend was commonly encountered, the groups however did (when probed) come up with various attributions of traumatic events. The figure below demonstrates a graphical representation of a hypothesised relationship between different classes of explanations for traumatic events.

Figure 5: Cultural (focus group) interpretations of traumatic event



As indicated in the figure above, three key themes (natural, supernatural and manmade) emerged in relation to the interpretation of traumatic events from the focus groups. Traumatic events that were termed natural (these had a natural scientific explanation as is generally understood from a modern scientific paradigm) were described to be independent of the supernatural (God/Allah, gods of the land, ancestors and witchcraft) and manmade causes. However, supernatural causes of traumatic events were related to and were explained as resulting from human agency (simply referred to as manmade). This implies that humans have a degree of control over these events, but that the mechanism of causation is supernatural. The finding is at odds with the common understandings of African cultures which often assume greater external control because of supernatural causation (Wilson & So-Kum, 2007). However, a study by Okello (2006)

also found the acts of the supernatural as predictable and that human activities could control the supernatural and subsequent traumatic events. Although findings below are based on a fair degree of consensus of the focus groups, there were some differences between what males and females said in terms of some events. The relationships and nuances are explored more comprehensively below.

4.1.2.1 Naturally occurring events

It was noticed that male respondents were more likely to attribute the loss of farm produce/crops to natural causes whereas female respondents commonly assigned a supernatural cause (explored below). The contrasting views could result from the patriarchal nature of the community. A personal communication with Jacob Abudu, a scholar and a native of Mole-Dagbon who also conducted a study on witchcraft in the Mole-Dagbon area of the Northern region of Ghana, on the 2nd of May 2016 at 16:24, revealed:

> "men in the Mole-Dagbon community are well informed, they mostly listen to news in English and Dagbani (dialect) versions whiles the women are consigned to house chores and hardly listen to news. You can find wireless sets with high volumes on the back of men's bikes when they are going to farm and to perform other jobs such as security".

The quote above indicates that different levels of exposure to other sources of information (i.e. ideas outside the immediate village) may be an explanation for the different interpretations that evolved between the males and females regarding the

destruction of crops. From the males' perspective, any event that has a logical/scientific underpinning is described as a natural cause and in no way related to either supernatural or human activities. An example of such an event is the loss of crops and farm produce resulting from the overflow of the Bagre Dam at the border with Burkina Faso. The quote below is one that exemplifies frequent responses given by male respondents:

> "Regarding the spillage of the dam, it only has a scientific explanation. You know we are close to Burkina Faso and our farms are closer to that dam and our soil is very fertile so most of us have our farms there. Usually the dam is full to its capacity at a point in the year which is a natural thing and has to be spilled. This happens when crops mature and are ready for harvest and when the dam is spilled it washes away our crops. This is very traumatic but cannot have a spiritual understanding or a deliberate thing done by a person"

Information gathered from the focus groups indicates that farming is the predominant occupation in the Mole-Dagbon traditional area. Farmers invest considerable amounts with the intention of yielding farm produce to export and market locally. From their point of view, they become traumatised by the loss of crops as their survival is tied to agriculture. Although the DSM criteria do not include such an exposure (loss of crops and farm produce) as traumatic because it lacks the life threatening element, the Mole-Dagbon considers such an event as traumatic. This position of the Mole-Dagbon is consistent with Wilson and So-Kum (2007) and Herbert and Formans' (2010) assertion that what is considered traumatic in other cultures do not necessarily conform to Western expectations.

In a theoretical sense agricultural activities may have become tied to schemas of survival that are core to the Mole-Dagbon and threat of loss or the actual loss of crops would generate considerable threat in relation to these core schemas. Such non-physical threat to core schemas has been hypothesised to be sufficient to be considered traumatic in a diagnostic sense (van Rooyen & Nqweni, 2012). An individual interview with a victim (male) revealed a subjective link between such an event and changes in his thinking processes:

> "During my sleep or when I go to bed, I think of the event in so many ways and sometimes I feel I am even damaging my brain or tensing it to the extent that I was going insane. I think about it so much not knowing how to survive and that answer of how to survive was also not coming. As part of the thinking, I ask myself "how am I going to feed my family? Where do I get money to pay the bank this huge sum with interest? I was always reflecting on that and I experience a little or no sleep throughout the night."

Although some of his fears here are clearly related to the future rather than the past (as with PTSD), his reported symptoms (intrusive distressing thoughts and sleep disturbance) are reminiscent of the DSM-5 PTSD criteria that were causally linked to this naturally occurring event. This evidence is of course not conclusive, but does point to the fact that the different realities experienced by people from different cultures would lead to different kinds of events being considered traumatic (Marsella, 2010; Okello, 2006; van Rooyen & Nqweni, 2012).

Although the discussions above capture the male view of what leads to the overflow of the Bagre dam from Burkina Faso, the female respondents on the other hand, understood the overflow of the event as having supernatural origins, stimulated by human activities. Thus the female view seems to reflect an African traditional view more strongly. From the researcher's perspective, regardless of the differing views, an element of human agency is identified as resulting in the event. There is therefore a measure of control in minimising the effect of the event (loss of farm produce). The mechanisms of the supernatural are explored more fully below.

4.1.2.2 Supernatural Causes of Traumatic event

Expressed beliefs in the supernatural were commonplace among the respondents that were a part of the study. The fact that such beliefs are salient and important to the Mole-Dagbon of Ghana was also found by Twumasi (1996). From the focus groups' perspectives, supernatural causes and human actions are interrelated: human activities are reported to stimulate the workings of the supernatural. Additionally, supernatural forces are believed to also be under the control of agents that have near-omniscience and some people are afraid to take part in certain activities for fear that they will be caught and punished (Twumasi, 1996). God/Allah (*creator*), the gods (*buga*) of the land, the ancestors (*tiyaanima*) and practitioners of witchcraft (*sotim*) are classified as such supernatural agents. The supernatural forces were additionally clustered into two categories dependent on how they operate. Similarly to other findings (cf. Okello & Neema, 2007), both categories are believed to cause misfortune and traumatic events. The first category comprises of God/Allah, the gods of the land and ancestors. These external

forces are considered higher powers that people can resort to in times of difficulties (Chapple, Swift & Ziebland, 2011). However, they are believed to invoke their anger by permitting events that are considered traumatic to occur. Such events serve as punitive measures to an individual or members of the community for transgressions such as promiscuity, violating taboos and a lack of unity among the Mole-Dagbon (e.g. intra-tribal conflict). The ongoing intra-tribal conflict is seen as both a traumatic effect (caused by outside manmade political interference) as well as a cause for further traumatic events. In terms of the conflict being perceived as a cause, the respondents believed that, the war results in additional traumatic events because it is regarded as immoral by the supernatural forces:

> "some terrible things also happen to us here in Dagbon because we are fighting among ourselves. The gods are angry because we are always fighting and don't want to make peace. They let these accidents and other harmful things to happen for us to know that they are not happy to see us fighting as a family".

Mostly the dynamic described by respondents are that of human agency influencing supernatural mechanisms and essentially human agents therefore exert a great deal of control over traumatic event causation. With reference to the different views held between men and women in relation to the loss of crops, one (female) respondent explained:

> "The loss of farm produce is as a result of lack of unity for so many years in this community resulting from the ongoing war. I think this spillage from

> Burkina means that the gods of the land are not happy and it is about time that we stop fighting among ourselves and live in peace. We are now fighting with our own blood. Those days we were all each other's keeper but now irresponsibility is taking over the love we once showed and I think this makes the gods of the land and our ancestors angry so they decide to cause the spillage of the dam to create such a huge damage to the farms so that we can realise there is something wrong and come together. If we all come together and stop fighting and rather be responsible, all these happenings will stop for us to have peace and also enjoy the benefit from our husbands' farms".

This quote was similar to the expressed views of other women related to the supernatural cause of the overflow of the Bagre dam. It is an example of the expressed understanding that human activities spark the works of the supernatural.

The second category of supernatural agents consists of individuals capable of witchcraft. These are human individuals that are seen as having some supernatural power that can be used for good and progressive purposes as well as destructive purposes. They are believed to act on their own volition and are therefore not subject to predictable consequences of other humans' acts. They are perceived to be malicious agents according to the focus groups and their harmful actions have no justifiable origins nor are they influenced by human agency. Others have found similarly in Ghana and elsewhere on the continent (Awedoba, 2006; Twumasi, 1996; Shrestha, Sharma & Van Ommeren, 1998). Respondents were of the opinion that the malice of these forces would often be driven by mere jealousy and hatred for another person (and therefore undeserving and unpredictable

exposure to traumatic events). This is in line with research by Awedoba, (2006), Twumasi, (1996) and van Duijl, Kleijn and de Jong (2014) which also found that these malicious supernatural agents were considered to be driven by jealousy. They are mostly suspected when there is an unexplainable death or some other unpredictable misfortune:

> "sometimes some unexplainable death could be a witchcraft cause. You know these devils act anyhow especially when you are progressing. If they realise your husband is getting more money to support the family, they act out of jealousy and your husband can get sick suddenly and die. They always want to see people sad and not excelling in life".

All the focus groups were of the opinion that women in the Mole-Dagbon area of the Northern Region of Ghana get accused of being such malicious agents or witches (*sonnya*) more frequently than men (despite the fact that both genders are capable of being witches). Further probes with respondents revealed that this might result from very patriarchal nature of the community:

> "here in Dagbon, we the men make the rules and regulations. We are seen by our women as more powerful as we control the political and social space of the region."

It appears from the above quote that gender role differentiation seems to put the women at a disadvantage. Respondents also indicated that women who usually get accused are the elderly who are fifty and above. Most of these women are widows who are living under stressful conditions and no longer have the social support that used to be

readily available in typical traditional African societies. This plight was seen to be a result of the extended family system getting replaced by the nucleated family system and the myriad of problems that are seen to go with this change. Twumasi (1996) had similar findings from the same traditional area. While these malicious human agents are seen to cause misfortune and traumatic events in an unpredictable manner, the supernatural powers are somewhat more predictably influenced by human (manmade) acts.

4.1.2.1 Human Agency stimulating Supernatural Causation

Manmade activities are said by the focus groups to stimulate the works of the supernatural. Examples of activities that could lead to traumatic events are immoral behaviours (e.g. adultery) and curses (resulting from arguments between people). These traumatic events according to the Mole-Dagbon are punishments by God/Allah, the gods of the land or the ancestors. Others have found similarly elsewhere on the continent (Foster, 2014). A quote from one respondent illustrates this finding as follows:

> "for instance if a man have an affair with another man's wife, it is considered impure by the supernatural beings and they can let a terrible illness occur to this man and if care is not taken, could lead to his death".

While traumatic events as punishments from deities is not a new explanation, other ways in which human agency lead to supernatural causation was by disrupting the natural order of things. One such occurrence considered as key in stimulating traumatic events is that of intra-tribal war among the Mole-Dagbon community. The intra-tribal war resulting from political interference was perceived as a cause and effect (the effect part has been

described above – the focus here is on the cause of the conflict). The respondents indicated the intra-tribal war is a traumatic event caused by human agency that results from people striving for leadership and recognition. This in effect leads to injuries and death of loved ones:

> "To my understanding, it is just that some people want to be recognized. Like I am a half Dagomba. Maybe either of my parent is a Dagomba and I also want to be recognized. So what I will do is, to get an area in which I will be a leader so that I will have the followers. So like if we all come together, some of us will lose our leadership. So that is leading to this our conflict and our trauma in this part of the country. Like when they say Abudu and Andani, they are all the same family with the same grandfather so I have to remove my hand and you remove your hand and leave the only family to reconcile. We those who want to be recognise will come in front and will not agree, we contribute money to go and see people and we invite the politicians in here. Now if you are in NPP, they blame you to be Abudu, if you are in NDC, they blame you to be Andani. So that is leading to the problems were are having now. Unless the politicians remove their hands and put a stop into interfering in chieftaincy issues and we those who are not concern about the chieftaincies, we also remove our hands and leave the family to reconcile, there will always be war and people will be dying and we the ones alive will be traumatised".

Most of the towns and villages in the Mole-Dagbon area of Northern Ghana where the study took place are ruled by Chiefs and Kings. According to the focus groups, political interference into the chieftaincy in the traditional governance of the area has resulted in dispute (e.g. installment of a chief and land allocation) stimulating the ongoing intra-tribal war. It is general knowledge in Ghana that this conflict has led to the death of the King of the Mole-Dagbon traditional area ten years ago. He has until now not been buried because the conflict has not yet come to an end. The respondents indicated that this conflict and sporadic war has led and is still leading to the destruction of properties, displacement of families and these events leave members of the community traumatised.

Curses from individuals or witches are also believed to cause traumatic events. The focus groups indicated that curses are words pronounced to cause harm to a person or a group. Information gathered from the respondents revealed that curses could come from any individual and the belief is that these words are usually expressed out of hatred or when there is a disagreement between people. It was however noted that for these curses to have effect, the manipulation of the supernatural via witchcraft is necessary:

> "Sometimes you can have a problem with someone and when you are quarrelling. She will say like "you will die or you will get an accident". The moment they say that the witch will hear it and use her power to let what they said happen".

In summary, it could be noted that there is a great deal of consensus about the causation of traumatic events among the focus groups. Three different explanations

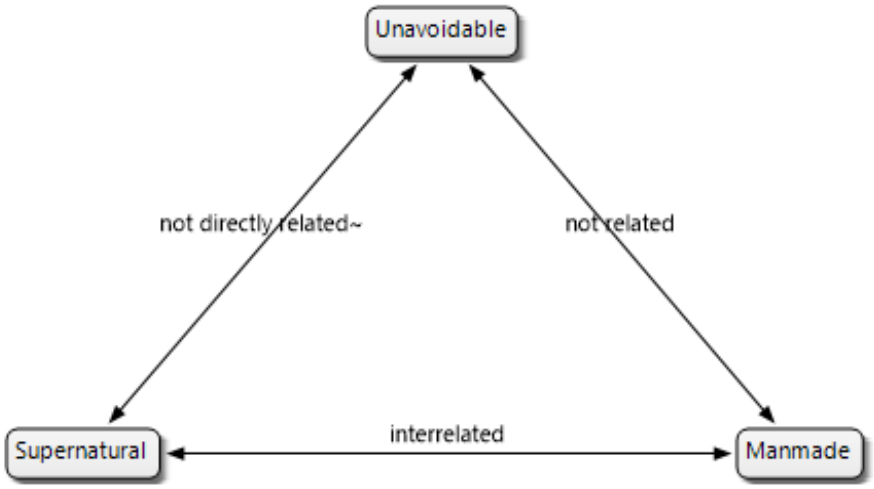
(natural, supernatural and manmade) for traumatic events were discussed among the groups. It was noted that attributions were usually dependent on the nature of the event. Certain attributions of events were seen as predictable (human agency influence) or unpredictable (malice of witches). In terms of existing theory, events that are seen as predictable would generally be more conducive to healing than those that are seen as unpredictable (Ehlers & Clark, 2000). A thread through much of the predictable attributions was that traumatic events result from actions that threaten the core values of an interdependent culture. For example, the work of witches, curses as well as infighting which led to the death of the king, had elements of trying to promote oneself above a neighbour or fellow Mole-Dagbon. Although there was a general agreement regarding the perception of certain kinds of events, there was not a specific kind of rule as to how these attributions work. That is, one cannot say that the Mole-Dagbon use primarily supernatural explanations for events and augment these with natural explanations when it does not fit the supernatural world. Or alternatively, that natural explanations are primary and that the supernatural is only used when there isn't a plausible natural explanation. In the view of the researcher, the choice of attribution might be quite dependent on the individual, which chooses to draw from a variety of attributional options available. The attributional elements described in this section would therefore interact with the unique internalised processes of a person to come to the unique attributions that will produce personal behaviour and symptoms. The following section considers these more individualised processes.

4.2 INDIVIDUALLY INFORMED CONCEPTIONS OF TRAUMATIC EVENTS

Discussions in this section will focus on the individuals' view of traumatic events, taking into account the extent of incorporation of cultural values. Among the individuals, the most commonly reported trauma was the traumatic death of a loved one. Other forms of trauma included involvement in a motor vehicle accident, witnessing someone being killed, loss of crops or farm produce, experiencing a natural disaster, and being attacked, robbed and assaulted. The respondents were mostly Muslim, but a significant minority was Christian. Unfortunately, there were no individuals that identified primarily as being a traditionalist although they are the second largest group of the Mole-Dagbon traditional area (Awedoba, 2006). Most of the individuals indicated that they were not sure of the cause of their traumatic events but that they could speculate. This tendency not to interpret events was also noted during the focus group interviews. Surprisingly, despite not identifying primarily with the traditional belief system, almost all the respondents indicated that they used traditional cultural elements and remedies. Most incorporated traditional cultural elements with the exception of a few who for reasons such as religion and upbringing, did not adopt the elements of the traditional Mole-Dagbon culture. Such individuals tend to distance themselves completely from traditional beliefs and values. Below is the description of the individuals' attributions of traumatic events.

4.2.1 Conceptions of Traumatic Events

Figure 6: Individual Conceptions of traumatic event



As indicated above, the themes derived from the individual interviews were clustered into three categories: unavoidable, supernatural and manmade. It was also noted that the subthemes that are classified as unavoidable were not directly related to supernatural or manmade whereas supernatural and manmade were interrelated. This finding is similar to that of the focus groups. These views are similar to the belief of the Baganda of Uganda that human activities stimulate the acts of the supernatural forces (Okello, 2006). Thus humans have a fair measure of control over the traumatic events perceived to have its source from a supernatural cause.

4.2.1.1 Unavoidable Events

Subthemes captured as unavoidable involved nature, coincidence and destiny (i.e., unavoidable events). From respondents' perspective, certain events were seen as unavoidable. An example is the overflow of the Bagre Dam from Burkina Faso which washes away crops periodically. A quote from an individual who experienced loss in this manner illustrates a natural cause attribution:

> "It damages our farms just at the time of reaping. I know that the dam gets full and spills. It is a natural thing. We all know it occurs some parts of the year".

This view of the individual is in line with the views offered by the men in the focus groups. It appears that the individual has accepted and internalised the commonly held idea that the overflow of the Bagre Dam is a naturally occurring event.

Individuals had other explanations related to natural causes which were not raised among the focus group. One such view involves random coincidence where an event occurred without any specific causal connection. A quote from a respondent who was attacked and robbed at gun point illustrates this kind of interpretation:

> "the only meaning I will attach to this is that in my case, it was just a coincidence because armed robbers hide at places and attack randomly to collect money. Those who steal in the house come unannounced and I think mine is just one of those."

There seems to be a difference between what focus groups said and what this individual is saying. Focus groups seemed to attribute random events to malicious supernatural agents. Here, even though there are actual human agents, the attribution of randomness is still made and labelled 'coincidence'. In terms of general explanations, the focus groups seemed to look for culprits, while on an individual level people seemed to be comfortable to assign coincidence or randomness as an explanation without reverting to supernatural explanations.

Some individuals also held the notion that people are simply "destined" to experience certain events which they have no control over. This view is similar to Marsella's (2010) notion of individuals having beliefs in the role of destiny in determining the perception of traumatic events. The dynamics of destiny was in a way tied to a supernatural cause (God/Allah). From respondents' view, people are destined to encounter traumatic events in various forms (e.g. vehicular accident or incurable illness) and it is the will of God/Allah. A quote from a respondent who had an accident illustrates this belief:

> "God knows why I had that accident. It was my calling because God has arranged everything in our lives and he said I was going to have that accident at that time and it happened. So to me fate made it happen".

An interesting phenomenon was noted during this interview. Just from reading the above statement, one may surmise that the individual has integrated the specific event into a broad worldview and overall life narrative. While the description itself seems coherent in a manner reminiscent of victims of traumatic experience that have successfully

integrated their experiences, the individual involved still had a great deal of symptoms of traumatic stress. In the view of the researcher, this individual might have given views that concur with generally held religious beliefs, but may not have been completely internalised by the individual. It may therefore constitute an attribution that does not seem to be completely comfortable, but is accepted nonetheless.

This specific subtheme parallels what was termed "natural" in the focus groups. The term "unavoidable" has been used here because of the role of God/Allah in the descriptions. Even though individuals referred to God/Allah when referencing fate, the sentiment was that God/Allah was a part of the natural order as the highest authority of it. God/Allah as a more active supernatural agent was also present in descriptions that can be labelled "supernatural".

4.2.1.2 Supernatural Causes of Traumatic Events

Reasons that were clustered under the supernatural subtheme were: belief in God/Allah, gods of the land, witchcraft and spirits of the dead (the term "spirits of the dead" were used interchangeably with "ancestors" and the meaning is the same). Most of the individual respondents believed that their exposure was as a result of the influence of these supernatural forces. The views expressed were very similar to those expressed by the focus group. Similar beliefs have been found in traumatic brain injury patients living in rural African communities (Mokhosi & Grieve, 2004). The name "God" was used consistently by Christian respondents whereas "God/Allah" were used interchangeably by Muslim respondents. God/Allah according to the respondents is believed to be the creator

of the universe and have control over everything he created. According to the respondents God/Allah permits certain events to occur on purpose. A quote from a respondent to illustrate how God/Allah permits the occurrence of traumatic events:

> "I think this is the work of God. Sometimes he would want to test my faith in him. Maybe he realised that my husband was suffering as a result of the illness so he felt there was a need to end his life so he wouldn't go through the pain anymore and I can also rest because I was always at home doing eventually everything for him. So I will say it is the work of God."

God's will/fate was also used in relation to events which were unavoidable (the subtheme preceding this section). The difference here is that in this instance God is perceived to have a specific benevolent purpose in mind, whereas in the 'fated' examples the event is simply dismissed as inevitable. There are some similarities in terms of tentativeness between the focus group and individual causes of traumatic events.

Even though the individual seems to settle on the idea that it was God's work, the tentativeness of statements as well as the multiple secondary reasons offered creates the idea of uncertainty. This kind of speculative answering was commonly found in the individual interviews. It was as if respondents had not really thought extensively about the reasons for their traumatic events. This is interestingly very similar to findings of De Villiers (2013) that indicated that isiXhosa-speaking individuals suffering from PTSD had only made tentative judgments about causality. However, in the current sample it was not only those with tentative attributions that were suffering. The researcher noted that even

those with more certain attributions also exhibited traumatic stress. Whereas, common cognitive understandings (e.g. Ehlers & Clark, 2000) state that people who understand the cause of the traumatic event should experience less symptoms, this was not the case among the current Mole-Dagbon sample. The mechanism of God/Allah seems to be somewhat different to those of the gods of the land.

The gods of the land are termed "smaller gods" by respondents and are believed to either cause a traumatic event for an individual or the community as a whole. The view held is that traumatic events are mostly associated with these gods when an individual engages in immoral behaviour. Twumasi (1996) has indicated that the supernatural (e.g. gods of the land) is believed to know everything and some people are afraid to engage in an immoral life for fear that they will be caught and punished. In instances where acts are not considered immoral (and therefore do not deserve punishment from the gods), individuals attributed traumatic events to witchcraft.

Individual respondents held the belief that human activities are not necessary to activate witchcraft. Instead, witches are believed to act out of malevolence to cause harm to other people. An individual example illustrates this by relating illness to witchcraft:

> "I am now suffering from this terrible leg ache. This started after I lost my wife and I suspect the witches in my wife's family are behind this. They only want to cause me pain for no reason. They do this mostly out of jealousy."

Similarly to what has been said in the focus groups, the respondent believed that the acts of witches could be driven by mere jealousy for another person. However, in a few instances individuals also indicated that the occurrence of a witchcraft related traumatic event could also be initiated by an argument between people. A witch can cause a distressing event for another as retribution after an argument. A quote to illustrate this view:

> "I believe it could be as a result of a witch. Maybe my wife had a misunderstanding with someone who has the witchcraft powers and the person decided to kill her".

Respondent uses "misunderstanding" in this instance to signify "argument". These two words were used interchangeably by most respondents who commented on the act of witches. However, they implied "argument". The idea that witchcraft leads to traumatic events is slightly more nuanced with the individual expressions of the idea in that a witch may act in their own self-interest rather than being randomly malicious. Other researchers have also found that witches may act of their own interest and volition to cause harm to others (Awedoba, 2006; Okello & Neema, 2007). What seems to be central to explanations of witchcraft is the idea of malice and jealousy driving random traumatic events. These events stand in contrast to explanations for random events that are attributed to fate or coincidence. Certain events were also associated with the ancestors or spirits of the dead.

Spirits of the dead were believed to be capable of causing a range of traumatic events. This view of the individuals of Mole-Dagbon is in line with natives of Uganda who believe in distressing events as having its origins from poor relationships that existed between the living and the dead (Okello, 2006). Thus the spirits of the dead are believed to exert these events as a form of punishment to the living. A quote from a man who lost his wife:

> "My wife was requested to become a regent after she lost her auntie who is a queen mother. My wife refused to act accordingly because I was sick then. Since she is very dear to her auntie, her spirit might have punished her for disobeying the elders".

From this individuals' perspective, spirits of the dead act with purpose. Thus, punitive measures were meted out when an individual's actions were contrary to their desires or assumed request. These supernatural forces were not only believed to react to the person who infringed on their desires but could extend these reactions to the close relations of the person.

> "After I lost my wife, my legs got swollen and I am suspecting this is resulting from what my wife's' refusal to be a regent. I am her husband so the spirits know I also contributed to her not accepting to act in place of her auntie."

Thus in this instance the respondent believe his current illness could also result from the ancestors/spirits of the dead. The difference between supernatural agents using witchcraft and that of the ancestral spirits seem to be that the ancestors act with and within reason rather than out of spite, jealousy and malice. It could be suggested that experiences that are attributed to random malice should be more traumatizing than those that are more understandable and almost 'sanctioned' if we consider current Western understandings of posttraumatic stress disorder. It can of course not be surmised from the current sample and study whether this was the case, but the difference in frameworks for event attribution here may be a valuable avenue for future exploration.

4.2.1.4 Manmade Causes of Traumatic Events

Reasons grouped as manmade causes of traumatic events included immoral acts, carelessness, political reasons (in terms of intra-tribal conflict), enemies and curses. These reasons closely corresponded to those offered by the focus groups. Again, respondents were not very certain about these attributions and they were offered as speculative possibilities. However, they associated immoral behaviours (e.g. promiscuity) as stimulating the supernatural punishments of the gods of the land. These dynamics have been discussed above and remained similar within the individual interviews.

However, in some instances, individuals were very confident and eliminated immoral acts as triggers of the wrath of the gods and instead blamed specific individuals for their carelessness. One example of a very confident reason was provided by the following individual who had been provided with information from emergency personnel:

> "I strongly believe it was carelessness on the part of my husband because information that reached me was that my husband over sped a tanker driver on a high road resulting in a head on collision".

Although carelessness was identified in the quote above as a major attributional element for this woman, the respondent also expressed views about God earlier in the interview. An interesting dynamic here was that the respondent maintained both carelessness and God as her understanding of the event. Although this might suggest tension in her thoughts, she remained confident and comfortable about both attributions. The explanatory framework involving human agency seemed to be a much more accepted or internalized explanation than the unavoidable/fated explanation. Some events were also attributed to political reasons and the ongoing intra-tribal war in the region.

The intra-tribal conflict in the Mole-Dagbon traditional area was perceived by the focus groups as a cause and effect (discussed above). Although this is taken as the normative cultural view, individuals only perceived the conflict as a cause of traumatic events and did not really refer to it as an effect of human activity. A respondent witnessed his brother being shot and killed and was also taken to the military barracks to be interrogated:

> "the death of my brother and the torture I had at the barracks was on political grounds, I wouldn't attach any other meaning to this because I a political figure and we likely expect some of these from our opponents".

Another respondent who had his house entirely burnt also indicated:

> "Yes, we lost our fully furnished house, all our money and hard earned certificates but I assign blames to the ongoing intra-tribal war. The youth from the other tribe are behind this. They are our enemies and wish our downfall."

Although a slight difference exists between the individual and normative cultural views, there is a great level of agreement in that the ongoing tribal war is a major cause of traumatic events. Such an interpretation closely aligns with the DSM conceptualisation of traumatic stress. Individuals also perceived traumatic events as attributable to the work of enemies.

Having a political or military enemy may be a natural consequence of power struggles, but enmity could also ensue between two individuals after an argument. They held the view that such enemies are capable of causing harm to others, by consulting a witch to cause a traumatic event. One respondent who made mention of enemies as being behind traumatic events also specified:

> "I suspect my brother who is my enemy now, is behind this accident. I had an argument with him on a land and he cursed me. He said "You will meet your untimely death" and in no time I had this car accident."

The belief held here is that the words from the enemy is powerful and has the power to cause traumatic occurrences. Most of the individuals' views corresponded closely to the normative cultural elements in this regard.

4.3 INDIVIDUALS PERCEPTION ABOUT CULTURAL BELIEFS (TRAUMATIC EVENT)

After individuals' views regarding their traumatic events were solicited, they were also asked to comment on the general cultural beliefs as indicated by their cultural leaders. A quote to illustrate a response from an individual:

> "Umm, putting my fathers' incidence aside, those events may occur on several grounds. In Dagbon here we have do's and don'ts. It is belief that if you do some of the don'ts you could invoke the anger of our ancestors or of the gods. For instance, for a very long time we were not supposed to go to the farm on Friday and people who go to farm on Fridays could suffer bad yields or could get good harvest but before the farm produce are taken from the farm, a devastating fire could come to finish everything. These were happening. We have a situation where a beautiful girl gets married, a member in the family is not happy with their marriage. Usually, if that member of the family is somebody who have sacrifice for the girl, the girl may never give birth or the girl may never be happy in that house. So sometimes some of these things happen. It is believed that if the auntie, the mother or uncle who is not happy with the marriage have never

> sacrifice anything for you, it cannot follow you or using the literal English "it cannot catch you" but if you are somebody who have suffered to bring up the child and against it, we have instances, example: the couples will be fertile but cannot give birth although they are declared fit by doctors and many more. We even have em a belief that actually works. When somebody have hatred can do something demonic to make something either go worse or make someone die instantly or any other thing. All these beliefs exist in us and we see it sometimes. There are instances where somebody dies and you cannot explain it or just as I stated, you go to the hospital, doctors do their examination and say "oh you can give birth, you are fertile" but you are not giving birth. This calls for more explanation and we point a figure to such issues. Once science cannot explain it and it is happening, then we have to look elsewhere for a better explanation or there are more workable explanation".

This view was similar to most of the comments gathered from individuals regarding the Mole-Dagbon cultural views. It seems clear that for many individuals there was a preference for scientific explanations, but that traditional beliefs were incorporated to explain the unexplainable. What is also evident in the quotation above is that there does not seem to exist a strong dichotomous thinking. Individuals that expressed views similar to the above were quite comfortable in using what may be seen as two quite contrasting systems of explanation in understanding traumatic events. Many individuals also used anecdotal evidence or personal experience to support the veracity of the mechanisms

explained by the focus group. What did seem to be different is that with individuals there seemed to be a clear preference for 'scientific' explanation with traditional beliefs acting as a backup explanatory framework. It must be remembered that the individuals were sampled via a local psychologist and had attended a 'Western' medical facility – they may have therefore been predisposed to favour 'scientific' explanations. There were also quite clearly a number of individuals that outright dismissed the cultural explanations offered by the focus groups. A quote from one such respondent is presented below:

> "Yes, some are there like that, witchcrafts, curses, gods and all that but through my upbringing and religion, I don't think of any of these and will not attach any spiritual meaning and what the spiritual leaders think. Normally it is those who think badly are those who will attach these meaning and I have seen some people go through what I experienced and they point hands on these beliefs".

This individual acknowledges that cultural beliefs exist and are practiced. However, her exposure (upbringing and religion) forbids her to incorporate these cultural beliefs. And she also seems quite happy to forego these beliefs in her own understanding of traumatic events. The religion that she is referring to here is monotheistic and generally speaking monotheistic religions may preclude the inclusion of other explanatory frameworks because of the primacy afforded to a single omnipotent deity. The acceptance of one framework therefore precludes the inclusion of others. This is somewhat in contrast with the first example where there seemed to be a relatively easy co-existence between

quite disparate systems of attribution. What this may mean for traumatic symptomology is equivocal. One the one hand, having a very fixed attribution system may make meaning making easier and efficient, but on the other hand, having a range of explanations available may increase the range of explanations available to make sense of a traumatic event. What is quite clear however, is that in the current sample, the idea of culture refers not only to the traditional culture of the Mole-Dagbon, but also to the competing systems of understanding that is brought into the equation by Western thinking as well as religious (monotheistic) thinking.

Although there are differences as to how traditional cultural values are incorporated by individuals, it seems most of the Mole-Dagbon are aware of these traditional interpretations. One group of individuals seem to incorporate these values when science fails, but another seems to disregard the explanatory framework altogether (this latter group is marked by strong beliefs in monotheistic realities). In the current sample the second group was present, but definitely a minority. Mole-Dagbon individuals mostly seem to incorporate traditional cultural beliefs irrespective of primary systems of belief and attribution. In few instances individuals disregarded the traditional cultural explanatory frameworks, but they did not dispute the existence and effectiveness of the cultural elements. Individuals' dynamics in attributing and explaining causalities (natural, supernatural and manmade) very much paralleled and were embedded in normative cultural understandings. Information gathered from both the focus groups and individuals, portrayed that there was not a particular pattern but a range of possible attributions emerged. A notable exception here was with regard to the malice exercised by witches

(supernatural). These were usually reserved for unpredictable and otherwise unexplained events of personal injury and death. There were also predictable factors that were considered to have stimulated the works of the supernatural. A noticeable aspect of these predictable factors are that they often contained elements that are contrary to the central values of a collectivist/interdependent culture (e,g. the intra-tribal conflict was seen as related to selfish self-promotion above others). This was evident in both the focus groups as well as the individual interviews. This is quite thought provoking. In the researchers' view most Ghanaians lean more towards a collectivist/interdependent culture. For the generally more traditional Mole-Dagbon to have engaged in such decidedly un-collectivist activity might make one wonder about possible triggers for this 'deviation'. Some of the focus group members suggested outside political influence as contributing to the unrest, but from other data factors such as exposure to other cultural elements (monotheism) or more individualistic/independent western thinking may have also contributed to the turmoil.

Individual's responses to cultural perceptions were similar to that of the findings by other authors elsewhere (Barnes, 2015; Herbert & Forman, 2010; Wilson, 2005). Although in most instances individuals were uncertain about the causes and frequently speculated, they appear to have included normative cultural elements in their interpretive behaviour. It is of course difficult to say what the effect of the above descriptions may be, but possible implications are offered below.

4.4 IMPLICATION OF BELIEF SYSTEM (POSITIVE AND NEGATIVE)

One major observation made by the researcher was the tentative responses from participants. Widely varied responses (e.gs. scientific and traditional) were given to explain events. The focus of responses on questions about causality were not primarily cognitive and explanatory. Respondents focused much more on the consequences of events rather than on the causes. This focus difference may have led to the tentativeness of causal attributions offered. In terms of current cognitive understandings of PTSD, such tentativeness may be a sign of schema disruption.

Individually perceived views adopted and internalised from cultural beliefs are likely to influence schemas around control and survival (van Rooyen & Nqweni, 2012). Most often when these schemas are challenged, it leads to the behaviours and symptoms we associate with traumatic stress (Ehlers & Clark, 2000). Most often, individuals in the current study conceptualised their exposure in a way that suggested a positive adaptation – it seemed as if they had made sense of the event. However, they still had significant symptoms which are suggestive of a negative interpretation of the event. It is possible that these symptoms may be related to the consequences of the event, rather than to the understandings of the event itself. Traumatic events do not necessarily stimulate symptoms directly after the exposure. It is the meaning attached to the event and the consequences that result in the symptoms (Ehlers & Clark, 2000; Foster, 2014). However, meaning may not only be a cognitive element. Traumatic memories could either have a positive or negative valence depending on the context in which the individual perceives it

(Kirmayer, 2009). Perceptions of traumatic consequence among the Mole-Dagbon of the current sample had both positive and negative connotations. In some instances, the respondents seemed to appraise the event as resolved which should activate minimal or no traumatic symptoms (Ehlers & Clark, 2000). An example could be about God as the cause of traumatic event (e.g. with the individual that was attacked by armed robbers). The individual appraised the event in a way that suggest cognitive resolution and minimal traumatic symptoms. In the case of the Mole-Dagbons, it appears that the consequences (e.g. lack of finances) of the event were those that were comprehensively appraised negatively hence precipitating the symptoms thereafter. Ehlers and Clark (2000) similarly asserts that negative appraisal of event will lead to an initial behavior which could further have negative consequences if it is negatively perceived. The distinction here is that the meaning attached to the event does not have only cognitive elements but also consist of element of valence that will be discussed later in this chapter.

4.5 FOCUS GROUP INTERPRETATION OF TRAUMATIC SYMPTOMS

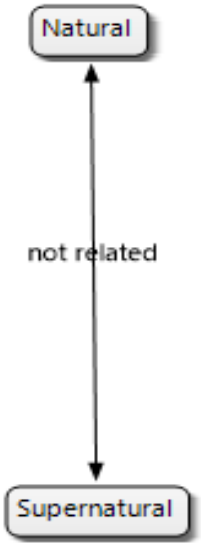
The culturally informed interpretation of traumatic symptoms were grouped as natural and supernatural. Similar to the understandings of traumatic events, respondents were again uncertain when questions were asked on the causes of traumatic symptoms. They seem not to have preconceived ideas on the cause of traumatic symptoms. Again, the soothsayer to them rightfully concludes about the causes of these symptoms. The focus groups mostly discussed answers among themselves as if figuring out a response (i.e. there was not a readily available explanation) and then one person would conclude and provide a

response to the question on causality of symptoms. The responses mostly prioritised means of coping and conceptions of the symptoms followed as an afterthought:

> "When these symptoms occur, we all get close to the person, assist her and make sure she no longer takes up any responsibility. We also advice and encourage her to let her know she is not alone. These symptoms come because the person is thinking too much"…

These routine responses suggested a cultural practice which members were ready to engage in, when there is a traumatic event rather than thinking more of the cause of the event and symptoms. When actual causality was probed more, the responses yielded similar classes of explanation as to the events (e.g. supernatural and natural). Slightly different relationships however existed between elements. These are described and discussed below.

Figure 7: Cultural interpretation of traumatic symptoms



4.5.1 Natural Causes of Traumatic Symptoms

An interesting angle that was somewhat unexpected is illustrated by the following response intended to explain the symptoms contained in the vignette:

> I think the way some people interpret the trauma behaviour also affect their memory and they do more unusual things.

The direct reference to memory and the interpretation of "trauma behaviour" would fit current Western cognitive understandings of traumatic stress and is considered an example of a natural cause. These almost textbook responses were offered by focus group members who had some level of education and were currently practicing teachers. The question arises whether familiarity with Western cognitive traditions contributed to the responses from these leaders? From the researchers' view, exposure to the Western culture or perspective could have influenced their understanding. Irrespective of the origins of understanding in these cases, a quote from another respondent illustrates that thinking processes in general are considered important in producing symptoms:

> "Sometimes people think too much of the lost and will be wondering about the death and will be thinking of when they will be giving birth again and who did that to them and all that. That is mental agony. You become disturbed and cannot rationalize judgment or judge correctly. It can make you begin to show those symptoms. Your mind becomes affected and not functioning normally".

In the respondents' view thought processes are important in producing symptoms. Thinking too much (rumination) and irrational thinking patterns of a mind that is "not functioning normally" are implicated as specific cognitive processes. A quote from another participant expands the list of mental processes:

> "When the woman is always in the room and doesn't come out to associate with people, she will be having and encouraging plenty thoughts which will be dangerous for her and can affect her memory processes. This can let her have symptoms such as avoiding friends and families, she wouldn't want to even pass where the child had the accident and many more."

This respondent again emphasized the relationship between symptoms and thought processes. Here specific mention again is made of memory being affected and once again too much thinking ("plenty thoughts") is implicated in the explanatory dynamic. It is also interesting that here the origin of the rumination is related to social avoidance and a lack of contact with others. The views expressed are reminiscent to the link between intrusive disturbing memory and avoidance symptoms that has been found across cultures (Hinton & Lewis-Fernandez, 2011). Usually this link is conceptualised as individuals avoiding triggers because they cause intrusive symptoms. The intrusive symptoms are considered the original cause, but in the example above, the direction of causality is reversed and the social avoidance is seen as the cause of the symptoms.

The focus groups also commented on the mixing of traditions. The groups expressed the view that every religion has its own accepted practices and that most Christians and

Muslims have incorporated some aspects of the traditional belief system. Such mixing is considered as an explanation for symptoms after a traumatic event. An instance from the leaders' point of view to illustrate mixing beliefs and its effect:

> "An Islam is not allowed to engage in other practices or have different beliefs. If you are a Muslim and you knowingly or unknowingly do that you can have behaviours like that after the traumatic event."

The "that" in the quote refers to traditional African practices of the region. The idea held by the leaders is that symptoms are caused by acting contrary to ones chosen religion (Islam in this specific case). Because this specific tradition does not allow for other practices, the unsanctioned use of traditional remedies (even inadvertently) leads to the symptoms. What is significant here is that the person is not trying to say that Islam is the *correct* religion and therefore acts that do not fit the *correct* way of doing will lead to symptoms. It is rather that a person is acting in a manner contrary to the way in which they have chosen ("if you are a Muslim"). It is therefore related to the mixing of belief systems and if it can be further interpreted, an individual may become confused by using contradictory belief systems and this cognitive disruption could possibly contribute to symptoms of PTSD. The mixing of traditional beliefs with the major monotheistic religions was quite common among the individual interviewee responses, but it was never offered as an explanation for the symptoms. The following example illustrates the relatively easy mixing of traditions:

> "I told you there were lots of speculations. I also don't really know where those behaviours were coming from. It could be that somebody is behind all that I was doing because of the hatred he or she had for my father, it could also be that because I was thinking too much about the death or a particular person who wished for my downfall is behind it. I think so many things could be a contributing factor. May be it is Allah's way of doing things".

In the quote above the respondent referred to both traditional and Islamic content without missing a beat. This was very common, but a difference between the normative and individual understandings can be highlighted here. The cultural leaders saw this mixing of systems as a possible cause for symptoms, but individual interviewees mixed traditions very easily in producing explanations for their symptoms without seeing the mixing itself as a causal factor in producing symptoms.

One of the key observations from the focus groups was encountered frequently with individuals as the mixing of belief systems in the explanations of individuals happened so naturally that the inconsistency presupposed by the focus groups were unknown to them. In the quote below, the commonly encountered uncertainty leads into explanations that rely on varied systems of explanation:

> "In my fathers' case, we don't really know what happened. There were lots of speculations. It could be that somebody has hatred for him and bewitched him or it is heart related because he was hypertensive. We think

so many things could be a contributing factor. May be it is Allah who called him or it is his time to die. For my unusual behavior, I sometimes will say it is from Allah or the person with hatred for the family, maybe normal or even some spirits. All these I believe can make you behave that way after the trauma event happen".

The rapidness with which this individual switched between explanations and the fact that there seemed to be no comfortably internalized explanation for his experiences, did make the examiner wonder whether the competing belief systems did indeed make it difficult for him to make sense of his experiences. Such competing conceptual systems may present different meaning making sets of rules to adhere to, which has been implicated in maintaining the symptoms of PTSD (Ehler's & Clark, 2000).

4.5.2 Symptoms resulting from Supernatural forces

The cultural leaders from the focus groups indicated that the spirits of the dead, gods of the land and witchcraft could also cause symptoms after an exposure. Similar to the views about the supernatural in relation to traumatic events, perceptions about the works of the supernatural regarding traumatic symptoms were also classified into two categories (one predictable and another unpredictable). Predictable symptoms were believed to stem from spirits of the dead and gods of the land, whereas the unpredictable had its roots in witchcraft.

Respondents indicated that actions and thinking processes that are different to a persons' usual way of behaving after an exposure is believed to be caused by the spirits of the dead. A quote from a cultural leader:

> "After something traumatic happens to you if you start doing things that you were not doing before the accident then it means that you have been visited by the spirit of the dead or the ancestors".

The existence of the spirits of the dead is a widely held belief among most African cultures (Okello, 2006; van Duijl, Kleijn & de Jong, 2014). The belief that these spirits may cause symptoms are especially held in instances where the person is suspected to have had a hand in the death of the deceased, has unjustly interfered with the estate of the deceased and or is not treating the family fairly (van Duijl, Kleijn & de Jong, 2014). The Mole-Dagbon in the current study's focus groups assigned similar agency to the spirits of the dead in explaining the traumatic stress symptoms of the vignette. From the focus groups' perspective, spirits of the dead are powerful and could inflict harm when they are disobeyed (an example is indicated in the individual interview section below) or as punishment when an individual is suspected to have caused the death of the person in question. A respondent from the focus group used an information from the Bible to illustrate this dynamic:

> "Even the Bible and the Quran says that the earthly forces are great. The Bible for example says whoever pulls a knife will die through the knife. If you kill anyone, the spirit of the person comes back to hunt you down and

> you can have terrible sickness or join the person in the grave. If you refuse to do what they ask you to, you can also get a car accident and after that you will behave like you are not normal. If these spirits do not exist, they wouldn't have been quoted in the Bible. They exist and might have caused those symptoms. Maybe the woman offended someone before the person died so the spirit of the dead person also harmed her by letting the daughter get that accident."

Here the Bible and Quran are also used as authoritative texts to serve as evidence for the existence of the lesser "earthly" powers. This kind of hierarchical understanding may of course also explain how individuals in the sample are able to combine elements of monotheistic belief and traditional African culture.

The gods of the land are also perceived to cause symptoms after an exposure in a manner similar to that of the ancestors. According to respondents symptoms are punishment and indicative of the anger of external forces behind the traumatic event. This view is similar to Bhutanese refugees who interpreted traumatic symptoms as a punishment from the angered spirits (which includes gods and ancestors) (Shrestha et. al., 1998). From the cultural view, symptoms therefore signal to victims the need to consult the soothsayer in order to learn how to appease the gods or ancestors on their behalf. A commonly suspected dynamic is therefore that the individual has faulted in some way and have behaved in a manner contrary (taboo) to the norms of Mole-Dagbon society. A respondent explained how this occurs:

> "We have taboos in this community. We do not farm on certain days and if you are stubborn and go to farm on that day, you can suffer some harm from the gods and this could take so many forms. Either a terrible illness or like what happened to the woman. If that is the case, maybe the husband went to farm on one of those days and that was the punishment they received. When it happens like this you will also be going through so much pains and you will be hiding in the room and be thinking and people can even go crazy unless you take them to the soothsayer to find the cause and heal the person".

Something which is illustrated in the above quote is the easy focus on the symptoms (consequences) rather than on the event itself, and the primacy of the soothsayer in providing a general explanatory framework and the means to alleviate the symptoms.

Witchcraft is also believed to have an influence in the symptoms a person displays after traumatic exposure. Practitioners of witchcraft are believed to subject a person through these behaviors to bring shame and suffering to the person. Additionally, these external forces cause symptoms so others will recognize the signs and believe in their existence:

> "these witches acts out of jealousy. They use their evil powers to bewitch the person to behave in ways so that people will also know that they exist. Some of these witches they live with us. In fact I can say that some of them are our neighbours and jealous your progress".

In the above quote the link between jealousy, malice and witchcraft is once again highlighted.

In conclusion, symptoms were perceived as emerging from both natural and supernatural sources. Even though symptoms were not considered to be "manmade" as with traumatic events, there were indications that in some ways both the natural and supernatural symptoms were subject to human agency. Natural sources were perceived to be controllable as a person could reasonably not "think too much" or not engage in mixing belief systems. Supernatural causes were perceived as predictable in the sense that controllable human behaviour could avoid the punishments meted out by ancestors or the gods of the land. Supernatural causes related to witchcraft was once again more unpredictable, malicious and driven by jealousy. Human agency was present in between the lines, but because it was not an element really highlighted by respondents, it was not included as a separate subtheme.

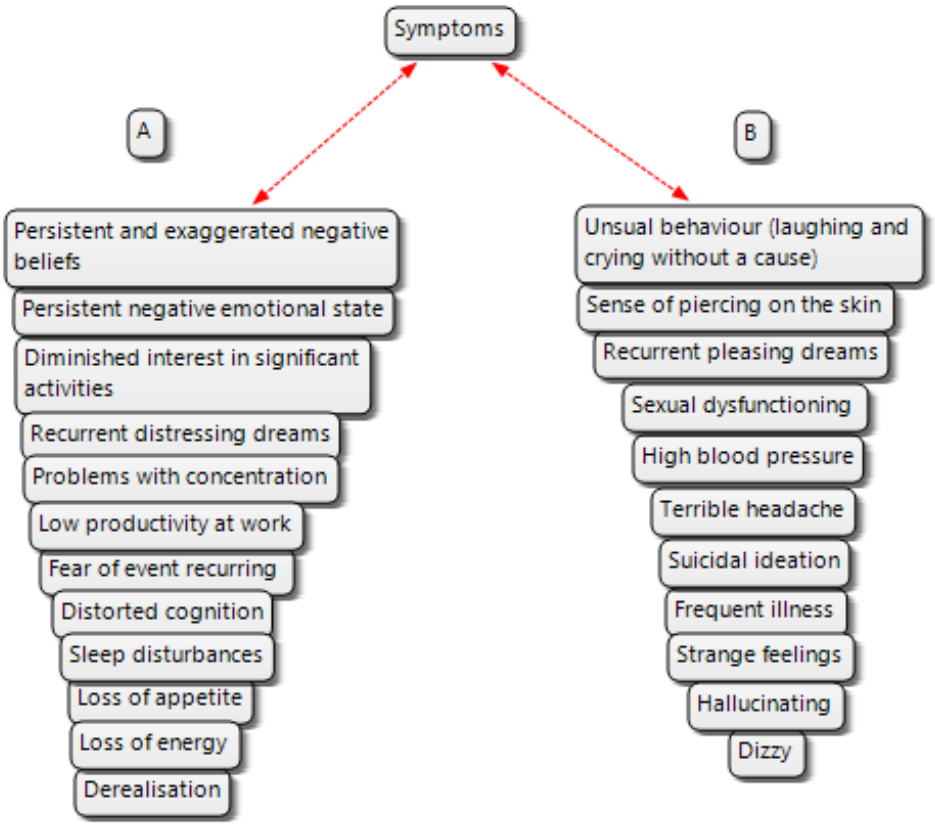
4.6 LIST OF TRAUMATIC SYMPTOMS AND INDIVIDUALLY INFORMED CONCEPTIONS

4.6.1 Traumatic Symptoms

Individuals experienced various forms of symptoms that are common reactions to traumatic events (Ehlers & Clark, 2000). These symptoms experienced by the individuals are either behavioural, cognitive or emotive and have been clustered into two categories below. The first (A) consist of symptoms associated with the DSM conceptualisation and the second (B) contains the common experiences that falls outside of this classification.

The diagram below shows and describes a list of individual symptoms as they were reported by respondents.

Figure 8: Individuals' symptoms after a traumatic exposure



From the researcher's point of view the symptoms in B are not completely independent from those in A and may not be wholly unique. Some behaviours or thinking patterns from A are likely to related to experiences in B. "Strange feelings" (B) may, for example, be related to "Derealisation" (A), but it was also clear to the researcher that the phenomenology of some of the B experiences were different to what the DSM tradition presupposes. . Allthough this was not the central purpose here, the symptoms in "B" also

illustrates that symptomatic expression after a traumatic exposure differs cross-culturally (Terranova, 2011; van Duijl, Kleijn & de Jong, 2014; van Rooyen & Nqweni, 2012).

An interesting aspect noted with one of the *symptoms* (recurrent pleasing dream from the "B" list) was that this experience was actually a positive one:

> "Since her death I rather have pleasing dreams about her. I see her and I am okay. She tells me she is in heaven preparing a place for me. Sometimes the feeling is as if she is not dead and I would wish that it continues. I wish I could have this dream every day because it gives me much strength and I stop thinking about her death."

This experience and the accompanying interpretation could be contributing to rebuilding a helpful core schema (cf. van Rooyen & Nqweni, 2012). The interviewee seems to be making sense of his world in an adaptive manner. This experience also illustrates how a positive interpretation of a symptomatic consequence could be helpful in dealing with traumatic stress symptomatology (Ehlers and Clark, 2000). This was a relatively unique expression and individuals' conceptions of their symptoms usually indicated natural and supernatural causes. These are discussed next.

4.6.2 Individually Informed Conceptions of Traumatic Symptoms

Individual interviewees' conceptions of traumatic symptoms, revealed a very similar pattern to that observed in the focus group discussions. Individuals did not seem to think a great deal about the causes of the symptoms they experienced after traumatic exposure.

Both cultural leaders and individuals focused primarily on means of coping rather than explanations of the symptoms. From their responses, it appears that the soothsayer (discussed below) is once again relied on to determine the cause of traumatic symptoms. This portrays that personally generated understanding of events and symptoms may not be a natural part of the world view generated by Mole-Dagbon culture. This would stand in somewhat stark contrast to current (Western) cognitive understandings in which personally generated understanding of the events and symptoms are central in facilitating healing. The current finding is very much in line with van Duijl, Kleijn and de Jongs' (2014) assertion that in most African countries, symptoms are often dealt with by traditional healers and individuals are simply expected to perform the accompanying rites. This of course does not mean that meaning making and understanding does not happen, but what seems to be quite clear from the current research is that multiple societal agents are involved in the process, but that the focus is on resolving the problem rather than understanding the causes thereof.

Most respondents' starting position was that they were not very sure of the causes of their symptoms and could only speculate. Although this was generally the case, a few of the respondents did explain their symptoms. These explanations could be categorised as natural and supernatural, which paralleled that of the focus groups. There were however, some distinctive features (discussed below) regarding the works of the supernatural. Also, whereas the focus groups indicated that the merging of belief systems causes of symptoms, this was not mentioned among the individuals. Their responses demonstrated the mixing of beliefs, just not that such a mixing has led to their symptoms. The individuals'

perspectives are described and discussed below with reference to the focus group information being provided throughout.

Figure 9: Conceptions of traumatic symptoms

As indicated in the diagram above, the symptoms that follows traumatic events were associated with natural and supernatural causes. It was noted that the natural and supernatural were related in some instances (discussed below). This differs slightly from the information provided by the focus groups where these causes functioned relatively independently. However, both individuals and focus groups considered supernatural forces to exert a great degree of control over the symptoms a person exhibits after a traumatic exposure. Thus, in the opinion of the researcher the supernatural causes of symptoms were weighted more heavily overall.

4.6.2.1 Natural Cause of Individuals Traumatic Symptoms

Individuals were of the view that the extent of thinking after the event affected the memory processes and led to traumatic symptoms. The views were very similar to those encountered during the focus group discussions. A respondent who was suspected of killing someone and had his house burnt by the youth of his community, explained:

> "I think it is because I was thinking about it too much otherwise I would be fine. Because I was just asking myself so many questions. This thinking was affecting my memory and I started showing those behaviours."

For this respondent a variety of cognitive processes were important in determining symptomatic behaviour after traumatic exposure. In particular this respondent also mentions 'thinking too much' as a potential cause of the symptoms. While he mentions memory being affected, this may refer to problems in remembering rather than the memory disruption and dysfunction described in the cognitive tradition. The memory processes of another responded came a great deal closer to how the cognitive tradition would explain the dynamics of traumatic stress. He understood his symptoms as resulting from "cues". When asked where he thought his symptoms (intrusive disturbing memory and avoiding external reminders) were coming from, he stated:

> "Ah, they are coming from perhaps our memories because any event that looks similar to it will quickly remind you of that event which you did not like much. For instance, these days when I go to Damba festival, I am not so excited and even if I want to be excited, it looks like somebody will see me and say "look at this man, is he not the one whose father died some time ago during this festival?" so this Damba festival, I don't even want to go and don't also know what will happen even if I become a chief myself, Hmmm. "

For this individual, his distress (and avoidance) is triggered by events similar to the original traumatic event. Events that were reminiscent of the death of the father cued his traumatic symptoms. The cues that he describes here are however not the context and meaning absent ones assumed by the cognitive tradition – there seems to be a social component to the triggered responses. If one considers that both the focus groups and individuals indicated similarly, the idea of thought processes being involved in producing symptoms is not a foreign concept among the Mole-Dagbon. Individual respondents also perceived their symptoms to be caused by the supernatural.

4.6.2.2 Supernatural Cause of Individual Traumatic Symptoms

The actions of God, the spirits of the dead and witchcraft were all used as explanations of supernatural causation of traumatic symptoms. Similar to other findings, (cf. Okello & Neema, 2007), these supernatural forces are perceived to be behind ill health and human misfortunes in general. Individuals in the current sample expressed similar views and blamed their symptoms on these supernatural forces. God for instance was indicated as the cause of an individual's symptoms in one of the interviews. The respondent who was robbed at a gun point explained:

> "God has created us and created "fear". So if anything like this happen to you, automatically the fear and thinking comes".

This quote demonstrates a clear link between the supernatural (God) and the natural (fear). To this individual, fear of the event recurring as a symptom is perceived as caused

by God and occurs inevitably after an exposure to a traumatic event. There was a thought provoking aspect with this individual. Although she seemed to have created a comprehensive understanding and acceptance of where the symptom is coming from (something which would contribute to healthy adjustment according to the cognitive tradition), she was still highly traumatised and sought professional assistance. For example, she exhibited symptoms such as persistent negative distress dreams, fear of event recurring and lack of concentration. The researcher in this instance, believes that she might have perceived the consequences of the event more negatively which in the view of Ehlers and Clark (2000) has the potential of activating unhealthy outcomes.

The mechanisms of the spirits of the dead in causing symptoms was explained differently by the focus groups and the individuals. Both groups agree that the ancestors produced symptoms, but the focus groups explained the symptoms as a form of punishment, whereas the individuals perceived that the symptoms were signs of the presence of the dead. In terms of the presence if the dead, an individual's level of closeness was related to the traumatic symptoms. From the respondents' perspective, the spirits of the dead remains with the living if they were close in life. This lingering presence after death causes the traumatic symptoms. For example, a respondent who lost his wife stated:

> "I attributed my symptoms to my closeness to her immediately she passed on. In Dagbani we call something "Peuw" a scent you get from the spirit of the dead person so I associated it with the closeness I was with her".

From the respondents' point of view, his persistent negative emotional state, recurrent distressing dreams, strange feelings and sense of the skin being pierced were all suggestive of the presence of the spirit of the dead. According to the respondent, these symptoms are not necessarily a form of punishment but a signal that the spirit of the dead has not departed from the loved one yet.

Respondents understanding of their symptoms were in few instances related to witchcraft. In response to a question on symptoms, a woman who lost her husband and brother at the same time, indicated:

> "Me if I knew who caused it, I would have also gone to a traditionalist or the chiefs' palace for them to arrest the person and ask why she did that and if possible they will send her to the witchcraft camp to suffer. This is a complete work of the witch. They wanted to bring shame to me because they knew how close I was to these people. Witches here in Tamale are capable of anything."

The malicious and somewhat random elements in witchcraft explanations are once again alluded to here. It also seems as if the purpose of the symptoms is partly to bring shame to the person in this particular case. This link between witchcraft and shame was relatively common. Shame has been included in the DSM-5 criteria and has been confirmed in Western cultures as complicating PTSD presentations and increasing symptom severity (Dutton, 2013). Witchcraft in particular as a causal attribution to contain elements that have been associated with poorer prognosis in PTSD (e.g. random malice

and shame) in Western cultures. This does not necessarily mean that the mechanisms of these cognitive processes are comparable in the Mole-Dagbon, but in the view of the researcher, these mechanisms emerged as an area of interest that warrants more focused investigation.

4.7 INDIVIDUALS PERCEPTION ABOUT CULTURAL BELIEFS (TRAUMATIC SYMPTOMS)

Individuals were generally in agreement with the information that was offered by the focus groups. A quote from a participant who follows Islam as well as traditional practices:

> "With these beliefs held by the cultural leaders, I side with them because they have experienced it and my spiritual leader also confirmed that".

Interestingly, "spiritual leader" in the quote above refers to the respondent's Imam (a Muslim religious leader). In this case the mixing of beliefs seemed to be sanctioned by a religious leader – this of course may have been interpretation on the side of the respondent. Even in instances where individuals consciously chose not to incorporate cultural beliefs, they admitted its existence and that it does work:

> "Even though as Muslims we do not agree with them and always tell them to discard the beliefs in their minds but nevertheless those beliefs are there. We know witchcraft exist. Somebody can claim to be a traditional leader and when you visit the person, the person can predict to you that so so and

> so could happen if you do not do these 1 2 3. So majority of people hold on to these beliefs. They are always guided by those things. For instance, someone will not even travel without visiting traditional leaders for them to tell him or her to go or not to go. You know they are there so a reasonable number of people hold on to those beliefs".

Although this respondent throughout the interview, rejected the traditional cultural practices, it was noted from his responses that the cultural elements exist, works and were key to shaping others thought processes.

Culture is believed to be a key determinant of individuals' conception of traumatic experiences (Barnes, 2015; Herbert & Forman, 2010; van Rooyen & Nqweni, 2012; Wilson, 2005). Most individuals' responses confirmed a level of incorporation of cultural values in their understanding of traumatic symptoms. Even in the few instances where individuals chose not to include traditional cultural views, they admitted to the existence and effectiveness of those cultural norms and practices. The influence on meaning making of normative cultural understandings was evident, but individuals experienced it somewhat differently than the focus groups presupposed. For instance, the works of supernatural were perceived by the focus groups as more predictable and symptoms could be managed by engaging in certain acts. In the individual interviews, the sense of the researcher was that the supernatural control over the symptoms was rather inevitable. Or if there were actions to be taken, that these actions were up to the recently deceased for example. In making sense of these symptoms it may be quite differently explained by someone that is

observing the symptoms (the focus groups) in another and actually experiencing the symptoms. For the person viewing the symptoms it may be easier to believe that the individual suffering from the symptoms can actually do something about them. This kind of bias is of course not unknown in Western mental health.

4.8 IMPLICATIONS OF BELIEF SYSTEM (POSITIVE AND NEGATIVE)

Theory holds that initial symptoms emerging from a traumatic exposure is not inherently permanent (Ehlers & Calrk, 2000), but could be maintained or alleviated depending on the interpretation assigned to it. Cultures have their own attributions to traumatic events and symptoms (Marsella, 2010; Terheggan, Stroebe & Kleber, 2001). In addition, these attributions could be either positive or negative. Irrespective of the origins of an interpretation, those understandings that lead to decreases in continual threat is likely to contribute to positive adaptation after a traumatic event (Ehlers and Clark, 2000). In contrast, negative adaptations is predicted by threat enhancing interpretations or interpretations that lead to continued disruption and challenge to cognitive schemas around self-control and survival (Ehlers & Clark, 2000; Foster, 2014; van Rooyen & Nqweni, 2012).

Mixed beliefs as indicated by the cultural leaders as a persistent practice among traumatised individuals in this instance, could contribute to the cognitive processes that perpetuates a fragmented/traumatic memory pattern which could maintain the PTSD symptoms (Foa & Rothbaum, 1998; Halligan, Michael, Clark & Ehlers, 2003). There were individual cases in the current research where this kind of conflict brought in by

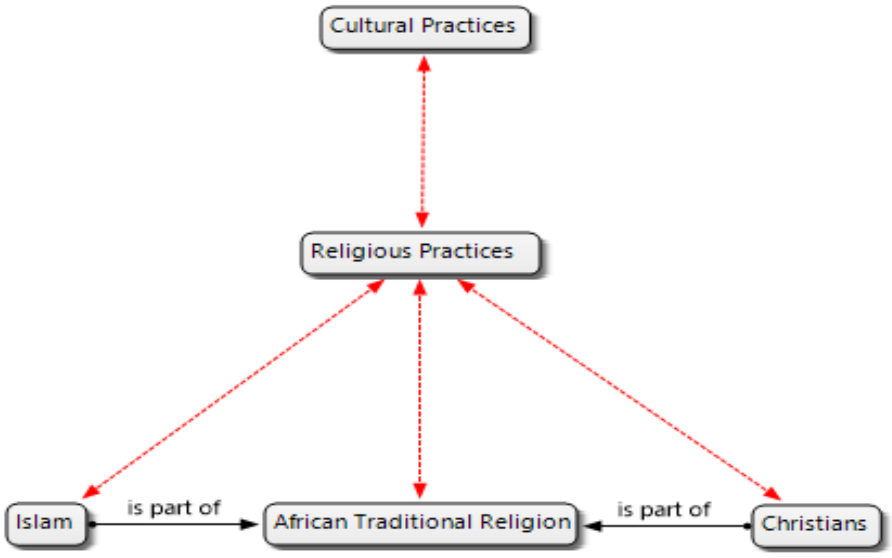
competing meaning systems may have been at play, but this was not always the case. In some instances the narratives of respondents were quite coherent in using the different belief systems. The nature of the current research means that it cannot truly be comparative in a causal sense of the argument. The mixing of belief systems is a culturally related phenomenon and requires more attention because of its potential to negatively influence post-traumatic responses.

The mixing of different belief systems was also quite prevalent in coping with the symptoms. Coping strategies are discussed next.

4.9 COPING STRATEGIES

Ghanaians have a variety of practices to deal with traumatic experiences (Terranova, 2011). These practices serve as coping mechanisms used to minimise symptoms and facilitate the healing process after traumatic exposure. The diagram below serves to illustrate the mechanisms by which different healing practices are seen to work.

Figure 10: Culturally informed coping strategies



.4.9.1 Cultural Practices

The major coping mechanisms identified by the focus groups included cultural practices (social support, soothsayer and counselling) and religious practices (including specific rituals). A hierarchy in terms of cultural practices were indicated by the focus groups. It is believed that alleviation from traumatic experiences firstly requires social support. This support should be augmented by a visit to the soothsayer and subsequently followed by counselling from religious leaders in the community. The primacy of social support in Mole-Dagbon culture is positive if one considers that the presence of social support enhances healing after an exposure to trauma (Dirkzwager, Bramsen & van der Ploeg, 2003). The significance of this kind of support is twofold (Stroebe & Schut, 2001). The first part involves the alleviation of additional emotional burdens. In instances involving the death of a loved one, a network of individuals will ease the practical burdens

and challenges that are likely to become worrisome. The second part involves the alleviation of loneliness that comes with losing a companion. The lack of these elements may explain why inadequate social support has shown to be a contributing factor to the maintenance of symptoms after a traumatic event (Johnson, Williams & Pickard, 2016).

The focus groups had a common initial response when coping was explored. Their responses suggested that social support is provided by members of the community irrespective of one's religious practice. The following kind of response was typical:

> "Traditionally, we all get close to the person, speak to her to understand that she is not the first to encounter such experience and we also encourage her to come out and mix (socialize) with people. We also ensure that her usual responsibilities are taken over by other family members to calm her and reduce her stress level throughout the grieving process".

Social support as a code was noticeably very frequent during the analysis process and the primacy of social support as a routine coping strategy in many African countries have been noted by other authors (Gallaher & Hough, 2001; Saltapidas & Ponsford, 2008). Social support has also been noted to be effective in Western cultures in enhancing the overall coping process and relieving symptoms after an exposure (Nickerson, et al., 2014; Thompson, Kaslow, Kingree, Rashid, Puett, Jacobs & Matthew, 2000; Yeomans & Forman, 2008). Social support therefore seems to be an effective mechanism of healing across the cultures on the globe. In the current Mole-Dagbon sample, social support was first among coping strategies and it was clear that it should always happen – irrespective of

a person's religious affiliation. In addition to social support, a visit to the soothsayer was also commonly recommended.

Soothsayers play a key role in traumatic experiences for the Mole-Dagbon. Twumasi (1996) also found this in the same region. According to the focus group a traumatised individual should be encouraged by family and the community to consult the soothsayer after traumatic exposure. From the groups' perspective, soothsayers have a connection with the spiritual world and are pivotal points of contact to facilitate understanding and healing. A quote to illustrate the importance of the soothsayer:

> "When anything we consider traumatic happens in this area. The first thing we do is to get closer to the person to give our support. We also help the person to contact the soothsayer to tell us the cause of the event. If the person is also putting up some new behaviours we don't understand, the soothsayer is the same person who will tell us where that behaviour is coming from and then he will tell the person and the family what to do. Mostly when the event is traumatic, you are given a leaf called "Mogu" which you will drink and put some in your water to bath. When you do that no event will happen to you again. If you do not see the soothsayer for him to do all these then it means you will live with your behaviour that is abnormal forever. He is the only person that can help you. Even the Christians and Muslims come to see the soothsayer and also go back to pray and do the other things their religion tell them to".

This traditional practice described in the quote above, works because it drives away spirits within and around the traumatized individual. Belief in the importance of the soothsayer is particularly salient in instances such as the death of a loved one (which was used in the vignette), but it is clear that soothsayers have a final say in terms of both the attributions and prescribed alleviation of traumatic experiences. The question may arise about the absoluteness of this power of the soothsayer and what regulating mechanisms exist within Mole-Dagbon culture to limit it. But that question was not only outside of the scope of the current enquiry, it may also be an imposition of Western thinking on a phenomenon that is not Western.

The use of the Mogu leaf was considered a universally common coping strategy among every member of the Mole-Dagbon community according to the cultural leaders. It is used irrespective of religious affiliation in the event of encountering a traumatic exposure. If the use of the leaf is considered a spiritual or religious act, one may raise questions about the mixing of belief systems. However, this collective practice of the Mole-Dagbon can be understood against the background that people can regulate their behaviour by observing others (Buck, 2010). Thus the use of a particular leaf as a means of coping has probably been adopted by almost every member of the culture (regardless of their religion) because of its effectiveness as espoused by others. In contrast, they would have likewise rejected this remedy if the consequences they observed were poor or if others did not believe in its effectiveness. The commonality of the practice as well as the fact that it is not ultimately dependent on a spiritual understanding is why this element was

labelled ‘culture’ rather than ‘religion’. The practice of consulting the soothsayer and the use of the Mogu leaf was to be augmented by counselling.

Counselling as a means of coping is the other cultural mechanism that is seen as supportive to overcome distress. Counselling in this instance does not refer to an act delivered by a registered professional. A quote from a respondent illustrates the process:

> “After you have performed all those things the soothsayer said, we encourage you to visit the Elders, Pastors and Imams of the community depending on where you feel you belong to. They will take you through counseling to know that this thing happen to other people too”.

The quote “where you feel you belong to” refers to an individual’s religious affiliation. The leaders of these affiliations (Elders, Pastors and Imams) are regarded as knowledgeable counsellors who could encourage and guide traumatised individuals in order to minimise symptoms. Similar views are found elsewhere in the continent (Okello, 2006; Wilson, 2005). This practice of engaging the services of an Elder or a religious leader according to the focus group is to be done in conjunction with the social support given and the rites or rituals prescribed by the soothsayer. These practices were indicated as key to facilitating the healing process to alleviate traumatic stress symptoms. Even though they contain religious elements, the details and content of religious counselling was not emphasised – the importance of consulting whichever religious leader was appropriate was more important. However, specific religious practices were also mentioned as important supportive factors to alleviate traumatic distress.

4.9.2 Religious Practices

A large number of people are believed to resort to religion or spirituality to aid them to deal with traumatic experiences (Chapple, Swift & Ziebland, 2011). Religion serves as an element that provides comfort, practical support and a way of making sense of traumatic experiences (Eisenbruch, 1991; Herbert & Forman, 2010; Koenig, 2005; Terheggen, Stroebe & Kleber, 2001). The current Mole-Dagbon sample recommended that Christians and Muslims should inculcate the habit of reading the Bible/Quran and engaging in prayers either individually or in a group to alleviate symptoms. From the traditional African religious perspective, if the event and its associated symptoms were linked to a supernatural influence (known by consulting a soothsayer), certain rites or rituals had to be performed to appease the gods of the land or the ancestors. The three quotes from the different respondents below illustrate the various practices among the three religions (Islam, African Traditional Religion (ATR) and Christianity) respectively:

> "The Muslims go to the mosque and pray to Allah and also read scriptures from the Quran because they believe Allah says if they have any problem, they will find solutions in prayers and the Quran.
>
> The Christians also pray to God. They pray in their rooms or go to the church. They say God listens to prayers and answers them.
>
> The traditional practice is that you must first go to the soothsayer to tell you the cause. For example if the soothsayer gets to know it is a witch, he

will find her and we will take her to the camp, you then become happy that they found the person behind your symptoms and the symptoms will also leave so you can have your normal life back".

Even though the specifics are noted here, the common theme is that you must engage in your religious and spiritual practices. The researcher had the sense that the actual religions in themselves was not that important in this recommendation. If Buddhism was a major religion in the area this might also have been recommended. The cultural practice is to consult a religious leader, even if the specific actions prescribed may be different. The principle seems to be to find a more knowledgeable and authoritative individual for guidance.

In conclusion, the culturally normed coping strategies of the Mole-Dagbon are mostly communally driven and involve accepted cultural practices as well as prescribed rituals. Although this could probably be said about many African cultures, the specifics of these adaptations do vary across cultures (Marsella, 2010). Whereas the usual cultural practice in Uganda for instance is to identify both traditional and modern care providers as sources of help, depending on what was considered to be the cause of the event (Okello, 2006), this was not the case among the present sample of Mole-Dagbon of Ghana. Irrespective of what might have triggered the event, the main sources of help recommended did not include modern healthcare providers. It was of course also noted that primarily medical/biological explanations for the symptoms were absent and this may have influenced the recommended remedies. Even though cognitive processes were

implicated as important in producing symptoms, it may be that these are to be corrected with social support and the guidance of an authoritative religious figure.

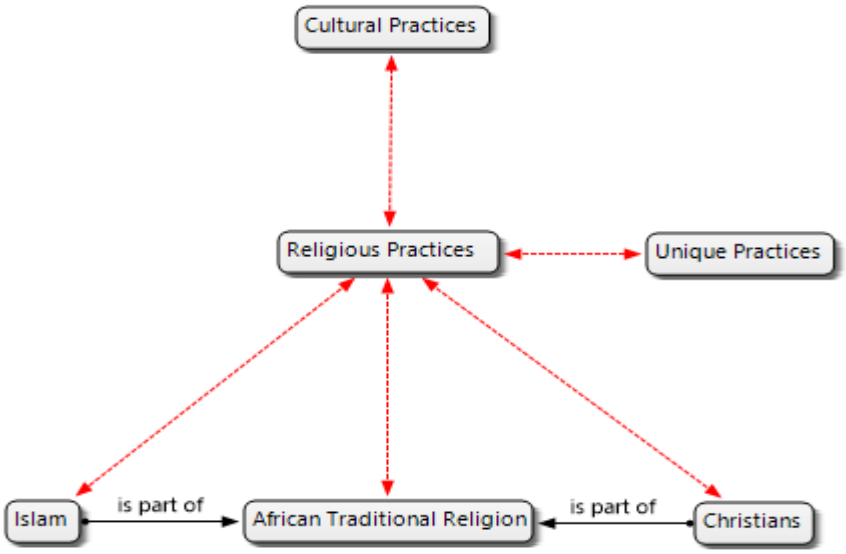
Spiritual/supernatural explanations for symptoms were more salient than other explanations and it is therefore not surprising most of the recommended remedies focused on spiritual or religious acts. An example of how understanding led to remedies can be found in the distinctive explanations of men and women regarding the overflow of the Bagre Dam. Men indicated a practical solution (avoid farming near the river) to their scientific/natural explanation and women women indicated and spiritual solution (consulting the gods of the land) to their understanding that a lack of unity was causal in the overflow. Thus the normative Mole-Dagbon view of traumatic stress symptoms coherently and logically leads to prescribed remedies. Some potential dynamics using existing knowledge on PTSD were noted above and the social and communal nature of adaptation seems to be a particularly salient positive aspect of coping. The Mole-Dagbon example once more illustrates how culture shapes traumatic experiences (Kirmayer, 2009; Theron& Liebenberg, 2015; Wilson, 2005) and how helpful cultural practices in themselves can be (Marsella, 2010; Yeomans & Forman, 2008).

4.10 INDIVIDUALLY INFORMED COPING STRATEGIES

The strategies individuals adopted to deal with the symptoms after a traumatic exposure were mostly similar to that recommended by the cultural leaders. It was noted that a few of the respondents had contact sessions with a clinical psychologist or a professional counsellor. Their traumatic symptoms were not their primary reason for seeking such help. All had other symptoms (e.g. frequent illness, high blood pressure etc.)

which prompted a visit to the hospital. This initial contact usually led to the identification of the symptoms and referral to a mental health professional. Most of the individuals had minimal professional contact with the psychologist/counsellor as they found solace in their cultural, religious and own unique ways of dealing with their symptoms. In the experience of the individuals these (non-therapy) sources of help were more important and effective than visits to the psychologist. This practice was similar to the views of the focus groups which excluded the Western perspective in dealing with traumatic stress symptoms. Similar findings have been found in other parts of Africa (e.g., Okello, 2006). The diagram below illustrates the various means that individuals used to deal with their symptoms.

Figure 11 Individual means of coping with traumatic symptoms



The illustration above shows that a number of belief systems were used in dealing with the symptoms of traumatic stress. Most individuals comfortably mixed elements

from a variety of systems, but there were few individuals who held strongly to a single religious system (usually Islam or Christianity). An interview with the man I will refer to as Jake Saviour (actual name withheld) will be used to illustrate the common processes that individuals used to cope. Jake was one of the respondents who had a full contact session with the clinical psychologist and he indicated that his high blood pressure prompted seeking help – not his traumatic stress symptoms. Jake's scenario often mixed belief systems in understanding his experiences and coping with them. These included, traditional African cultural, Islamic and Western elements. Jake relied somewhat more on Western elements possibly due to his educational background (Teacher). However, in the end he definitely leaned towards more cultural and spiritual understandings of his event as well as the coping with the symptoms. And he perceived the cultural elements to be more effective than the professional mental health assistance he received. Jake experienced significant intrusive and distressing memories, a diminished interest in significant activities and problems with concentration. These were comorbid with extremely painful headaches, high blood pressure and a sense of piercing on his skin after the death of his wife. In the following quote he recounts the role of social support from a variety of sources:

> "When she passed on, my children went to live with my mother. After the funeral, I arranged for my second and third born to come and stay with me here in Tamale because it is not good for me to stay alone. My colleague teachers, spiritual leaders and friends were also very supportive. They paid

> frequent visits before and after the funeral. They said a lot to console me and also donated money and items to support me."

It was clear during the interview that Jake experienced the support from his family and other members of his community as very positive. This kind of experience of support was noted with all respondents and all believed this manner of coping was very effective. The positive experience as well as effectiveness of social support has been noted in the literature (e.g. Dirkzwager, Bramsen & van der Ploeg, 2003; Johnson, Williams & Pickard, 2016).

While social support as a means of coping was the most commonly noted practice, religious practices were also noted as common. In many cultures, religion seems to play an important role in preventing mental health problem as well as down-regulating the symptoms after a diagnosis has been made (Herbert & Forman, 2010). Jake, for instance, identifies with being Muslim and from his perspective, praying with his Imam or on his own and reading from the Quran were other means that he thought appropriate to deal with his symptoms. In conversation with Jake, he noted:

> "What I will also say is that after her death, even though I had some dreams which were not all that bad or frightening. I consulted my spiritual leaders and they said that it was as a result of enmity, those are signs of enmity and so I should continue with my spiritual fortification so the first I did and I am still doing is praying for her and the children and I also read verses from the Quran".

This view from Jake was very similar to that of the Christian respondents. An excerpt from one of these respondents highlights the perceived importance of prayer:

> "I believe in God almighty and I know he healed me. I resorted to prayers and that is what has actually brought me this far. I have been praying so my children can get better jobs for me to stay home and not encounter anymore of these wicked individual plans"

Individuals commonly reported turning to religious practices in dealing with the symptoms that ensues after a traumatic event. The correspondence between the individual practice and that recommended by the focus groups indicates that religion seems to be a well accepted and sanctioned way for an individual from the Mole-Dagbon community to deal with traumatic stress symptoms. The potential positive role of religion in overcoming stress and mental health challenges have been noted before (e.g. Kennedy, Devis, & Taylor, 1998); Adedoyin, Bobbie, Griffin, Ahmad, Nobles & Neeland, 2016) The above examples refer mostly to the influence of Islam and Christianity, but there were examples of the use of remedies prescribed by the traditional African belief system.

And these remedies were not simply used because a person considered themselves an adherent of a specific religious orientation. All respondents identified with either Islam or Christianity respectively as their religion. However all relied heavily on the traditional African ways of dealing with symptoms after an exposure. The experiences reported by the individuals in this regard therefore aligned with that which was by the cultural leaders in the focus group discussions. Jake is not an exception in this situation. He gave

instances where he had to merge the different religious practices to deal with his symptoms:

> "I also belief in the traditional practice. When I was experiencing the headache, I consulted those who buried my wife, they performed some rituals and gave me that herbs (Mogu) to drink and also bath with it. My mother also insisted that I do as directed. By then my second wife was there so I asked one of the boys to get that for me. My mum kept reminding me that even at a point when my father died she also used it. She was so close to my father. So with the use of the leaves I believe it helped."

The experience of a Christian who had a car accident is reminiscent of Jake's own tale:

> "Well I was sent to the hospital and I stayed there close to 4 months. I gain consciousness the second month and noticed I was thinking and behaving funny. I started praying to God to heal me so that I can get home to attend to my family. I was also on medication at the hospital but some family members who visited me at the hospital suggested when I recover and discharged, there is a need for me to see a soothsayer to let me know the cause of all these. In fact an auntie escorted me to the soothsayer and low and behold I was told that a family member was behind this. However the name was not mentioned but I suspected the person and it is my brother. The soothsayer asked me to start wearing white clothes to signify victory

> and also asked me to bring a cock and he performed some rites. He gave me some leaves to boil, drink and also bath with some of the leaves and that has brought me this far".

These mixed practices as coping mechanism as indicated by the focus groups were observed from most of the individual respondents.

Individuals also had fairly unique strategies to deal with traumatic symptoms. Jake remembers:

> "Her last words to me are also a form of healing to me. She said "dada" and I responded and she said "akpanga, nkpaye" meaning Allah will help you take care of the children. Again "dada akpanga amaha" meaning dada you have done well. I am thankful Allah will help you take care of the children. Those were her last words so sometimes when I am there and reflect on the words, I imagine how the pain would have been if I had gone home before she died or went somewhere only to hear she died. Those words consoles my soul when I keep reflecting. Those words are very encouraging."

Jake's very personal experience here has led to a memory that contains a positive meaning attribution to the event. Such a positive attribution is likely to inhibit a sense of current threat and enhance the healing process (Ehlers and Clark, 2000).

A fairly common practice among the respondents that was not mentioned by the focus group was a change in environment. Jake's example is presented here:

> "I also decide to move out of this apartment and get another place. It is not good for me to stay here alone. Memories of her will keep reflecting and this will mean those symptoms could come back. I am contemplating to move to one of the school accommodation but they say first come, first serve. However I know because they are aware of my situation, they will speed up things for me to move from here".

The above coping strategy can be seen as a form of avoidance, which according to Ehlers and Clark (2000) would not work to alleviate the symptoms in the long run. Jake did not actually engage in the behaviour, but did have the common reaction of wishing to avoid triggers of the symptoms. Avoiding triggers will of course help to minimise symptoms that are cue dependent in the short term, but in the long term the avoidance will also inhibit cognitive reprocessing (van Rooyen, 2016). This manner of coping was not something that was recommended by the cultural leaders of the focus groups, which indicates that this potentially maladaptive strategy may not be an inherent cultural dynamic for the Mole-Dagbon.

Although means of coping were relatively consistent among the respondents, there were two Christian and one Muslim respondent who actively refused the traditional practices as coping strategies. According to them their only means of coping was prayers (Christians and Muslim), reading verses from the Quran (Muslim) and self-encouragement. Prayers to God/Allah has been indicated by Dyregov, Gupta, Gjestad, and Raundalen (2002) as a healing mechanism after an exposure. Reading scriptures and dependence on God was also used by African refugees in the United States to overcome

stress and mental health challenges (Adedoyin, et.al., 2016). A quote to illustrate what one respondent said:

> "As for me, I always pray, read the Quran and encourage myself. When I was visiting the clinical psychologist as part of the healing process, he noticed that I was a strong man and could cope without difficulties during therapy sessions. I was also made to see a counsellor and she also said the same thing to me. I think it is the God I serve who gave me hope that amputation does not imply end of one's life. So for me it is God and no one else".

To these respondents healing lies in communicating with God/Allah through prayers, reading authoritative religious texts and encouraging themselves. For these very religious individuals it seemed that the causes did not matter – religious activities were always the solution. Their expressed sentiments were similar to what was encountered in the Baganda of Uganda (Okello & Neema, 2007). Patients and significant others could have the causal interpretation that witchcraft caused the symptoms, but staunch religious individuals refused to look for alleviation using traditional means (Okello & Neema, 2007). Similarly here some individuals, irrespective of the cause of an event and the culturally informed means of coping, they prefer to seek help from their religious affiliation.

Although these individuals generally would not merge beliefs, they accepted the existence of cultural practices, the inclination of others to use it, and even its effectiveness.

4.11 INDIVIDUALS PERCEPTION ABOUT CULTURAL BELIEFS

Individuals' means of dealing with symptoms that result from traumatic exposure were generally closely aligned with the normative beliefs of the culture as espoused by the focus groups. Whereas there were some conceptualisations of symptoms that were reminiscent of Western attributions ('thinking too much'), Western remedies were wholly absent as strategies to alleviate symptoms. In many African countries, symptoms are often dealt with in a more traditional way and traditional healers are perceived to play a vital role in dealing with distress (van Duijl, Kleijn and de Jong, 2014; Okello, 2006). Culture has its own healing mechanism and the introduction of foreign cultural concepts may run the risk of breaking down the natural healing mechanism of a society (Dyregov, Gupta, Gjestad & Raundalen, 2016). It is imperative to understand how individuals of a particular culture use their world view, insights and therapies in dealing with symptoms after a traumatic exposure. The Mole-Dagbon culture believes in cultural practices and individuals' religious practices are considered essential in dealing with traumatic symptoms.

The individuals' practices also incorporated social and family support, religion (in the broadest sense) and unique ways of coping. Perceived social support has been demonstrated to be universally effective in dealing with symptoms after a traumatic exposure (Carlson & Dalenberg, 2000; Dirkzwager, Bramsen & van der Ploeg, 2003; Herbert & Forman, 2010; Hinton & Lewis-Fernandez, 2011; Johnson, Willaims & Pickards, 2016; Thompson, Kaslow, Kingree, Rashid, Puett, Jacobs & Matthew, 2000; Yeomans & Forman, 2008).

Religious practices (Islamic, Christianity and Traditional) were also widely practiced as a coping strategy. Religion is found to be a powerful tool in combating distress after traumatic exposure (Eisenbruch, 1991). Religion has the potential of decreasing physical and mental illness and also enable traumatic victims adjust to the ensuing symptoms (Herbert & Forman, 2010; Kennedy, Devis & Taylor,1998). The Mole-Dagbon culture to an extent tolerates a number of different belief systems, but indicates that the religious practices of an individual is essential in coping with symptoms from traumatic exposure. Religion can serve as a positive basis for integrating cognitive and sensory data resulting from traumatic experiences (Peres, Moreira-Almeida, Nasello & Koenig, 2007). Thus individuals seek for reasons and solutions to traumatic experiences based on their religion. The unique practices of various religions, were also observed to have been merged in effecting coping and most Christians and Muslims incorporated some aspect of the traditional religious practices.

An interesting facet of general coping strategy was the belief in the soothsayer to deal with traumatic symptoms by performing rituals to determine the causes of the event and symptoms and then to prescribe ways of dealing with the symptoms. Soothsayers according to the Mole-Dagbon have links with spiritual world and serve as mediators between the human and the supernatural. They are in most instances perceived as traditional healers with useful insights and therapies for supernatural causation. Other authors had similar findings elsewhere in Africa (e.g., Okello, 2006). This belief was very prevalent amongst the focus groups as well as the individual respondents. The frequency of occurrence of the soothsayer's role in understanding and treating traumatic stress

symptoms therefore seems to be very prominent in Mole-Dagbon culture. The mention of the leaves often used by the soothsayer was also widely practiced by most people regardless of their religion.

Although the cultural leaders believed in the above practices as the only means of coping, it was also noted that individuals have their unique ways that helped them in dealing with traumatic symptoms.

In conclusion, the findings from the study confirms the notion that cultural practices both shape the behavior and interactions of people and provide a context for understanding the world surrounding of groups and individuals (Theron & Liebenberg, 2015). In the current example there were some differences between individual experiences and what the culture indicated, but for the most part (and especially in terms of the coping strategies) there was agreement between what cultural leaders and individuals indicated.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

The aim of the final chapter is to provide a concluding discussion of the results that were presented in the previous chapter and to shed light on the strengths and limitations of the study as well as making recommendations for the future. The study explored the cultural understanding of traumatic events, symptoms and consequent coping strategies of the Mole-Dagbon of Ghana. More precisely, the study aimed:

- To explore and describe the culturally informed conceptions for traumatic events among the Mole-Dagbon in Ghana,
- To explore and describe the culturally informed conceptions of post traumatic symptoms among the Mole-Dagbons of Ghana,
- To explore and describe the incorporation and nature of culturally informed coping strategies adopted by Mole-Dagbon individuals to deal with the symptoms of traumatic events.

The results have been presented in the previous chapter.

5.1.1 Discussion of results

One of the most striking features of the current research was about the focus of the Mole-Dagbon when it comes to traumatic experience. Respondents very easily commented on how to cope with traumatic events and their symptoms, but there did not

seem to be a natural inclination to think about attributions for these phenomena. It is therefore also not surprising that the greatest degree of congruence between the focus groups and individuals were found on the coping aspects rather than causal attributions. Western models of understanding from the cognitive tradition relies heavily on the individual interpretation of events and symptoms. While the researcher is not arguing that eventually such meanings and interpretations are unimportant, but with the Mole-Dagbon they do not seem to be that important on an individual level. Much attribution is left to authoritative figures in the community and it seems as if meaning making is much more of a communal than individually driven effort. The foremost of authoritative figures is the soothsayer, but various religious figures also seemed important in this process. What this process of communal meaning making may mean in terms of PTSD is equivocal. On the one hand individuals may find comfort in the fact that an answer is available and that a remedy will be provided by an authority, but on the other hand this does mean that personal agency and control is undermined. In the experience of the Mole-Dagbon this personal agency in generating understanding was not that important, and it may be enough that there are communal mechanisms of creating meaning via the spiritual and religious leaders of the community.

In the explanatory framework of the Mole-Dagbon culture a variety of explanations for traumatic events were possible. To a great extent traumatic events were thought to be under the control of human action. Sometimes the dynamic was explained as a natural or scientific one, but human agency also to a great extent influenced the workings of most supernatural forces. On the other hand, explanations for random and unpredictable

misfortune could often be attributed to witchcraft, and often witchcraft dynamics included motivations of malice and jealousy. It seems as if there is little one can do to prevent such acts although allusion was made to acts that could be taken once one suspected the workings of a witch. In terms of current Western cognitive understandings of PTSD witchcraft as an explanation creates a framework where random traumatic events are possible – this is generally not considered a helpful framework. However, it must be noted that the current study did not go into depth in terms of the mechanisms of witchcraft and the rules that may govern a more predictable pattern. It may be that the societal figure of the soothsayer provides some kind of predictability here. Even though 'these witches can do anything' at least the soothsayer will know what to do. The exact understanding of the mechanisms of witchcraft and the influence of such mechanisms on PTSD is something that would be fruitful future study.

In terms of the traumatic symptoms, both natural and supernatural explanations were offered as attributions. The natural explanations centered on human thought processes such as "*thinking too much*", having memory problems and being confused. To some degree the focus groups expressed the sentiments that the symptoms were under the control of individuals, but the traumatised indviduals did not experience their symptoms in this manner. This was especially true in terms of supernatural attributions of the symptoms. The focus groups also attributed traumatic symptoms to the mixing of beliefs by indivividuals. While the mixing of beliefs were prominent amongst the individual respondents, none of the individuals attributed their own symptoms to the mixing of belief systems.. Different systems of belief shaped their understanding of the symptoms and

there did not seem to be much experience of incongruence on the part of the individual respondents. It seems as if a great deal more agency in producing symptoms was assigned by the focus groups to the individuals than were actually experienced by the individuals. This difference in experience may be a helpful avenue to explore in terms of the social support that is provided by victims. The authoritative figures that may provide support victims may not fully appreciate the phenomenology of experiencing symptoms that are automatically produced. Witchcraft was again implicated as a cause of symptoms and it seemed as if part of the purpose of such witchcraft would be to bring shame to the individual.

The coping strategies that the current sample of Mole-Dagbon described revolved around communal processes. Social support by community and family members were by far the most consistent and universal strategy that was described. The soothsayer was a central figure in the process in terms of understanding and providing the means to rid oneself of symptoms. In addition, a variety of religious practices were considered important. It was also quite clear that individuals drew from a variety of belief systems in terms of coping strategies, but the traditional African remedial processes were considered central – even if their purpose was languaged somewhat differently by individuals. In terms of existing understandings, the cognitive attributions of symptoms did not seem to translate directly into remedies. In summary there was also a great deal of deference to individuals that could be seen as custodians of a variety of belief systems. If one were to design intervention strategies from a mental health perspective, one would need to

consider the central role of these custodians as Western medicine was not mentioned as an option of coping – even by those who had been exposed to it.

In the end one of the most worthwhile contributions of the study was that it used a triangulated method which revealed the manner in which individuals incorporated cultural information in their understanding of PTSD and how to cope with it. While there were a great deal of commonality, there were also some differences which clinicians would need to consider when dealing with the Mole-Dagbon.

5.2 LIMITATIONS

Like all studies, the current study has various limitations that need to be acknowledged. Qualitative are useful for some investigations and particularly in trying to understand how individuals make sense of phenomena. But they usually use non-probability sampling and therefore cannot be generalizable in a quantitative sense. It is also very likely that the sampling process introduced some bias and that the cultural leaders may have promoted a particular viewpoint. the fact that there was a great deal of congruence between the focus groups and individuals alleviates some of this concern, but in the final analysis the sampling strategy would need to be considered by other authors to judge how transferable the knowledge is to their own contexts.

5.3 RECOMMENDATION FOR FUTURE RESEARCH

This study was exploratory in nature. Although some hypothesis were offered in terms of the dynamics that could contribute to PTSD, future studies could be designed to fully explore the implications of understandings around witchcraft or different cognitive

attributions for symptoms. One avenue that specifically needs more attention is the communal nature of coping that relies heavily on soothsayers and religious figures. The current study demonstrated that this is a feature in the Mole-Dagbon society, but the dynamics are not that well understood.

It was also quite clear throughout that juxtaposing the culture of the Mole-Dagbon against Western traditions provided useful information for consideration and future studies could include comparative samples.

It is almost needless to say that the intricacies of understanding presented in the previous chapter would need to be considered in any kind of treatment strategy designed for or presented to the Mole-Dagbon. While the current researcher is not arguing for a complete acceptance that everything that is culturally informed is necessarily helpful, one cannot ignore these features as they exist.

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7. APPENDICES

APPENDIX A

Appendix A: DSM-5 Diagnostic Criteria for PTSD

(American Psychiatric Association, 2013)

A. Exposure to actual or threatened death, serious injury, or sexual violence, in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).

2. Witnessing, in person, the event(s) as they occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s).

Note: In children, there may be frightening dreams without recognisable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific re-enactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

3. Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behaviour.

3. Hyper vigilance.

4. Exaggerated startle response.

5. Problems with concentration.

6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalisation: Persistent or recurrent experiences of feeling detached from and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. Derealisation: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

APPENDIX B

Appendix B: Information Letter (Individual Interview)

Dear Participant, Date:

My name is Sandra Thompson. I am conducting a research that is aimed at acquiring a clearer understanding of the culturally informed meaning a Mole-Dagbon individual assigns to traumatic experiences, its outcome and how the individual manages to cope with these experiences.While there is no direct benefit to yourself, the information produced can be used by mental health care providers to design helping projects for individuals that have been through experiences such as yours.

You are being asked to take part in an interview that will take about one hour (at a time and place that is convenient to you). Any information given during the interview will be kept completely confidential (no one outside of the research team will be able to see your information). There are no risks involved in the kind of questions that will be asked, but you will be asked to talk about your understanding and way of coping of your own traumatic event. Should you feel uncomfortable in continuing, you may stop the interview without any penalty whatsoever. If needed, you will be provided with information of someone that will be able to assist you with any strong feelings.

Please do not hesitate to ask the interviewer anything about this letter that is unclear. Should there be any questions, please do not hesitate to contact me. I can be reached at 0244603598 or s214053733@nmmu.ac.za. Alternatively you can also contact Dr. Wiafe-

Akenten (Primary Responsible Person, University of Ghana, Legon) at 0244632756; wabrenya@ug.gh. The ethics clearance number for this study is H15-HEA-PSY-029.

Yours sincerely

…….

Sandra Thompson

Researcher

(Principal Investigator)

Mr. Kempie van Rooyen

Supervisor

(Primary Responsible Person, NMMU)

APPENDIX C

Appendix C: Information Letter (Focus Group)

Dear Participant, Date:

My name is Sandra Thompson. I am conducting a research that is aimed at acquiring a clearer understanding of the culturally informed meaning Mole-Dagbon individuals assign to traumatic experiences, its outcome and how the individual manages to cope with these experiences. While there is no direct benefit to yourself, the information can be used by mental health care providers to design helping projects that are more culturally informed.

Information will be solicited from individuals who are members of the Mole-Dagbon community and have the relevant cultural knowledge (such as yourself). If you do agree to take part you will be involved in an hour group based (with approximately 9 other individuals) discussion that will ask you about the Mole-Dagbon view of traumatic events, how experiences after the event are understood and how they should be managed. This discussion will be conducted at a time and place that will be arranged with you telephonically (should you agree). Information given during the discussion will be based on your general knowledge - you will not be asked to reveal your personal experiences. There are no risks involved in the kind of questions that will be asked. However, should you feel uncomfortable in continuing, you may stop the interview without any penalty whatsoever.

Please do not hesitate to ask the facilitator anything about this letter that is unclear. Should there be any questions, please do not hesitate to contact me. I can be reached at

0244603598 or s214053733@nmmu.ac.za. Alternatively you can also contact Dr. Wiafe-Akenten (Primary Responsible Person, University of Ghana, Legon) at 0244632756; wabrenya@ug.gh. The ethics clearance number for this study is H15-HEA-PSY-029.

Yours sincerely

…….

Sandra Thompson
Researcher
(Principal Investigator)

Mr. Kempie van Rooyen
Supervisor
(Primary Responsible Person, NMMU)

APPENDIX D

Appendix D: Informed Consent Form (Individual Interview)

I, _____, hereby give consent to take part in a study that is aimed at acquiring a clearer understanding of the culturally informed meaning Mole-Dagbon individuals assign to traumatic experiences, the symptoms afterwards and how the individual manages to deal with the outcome of those experiences. I understand that I will be asked questions about my experiences of my own traumatic events and the ways I have coped.

The information below has been relayed to me prior to the interview and I have had the opportunity to ask questions;

1. My decision to take part in the study is voluntary and I can withdraw at any time (even in the middle of the interview should I choose so).

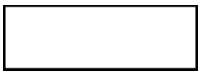
2. My responses will be recorded with an audio recorder, but my name will not be used in any publications that may arise from this study.

3. Should I experience any unease emotions during the interview, the researcher has provided details of a Psychologist at the Tamale Teaching Hospital to provide counselling services.

4. Information revealed during the research is entirely confidential and will not be released to anyone that is not a part of this research project specifically.

5. I would like to have a feedback of the outcome of this study:

Yes ☐ No ☐

Participant code: 

Name: _____ Telephone number: _____

E-mail address: _____

(These details are only to be used by the researcher in order to make contact with those who require feedback. It will not be used for any other purpose.)

_____ _____

Signature/Thumbprint of participant Date

_____ _____

Signature of Researcher Date

APPENDIX E

Appendix E: Informed Consent Form (Focus Group Interview)

I, _____, hereby give consent to take part in a study that is aimed at acquiring a clearer understanding of the culturally informed meaning Mole Dagbon individuals assign to traumatic experiences, the outcomes of these experiences and how individual manages to deal with the outcome of those experiences. I understand that I will be involved in a group discussion where questions about Mole-Dagbon culture's conceptualisation of traumatic events, the understanding of the experiences afterwards and the prescribed coping mechanisms to deal with these experiences, will be discussed.

The information below has been relayed to me prior to the discussion and I have had the opportunity to ask questions about the study;

1. My decision to take part in the study is voluntary and I can withdraw at any time.
2. My responses will be audio recorded, but my name will not be used in any publications that may arise from this study.
3. All responses are based on general cultural knowledge and not my personal experiences. However, the researcher has provided details of a Psychologist (Dr. Edward Abasini) at the Tamale Teaching Hospital to provide counselling services should it be necessary.
4. I would like to have a report on the outcome of this study:

Yes No

Participant code: ☐

Name: _____ Telephone number: _____

E-mail address: _____

(These details are only to be used by the researcher in order to make contact with those who require feedback. It will not be used for any other purpose.)

_____ _____

Signature/Thumbprint of participant Date

_____ _____

Signature of researcher Date

APPENDIX F

Appendix F: Demographic Characteristics

1. Age:……..

2. Sex: Male Female

3. Educational Background:

   a. Up to J.H.S ☐

   b. Intermediate: S.H.S ☐ Technical ☐ Vocational ☐

   c. Tertiary: University ☐ Polytechnic ☐ Training ☐ College ☐

   d. Post Tertiary ☐

4. Marital Status: Single ☐ Married ☐ Divorced ☐ Cohabiting ☐

The section below only needs to be completed by participants of focus groups.

5. I am a / an…….

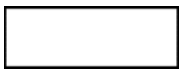
   a. Chief ☐

   b. Sub chief ☐

   c. Cultural leader ☐

   d. Influential leader ☐

For administrative use: Participant Code:



APPENDIX G

Appendix G: Individual Interview Schedule

1. I would like to explore with you your personal understanding of your traumatic event. There are no right or wrong answers – I would like to know your own story. Can you tell me why you thought that <insert traumatic event> happened to you?

   I have had interviews with cultural leaders on what causes traumatic events **[Provide some answers provided by cultural leaders]**. Your personal experience is more important to me than these answers, but I would like to also know what you think about these answers? [Note to interviewer: explore why the individual has incorporated or not incorporated these views]. That's very interesting, why do you think you have/have not ascribed to these views?

2. What are the symptoms or changes you experienced after an encounter with a traumatic event? These can be anything that was different in the way you felt or thought or behaved after <insert traumatic event>. How do you understand these changes? Where do they come from?

   I have had interviews with cultural leaders on what causes these kinds of experiences **(provide some answers provided by cultural leaders)**. Your personal experience is more important to me than these answers, but I would like to also know what you think about these answers? [Note to interviewer: explore why the individual has incorporated or not incorporated cultural views]. That's very interesting, why do you think you have/have not ascribed to these views?

3. How did you cope with the symptoms of these traumatic events? I am referring to the ones that we have just discussed. [Note to interviewer: ask about specific symptoms that were mentioned] How did you cope with or manage <insert symptom>?

   I have had interviews with cultural leaders on how one should cope with these kinds of experiences **(provide some answers provided by cultural leaders)**. Your personal experience is more important to me than these answers, but I would like to also know what you think about them. [Note to interviewer: also explore why the individual has incorporated or not incorporated cultural views]. That's very interesting, why do you think you have/have not ascribed to these views?

APPENDIX H

Appendix H: Focus Group Interview Schedule

In this region, there have been events such as **(list of traumatic events)** and when we talk of traumatic events, we are referring to events that can lead to serious damage or harm and even the death of individuals.

1. In terms of Mole-Dagbon culture, why do these events happen? What are the reasons for these events?

The following two discussion points are based on the description below. [The facilitator reads out the vignette]

A 28 year old woman lost her daughter in a car accident. Afterwards, she complains of flashbacks (she feels like she is back in the car accident and sees visions of the event), She also acts helplessly – she seems to doubt herself and her ability (especially her ability to drive). She has distressing dreams and nightmares almost every night – the dreams aren't always about driving in a car, but they usually involve someone getting hurt badly or dieing. She also seems to think and feel differently: she seems down and like she has no energy, she does not seem to trust strangers as she used to. She does not interact with her family and friends as she used to and doesn't engage in the usual social interactions. Sometimes she just sits staring out into space. At other times she seems very irritable and short tempered and becomes very angry over small things. She has tried to overcome this symptoms on her own but it has been largely unsuccessful.

2. According to the cultural perspective of Mole-Dagbon, where are these symptoms coming from? Why is this person having the experiences that she is having?

3. In terms of the cultural understanding of the Mole-Dagbon, what must she do to overcome these symptoms?

4. Why do you think some members of the community believe and adhere to these mechanisms whereas others do not?

APPENDIX I

Appendix I: Verbal Information for Approaching Identified Potential Participants

Good Morning,

My name is Sandra Thompson. Am I speaking to **<name of selected participant>**? <Name of gatekeeper> has indicated that he has spoken to you and that you may be able to assist in a study that I am conducting. Do you have a few minutes to talk? [Continue upon acknowledgement]. I am a Ghanaian and a first year Masters student of Nelson Mandela Metropolitan University (NMMU). I am about to conduct a research aimed at acquiring a clearer understanding of the culturally informed meaning individuals assign to traumatic experiences, the things people experience after such events and how they cope with them. It is mainly for academic purposes and any information revealed will be entirely confidential.

I would like to arrange for a mutually convenient date and time to give you further details of the study and to possibly interview you (should you agree). Will you be willing and available to arrange such a time? **[If the response is the affirmative, the date, time and venue will be arranged.]**

Thank you