THE RELATIONSHIP BETWEEN POSTTRAUMATIC STRESS DISORDER AND ALCOHOL USE: A QUALITATIVE STUDY OF OUT – PATIENTS IN THULAMELA HOSPITALS IN VHEMBE DISTRICT MUNICIPALITY OF LIMPOPO PROVINCE

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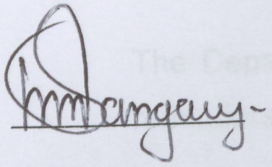
DECLARATION

I, Leslie Manganye hereby declare that the dissertation for the Master of Arts degree at the University of Venda, hereby submitted by me, has not been previously submitted for a degree at this or any other university, that it is my own work in design and in execution, and that all reference material contained therein has been duly acknowledged.



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DEDICATION

This dissertation is lovingly dedicated to my parents Mr Samson Manganye and Mrs Malehu Josephine Makutudise and my son Rhulani Manganye who have been my constant source of inspiration. They have given me the drive and discipline to tackle any task with enthusiasm and determination. Without their love and support this dissertation would not have been possible.

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Abstract

Posttraumatic Stress Disorder (PTSD) is a risk factor for alcohol use and in turn has been independently associated with increased health problems. PTSD is a serious and disabling disorder that is commonly seen in primary – care setting. Many people experience a traumatic event at some point in in their life, however, not all individuals who experience a trauma event eventually go on to develop PTSD. Being diagnosed with PTSD increases the risk of developing an alcohol use disorder. Alcohol use is known to be a major factor affecting the incidence of traumatic injury. PTSD does not automatically cause problems with alcohol use because there are many people with PTSD who do not have problems with alcohol. However PTSD and alcohol together can cause serious troubles for the trauma survivor and his or her family. PTSD symptoms are often worsened by alcohol use. Although alcohol can provide a temporary feeling of distraction and relief, it also reduces the ability to concentrate, enjoy life, be productive, and is associated with chaotic lifestyle which reduces family emotional closeness; on the other hand it increases family conflicts, and reduces parenting abilities.

The main aim of the study was to investigate the relationship between PTSD and alcohol use among PTSD out- patients.

This study used a qualitative approach. A phenomenological research design was used for the study because I wanted to understand and interpret the meaning that respondents give to their everyday experiences of a phenomenon. The study was conducted in Thulamela Municipality of the Vhembe District Municipality in Limpopo Province. The population comprised of out-patients receiving treatment for PTSD from the three hospitals in Thulamela Municipality. A sample size of ten (10) PTSD out-patients, who use alcohol, I were randomly selected through purposive sampling.

Data was gathered through a structured face – to – face interview and respondents were encouraged to use their mother tongue in order for them to participate freely. Individual interviews were conducted outside the respondents' respective hospitals. Tshivenda and Xitsonga were used to conduct the interviews and data was transcribed, and was later translated into English. An interview guide was used as an instrument to collect data and this contained nine (9) open-ended questions. Data gathered was analysed through the five stages of content analysis. Ethical

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consideration was observed to ensure that respondents were well informed and protected against potential harm.

The findings of this study show that respondents were exposed to different traumatic events which included motor vehicle accidents, sexual assaults, robbery, rape, seeing someone getting hurt and killed, and fire. Most of these events were found to be individual traumas hence reactions to these exposures were different from one respondent to the other. Respondents reported that they have intrusive, avoidance and hyperarousal symptoms.

Findings of the study have revealed that some of the respondents were sexually abused while they were still young and this has resulted in them feeling weak or even worthless, and a shame-based sense of self has developed in these respondents. Respondents indicated that they were not only exposed to a single event but multiple events that led to the development of PTSD. Respondents on this study were found to have increased their drinking pattern following trauma exposure and the main intention for this behaviour was to cope with their overwhelming experiences.

The study also revealed that respondents' occupation and other areas of functioning were also affected. For example, productivity at work, performance at school, and socially they have become withdrawn. Self-medication through alcohol use was found therefore to be the main defence used to deal with these painful experiences by respondents. Data collected also revealed that respondents have used other ways of dealing with these experiences.

The study had a few limitations that would limit generalization of the findings: one is that respondents were drawn from a single geographical location which is Thulamela Municipality and also that the study included respondents who were suffering from both acute and chronic PTSD.

Based on the findings of the study, the following recommendations were made: establishment of wellness programmes at workplace, educating people about the basic symptoms of PTSD and awareness campaigns on alcohol use, treatment of both psychological and physical health symptoms, need for training of educators, treatment of trauma respondents, and Urine test.

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List of Acronyms

APA	-	American Psychiatry Association
ASD	-	Acute Stress Disorder
CAM	-	Complementary and alternative medicine
DHSD	-	Department of Health and Social Development
DSM-IV-TR	-	Diagnostical Statistical manual of Mental Disorders
FDA	-	Food and Drug Administration
GDP	-	Gross Domestic Product
HIV	-	Human Immunodeficiency Virus
MVA	-	Motor vehicle accident
NCCAM	-	National Centre for Complementary and Alternative Medicine
NGO	-	Non-Governmental Organization
PTSD	-	Posttraumatic Stress Disorder
SSRT	-	Selective Serotonin Reuptake Inhibitor
USA	-	United States of America
WHO	-	World Health Organization

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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction and Background

Trauma is an event outside normal human experience and it generally leaves one feeling powerless, helpless, and paralyzed. It tends to be sudden and overwhelming, completely owning the victim. One cannot think clearly during and after a severe trauma; at the same time, one is forced to be conscious in an attempt to deal with the situation. There is a one-time trauma, which arises from events such as, natural disasters, rape, assault, mugging, robbery, accidents and fires. There is also a prolonged trauma, arising from physical or sexual abuse experienced as a child or spouse, war, hostage situations or life as a refugee. Both types of trauma are capable of causing Posttraumatic Stress Disorder (PTSD). Africa is a continent with sources of different severe trauma such as child soldiers, people living in war and conflict zones, and people struggling with the HIV and AIDS pandemic. These events cause high levels of trauma (Van Dyk & Van Dyk, 2010). People respond differently to traumatic events since they occur in varying degrees.

Green (1996) and Bowley, Rein, Cherry, Vellema, Snyman, and Boffard, (2004) indicate that the effects that trauma have on a person may be emotional, cognitive or physical. People who experience or have experienced a traumatic event often initially respond with shock and denial, they do not believe that it is happening or it has happened to them. They then become extremely anxious and insecure, they find it difficult to think and concentrate because of confusion. What worsens their situation are the memories they constantly have about the event which intrude on everyday living.

Trauma is a major cause of mortality and morbidity. There is a growing awareness among health-care providers that traumatic experiences are wide-

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spread and that it is common for people who have been traumatized to develop medical and psychological symptoms associated with the experience. Victims of trauma related to physical and sexual assault face a great risk of developing PTSD. The American Psychiatry Association (APA), (2000) defines PTSD as a disorder which develops after someone is exposed to an extremely traumatic event. Steyn, (2009) adds that the symptoms of PTSD include significant distress and social impairment which are caused by the consistent re-experience of the traumatic event. The victim reacts to the event with intense fear, horror and helplessness. Women are about twice as likely to develop PTSD as men, perhaps because women are more likely to experience trauma that involves types of interpersonal violence, including rape and severe beatings. Victims of domestic violence and childhood abuse are at tremendous risk of developing PTSD (Waller, 1988).

Waller (1988) and Ozer, Best, Lipsey, and Weiss, (2003) state that PTSD is a complex disorder that is often misunderstood. It may develop following exposure to extreme trauma such as a terrifying event or an ordeal witnessed or learned about, especially one that is life threatening or causes physical harm. The experience causes the person to feel intense fear, horror or a sense of hopelessness. Although exposure to traumatic events does not automatically result in PTSD (Joseph & Linley 2008), exposure to traumatic events is a prerequisite for the diagnosis of PTSD (American Psychiatric Association, 2000).

According to Maull (1982), many people who experience an extremely traumatic event go through an adjustment period following the exposure. For some people; a traumatic event changes their views about themselves and the world around them; the experience may lead to an inability to cope and function productively in their daily lives. They may become so distressed by memories of the trauma and it would seem as if those memories will never go away. These people then try to avoid any reminders of what had happened to them Thus, for these people, getting beyond the trauma and overcoming PTSD requires the help of a

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professional. In some cases, lack of effective ways of coping and dealing with trauma may lead to alcohol use or abuse. On the other hand, problematic alcohol use may in turn lead to exposure to traumatic events. However, because of definitional and methodological difference across alcohol and trauma studies, it is difficult to obtain precise estimates of alcohol's role in trauma events. Roizen (1988) reviews emergency room studies and found that between twenty to thirty seven percent of all emergency room trauma cases involve alcohol use.

Waller (1988) estimates that between 20 and 25 percent of all people hospitalized with an injury have an identifiable drinking problem or alcoholism. Some physicians view trauma as an indicator of alcohol abuse and alcoholism (Abrams, 1986). This study focused on alcohol use by posttraumatic stress disorder patients in an attempt to find the relationship between posttraumatic stress disorder and alcohol use and identify the coping mechanism being used by the patients to deal with the situation.

1.2 Problem statement

Alcohol is used by many people all over the world. It is mostly preferred during celebrations where for most people it becomes a source of socialisation. Alcohol consumption is acceptable until it is misused because of its negative impact on people's lives. Men abuse alcohol more than women and any person's misbehaviour when under the influence of alcohol disrupts lives. Men with alcohol use disorders tend to be also abusive towards their partners and children. The abuse may be physical, sexual or emotional (Evans & Sullivan, 1995). Pingo and Seedat (2009) and Evans and Sullivan, (1995) indicate that women and children, who are the victims of domestic violence due to problematic alcohol use by their husbands or fathers, tend to develop trauma. Depending on the severity of the trauma or domestic violence, the victims may even suffer from PTSD. Ironically, a traumatic experience such as rape, natural disaster or kidnapping may also lead to the use or misuse of alcohol as a coping mechanism. Bowley, Cherry, Vellema, Snyman and Boffard (2004) state that alcohol use in PTSD

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patients has been shown to predict increasing injury severity, higher numbers of adverse events, and the presence of multiple injuries. Alcohol use increases the risk of all types of injury by impairing motor skills, reaction time and judgment (Yaghoubian, Kaji, Putnam, De Virgilio, & De Virgilio, 2009). Independent of the negative effects of trauma exposure and PTSD, alcohol use itself is also associated with increased risk for both acute and chronic health consequences, including injuries, cancer, stroke, and coronary heart disease (Rehm, Gmel, Sempos & Trevisan, 2003; Rehm & Monteiro, 2005; Room, Babor, & Rehm, 2005). Excessive alcohol consumption can cause physical and mental health problems and can lead to traffic accidents, falls, fires and violence. Alcohol-related injuries are serious compared with other diseases and are responsible for economic loss due to lost productivity. Setlalentoa, Pisa, Thekisho, Ryke and Loots, (2010) state that the use of alcohol may have psychological and social effects, for example, violence and crime, sexual risk behaviors, family disruption, and low performance at work. The following are other risks associated with alcohol use:

Psychological effects

Alcohol use could lead to stress and anxiety. This could cause individuals to increase their dosage in order to cope with their problematic situations, only to experience the same disillusionment when the effects wear off. Bezuidenhout, (2004) state that some people may experience stress and anxiety due to alcohol use and it could be because of personal problems or failure to control their drinking. If not attended to in such a situation, he or she might commit suicide (Mallet, Rosenthal & Keys, 2005).

Family disruption

The function of a family, as a system, is to provide shelter as well as emotional, economic and psychological support. But when one member uses or misuses

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alcohol, the family becomes destabilized or its balance is affected. Money that should be used for the family is misused on alcohol and this could contribute to violence and poverty. Relationships are affected because the perpetrator when under the influence of alcohol is not able to care and love. Excessive intake of alcohol could also lead to divorce, affecting the partners, who have to go through emotional traumatic experience and adjustments, which could be social, economic and sexual, as well as children who might have difficulty in dealing with separation and divorce. Setlaletoa et al. (2010) state that it also exposes children to anti-social behaviours since parents became negative role models. Homelessness and alcohol use have similar roots causes, namely, stress at home, workplace or school. Family conflict, violence and abuse are critical factors for both experiences. In a study conducted in Australia, one quarter of the sample under investigation indicated that familial drug and alcohol use was critical factor that have resulted in children leaving home (Mallet, Rosenthal & Keys, 2005).

Risky Sexual behavior

A study conducted by Morojele, Kachiengla, Mokoko, (2006) confirms that heavy alcohol consumptions is a major health concern in South Africa and that there is a link between alcohol consumption and risky sexual behaviour. The study also revealed that there were high levels of alcohol consumption and unprotected sex among people who engaged in casual relationships. Alcohol use is prevalent in South Africa and it may be associated with a higher risk of Human immunodeficiency virus (HIV) transmission.

Economic cost and injuries

The annual economic cost of alcohol use or misuse in South Africa could range between 0.5% and 1.9% of the Gross Domestic Product (GDP). These figures are based on the utilization of middle-of-the-range estimate that considers costs associated with treatment, trauma, mortality and crime which is about 1% of GDP

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(Setlalentoa et al., 2010). This translates to about R8.7 billion per year, an amount almost exceeding twice what is received in excise duties on alcoholic beverages in a period 2000/01, (Department of Social Development, 2007). Motor vehicle crashes in the country also account for approximately 11 deaths per 100 million kilometres travelled. Car crashes that involve pedestrians account for about 40% of annual mortality on the roads in South Africa. Alcohol use/misuse and poor roads are cited as the main contributing factors (Brysiewicz, 2001).

Historically, alcohol consumption contributed towards the strengthening of socio-cultural fibre of African communities. Alcohol was regulated by social rules and used in moderation, however with time the pattern has changed. The use of alcohol today poses a major threat to the quality of life of many South Africans, ultimately causing detrimental public health effects on the country. Alcohol use/misuse has become an everyday reality that directly or indirectly impairs peoples' lives, not only individually but also on familial, societal and national levels (Parry & Bennets, 1998).

1.3 Significance of the study

It has been discovered that some of the PTSD patients use alcohol as a way of coping which rather worsens their condition. Alcohol consumption increases the risk of all types of injury by impairing motor skills, reaction time and judgment. PTSD respondents who use alcohol tend to also experience family conflict, reduction in family emotional closeness, and parenting abilities. The findings of this study will help greatly in the generation of knowledge on whether or not there is a link between PTSD and alcohol use, patterns of alcohol use and also the effects of alcohol on PTSD. Furthermore, this study will identify traumatic experiences which are likely to cause people to drink alcohol excessively. The findings will also provide guidance for policy makers, such as the government, and non-governmental organizations (NGO), to come up with strategies to minimize the use of alcohol by PTSD patients. Through the recommendations

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from the study, the findings will also help health professionals to manage PTSD cases more effectively as they will be able to make informed decisions.

1.4 Aim and objectives

The aim of this study was to investigate the relationship between PTSD and alcohol use among PTSD out- patients.

The study was guided by the following objectives;

- To explore traumatic events experienced by out - patients suffering from PTSD;
- To explain the relationship between trauma and alcohol use among out-patients;
- To identify the types of beverages containing alcohol and patterns of use by the patients;
- To identify patterns of alcoholic use by the patients;
- To describe effects of alcohol on out-patients suffering from PTSD; and
- To explain the coping mechanism used by PTSD out-patients in dealing with traumatic experience.

1.5 Research questions

1. Which traumatic events did the patients experience?
2. What experiences did PTSD patients have after exposure to traumatic event?
3. What are the types of alcohol beverages that PTSD patients use?
4. What are the effects of alcohol on PTSD patients?
5. What is the relationship between traumatic experience and alcohol use?
6. What coping mechanisms do PTSD out-patients use?

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1.6 Delimitation of the study

The study will focus only on respondents who suffer from PTSD, who speak Tshivenda or Xitsonga, and receive their primary health services in selected hospitals in the Thulamela Municipality of the Vhembe District Municipality.

1.7 Definition of concepts

Alcohol

In this study alcohol refers to a chemical substance which when taken can stimulates ones mood and if consumed excessively or abused can cause intoxication and dependency or alcoholism

Patient

Patient is a person who is under medical care or treatment.

Out-Patient

An out – patient is a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment.

Posttraumatic Stress Disorder

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR), (1994) defines PTSD as an anxiety disorder currently defined by the coexistence of three clusters of symptoms persisting for more than one month in survivors of a serious traumatic event. These clusters are:

- Intrusive cluster: Intrusion can take the form of repeated, unwanted and uncontrollable thoughts of the trauma and can include nightmares and/or flashbacks.
- Avoidant cluster: These symptoms consist of the person's attempt to reduce exposure to people or places that may elicit memories of the

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event. This also involves symptoms such as social withdrawal, emotional numbing and sense of loss of pleasure.

- Hyperarousal cluster: This refers to physiological signs of increased arousal, such as hypervigilance or increase startle response.

In this study PostTraumatic Stress Disorder refers to any psychiatric condition that develops after exposure to a traumatic event.

Trauma

Trauma is a psychologically distressing event that is outside the range of usual human experience (Perry, 2006). He continues to say that trauma often involves a sense of fear, terror and helplessness. In this study trauma refers to an emotional event or shock that creates substantial lasting damage to one's psychological development.

1.8 Conclusion

This chapter presented the background and the problem statement regarding alcohol use. It outlined the main aim and the objectives and highlighted the significance of the study. Delimitation of the study was also highlighted and different relevant concepts have been defined. The next chapter presents a review of relevant literature.

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CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This study will review current and relevant information on trauma, PTSD and alcohol use. The literature will review factors causing trauma, symptoms associated with trauma, effects, treatment of trauma and coping mechanisms. The literature will continue to review Posttraumatic Stress Disorder, symptoms associated with PTSD, how is PTSD diagnosed, relationship between PTSD and alcohol use, treatment for Posttraumatic Stress Disorder and complementary and alternative treatments for PTSD Prevention. The literature will also review alcohol, its uses, types of alcoholic beverage, effects, and the relationship between alcohol and PTSD.

2.2 What is trauma?

The Diagnostic and Statistical Manual of Mental Disorders and APA, (2000) specifically defines a trauma as direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the response to the event must involve intense fear, helplessness, or horror; in children, the response might involve disorganized or agitated behaviour.

Trauma can be seen as the influx of violent and urgent events which exceed the defensive capacity of a person, such that the person cannot master these events through normal adjustment processes. Trauma is most often the result of a critical incident (rape), series of incidents (disasters) or a situation like war. Lewis, (2001) describes trauma as any unplanned, unexpected or unpleasant situation faced that causes individuals to experience unusually strong emotional

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reactions and which have the potential to interfere with their ability to function either immediately or later.

2.2.1 Factors causing trauma

Anyone who has gone through a traumatic event or has even witnessed something traumatic can be affected. There are many different events that can cause someone to react badly. DSM-IV-TR, (2000) provides a list of potential traumatic events that can cause trauma;

- Witnessing death or serious injury by violence assault
- Combat
- Sexual and physical assault
- Being kidnapped
- Being taken hostage
- Terrorist attacks
- Torture
- Severe automobile accident
- Robbery
- High-jacking
- Natural disaster
- Childhood sexual abuse
- Domestic violence

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- Divorce, or termination of relationship
- Life-threatening illnesses

2.2.2 Symptoms associated with trauma

After a traumatic experience, the mind and the body are in shock. But as you make sense of what had happened and process your emotions, you come out of it. DSM-IV-TR, (2000) states that reactions may include:

- Nightmares
- Sleeping difficulties
- Changes in appetite
- Anxiety and fear
- Irritation, agitation or anger
- awareness and being ready to act
- No energy, feeling tired all the time
- Feeling depressed/sad mood, crying a lot of the time
- Avoiding people, places and things that remind you of the event
- Not being able to concentrate on work or normal everyday actions
- Feeling worried about the safety of people that you love.

For most people these symptoms get less and go away after a couple of weeks. However, if they continue for 6 weeks or longer, PTSD may develop.

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2.2.3 Effects of trauma

Trauma affects every part of a person's being – their thoughts, emotions, behavior and physical reactions. Trauma also refers to overwhelming, uncontrollable experiences that psychologically impact on victims by creating in them feelings of helpless, vulnerability, loss of safety and loss of control. These traumatic feelings can result in psychological disorders such as PTSD, Acute Stress Disorder (ASD) and combat stress reaction in situations of military operation. Trauma destroys the trust relationship of victims with themselves and the world. This creates an inordinate amount of stress on the mental, emotional and physical capabilities of the victim whose coping behaviors and believes have been shattered by the trauma. The victims no longer know how to act or what to expect from the world in order to survive (Whitmer, 2001).

Approximately 20 percent of individuals in the United States have experienced a serious motor vehicle accident (MVA). A substantial number of these people go on to develop significant psychological disturbances, especially if the accident involved major injury or resulted in the death of others. In addition, survivors of major MVAs may sustain traumatic brain injury which can further complicate assessment and treatment (Harvey & Bryant, 2002). Physical injuries from fire can be particularly traumatic. The lasting effects of serious burns could be a long recovery period, reconstructive surgeries, the development of visible or painful scares and sometimes chronic pain and reduced mobility (Gilboa, Friedman, Tsur & Fauerbach, 1994). Kessler et al., (1995) state that sexual assault and rape can be particularly devastating and traumatizing events and are substantial risk factors for PTSD among women in the general population. (Classen, Palesh & Aggarwal, 2005) state that child abuse and neglects not only produces significant, sometimes enduring, psychological dysfunction, it is also associated with a greater likelihood of being sexually or physically assaulted later in life.

Some trauma events can produce extreme behaviour such as intense fear, helplessness, withdrawal or detachment, lack of concentration, irritability, sleep

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disturbance, aggression, hypervigilance and flashbacks. Traumatic events may have serious medical consequences requiring attention from trauma nurses and in extreme cases, results in death. Victims of collective violence, that is wars, terrorism and political conflicts, genocide, torture and organized violent crime, suffer from increased morbidity, disability and mortality due to external causes and infectious and non-communicable diseases (Krysinska Lester & Martin, 2009). The experience of trauma can result in a wide range of psychological and psychiatric disturbances, including depression, substance abuse, personality disorder and complex psychiatric comorbidity. Krysinska et al., (2009), state that there are numerous types of traumatic events including personal assaults, accidents, terrorist attacks, military combat, torture, incarceration, being kidnapped, being taken a hostage, natural disasters, and being diagnosed with a life-threatening disease. Several broad categories based on duration, frequency and causation of trauma have been proposed for classification of such a wide range of events, for example, distinguishing between type 1 and type 2 traumas. There are individual traumas and collective traumatic events which affect many individuals.

Individual traumas may involve being frustrated by others (such as being assaulted or divorced) or be a result of natural events (such as a partner dying of natural causes) or may involve violence and may be experienced directly or witnessed. Collective trauma may be subdivided into human-caused, technological and natural disasters. A number of factors that increase risk for PTSD have been identified. According to Baumann (1998), factors that influence the vulnerability of the individual to the development of PTSD include the following:

- Psychological difficulties present before the traumatic event;
- The trauma is severe and/or persisting;
- The age of the person;

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- Absence of social support system;
- Previous exposure to trauma;
- Lack of safety in their environment; and
- The trauma was initiated by people rather than nature.

The more factors that are present, the more likely it will be that the person will be vulnerable to trauma. It is important to understand what may increase risk for PTSD because traumatic events are quite common. Many people will experience a traumatic event at some point in their life. However, not everyone who experiences a traumatic event will eventually go on to develop PTSD. Researchers have done numerous studies in an attempt to identify certain characteristics of a person or traumatic events that determine who does and does not eventually develop PTSD after a traumatic event (Ozer et al., 2003).

Traumatic events affect not only the direct victims but also those who come in contact with such individuals on both personal and professional levels. Family members, emergency services personnel, mental health, and other medical professional, as well as witnesses of trauma may show symptoms of PTSD and/or other changes in behavior and cognition, which is labeled secondary or vicarious traumatization (Salston & Figley, 2003). Korn, (2001) states that listening to horrifying experiences, witnessing others' pain, attending to chronic stress and anger, shouldering excessive responsibilities, suicidality and responding to the compelling needs of traumatized individuals precipitate a sequelae common to trauma itself. People who help trauma and crisis victims are sometimes at risk of secondary trauma because of the consistent exposure to human suffering and possibly feeling responsible for the safety of victim. Symptoms of secondary trauma include the following:

- Intense emotions and reactivity, sadness, depression, discouragement and loss of compassion;

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- Hyperarousal, fatigue, sleep disturbances, flashbacks of intrusive nightmares;
- Somatic problems; headaches, dizziness, weakness, join pains and abdominal discomfort, heart palpitations, profuse sweating, changes in appetite and digestive problems;
- Feelings of helpless, numbness, detachment, denial, disbelief, anger, and rage;
- Their response to life and other people are either greatly exaggerated or no longer exist;
- Increased alcohol consumption and/or substance abuse;
- Job performance goes down, mistakes go up, morale goes down, personal relationships are effected, home lives start to deteriorate, personality deteriorate and eventually an overall decline in general health;
- Lose of sense of boundaries; and
- Become increasingly sensitive to violence (Korn, 2001).

Caspi, Saroff, Suleimani and Klein (2008) point out that experience of traumatic events can always be drawn from a list corresponding to the broader definition of DSM-IV-TR criterion A1. This list of traumatic events include combat, severe motor vehicle accidents, other severe accidents, sudden death of a close friend/relative, risk to one's own life or the life of a close friend/relative, witnessing or experiencing assault, domestic violence or physical abuse in childhood, and other traumatic experiences.

Steyn (2009), states that PTSD is a psychiatric condition that occasionally develops after exposure to a traumatic event while some literatures suggest that certain types of events relate to the development of PTSD. Ford and Smith

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(2007) state that PTSD is only one of several potential sequel of exposure to psychological trauma, particularly when trauma occurs in childhood; it results in a compromise of important relationships. Such sequel of developmentally adverse interpersonal trauma includes persistent problems with severe emotional, behavioral, and somatic dysregulation, dissociation and fundamentally altered self-perception, relationship, and existential and spiritual beliefs.

Extreme use of substance and alcohol has been shown to be associated with experiences after traumatic exposure. Simons, Gaher, Jacobs, Meyer and Johnson-Jimenez (2005) point out that victim of disaster are at an increased risk for a range of psychopathology and alcohol use and dependence. For example, a survey of New York City residents, 5-8 weeks following the September 11, 2001 attacks indicated that alcohol and other substance use increased. Van Dyk and Van Dyk (2010), add that trauma victims experience uncontrollable thoughts, emotions, behavior, physical reaction, and may have a range of different reactions including anger, self-blame, fear and anxiety. They further state that trauma patients experience vulnerability, loss of safety, loss of control and other psychological disorders such as PTSD.

There is also ample evidence pointing to the increase of suicidal ideation and behavior among people who have experienced traumatic events such as war veterans, victims of interpersonal violence, individuals exposed to childhood abuse and neglect, survivors of natural disasters, people exposed to torture and holocaust victims and survivors (Krysinska et al., 2009).

2.2.4 Treatment of trauma

Some of the problems people experience after a traumatic incident are part of the diagnoses of Acute Stress Disorder (ASD) and post-traumatic stress disorder (PTSD). ASD describes experiences of dissociation (for example, feelings of unreality or disconnection), intrusive thoughts and images, efforts to avoid reminders of the traumatic experiences, and anxiety that may occur in the

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months following the event. Drinking or using drugs by a traumatized person may be a well-intentioned (but ultimately self-destructive) attempt to "self-medicate" against memories or reminders of horrific traumatic experiences. It may also help with sleep problems such as trouble falling or staying asleep, traumatic nightmares, and constantly being "wound up." Using alcohol as a way to self-medicate however may worsen the situation. For example, drinking alcohol may temporarily decrease the severity and the number of frightening nightmares but may also increase irritability and hypervigilance (National Centre for PTSD, 2003).

International Society for Traumatic Stress Studies, (2005) states that treatment for trauma should include a discussion between the treater and the client about the possible effects of trauma-related problems, including sleep, anger, anxiety, depression, and work or relationship difficulties. Treatment can include education, psychotherapy, and support groups that help the client address the trauma in a manner acceptable to the client. Traumatization and alcohol – related problems should be designed as an overall plan that addresses both sources of difficulty and their interrelationships. Although there may be separate meetings or clinicians devoted primarily to traumatization or to substance problems, all interventions should be carefully coordinated and integrated.

2.2.5 Coping mechanisms

Fortney and Oelschlager (2008) suggest that people who are suffering from trauma can do the following to cope:

- Accept their feeling as being a normal reaction to extreme situations. They are not going crazy, rather they are having intense feelings that are perfectly understandable and cab be expected.
- Be gently to themselves. They should not function as if nothing had happened or beat themselves up for not getting things done right now.

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- They must not withdraw – reach out and stay connected to peers, family and friends. Bottling up feelings will not make them go away; in fact, it may prolong them.
- Whenever possible, they must structure their time and attempt to continue at least some of their customary daily activities.
- They must use exercise, physical activity and relaxation techniques to help them get through this time.
- Seeking professional help, for example, counseling.

2.3 What is Posttraumatic Stress Disorder?

Any traumatic event can cause PTSD and can affect anyone who has been caught up in a traumatic event. PTSD makes an individual re-live the pain and memories of trauma all the time. Not all people who have been through a trauma will develop PTSD or need treatment; some get better with the help of family, friends or other support. But many people need professional help to recover. Children can also get PTSD. Domestic violence and abuse, loss of parents, war and natural disaster impact on the lives of children. PTSD is an anxiety disorder that may develop after exposure to a terrifying event/ordeal in which grave physical harm occurred or was threatened. Trauma events that can trigger PTSD include assaults such as rape or mugging, natural or human-caused disasters, accidents and military combat (Okulate & Jones, 2006). In the Diagnostic and Statistical Manual of Mental Disorder Disorders, 4th edition, (2000), PTSD is described as a syndrome that followings exposure to a stressor that would evoke significant symptoms of distress in almost everyone. PTSD symptoms include persistent re-experience of the trauma, avoidance of trauma-associated stimuli and hyperarousal.

PTSD is negative for both the sufferer and his/her family. People suffering from PTSD try to get rid of painful memories, loneliness and nervousness by using

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alcohol or drugs as a form of self-medication. Substance use or abuse helps to take away feelings and memories for a little while. Sufferers also cannot get over the grief and anger, the injury or loss and this can cause depression as the person begins to see himself or herself as worthless and a failure. The symptoms of depression – like not being able to think properly, a negative view of the world and changes in sleeping habits all make PTSD worse. A person may also feel their pain will never end and therefore can be at risk of suicide.

2.3.1. Symptoms associated with PTSD

PTSD usually appears within three months of the trauma, but sometimes it may come on months or even years later. The symptoms of post-traumatic stress disorder (PTSD) can arise suddenly, gradually, or come and go over time. Sometimes symptoms appear seemingly out of the blue. At other times, they are triggered by something that reminds you of the original traumatic event, such as a noise, an image, certain words, or a smell. While everyone experiences PTSD differently, according to DSM-IV-TR (2000), there are three groups of PTSD symptoms; intrusive, avoidance and hyperarousal.

Intrusive symptoms: people suffering from PTSD may have times when the traumatic event takes over their life; when they have sudden very realistic memories and painful emotions. Flashbacks – a memory so powerful that the person feels as if the trauma is happening all over again – is a common symptom of trauma and PTSD. At times the re-experiencing occurs in nightmares that are so real that the person wakes up screaming in terror. In children dreams of traumatic events are often nightmares of scary animals, danger to people they love like friends and family. Other intrusive symptoms includes, feelings of intense distress when reminded of the trauma and intense physical reactions to reminders of the event, for example, pounding heart, rapid breathing, nausea, muscle tension, sweating.

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Avoidance symptoms: PTSD sufferers often stay away from situations that may remind them of traumatic event. A hijack victim, for example, may find it extremely frightening to drive. Over time the person may become so scared of particularly situations that their daily lives are affected by them trying to avoid these situations. These also affect a person's relationship with other people, because he or she will try to stay away from having a close emotional relationship with family, friends and colleagues. At first the person may feel emotionally dead and not be able to talk about their emotions. They may seem bored, cold or busy with other things. Family members may often feel rejected by the PTSD sufferer because he/she is not affectionate. Other avoidance symptoms include, inability to remember important aspects of the trauma, loss of interest in activities and life in general, feeling detached from others and emotionally numb and a sense of a limited future- for example, you do not expect to live a normal life span, get married, and have a career or other plans.

Hyperarousal symptoms: PTSD can cause sufferer to act like they are still threatened by the trauma that caused their illness. Sufferers often become irritable and may have trouble concentrating or remembering things. They often get insomnia (difficulty sleeping). PTSD sufferers get frights easily and children may also show physical symptoms including stomach and head pains.

2.3.2 How is PTSD diagnosed?

Diagnostic criteria for PTSD include a history of exposure to a traumatic event and meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyperarousal symptoms. Next criterion concerns duration of symptoms and finally functioning assessment. The diagnostic criteria for posttraumatic stress disorder (DSM-IV-TR, 2000) are as follows:

A. The person has been exposed to a traumatic event in which both of the following were present:

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1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror. In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distress recollection of the event, including images, thoughts or perceptions. In young children, repetitive play may occur in which themes or aspects of trauma are expressed.
2. Recurrent distressing dreams of event. In children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring. This includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashbacks episodes; these may occur on awakening or when intoxicated. In young children, trauma specific re-enactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolizes or resembles an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues symbolizes or resembles an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

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1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma;
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma;
3. Inability to recall an important aspect of the trauma;
4. Markedly diminished interest or participation in significant activities;
5. Feeling of detachment or estrangement from others;
6. Restricted range of affect (for example, unable to have loving feelings)
7. Sense of a foreshortened future, for example, one does not expect to have a career, marriage, children, or a normal life span.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep;
2. Irritability or outbursts of anger;
3. Difficulty concentrating;
4. Hypervigilance; and
5. Exaggerated startle response.

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

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

Specify if: Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if: With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

2.3.3 Relationship between PTSD and alcohol use

The link between exposure to traumatic events and the development of PTSD is well established (Boals & Schettler, 2009). However, PTSD does not automatically cause problems with alcohol use; there are many people with PTSD who do not have problems with alcohol. However, PTSD and alcohol together can be serious trouble for the trauma survivor and his or her family (Evans & Sullivan, 1995). Evans and Sullivan (1995) point out that people with PTSD are more likely than others with similar backgrounds to have alcohol-use disorders both before and after being diagnosed with PTSD, and people with alcohol use disorders often also have PTSD. Being diagnosed with PTSD increases the risk of developing an alcohol-use disorder. Women exposed to trauma show an increased risk for an alcohol-use disorder even if they are not experiencing PTSD. Although exposure to traumatic events does not automatically result in PTSD (Joseph & Linley, 2008), women with problematic alcohol use are more likely than other women to have been sexually abused at some point in their lives.

Furthermore, men and women reporting sexual abuse have higher rates of alcohol and drug use disorders than other men and women. Twenty-five to seventy-five percent of those who have survived abusive or violent trauma also report problems with alcohol use. Ten to thirty-three percent of survivors of accidents, illnesses, or disaster traumas report problematic alcohol use, especially if they are troubled by persistent health problems or pain.

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A number of risk factors for developing PTSD after a traumatic event have been identified, including the type of traumatic event, history of mental illness, and a person's response at the time of the event (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). A number of factors have also been found to reduce risk for developing PTSD after the experience of a traumatic event, such as:

These characteristics are referred to as 'risk factors'. Ozer et al., (2003) have also identified several risk factors that have consistently been found to increase the likelihood of developing PTSD after a traumatic event:

- The experience of another, posttraumatic event;
- The experience of psychological difficulties prior to experiencing the traumatic event;
- Family history of psychological problems;
- The extent to which there was a threat to life during the traumatic event;
- The amount of support that people felt they had after experiencing the traumatic event;
- The person's emotional response (fear, helplessness, horror, guilt, and shame) at the time of the traumatic event; and
- Dissociation at the time of the traumatic event. Dissociation is a particular type of response to a stressful experience where a person may actually feel separated or cut-off from themselves and/or their surroundings. When in a "dissociative state," someone may feel numb, lose track of time, feel as though they are floating outside of their body, or have no memories about a certain period of time.

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Many people find themselves in a vicious cycle in which exposure to traumatic events produces increased alcohol use, which produces new traumatic event experiences

Jasinski et al. (2000) state that some researchers have theorized that child sexual abuse may increase risk victims's chances of alcohol problems because abuse survivors may use alcohol to self-medicate to alleviate some of the symptomology associated with child sexual abuse such as, painful intrusive memories or anxiety. When victims of child abuse have low self-esteem or suffer from a negative self-concept as a reaction to the experience or have difficulty controlling emotions, alcohol may be consumed in an effort to gain mastery and a sense of power over these emotions. Victims of child sexual abuse may also use alcohol to relieve feelings of guilt or discomfort especially when such guilt or discomfort is coupled with sexual dysfunction and/or the sexual partner encourages alcohol use to relieve anxiety about sex (Wilsnack, Klassen, Schur, & Wilsnack, 1991).

2.3.4 Treatment for posttraumatic stress disorder

Treatment for PTSD relieves symptoms by helping one deal with the trauma experienced. Rather than avoiding the trauma and any reminder of it, treatment will encourage one to recall and process the emotions and sensations felt during the original event. In addition to offering an outlet for emotions one has been bottling up, treatment for PTSD will also help restore ones sense of control and reduce the powerful hold the memory of the trauma has on ones life.

In treatment for PTSD, one will

- Explore ones thoughts and feelings about the trauma;
- Work through feelings of guilt, self-blame, and mistrust;
- Learn how to cope with and control-intrusive memories, and

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- Address the problems PTSD has caused in one's life and relationships (National Centre for PTSD, 2003).

2.3.4.1 Types of treatment for Posttraumatic Stress Disorder

- **Trauma-focused cognitive-behavioural therapy:** cognitive-behavioural therapy for PTSD and trauma involves carefully and gradually "exposing" oneself to thoughts, feelings, and situations that remind one of the traumas. Therapy also involves identifying upsetting thoughts about the traumatic event particularly thoughts that are distorted and irrational and replacing them with more balanced pictures.

- **Family therapy:** since PTSD affects both you and those close to you, family therapy can be especially productive. Family therapy can help ones loved ones understand what one is going through. It can also help everyone in the family communicate better and work through relationship problems caused by PTSD symptoms.

- **Medication:** this is sometimes prescribed to people with PTSD to relieve secondary symptoms of depression or anxiety. Anti – depressants such as Prozac and Zoloft are the medications most commonly used for PTSD. While anti – depressants may help you feel less sad, worried, or on edge, they do not treat the causes of PTSD.

- **Eye Movement Desensitization and Reprocessing (EMDR):** incorporates elements of cognitive-behavioural therapy with eye movements or other forms of rhythmic, left-right stimulation, such as hand taps or sounds. Eye movements and other bilateral forms of stimulation are thought to work by "unfreezing" the brain's information processing system, which is interrupted in times of extreme stress (National Centre for PTSD, 2003).

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2.4 Complementary and Alternative Treatments for PTSD

Broadly conceptualized, the term "complementary and alternative medicine" (CAM) refers to treatments not considered to be standard to the current practice of Western medicine. "Complementary" refers to the use of these techniques in combination with conventional approaches, whereas "alternative" refers to their use in *lieu* of conventional practices (Hollifield, 2011). Of course, many treatments and techniques, for example, acupuncture that are considered CAM within U.S. borders are elementary to conventional medicinal practices in other parts of the world. As Western practitioners and consumers increasingly adopt these approaches, the boundaries between conventional medicine and CAM continue to shift. The National Center for Complementary and Alternative Medicine (NCCAM) has proposed a five-category classification system for CAM therapies: 1) natural products, for example, herbal dietary supplements; 2) mind-body medicine, for example, meditation, acupuncture, and yoga); 3) manipulative and body-based practices, for example, massage, and spinal manipulation; 4) other alternative practices, for example, movement therapies, energy therapies); and 5) whole medicine systems, for example, traditional Chinese and Ayurvedic medicine.

Within the U.S., CAM has broad appeal among consumers for the prevention and treatment of a range of physical and mental conditions, and to enhance overall wellness and health (Kessler et al., 2001). Mental health concerns, including PTSD, are among the most common reasons for seeking CAM. Among those with PTSD, nearly 40% report use of CAM to address emotional and mental problems. Mind-body treatments, including meditation, relaxation, and exercise therapy, were the most frequently reported and used as both alternative and complementary therapies (Libby, Pilver, & Desai, 2012).

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2.5 Prevention strategies of PTSD

Recovery from posttraumatic stress disorder (PTSD) is a gradual, on-going processing. Healing does not happen overnight, nor do the memories of the trauma ever disappear completely. This can make life seem difficult at times, but there are many things one can do to cope with residual symptoms and reduce anxiety and fear (National Centre for PTSD, 2003).

2.5.1 Reach out to others for support

Posttraumatic stress disorder (PTSD) can make one feel disconnected from others. One may be tempted to withdraw from social activities and loved ones. But it's important to stay connected to life and the people who care about. Support from other people is vital to ones recovery from PTSD, so ask close friends and family members for their help during this tough time (National Centre for PTSD, 2003).

One should also consider joining a support group for survivors of the same type of trauma you experienced. Support groups for posttraumatic stress disorder (PTSD) can help one feel less isolated and alone. They also provide invaluable information on how to cope with symptoms and work towards recovery. If one cannot find a support group in an area, look for an online group.

2.5.2 Avoid alcohol and drugs

When one is struggling with difficult emotions and traumatic memories, one may be tempted to self-medicate with alcohol or drugs. But while alcohol or drugs may temporarily make one feel better, they make post-traumatic stress disorder (PTSD) worse in the long run. Substance use worsens many symptoms of PTSD, including emotional numbing, social isolation, anger, and depression. It also interferes with treatment and can add to problems at home and in relationships (National Centre for PTSD, 2003).

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2.5.3 Challenge sense of helplessness

Overcoming ones sense of helplessness is a key to overcoming posttraumatic stress disorder (PTSD). Trauma leaves one feeling powerless and vulnerable. It is important to remind one that one has strengths and coping skills that can get one through tough times.

One of the best ways to reclaim ones sense of power is by helping others; volunteer time, give blood, reach out to a friend in need, or donate to ones favourite charity. Taking positive action directly challenges the sense of helplessness that is a common symptom of PTSD.

Other positive ways of coping with PTSD includes;

- Learn about trauma and PTSD;
- Join a PTSD support group;
- Practice relation techniques;
- Confide in a person one trusts; and
- Spend time with positive people (National Centre for PTSD, 2003).

2.6 What is alcohol?

Alcohol is a clear drink that is made from corn, barley, grain, rye, or a beverage containing ethyl. When a person drinks alcohol, about 20 % is absorbed in the stomach, and 80 % is absorbed in the small intestine. The concentration of alcohol, the type of drink, and whether the stomach is full or empty affects how fast the alcohol is absorbed. Once the alcohol is absorbed into the tissue, it affects the mind and body. Blood alcohol concentration can rise up to 20 minutes after having a drink. The term 'alcohol', unless specified, refers to ethanol or ethyl alcohol. It is a thin, clear liquid with harsh burning taste and high

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volatility. It is usually consumed in diluted concentrations of absolute (i.e. 100 per cent) ethyl alcohol. Alcohol consumption is part of our daily lives. It is used and enjoyed in most developed and developing countries around the world. Alcohol is a central nervous system depressant even though it is commonly mistaken as a stimulant (Butcher, Mineka & Hooley, 2005).

Alcohol is a generic term for ethanol which is found in drinks intended for human consumption. Other forms of alcohol, includes methanol, which is more toxic to humans than ethanol and therefore not suitable for human consumption (National Health and Medical Research Council, 2009). Alcohol is produced when certain food stuffs such as barley, grapes and hops are fermented by combining yeast and sugar (Barlow & Durand, 2009).

2.6.1 What is alcohol used for?

People use alcohol for a wide range of reasons and in different social and cultural contexts. They may drink for sociability, cultural participation, and religious observance or as a result of peer influence. Individuals may also drink for pleasure, relaxation, mood alteration, enhanced creativity, intoxication, addiction, boredom, and habit, to overcome inhibitions or to escape or forget troubles' (National Health and Medical Research Council, 2009).

There are different types of alcohol. Some are used in chemistry laboratories and industry, for example, isopropyl and methyl alcohol. Isopropanol, Orisopropyl alcohol is also used in industrial processes as well as in home cleaning products and skin lotions. It is also commonly known as "rubbing alcohol". Methanol or methyl alcohol or wood alcohol has been used as an industrial solvent and is also commonly available as methylated spirit. It is found in cleaning solvents, paint removers, photocopier developer and anti-freeze solutions. As such, it is often available in large quantities, inexpensively. Methanol is similar to ethanol but the end product after it is digested by the body is formaldehyde, which is poisonous. This is responsible for "alcohol poisoning". Methanol poisoning

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leading to blindness has been known to occur on consuming, even small amounts. Another type of alcohol is ethyl alcohol, also known as ethanol. This has been consumed by human beings for its intoxicating and mind-altering effects.

Ethyl alcohol is also used as a reagent in some industrial applications. For such use, ethyl alcohol is combined with small quantities of methanol, with the mixture being called "denatured ethanol" to prevent theft for human consumption. There are three basic categories of alcohol drinks, namely, beer, wines and spirits. The use of alcohol can provide a temporary distraction and relief for traumatized people who may be suffering from very serious and even debilitating problems across multiple areas of their lives (thoughts, feelings, bodily experiences, relationship to self and others, and behaviours). However, this relief is only temporary, and the use of substances to reduce symptoms ultimately can be harmful. Substance abuse reduces a person's ability to concentrate, to be productive in work and life in general, and to cope with traumatic memories and external stressors. Substance abuse can increase emotional numbing, social isolation, anger and irritability, depression, and the feeling of needing to be on guard (hypervigilance).

Binge drinking by a traumatized person may be a well-intentioned, but ultimately self-destructive, attempt to "self-medicate" against memories or reminders of horrific traumatic experiences. It may also help with sleep problems such as trouble falling or staying asleep, traumatic nightmares, and constantly being "stressed." Using alcohol as a way to self-medication may help with one problem but worsen another. For example, substance abuse may temporarily decrease the severity and the number of frightening nightmares but may also increase irritability and hypervigilance (International Society for Traumatic Stress Studies, 2005).

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2.6.2 Types of alcohol beverage

An alcoholic beverage is a drink containing ethanol, commonly known as alcohol. Alcoholic beverages are divided into three general classes – beers, wines and spirits. They are legally consumed in most countries and over countries have laws regulating their production, sale and consumption. In particular such laws specify the minimum age at which a person may legally buy or drink them. This minimum age varies between 16 and 25 years depending upon the country and the type of drink. Most nations set it at 18 years of age.

2.6.2.1 Description of alcoholic beverages

Beer

It is widely consumed throughout the world and is a part of several world cultures. Beer is produced by fermenting and brewing different starches of cereals like wheat, corn and rice. To lend beer its characteristics bitter taste, hop cones are added. They also act as preservatives for the beer. The alcoholic content of beer is around 2% to 4%. But in some, it can go up to 20% as well. The two main types of beers are lager and ale. The difference between lager and ale is the different temperature at which they are fermented. Ale beers are fermented between temperatures of 60 – 70 degrees F, whereas Lager beers are fermented between 50 -58 degrees F.

Wines

Wines are very popular in several cultures and are used as an accompaniment with many foods. They lend a different flavour to the food if teamed with the right kind. Wines are mostly made from grapes. These grapes are crushed using different types of yeast which is responsible for converting the sugar from grapes into alcohol. The fermentation process that is involved in brewing wines is longer and wine could be aged for several months or even years. The more it is fermented, the better its flavours run. The alcoholic content of wines is around

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9% - 16%. Wines can be divided into two categories – red and white wines. The determinant factor of whether a wine is red or white depends on whether the skin of the grape is included in the fermentation process or left out.

Spirits

Spirits is the term given for those forms of drinks that are unsweetened and distilled. They are made by the distilling of an already fermented product; that results in the formulation of alcohol. The content of alcohol in spirits is 20% and above. There are countless drinks that fall in the category of spirits and they are colloquially referred to as 'hard drinks'. These drinks have a high alcoholic content in them and therefore can hit the person very hard if not consumed with care. The effect of these drinks can be lessened by diluting them with certain mixers like soda, energy drinks and bottle water. The more popular types of spirits are; whiskey, rum, brandy, gin, liqueurs and tequila.

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The Table shows the content of alcohol basic categories of alcohol drinks.

Table 2.1: Types of alcoholic beverages

Beverage	Container	% alc/vol	Standard Drink equivalent
BEER			
Light	375 ml or bottle	2.7%	0.8
Mid strength	375 ml or bottle	3.5%	1.0
Full strength	375 ml or bottle	4.5%	1.5
Light	285 ml glass (middy/pot/schooner)	2.7%	0.5
Mid strength	285 ml glass (middy/pot/schooner)	3.5%	0.7
Full strength	285 ml glass (middy/pot/schooner)	4.5%	1.0
WINE			
White/red	100 ml glass	12%	1.0
	180 ml average restaurant serve	12%	1.8
	750 ml bottle	12%	7.0
	2 litre cask	12%	20.0
	4 litre cask	12%	40.0
Cider	375 ml bottle/stubble	4.7 – 7.5%	1.4 – 2.0
	750 ml bottle		2.8 – 4.0

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FORTIFIED WINES e.g. port, sherry	60 ml glass	21%	1.0
	750 ml bottle	18%	11.0
	2 litre(cask/flagon)	18%	28.0
PREMIX COOLERS AND SODAS	340 ml bottle 375 ml can	5 – 8%	1.5 – 2.4
	250 ml – 350 ml bottles	3.5 – 5.5%	0.7 – 1.4
SPIRIT	30 ml (nip)	42%	1.0
	700 ml bottle	40%	22.1

Source: adapted from NHMRC, (2001).

It appears that in many studies conducted on trauma and alcohol use, types of alcohol used by PTSD patients have not been the subject of studies. As such, there is insufficient literature gathered on the types.

2.6.3 Effects of alcohol

The multitude of data linking alcohol and trauma deserve close scrutiny. Simons, Gaher, Jacobs, Meyer and Johnson-Jimenez (2005) state that individuals who are experiencing stressful life events may use alcohol at higher rates and are at risk of developing alcohol-related problems. Alcohol use has been linked with both general stress as well as symptomatology associated with traumatic experience. With respect to traumatic experience, alcohol use is frequently comorbid with PTSD. Problematic alcohol use is most consistently associated with hyperarousal symptoms of PTSD. In addition to PTSD symptoms increasing, risk of problematic alcohol use may in turn cause or exacerbate traumatic stress symptoms. Alcohol frequently complicates diagnosis of trauma-related injury (Lowenfels, 1982; Soderstrom, Dupriest, Benner, Maekawa, & Cowley, (1979).

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Alcohol affects every organ in the body. It is a central nervous system depressant that is rapidly absorbed from the stomach and small intestine into the bloodstream. Alcohol is metabolized in the liver by enzymes, however, the liver can only metabolize a small amount of alcohol at a time, leaving the excess alcohol to circulate throughout the body. The intensity of the effect of alcohol on the body is directly related to the amount consumed. Moreover, research has found that when a person is experiencing problems with both traumatic stress and alcohol, he or she will often have other psychological or physical problems. For example, traumatized people who also abuse substances are often troubled by anxiety disorders (such as panic attacks, phobias, incapacitating worry or compulsions), mood disorders (such as major depression or dysthymia), disruptive behavior disorders (such as attention deficit or antisocial personality disorder), and multiple addictive behaviors (alcohol abuse, use of illicit drugs and abuse of prescribed medication).

Individual reactions to alcohol vary, and are influenced by many factors, such as:

- Age;
- Gender;
- Race or ethnicity;
- Physical condition (weight, fitness level, etc);
- Amount of food consumed before drinking;
- How quickly the alcohol was consumed;
- Use of drugs or prescription medicines; and
- Family history of alcohol problems (Bisby, Brewin & Leitz, 2009)

Alcohol plays a role in traumatic injuries. According to Lowenfels and Miller (1984), alcohol intoxication is associated with 40 to 50 percent of traffic fatalities;

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25 to 35 percent of non-fatal motor vehicle injuries; up to 64 percent of fires and burns; 48 percent of hypothermia and frostbite cases; and about 20 percent of completed suicides. Although not necessarily at the level of intoxication, alcohol also has been estimated to be present in 40 percent or more of falls and nearly 50 percent of homicides (victim or perpetrator). Alcohol consumers also experience problems with conflict and intimacy in relationships. Problematic alcohol use is associated with a chaotic lifestyle, which reduces family emotional closeness, increases family conflict, and reduces parenting abilities (Matsakis, 1992).

A critical problem with acute intoxication during anesthesia appears to be regurgitation and aspiration of the stomach contents (Abeloos et al., 1985). Because of definitional and methodological differences across alcohol and trauma studies, it is difficult to obtain precise estimates of alcohol's role in trauma events. However, Roizen (1988) reviewed emergency room studies and found that between 20 and 37 percent of all emergency room trauma cases involved alcohol use. Waller (1988) estimates that between 20 and 25 percent of all persons hospitalized with an injury have identifiable problem drinking or alcoholism. Some physicians view trauma as one indicator of alcohol abuse and alcoholism (Clark, McCathy & Robinson, 1985; Maull, Clap & Ellis, 1986; & Abrams, 1986)

Bisby, Brewin and Leitz (2009) state that alcohol's acute effects are complex, for example, it produces differential effects on separate components of memory. Research on alcohol's effects on emotional memory is limited although alcohol may impair the mnemonic benefit of emotional stimuli on explicit memory tasks (Knowles & Duka, 2004). In addition to impairing episodic memory for trauma, alcohol may also affect processing of emotional aspects of an event. Although alcohol can provide a temporary feeling of distraction and relief, it also reduces the ability to concentrate, enjoy life, and be productive. Excessive alcohol use can impair one's ability to sleep restfully and to cope with trauma memories and stress. Alcohol use and intoxication also increase emotional numbing, social

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isolation, anger and irritability, depression, and the feeling of constantly needing to be on guard (Matsakis, 1992).

Yaghoubian, Kaji, Putnam, De Virgilio, and De Virgilio (2009) show that that there are differential effects of alcohol on cytokine production and release depending on the duration and pattern of alcohol exposure. Alcohol can seriously complicate the management and treatment of the trauma patient. For example, several investigators Lowenfels, (1982); Abeloos, Rolly, Timperman, & Watson, (1985); Edwards, 1985) emphasize the risk of administering anesthesia to intoxicated patients. Abeloos et al. (1985) suggest that given the extreme risks of anesthesia with highly intoxicated patients, surgery may need to be delayed, if possible, until blood alcohol levels fall below the level of 250 mg/dL.

2.6.3.1 Psychological Effects

Prolonged alcohol use can lead to psychological damage. Research has demonstrated a strong association between alcohol misuse and mood disorders, particularly depression and anxiety. The reciprocal implications of this suggests that alcohol, on one hand, may be used in an attempt to self-medicate against various mood disorders, while on the other hand it can also exacerbate mood disorders if used in excess (Prince, Akincigil, Hoover, Walkup, Bilder & Crystal, 2009; Agabio, Marras, Gessa & Carpiniello, 2007).

For example, studies have found that people with alcohol disorders often suffer from some kind of depression, whereby to relieve the symptoms of the depression, they will often embark on excessive alcoholic use which in turn exacerbates their depression. The prevalence of depression in alcohol abusers or dependent individuals range from 15 to 70%, including primary depression. Depression ranks high among mood disorders that are comorbid with excessive alcohol use (Butcher, Mineka & Hooely, 2007). Changes in personality such as increased irritability, impaired reasoning and poor judgment are said to be consequences of excessive alcohol use (Butcher, Mineka & Hooley, 2007).

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The psychological effects of alcohol intoxication include lack of inhibitions, increase in aggression and violence, uninhibited sexual behaviour/lack of interest in sex, mood swings, depression, impaired memory and sensory-motor co-ordination. There is also a well-established comorbidity between schizophrenia and heavy alcohol use (National Health and Research Council, 2009). It is suggested that heavy alcohol use may increase the severity of common symptoms associated with schizophrenia such as, hallucinations. Many individuals with PTSD experience sleep disturbances (trouble falling asleep or problems with waking up frequently after falling asleep). When a person with PTSD experiences sleep disturbances, using alcohol as a way to self-mediate becomes a double sword. Alcohol use may appear to help symptoms of PTSD because the alcohol may decrease the severity and the number of frightening nightmares commonly experienced in PTSD. However, alcohol use may, on the other hand, continue the cycle of avoidance found in PTSD making it ultimately much more difficult to treat PTSD because the client's avoidance behavior prolongs the problems being addressed in treatment. Also finally when a person withdraws from alcohol, nightmares often increase.

Individuals with a combination of PTSD and alcohol use often have additional mental or physical problems. About 10 – 50 % of individuals with this combination have the following serious disorders:

- Anxiety disorders (such as panic attacks, phobias, incapacitated worry or compulsions);
- Mood disorders (such as major depression or dysthymic);
- Disruptive behavior disorders (such as attention deficit or antisocial personality disorder);
- Addictive disorders (such as addiction to, or, abuse of street or prescription drugs);

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- Chronic physical illness (such as diabetes, heart diseases or liver diseases); and
- Chronic physical pain due to physical injuries/illnesses due to no clear physical cause (Butcher, Mineka & Hooley, 2007).

2.6.3.2 Social effects of alcohol use

Excessive use of alcohol can have adverse impact not only on the individual user, but also on the general community. Heavy alcohol use has been implicated in increased incidents of violent crime. Family units are often affected if one member of the family is a heavy alcohol user (Butcher, Mineka & Hooley, 2007). Family issues such as marital breakup, domestic violence and spouse abuse are strongly tied to high use of alcohol (Skrtic, Karlovic & Kruljac, 2008; Ogborne, 2000).

Risk behaviours such as drinking and driving and inappropriate sexual behaviours are also common practices linked to alcohol use. Alcohol is also considered to be a causal factor in most motor vehicle accidents. Financial problems and job loss are also associated with high – risk alcohol use (Shand, Gates, Fawcett & Mattick, 2003).

The work force is impacted as personality and poor judgments deteriorate due to excessive use of alcohol. A study conducted in Australia found that $437m was lost in 2001 due to alcohol – related absenteeism (Pidd, Berry & Roche, 2006). In the UK, a study conducted in 2001 found that alcohol – related work absenteeism had an economic cost of an average £1.5bn per year (Institute of Alcohol Studies, 2009). Literature surrounding the topic of anxiety suggests that individuals with social phobia often feel a lot more comfortable in social settings if they have used alcohol (Abrams, Kushner & Reinertsen, 2002). Comorbidity of social phobia in excessive alcohol users is quite common.

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2.6.3.3 Behavioural effects of alcohol use

Alcohol use slows reaction time and impairs judgment and coordination, which are all skills needed to drive a car safely. The more alcohol consumed, the greater the impairment. Consuming excessive amounts of alcohol typically results in acute intoxication and can also result in increased risk of motor-vehicle traffic crashes, violence, and other injuries. Other behavioral effects may include; Balance and coordination impairment, talkativeness, acting and feeling self-confident, extreme feelings of relaxation, over confidence, slurred speech, visual attention impairment, inability to walk without help, unstable emotions, and loss of bladder control. In general, studies have shown that people who regularly consume alcohol or use drugs are also more likely to engage in high – risk sexual behaviour (MacDonald, Zanna, & Fong, 1996).

2.6.3.4 Physical health effects

Each year approximately 3000 people die as a result of excessive alcohol consumption and around 100,000 people are hospitalised. Long-term excessive alcohol consumption is associated with, heart damage, high blood pressure and stroke, liver disease, cancers of the digestive system, other digestive system disorders, (for example, stomach ulcers), sexual impotence and reduced fertility, increasing risk of breast cancer, sleeping difficulties, brain damage with mood and personality changes, concentration and memory problems, and risks to unborn babies. Excessive drinking can lead to high blood pressure damaging your heart muscle. Damage to the cardiovascular system can put you at increased risk of heart failure or stroke. Other physical effects include increased risk of certain cancers, stroke, and liver diseases particularly, when excessive amounts of alcohol are consumed over extended periods of time. Physical health problems are also very common among traumatized people. Such people are at greater risk of chronic physical illnesses such as, diabetes, heart disease, or liver disease) and often suffer from chronic physical pain, either due to physical injuries/illnesses or with no clear physical cause (Ogborne, 2000).

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2.7 Treatment strategies for PTSD

Many traumatized patients are reluctant to seek help for their symptoms, especially from mental health professionals. Patients should be made to understand that anyone may develop PTSD symptoms in response to extreme trauma and that the diagnosis is not reflective of a character flaw or personal weakness. Education, support counseling and providing a safe and supportive environment for discussing fear and concerns, should ideally be provided to all patients with PTSD. Patients can be treated with medication, psychotherapy or a combination of these modalities. Pingo and Seedat (2009) add that in clinical practice, the majority of adults with PTSD derive most benefit from a combination of treatment approaches encompassing psychopharmacology and psychotherapy.

An increasing number of studies argue that intensive care treatment carries a high risk of traumatic stress and PTSD (Griffiths & Jones, 2000). Many people who have experienced childhood abuse, criminal attack, disasters, war, or other traumatic events turn to alcohol or drugs to help them deal with emotional pain, bad memories, poor sleep, guilt, shame, anxiety, or terror. Tarrier and Sommerfield, (2003) state in their study that people use alcohol and other substance as a coping strategy to help block out traumatic memories. Most patients turn to believe that self-medication through the use of alcohol is efficacious in controlling anxiety despite the fact that their use appears to exacerbate such patient's clinical condition. Furthermore, Bowley, Rein, Cherry, Vellema, Snyman, and Boffard, (2004) state that without intervention, alcohol misuse is unlikely to decline. The following are the reasons why PTSD patients should seek help as outlined by National Centre for PTSD, 2003;

- Early treatment is better otherwise symptoms of PTSD may get worse. Dealing with them now might help stop them from getting worse in the future. Finding out more about what treatments work, where to look for

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help, and what kind of questions to ask can make it easier to get help and lead to better outcomes.

- PTSD symptoms can change family life as they can get in the way of family life. One may find himself/herself pulling away from loved ones, is not able to get along with people or getting angry or even violent. Getting help for PTSD can help improve family life.
- PTSD can be related to other health problems for which can make current physical health problems worse. For example, studies have shown a relationship between PTSD and heart problems and PTSD and mental health problems. By getting help for PTSD one can also improve physical and mental health.

The following treatment strategies have been recommended for treating PTSD:

2.7.1 Medications

The Selective Serotonin Reuptake Inhibitors (SSRIs), tricyclic antidepressants and monoamine oxidase inhibitors have been shown in randomized clinical trials to be effective in treating PTSD symptoms and improving the quality of life of these patients. SSRIs should be considered as a first-line option because they are safer and better tolerated than older depressant. Currently, sertraline and paroxetine are the only medications that are approved by Food and Drug Administration (FDA) in the United States of America (USA) for the treatment of PTSD. A trial of at least 6-8 weeks is needed to see if the medication will help. Patients who have experienced some improvements during this time are likely to continue improving for several weeks or months thereafter. If there is no response to an eight weeks trial of SSRIs, treatment should be switched to venlafaxine. For acute PTSD, experts recommend continuing medication for at least 6-12 months; chronic medication should be continued for at least 12 – 24 months, (Seedat, 2004).

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2.7.2 Psychotherapy

Three specialized types of psychotherapy used alone or in combination with medication are effective in helping patients confront their fears by reducing psychological and physiological distress associated with memories of the traumatic event: (i) Exposure therapy – helping patients confront the specific situations that remind them of their terrifying experience (for example, driving a car again after being involved in an accident). Repeated exposure helps the patient to realize that the feared situation is no longer dangerous and they can handle it. (ii) Cognitive therapy – helping patients change irrational beliefs, (for example, unrealistic feelings of guilt). (iii) Anxiety management – teaching patients skills such as relaxation training and positive thinking. Group therapy may also be helpful in some patients in reducing isolation, (Foa, Davidson & Frances, 1999).

Coping responses may include either increased or decreased alcohol use. Given the prevalence of use and the associated psychological benefits of moderate use, for many adults, moderate use may be interpreted as representing baseline healthy functioning. Although increased alcohol use following traumatic experience is often the focus of research, individuals may also respond to traumatic events by decreasing use. Macfarlane in Simons et al. (2005) report that both increase and decrease in alcohol use following a traumatic event were associated with increased rates of PTSD. Although decreasing use does not hold the additional risk of developing an alcohol use disorder, it may still be a cause for concern in that it may indicate that the individual is having difficulty coping with stress.

2.8 Theoretical perspective in PTSD

Researchers have proposed a number of theories or explanations as to why people with trauma and PTSD have higher rates of alcohol and drug use. In this section, only one theory will be discussed, namely, Self-medication theory, this

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may be advanced to explain the reasons why people with trauma and PTSD use alcohol (Brady, Back & Coffey, 2004).

Self-Medication Theory

Many vitamins, herbs, and other over-the-counter "supplements" are used to treat perceived conditions or nutrient deficiencies. Use of controlled drugs for self-medication is illegal without a prescription. The self-medication theory states that people with PTSD use substances as a way of reducing distress tied to a particular trauma and PTSD symptoms. It is often referred to in the context of a person self-medicating, in order to alleviate their own distress or pain and is also seen as gaining personal independence from established medicine. Sufferers of trauma and post-traumatic stress disorder have been known to self-medicate, as well as many individuals without this diagnosis who have suffered from (mental) trauma. For example, alcohol (a depressant) may be used to reduce extreme hyperarousal symptoms (Brady et al., 2004).

2.9 Conclusion

Having had a view into the contextual literature of PTSD and alcohol use, it was clear that traumatic events experienced may make a victim develop PTSD. Inability to find suitable ways of coping with these overwhelming experiences results in victims using alcohol as the main source of coping. Literature also indicates that using alcohol after a horrific experience can temporarily make the victim better cope with the experiences, however, if appropriate ways of coping are used, PTSD symptoms can successfully be treated. The following chapter presents the research methodology that was followed in conducting this study.

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CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This section presents the research methodology that was used in this study. It comprises the following sub-sections: research design, location of the study, validity and reliability, sampling, data collection, data analysis and ethical principles that were taken into consideration when conducting the study.

3.2 Research design

Mouton (2001) defines a research design as a plan or blueprint of how you intend conducting the research. It focuses on the end product, formulates a research problem as a point of departure and focuses on the logic of research. A design captures all the procedures or steps undertaken to ensure an objective test of the theory or problem under investigation. The present study used a phenomenological research design. This approach was aimed at understanding and interpreting the meaning that subjects give to their everyday lives. Creswell (1998) regards a phenomenological study as a study that describes the meaning of experiences of a phenomenon, topic or concept by various individuals.

In this study, a qualitative approach was used in order to explore in detail the relationship between PTSD and alcohol use among patients. A qualitative research design was chosen because such an approach helped to gather information concerning a study from first hand experiences of a person and it allowed close contact between me and the respondents.

3.3 Location of the study

The study was conducted in Thulamela Municipality of the Vhembe District Municipality in Limpopo Province. Thulamela Municipality is situated 70 km east of Makhado, 180 km North East of Polokwane the capital city of Limpopo

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Province. It is the gateway to the Kruger National Park which is the second largest in the world.

Thulamela Municipality is in a summer rainfall area (October - April). The summer months are hot and often balmy. Winters are usually cold but rarely reach freezing point. The area is blessed with the natural beauty which is beyond one's belief; it is mountainous and ever green.

Thulamela Municipality was established in the year 2000 in terms of the provision of the Local Government Municipality structures Act, 117 of 1998 Section 12. The administrative offices of the Municipality are in Thohoyandou with other offices in Malamulele, Shayandima, Makonde, Tshikombani and Saselmane. It falls under Vhembe District Municipality with a population of 584 257 with 261 304 males and 322 953 females. It is a category B Municipality with 40 Wards, 40 Ward Councillors and 40 Proportional representatives Councillors. The total number of municipal staff is 546.

The Thulamela Municipal area is characterized by rural settlement patterns, enormous backlogs in basic household infrastructure and services, discontinuous land uses, concentration of taxable economic resources in the formerly R293 town and on its periphery are scattered concentrations of extreme rural and urban poverty and the apartheid legacy that confronts most local governments.

The overall effects of these patterns have resulted in extreme poverty and under - development. In the deprived areas, household productivity was stifled due to the amount time people would usually spend to meet their basic needs like fetching water and gathering of wood. People in these areas also suffer poor health because of inadequate housing and health facilities.

Scattered small settlements and discontinuous land use make it extremely expensive to provide basic household infrastructure. These same patterns also

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impose a heavy burden on the poor who have to spend valuable time and money to travel long distances to access markets, economic opportunities and other social amenities.

Thulamela is divided into two geographical areas, which are Thohoyandou and its surrounding rural settlement and Malamulele. The largest portion of the population is of school – going age. Almost 89% of households in the Municipality area are provided with acceptable levels of water services; nine percent have access to water services, provided in their dwelling units. The culture of the people of this area is one of togetherness, peace and harmony; it is a place of many legends. Although Thulamela has many people with different cultures and languages, the predominant cultures are that of the Tsonga/Shangaan and VhaVenda people who both have their unique but yet unified histories.

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The Table below shows the health care services that are available in Thulamela Municipality.

Table 3.1: Health services in Thulamela Municipality

Type of service	Total
Regional hospital	1
District hospital	2
Clinics	49
Gateway clinics	2
Health information Centre	0
Mobile clinics	7
Accredited sites on HIV and AIDS comprehensive plan	4

Source: Vhembe District Health Plan 2008-2009

3.4 Population of the study

A population is a collection of objects, events or individuals having some common characteristics that the researcher is interested in studying (Mouton, 1996). The population of this study comprised of out-patients receiving treatment for PTSD from the three hospitals in Thulamela Municipality, namely, the regional Tshilidzini and two district ones, Donald Fraser and Malamulele. 10 respondents were sampled; 5 of them were males and 5 were females; 7 respondents were from the Venda ethnic group and 3 from Shangaan ethnic group. Their age ranged from 18 – 40 and their highest qualifications were secondary (9) and tertiary (1).

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3.5 Sampling and Sample size

Strydom (2005) defines sampling as a means of taking any portion of a population or universe as representative of that population or universe. This study used purposive sampling. Purposive sampling was used to select ten (10) respondents because it has noticeable advantages such as, it relies on the researcher obtaining a representation of the population and as far as possible, taking into account likely sources of differences in their views and experiences; it was easier to monitor the process and to do follow-ups; the response rate was high hence it was easy to retain the sample numbers. Furthermore, purposive sampling was the most appropriate in that it allows a researcher to select the cases that are especially informative (Neuman, 1994). In selecting respondents, I ensured that only out-patients with PTSD and are using alcohol were involved in the study. Posttraumatic Stress Disorder checklist (PCL) was also used as a screening measure for PTSD symptoms. The PCL is a 17-item self-report checklist of PTSD symptoms based closely on the DSM-IV criteria and it takes 5-7 mins to complete (Ruggiero, Del Ben, Scotti & Rabalais, 2003). The scale includes 17 questions which inquire about each of the three symptom domains represented in the PTSD diagnosis; re-experiencing, avoidance/numbing and physical symptoms. Respondents rated the presence of each symptoms on a 1(not at all) to 5 (extremely) likert-style scale.

The first three cases in each hospital were randomly selected until the desired number of ten respondents was reached. Tshivenda and Xitsonga-speaking respondents of both genders were selected to participate in the study, and their ages ranged from 18 to 40 years.

3.6 Entry negotiation

Marshall and Rossman (1989) state that despite acquaintance with the majority of the research subjects, entry negotiations require time, patience and sensitivity to the dynamics and norms of a group. As a researcher, I observed proper

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protocol procedures. The first step was for me to obtain permission to conduct the study from the selected hospitals' management where I made a presentation to seek permission to conduct the study. Secondly, I explained the purpose of the study and the recording procedure to the respondents. Finally, all respondents were then asked to sign a consent form.

3.7 Data collection Instrument

O'Leary (2004) defines a data collection instrument as a tool or device that the researcher uses to collect data. In this study, I used an interview schedule with a set of pre – determined questions. The interview schedule was developed in English and translated into Tshivenda, and Xitsonga. It was translated again from Tshivenda and Xitsonga to English to ensure that same meanings have been captured.

The following components were included in the interview guide:

- Traumatic events experienced by respondents
- Experiences of PTSD respondents after traumatic experiences
- Types of beverages containing alcohol used by PTSD respondents
- Effects of alcohol on PTSD respondents
- Relationship between PTSD and alcohol use
- Coping mechanisms used by PTSD respondents

3.8 Pre-testing

Pre-testing research instrument entails a critical examination of respondents, understanding of each question and meaning (Collis & Hussey, 2009). A pre-test was carried out under actual field conditions on three people with a similar profile to the study's population. The purpose was not to collect data but to identify problems that the potential respondents might have in either understanding or interpreting a question. A pre-testing was done therefore to identify problems in the wording of questions, the appropriateness of the meaning it communicates, whether different respondents interpret a question differently, and to establish

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whether their interpretation was different to what I was trying to convey. Problems encountered resulted in the questions being reexamined to make them clearer and unambiguous.

In this study, respondents were found to be having difficulty in understanding question number 7.

How do you relate PTSD and alcohol use?

I then modified the question to "What is the relationship between PTSD and alcohol use" I also did a lot of explanation when conducting the interview to ensure that respondents understand what the question required. One observation I made was that these respondents on the pretest did not seem to know that they were suffering from PTSD.

Three respondents from Elim hospital in the Makhado Municipality of Vhembe District were selected for the pre-testing. Tshivenda and Xitsonga-speaking respondents of both genders were selected to participate and their ages were ranging from 18 to 40 years. All three respondents did not go beyond secondary schooling.

3.9 Data collection

According to Grinnel (1993), a data collection method is a procedure which specifies how data will be collected. In this study, data was collected through structured face – to – face interviews. The following advantages of conducting structured interviews were identified by Bless, Higson-Smith and Kagee (2006):

- They help overcome misunderstanding and misinterpretation of questions;
- Interviewers can insure that all items on guide have been considered;

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- Interviewer can reassure respondents and encourage them to persevere; and
- Interviewer can also ask respondents for explanations concerning some of the answers.

Maree (2007) states that an interview is a two way conversation in which the interviewer asks the respondents question to collect data and to learn about their ideas, beliefs, views, opinions and behaviors. Arrangements for the interview were made with the respondents so that they felt comfortable and at ease. They were encouraged to use their mother tongue so the respondents could participate freely and the interviews were conducted per individuals, outside their respective hospitals. Permission was sought from respondents to tape record the interview and this was done using an audio tape. The conversations per individual interview were translated from Tshivenda to English and from Xitsonga to English by a language expert. The interviews were conducted in Tshivenda and Xitsonga in order to accommodate both Tshivenda and Xitsonga – speaking respondents. The duration of each interview was approximately 1 hour 20 minutes, including duration for completing PCL checklist

3.10 Data analysis

Data analysis is a process that unlocks the information hidden in raw data and transforms it into something useful and meaningful (Monnette, Sullivan & De Jong, 1990). According to Maree (2007), the goal of data analysis is to summarize what the researcher has seen or heard in terms of common words, phrases, themes or patterns that would aid the researcher's understanding and interpretations of that which is emerging. The present study used content analysis which is a systematic approach to qualitative data analysis that identifies and summarizes message content (Maree, 2007). Furthermore, content analysis is an inductive and interactive process where researchers look for similarities and differences in the text that would corroborate or disconfirm a theory.

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Neuendorf (2002) asserts that content analysis provides insight into complex models of human thought and it allows closeness to text which can alternate between specific categories and relationships and also statistically analyze were coded from of the text. In this study, I transcribed the audio-tapes of the interviews and I organized the transcription according to the question in the interview guide. I analyzed data following Van Mannen's stages of thematic content analysis (Kruger, 1998). The stages were:

Stage one: I read the text several times in order to acquire the overall understanding of it;

Stage two: The text was read again in order to underline or highlight words, phrases or sentences which were relevant to the research questions;

Stage three: Different units of the same meaning were grouped into themes of meaning;

Stage four: Appropriate titles were given to themes according to the contents of each theme.

Stage five: The relationship of themes was discussed, thereby presenting what the whole text portrays.

3.11 Ethical considerations

Ethics are guidelines, codes or behaviour that regulates the way members practice their profession. These guidelines have been developed to ensure that professionals respect the dignity of all people and animals and the rights of people to privacy, confidentiality and self-determination (Train, Ahmed, Bandawe, Cockcroft, Crafford, Greenop, Stacey, Tomlinson, Tommy & Dale – Jones, 2007).

The proposal was orally presented before the School of Health Sciences' Higher Degrees Committee for input/recommendations. After the recommendations were attended to, it was submitted to Senex for approval. Finally, it was

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submitted to the University's ethics committee for ethical clearance. The following ethical issues were taken into consideration when conducting the study:

3.11.1 Informed consent

As recommended by Edwards and Louw (1997), respondents were informed about the aim of the research and the procedure to be used, describing any risk involved including any discomfort and intense stress, or emotional problems that may arise, and the benefits the research holds for the respondents. Respondents were also informed about their right to withdraw from the research study at any stage, and that they may refuse to answer any question if they felt uncomfortable about the question. I ensured that no respondent was harmed physically and I adhered to these guidelines so that my behaviour as a researcher was within appropriate limits.

3.11.2 Confidentiality

Respondents were told how the information was going to be used, and were assured that such information will be used with great care. It was also explained to the respondents that no one, except the researcher will have access to the information, and that the information obtained will be stored in a safe place.

3.11.3 Avoidance of harm

Respondents were assured that the study is not going to harm them in any way. However, due to the nature of the phenomenon that I was investigating, two respondents showed some emotional discomfort. Although it was my intention not to harm respondents, emotional harm to subjects is often more difficult to predict and to pre – determine, than physical discomfort.

3.11.4 Dissemination of results

Respondents were informed about the findings of the study and were also informed that the findings will be made available to the University of Venda

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library, Department of Psychology at University of Venda, community libraries and the hospitals where the study was conducted. Findings will also be presented in conferences and published as an article in an accredited journal. This will help bring awareness about the study as well as the recommendations that may help in future research, in cases of PTSD.

3.12 Conclusion

This study was a qualitative in nature and the description of the design, population, location, sampling, procedure and methods of collecting and analysing data were all outlined in this chapter. The next chapter presents the findings of the study.

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CHAPTER 4: PRESENTATION OF THE FINDINGS

4.1 Introduction

This chapter presents the findings of the study. The findings are divided into seven sections: respondents' biographical information, types of trauma events, strategies for coping with posttraumatic experience, exposure to repeated trauma, effects of trauma, types of alcohol beverages used by respondents, onset of drinking alcohol by respondents, and relationship between PTSD and alcohol use.

4.2 Respondents' biographical information

This section provides biographical information of the respondents. Ten respondents were sampled for the study; both male and female who speak Tshivenda and Tsonga. The study revealed that some respondents were students, some were employed and only one was not employed. The study also revealed that respondents' ages ranged between 18 and 40.

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Table 4.1 Respondents' biographical information

Biographical item		Respondents N= 10	
		N	%
Gender	Male	5	50
	Female	5	50
Age	Between 18 – 30	7	70
	Between 31 – 40	3	30
Ethnicity	Venda	7	70
	Tsonga	3	30
Education	Secondary	9	90
	Tertiary	1	10
Occupation	Student	4	40
	Employed	3	30
	Self employed	2	20
	Unemployed	1	10

Table 4.1 shows that ten respondents participated in the study. 50% of the respondents were males and 50 % were females. The Table also shows that age range of the respondents was 70 % for those who are between 18 – 30 and 30 % were between 31 – 40%. The ethnic groups were 70 % Venda and 30% Tsonga.

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In terms of educational level, only 10 % had managed to reach tertiary and 90 % had reached secondary school level. 40 % were found to be students, 30 % were employed, 20 % were self-employed and only 10 % was not employed.

4.3 Types of traumatic events

This study revealed that respondents had experienced two different categories of traumatic events, namely, man-made unintentional/accidental disasters and intentional interpersonal violence. These findings show that these traumatic events were the results of intentional violence and human error. This includes actual or threatened violence and witnessing physical violence or emotional abuse. Furthermore, some of these events occurred once and some others repeated. It was also evident in this study that these events had made a devastating impact on respondents' life and they all felt that this was an overwhelming experience.

"Eish….. My friend, life is tough. I feel like the world is against me. I feel so helplessness; those that I trust are no more". (Respondent 6)

"Things are bad my friend. I think I have lost my real sexually orientation. I think am no longer a man any more". (Respondent 7)

4.3.1 Man-made unintentional/accidental disasters.

The study has discovered that some of the respondents have been involved in traumatic events such as, motor vehicle accidents, fire and witnessing deaths as a result of accidents. It is clear in this study that these unexpected events caused fear, stress, and physical harm.

"I have been involved in a motor vehicle accident 2 years ago while I was going to buy bread in the nearby shop. I didn't see it coming; all I can remember is when I was taken to the hospital". (Respondent 1)

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"It is quite a sad or perhaps emotional experience. I used to live in a two roomed house, so this other day it happened that the house caught fire. It appeared that there was no way out since the fire was huge and a lot of smoke. Three of us were all screaming for help and at the same one of my younger's clothes were starting to burn. And we felt so hopeless that will survive". (Respondent 10)

"I have witness three of my close friends being knocked down by car. Two of my friends died on the scene and the other sustained the very serious injury. One of those friends was my boyfriend. I always cry when I think of him". (Respondent 6)

4.3.2 Intentional interpersonal violence

In this study, respondents were also involved in traumatic events such as rape, robbery, assault and sexual abuse. It was found that these types of events had made a devastating impact on respondents' life and threatened their sense of security. Respondents end up suffering traumatic stress and bereavement as results of these traumatic events.

"I have been sexually assaulted by my uncle a year ago. Both of my parents have passed on. I together with my young sister, are always sexually assaulted by my uncle but as of now my young sister is no longer staying with us. We even tried to involve our relatives but nothing has changed". (Respondent 2)

"I have been involved in a robbery wherein my colleague ended up being shot on the head in front of all staff members in the shop. Three men came in pretending to want to buy some items in the shop. They then took out their big guns and started demanding cash, airtime and cigarettes. Right after one of them shot my colleague; he then pointed me with a gun". (Respondent 8)

"Hey my man, I got arrested six months ago. So while I was in prison things got tough. As you may know that some of the inmates form groups, this other day things got out of hand when I refused to be sodomized. I was severely beaten wherein I ended up fighting for my life". (Respondent 7)

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4.4 Exposure to repeated trauma

The study has shown that exposure to repeated trauma made respondents feel that these events are now disrupting their fundamental sense of trust and attachment. It also shows that the nature in which subsequent events occurred made the respondents more vulnerable to posttraumatic stress disorder.

"Yes, like I said before, it was a repeated experience. He kept doing it for several times. He always promises to kill me if I tell people and that he will stop buying food in the family. And I feel bad whenever he abuses my mother, I always witness that". (Respondent 5)

"Yhaaa, it was a repeated experience because few days after that traumatic experience, I had to be sodomized by the very same group. And this time I couldn't say no because of the fear of what happened to me last time. I have also seen terrible things happening to other fellow inmates which are very life threatening. Life is really tough there". (Respondent 7)

"Yes it was repeated because he used to do it in many occasions and he was always threatening not to buy food for us. Because we had no other source to provide us with food and shelter we were forced to live by his commands". (Respondent 2)

4.5 Effects of trauma

The study has discovered that after the traumatic experience, respondents feel that they are helpless, hopeless and always preoccupied with the feeling of fear. It is also clear in this study that some respondents are struggling with upsetting emotions, frightening memories and are unable to trust people and the environment they live in. Some feel that their future is shaken as the meanings they attach to their lives have changed. Some respondents feel that their relationships with others have been affected because they can no longer perform tasks that they used to do in the past. It also appears that their interactions with

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friends, family and co-workers have been affected significantly. Respondents were found to be experiencing posttraumatic stress disorder differently and were also experiencing three main types of symptoms which are discussed below.

4.5.1 Re- experiencing the traumatic event

The study has found that some respondents become upset whenever they are confronted with a reminder of the trauma and they sometimes feel like the event is happening again. It has also been discovered that some respondents were experiencing frightening dreams that are related to the traumatic events that they have been confronted with.

"Right now I can't cease to experience intrusive images of those two me" (Respondent 9)

"When I sleep, I often experience recurrent distressing dreams" (Respondent 10)

"I don't enjoy being with my boyfriend because each time he touches me I feel like is him (uncle). When I sleep at night, I usually have nightmare about him and other frightening thing he does." (Respondent 2)

4.5.2 Avoidance and numbing

Respondents were found to be trying by all means to avoid people, places and thoughts that remind them about the traumatic experience. As a result of these experiences some seem to have lost interest in activities they used to enjoy. Some due to the severity of the incident, they cannot even remember how they found themselves being the victims of it. Due to the severity of the trauma, other respondents believe that their lives have been disrupted and they do not expect to live a normal life again like getting married (for the respondent who was raped).

"These days I don't even feel comfortable watching action movies on TV because I fear that I may see motor car accidents" (Respondent 1)

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"You know what I feel that I have lost a value in life, am now a worthless person, who do you think can marry someone who have been gang raped, I have no future ….. So far I no longer spend much time in the bar because am scared that the same experience will repeat itself. I don't even want to meet the perpetrators, I hate them" (Respondent 4)

"This thing has affected me very bad you know, I used to play soccer but now I just need to be alone" (Respondent 10)

4.5.3 Increased anxiety and emotional arousal

The study has discovered that respondents were experiencing difficulty maintaining their sleep patterns due to trauma. Some were experiencing irritability and difficulty concentrating when doing tasks at work and school. Some were always alert about people who come to their work place. All these show that these respondents are still preoccupied with the traumatic experience they had and they had not dealt with these experiences.

"This has been disturbing in my life because I can no longer maintain my sleep and when am at work things have now changed because am always hypervigilance (I always look at who is coming in the shop) and this makes me not to concentrate on my work" (Respondent 8)

"I easily get irritated when people talk about things related to the trauma I experienced. (Respondent 6)

4.5.4 Impairment in occupational area of functioning

The study shows that these horrifying experiences has made some negative impact in respondents' lives as they are now unable to perform well, the good work they used to do. It is also clear that this impairment has destroyed and to some it threatens to destroy their occupations and they are likely to be jobless should they continue experiencing difficulty coping with the experience. This

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study also shows that some respondents could not proceed well with their schooling because they were repeating grades several times. This was a result of them being unable to cope with their overwhelming experience.

"I had been unable to concentrate at work and my supervisor had also given me verbal warning because I had not been doing my work properly" (Respondent 1)

"I used to work but now I can't because the supervisor says I can't concentrate and am not productive" (Respondent 10)

"You know what? Am now at school, but nothing is coming my way. I often find myself absent from school, if am there I can't really concentrate" (Respondent 9)

4.5.5 Interference with interpersonal relationships

It is also evident in this study that due to the horrific experience, interpersonal relationships were suffering. It was discovered that the manner in which the trauma occurred can contribute to interference in relationships. Respondents were found to be unable to maintain interpersonal relationships and some even went to an extent of ending them because they felt like they were re – experiencing the trauma when their loved ones touch them. It became clear from this study that respondents were experiencing problems in their intimate and family relationships and PTSD symptoms were interfering with trust and emotional closeness.

"I even divorced the one I love because each time he touches me I used to feel like it is my stepfather" (Respondent 6)

It was discovered that some respondents were sexually abused by the parents while they were still young. As a result of this, they have problems with both emotional and physical intimacy in adulthood. This has made them have problems with emotional closeness. Since the form of abuse have violated trust which makes it difficult to be close and vulnerable with people.

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"Right now I can't even maintain a good relationship with my partner" (Respondent 2)

4.6 Types of alcohol beverages used by respondents

Respondents were found to be drinking different types of alcohol. However, it appears that they preferred drinking beer because it is affordable and it is accessible everywhere in their areas. Wine was also found to be rarely drank by the respondents. It is clear that respondents were drinking beer mostly because they believe that after using it, they will forget or overcome their painful experience. Some respondents were found to be drinking whatever is readily available, as long as it is alcohol.

"Please don't judge me, I drink any alcohol except sorghum beer, beer, wine, brandy etc. it depends on what is available for the day and whether I have enough cash or not" (Respondent 2)

"I seem to enjoy beer because it helps me to temporarily overcome this traumatic experience" (Respondent 10)

4.7 Onset of drinking alcohol by respondents

This study found out that there were some respondents who started drinking before the traumatic exposure and those who started after. It is clear that respondents felt that overwhelming experiences can only be dealt with through consumption of alcohol.

4.7.1 Drinking patterns before traumatic exposure

Although there were some respondents who reported having drank alcohol before, these painful experiences caused them to continuously use alcohol and now, as a means of coping. To some extent respondents felt that they cannot cope without consumption of alcohol on a daily basis.

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"The pain was so unbearable and I felt that I needed something to bring my life back. Right now I can't imagine myself sleeping without having one or two and I think it is even taking control over my life" (Respondent 6)

It was also found that although respondents reported drinking alcohol before some had decreased their drinking pattern and some had increased it after the event. Some respondents had to decrease drinking because they were scared that the same traumatic event might be repeated.

"Yaaaaaa, ever since this experience I told myself to decrease my drinking patterns because am scared that other people may want to take advantage on me again" (Respondent 4)

This study has also revealed that some who have been using alcohol prior to the traumatic experience have increased their drinking patterns following their exposure. These respondents felt that they should increase the amount so that they can better cope with what happened. Some used to drink occasionally but after these overwhelming experiences they were be drinking almost every day.

"Yes, I think I increased because in the past I used to drink mmmmh maybe once or twice a week but now, hey things have changed" (Respondent 1)

"I really don't know what is happening; so many things have changed about me. I drink almost every day, and I don't even care whether it is in the morning or later in the day" (Respondent 8)

4.7.2 Drinking of alcohol after traumatic exposure

This study discovered that those who started drinking after the traumatic exposure felt that they needed something to make them cope with the experience. They felt that there is no other way of dealing with their experience except through using alcohol. They felt that they regularly want to forget these painful experiences due to pressure these events have brought into their lives. It

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was clear that their circumstance made them to choose drinking and perhaps lack of support may have contributed.

"I started drinking after the horrible experience I had. I needed to get something that will bring my life back. I feel better when am drunk" (Respondent 2)

"I started drinking after this horrifying experience because I wanted it to make me cope. I wanted to forget about the experience" (Respondent 9)

4.8 Relationship between PTSD and alcohol use

The study has discovered that respondents relate their alcohol use to the trauma that they have experienced. The respondents felt that they used alcohol as a way of reducing distress the tied to particular PTSD symptoms. They felt that alcohol provide a feeling of relief and it helped them to cope with trauma memories. Respondents felt that their use and increase in alcohol drinking was motivated by these overwhelming events. Some felt that without alcohol they could not really face the world. It is clear from the answers that respondents now depend on alcohol in order to function well in their lives. They also linked PTSD and alcohol use because they felt that there was not enough support is not enough from their friends and families.

" I think trauma makes a person to feel more vulnerable to the situation because you keep thinking about what happened and if you don't find necessary support one may turn to drink alcohol" (Respondent 1)

"PTSD is something that normally leaves you overwhelmed, and as such one is tempted to do whatever it takes to deal with it, many people that I know prefer dealing with it using alcohol, thinking that it will permanently go" (Respondent 5)

"The pressure is too much. Without someone or something you won't survive. I feel there is a relation though the other may seem to be dependent on the other" (Respondent 10)

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4.9 Strategies for coping with Posttraumatic experience

This study has shown that respondents have gone through a traumatic experience and have been struggling with upsetting emotions, frightening memories and a sense of constant danger. Some respondents were feeling angry, disconnected, irritable and were unable to trust other people. This study also reveals that respondents themselves do not really know that what they are going through needs professional help and as a result, they resorted to self-help strategies. It is clear that different mechanism were used to deal with these traumatic experiences. There are different sub-themes that emerged from this;

Psychologically, we connect traumas. If one experience a new trauma before one have had enough time to heal from previous trauma, one may experience the separate events as related. This can lead to intensified symptoms and prolonged recovery time. As a result of multiple traumatic incidents, one may experience a greater sense of disconnectedness from oneself, others, and work. One needs to seek out support from a friend or counsellor to help restore ones sense of order and control.

4.9.1 Counseling

The study has found out that some respondents used both alcohol and counseling as ways of coping. Although they did go for counseling, it appears that they did not go there voluntarily but they were referred and it showed that since they started attending sessions things were better.

"My friends suggested that I must go to counselling of which I did and am still on it. So it is the one that kept me coping with this pressure" (Respondent 9)

"So far the thing that kept me going is counselling sessions that I have attended. I must admit that things are getting better as compared to before" (Respondent 8)

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4.9.2 Alcohol use

This investigation has led to a discovery that alcohol has been used by respondents to help recovery from their horrific experience. Respondents felt that pressure was too much and the only way of coping was to drink alcohol. Although respondents tried to also deal with their traumatic experience using other means, alcohol became the primary source of recovery.

"So far alcohol has been keeping me going. I just don't know if am really doing the right thing but I believe it is making me to cope with all that I went through" (Respondent 6)

"I have being drinking alcohol which I believe it had been making me cope and I have also referred to the counsellor who is also helping me." (Respondent 10)

4.9.3 Social support

This study has also shown that respondents tried to use family and friends as support and as an option for recovery but they felt that their support was not enough and they do not seem to take the respondents seriously. Respondents reported confronting their families with their overwhelming experiences but no one seemed to listen to them. They also feel that sometimes when they turn to their friends, they judge them about the nature in which the trauma has occurred. This study has revealed that some respondents did not get family support because of dynamics in the families.

"I tried to talk about this with my friends but they don't seem to take me serious. As for the family and relatives is much better although their support is not enough" (Respondent 5)

"So far sharing with friends has being the option that has been available to me and of course drinking makes me try to forget" (Respondent 1)

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"My family has not been supportive and perhaps it is because we don't get along" (Respondent 6)

4.9.4 Spiritual support

This study revealed that some respondents did not only resort to alcohol, counseling and support from the family and friend, but they often went to church to seek for spiritual support. This was clear because they usually kept themselves busy by reading bibles and going to church.

"I sometimes find myself reading the bible and always keeping myself busy with family chores. I normally do this on the daily basis" (Respondent 4)

"Perhaps one may also say going to church is helping because my soul if being uplifted day by day" (Respondent 5)

4.10 Conclusion

The findings of the study showed different types of trauma events that were experienced by the victims and how these events changed their life. In some instances, respondents experienced multiple events of trauma that contributed to them developing PTSD. These experiences left respondents feeling helpless, hopeless and worthless. They reported that they were not able to cope and this led them to increase or decrease the amount of alcohol drank and for some the event caused them, even to start drinking different types of alcohol, counselling and spiritual involvement as ways of coping with these overwhelming experiences. Respondents reported to have used alcohol extensively mostly due to its availability and affordability. The following chapter discusses the findings.

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CHAPTER 5: DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study. The results of the study will be discussed and substantiated or disproved by the literature

5.2 Respondent's biographical information

The findings show that the study contained both males and females who had been exposed to different types of trauma. Ditlevsent and Elklit (2012) in their study found that both men and women can equally be exposed to any traumatic event but men are at a higher risk of being exposed to traumatic events during their lifetime as compared to women. They further state that PTSD prevalence varies across different trauma types and that women are at higher risk of developing PTSD than men. Exposure to traumatic events during one's lifetime is almost inevitable; it has been reported that 60.7% of men and 51.2% of women would be exposed to some kind of trauma in their lifetime (Kessler et al., 1995).

The findings of the study show that respondents were aged between 18 and 40 years. Javidi and Myadollahie (2012) show that PTSD can appear at any age, and it is more common in young adults, because they are more likely to be exposed to precipitating situations hence children can also develop PTSD. The findings of the study also show that respondents' level of education varied between secondary and tertiary. Kessler et al., (1995) show that exposure to traumatic events during one's lifetime is almost inevitable. Anyone can be exposed to trauma irrespective of age, occupation, ethnicity and gender.

The findings show that respondents were Tshivenda and Tsonga – speaking. Literature shows that no study has been conducted on these two ethnic groups about PTSD and alcohol use. However, Breslau, Aguilar-Gaxiola, Kendler, Su, Williams & Kessler, (2006) found no statistically significant difference in PTSD between Blacks or Hispanics and Whites, but Himle, Baser, Taylor, Campbell

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and Jackson, (2009) found Blacks had higher lifetime prevalence of PTSD than Whites. These studies however, did not decompose risk of PTSD by exposure to potentially traumatic events or the subsequent development of PTSD once exposed. Studies of race/ethnic differences in exposure to potentially traumatic events are limited by their data collection from a specific geographic area or by their focus on a limited number of event types. Furthermore, reviews of this literature highlight its inconclusive results (Kilpatrick & Acierno, 2003; Hatch & Dohrenwend, 2007). Race/ethnic differences in type of event exposure, particularly elevated rates of exposure to violence, may account for possible differences in PTSD by race/ethnicity, because type of event exposure is an important determinant of PTSD. A few studies do examine race/ethnic differences in other characteristics of event exposure which increases risk of developing PTSD, such as exposure to multiple events or younger age at exposure (Kessler et al., 1995)

5.3 Traumatic events experienced

The findings of the study show that respondents were exposed to different traumatic events and the major events experienced include motor vehicle accidents, sexual assaults, robbery, rape, seeing someone hurt and killed, and fire. Most of these events were found to be individual traumas. Individual trauma may involve thwarting by others such as being assaulted or be the result of natural events, may involve violence and may be experienced directly or witnessed. This is in line with Russel (2011) who state that trauma experiences include war, violent personal assault (for example, sexual assault, and physical attack) being taken hostage or kidnapped, confinement as a prisoner of war, torture, terrorist attack, or severe car accidents. In children, sexual abuse or witnessing serious injuries or unexpected death of a beloved one may cause PTSD. Peltzer (2000) in his study found that in a rural population in the former Northern Province, 28 percent had experienced physical assault, 14 percent had been exposed to crimes involving firearms, 10 percent gender violence and 10 percent sexual abuse and rape. Norris (1992) also confirms these results

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wherein he found out in his study with an American sample that sexual assault 13.6 percent, physical assault by 13.3 percent, motor vehicle crash by 11.5 percent and that experiencing an accident reflected the highest rates for developing PTSD among clients who have experienced traumatic events.

Traumatic events may have serious medical consequences requiring attention of trauma nurses. It was clear from this study that some respondents had experienced sexual assault that had resulted in them not wanting to have intimate relationship in future. Although other complications are not known about sexual assault on the respondents Krysinska et al. (2009), state that female victims of sexual violence frequently suffer from gynecological complications such as, vaginal bleeding or infections requiring medical attention.

5.4 Exposure to repeated trauma

This study has revealed that respondents were not only exposed to a single event but multiple events and that led to the development of PTSD. Although these respondents experienced repeated trauma had some significance the nature of trauma events played a role in the diagnosis of PTSD. Darves-Bornoz, Alonso, Girolamo, Graaf, Haro & Kovess-Masfety, (2008) confirm the results of this study by stating that the average person diagnosed with PTSD has experienced more than one traumatic event. Typically, one thinks of trauma as single life-threatening event; however, trauma can also arise from an accumulative of small incidents rather that one major incident. Examples include, repeated exposure to horrific scenes of accidents or fires, repeated involvement with serious crime, breaking news to others of bereavement caused by accidents or violence, especially if children are involved, repeated abuse (verbal, physical or sexual), regular intrusion and violence of one's physical or psychological space (Jasinski, Williams & Siegel, 2000).

Findings show that there were respondents who were sexually abused. Due to an inability to control the circumstances leading to the sexual abuse respondents

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continued to experience the abuse leading to feelings of powerlessness in their lives. Alcohol use by these respondents served to increase feelings of personal power and self-esteem. It also served to increase confidence and decrease the anxiety of normal social interactions. These findings are in line with several studies that indicated that women may use alcohol in an attempt to boost self-confidence, to relieve anxiety and to increase the feeling of power and control, (Jasinski et al., 2000). Howard and Crandall (2007) reported that if trauma is prolonged, extreme or repetitive, it can actually physically injure the brain. It keeps the body from operating a healthy combination of the hot and cool systems of the body and brain.

5.5 Effects of trauma

This study revealed that some of these respondents after the event could not maintain good relationships with their family members. Krysinska et al. (2009) observed that traumatic events not only directly affect the victims but also those who come in contact with traumatized individuals on both personal and professional levels. Family members and mental health professionals as well as witnesses of trauma may show symptoms of PTSD and other changes in behavior, which may also affect cognition. Furthermore, these authors state that there is an ample evidence of increased risk of suicide among individuals who have experienced a wide range of traumatic events including war veterans, victims of domestic violence and sexual traumatization, individuals exposed to childhood abuse and neglect, survivors of natural disasters, people exposed to torture and the holocaust victims.

Findings in this study show that respondents have reacted differently after the trauma exposure and these were in line with the criteria set out in DSM-IV-TR, (2000). Respondents reported that they have experienced a combination of fear, feelings of helplessness and horror following the exposure. Due to these overwhelming experiences, respondent went on to react with different with PTSD symptoms; some reported that they have intrusive feelings, avoidance and

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hyperarousal symptoms. As a result of these, they were unable to maintain their sleep patterns; they often had nightmares, some were always irritable, avoiding thoughts about trauma and some were always on the lookout as to who is around them. This clearly indicates that the trauma had left them vulnerable due to the experiences they went through. PTSD is difficult to treat, even difficult to diagnose. The disorder carries an especially strong stigma of dishonor and moral weakness. Howard and Crandall (2007) report that during the first and second world wars, people called some soldiers suffering from PTSD and stress – breakdown as cowards or deserters.

DSM IV-TR (2000) states that there are criteria for diagnosing of PTSD. (1) The person goes through periods or sees somethings that involve actual or threatened death or serious injury. The person responds to this with intense fear, helplessness or horror. (2) The person lives this traumatic event through dreams or recollections. He or she can behave as if the trauma is actually happening right then. (3) The person tries desperately to avoid this and to avoid anything associated with the trauma, in fact may not even remember the trauma yet will react strongly to certain stimuli. (4) He or she may be hypervigilant. (5) All these characteristics may last longer than a month and may cause significant distress in daily life. The person often has difficulty sleeping and concentrating. These symptoms were also found to be disrupting their daily lives in that they were no longer functioning well at school or their work places; hence teachers and superiors were not happy with their performance at school in their work place. The respondents also reported that they cannot maintain their intimate relationships and they do not see any necessity for them to have other intimate relationship in future.

Some even reported that their interpersonal relations do suffer because they tend to be isolated. These findings show that the symptoms were causing the respondents clinical distress or impairment in social, occupational and other areas of functioning. Howard and Crandall (2007) observed that since PTSD is actually the body's natural response to an injury, it is not really an illness in the

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same sense as depression. It is however often accompanied by depression and other mental illnesses.

Intrusion

The findings study show that some of the respondents experience flashbacks. They kept complaining that they still have vivid memories about the trauma. These lead to difficulty in doing their work well because these flashbacks kept coming back. American Psychiatry Association (2000) state that intrusion is when people complain that memories of traumatic incidents come back to them unexpectedly and intrude into their lives and cause discomfort. These sudden, vivid memories will normally be accompanied by strong painful emotions associated which can sometimes be so strong that the person feels that he/she is experiencing the traumatic event, all over again.

Avoidance

The findings revealed that indeed respondents were trying, by all means to avoid places and people who remind them about the pain. In some instances respondents could not even watch television because they felt they could see something that will remind them of the traumatic events. Baumann (1998) states that avoidance symptoms tend to affect relations with others. The person may try to avoid close emotional ties with family, colleagues and friends. At first the person may feel numb and only complete routine and mechanical activities. Then when re-living the traumatic event the individual may alternate between flood of emotions caused by the flashbacks of the events and an inability to feel or express emotions at all. A person with PTSD may try to avoid situations that are reminders of the original traumatic event.

Hyperarousal

The findings of this study shows that the respondents who had experienced trauma at work place, were always on a look out for people coming to their work

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environment as they always thought every strangers or customer might be coming to harm them. The results also show that some respondents could not concentrate at work and that resulted in low production and them being issued with warnings. Baumann (1998) observe that PTSD can cause individual to act as if they are constantly threatened by the trauma and this hyperarousal can cause them to become suddenly irritable or explosive even when unprovoked. They may have trouble concentrating or remembering current information and because of terrifying nightmares, may develop insomnia. Many people with PTSD also attempt to rid themselves of painful flashbacks, loneliness and anxiety by abusing alcohol or other drugs to help them forget the pain and trauma, temporarily.

Sexual and emotional intimacy

The findings of this study shows that due to climate of secrecy which generally accompanies sexual assaults, a shame-based sense of self have developed in these respondents. It was discovered that feeling of being 'bad' and 'at fault' for the assault were common and alcohol drinking was used to overcome these self – accusations. Kim, Talbot and Cicchetti (2009) observed similar results that sexual abuse in childhood can produce profound feelings of shame. Van Dyk and Van Dyk 2010 add that people who suffer from a traumatic event may have a range of different reactions including anger, self-blame, fear and anxiety. Andrew (1995) also state that women with sexual abuse histories report more shame-proness and inter personal conflicts. He also adds that the sufferers may not know that they are suffering from PTSD and may think it is madness; sufferers are afraid to tell anyone because of the social stigma associated with emotional distress. Jasinski et al., (2000) observe that this suggests that the feeling of responsibility for the abuse may trigger feelings of guilt and shame and increase the risk for heavy alcohol use.

Findings of the study have revealed that some of the respondents were sexually abused while they were still young. This has resulted in them feeling

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fundamentally flawed or even worthless. Young (1992) observes similar results that children who are sexually abused tend to see themselves as not being worthy of love and respect. They have low levels of trust and anticipate betrayal or abandonment. Childhood sexual abuse causes other problems in intimacy as well. Sex performed on a child is generally painful and frightening which can lead a person to be averse to sex later in life; the association of shame with sex can heighten a person's aversion to experiencing sexual pleasure later on even when it would be appropriate as an adult. This may result in them having difficulty forming intimate relationships. Jasinski et al., (2000) state that in adulthood, there are typically two types of situations that can arise in persons who were sexually abused as children; either lack of sexual interest or tendency to over sexualize relationship. However, findings in this study showed that only lack of sexual interest was experienced by the respondents.

5.6 Types of alcohol beverages used by respondents

The findings of the study show that respondents drink beer to relieve painful experience they had come across. Beer was the most common beverage containing alcohol that was used by respondents due to its availability in their respective communities. They reported that they could not use other beverages containing alcohol because they could not afford them. Setlalentoa et al. (2010) note that the South African liquor Act of 2003 regulates the times when liquor may be traded. However, outlets such as supermarkets and tarvens trade at different times to bottle stores. Some of the unregulated outlets operate according to demand. This makes alcohol easily and widely available and affordable to all races, genders and ages despite the restrictions. Historically, alcohol consumption contributed towards the strengthening of the socio-cultural fibre of African communities. The use of alcohol today poses a major threat to the quality of life of many South Africans; ultimately drinking is causing detrimental public health effects as well as negative socio-economic effects on the country. Alcohol use or abuse has become an everyday reality that directly or indirectly

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impairs people's lives, not only individually but also on familial, societal and national levels (Parry & Bennets, 1998).

5.7 Onset of drinking alcohol by respondents

The findings show that respondents started drinking before and others started, following their exposure to traumatic experiences. Those who had been drinking found themselves increasing their drinking amounts as in trying to be emotional stable. However, due to the nature of the trauma, others had to decrease their drinking patterns because of fear that they may have a repeated experienced of trauma. The study conducted by Steyn (2011) shows that 13% of respondents indicated that they started to increase their drinking of alcohol and other substances as a result of job-related circumstances. This clearly shows that they were not coping with the demands of their work which is similar to the current study wherein respondents had to drink alcohol in order to focus at work. Simons et al. (2005) add that individuals experiencing stressful life events may use alcohol at higher rates and are at increased risk of developing alcohol – related problems. Since some respondents have increased their drinking patterns, they are likely to develop alcohol-related problems should they do not adopt other coping strategies.

Mcfarlane in Simmons et al. (2005) state that both increase and decrease in alcohol consumption following a traumatic event were associated with increased rates of PTSD. Such deviations from a person's normal functioning in response to stress likely indicate that the individual is struggling to maintain previous emotional equilibrium. Although decreasing use does not hold the additional risk of developing an alcohol – use disorder it may still be a cause for concern in that it may indicate that the individual has difficulty coping with stress. Individuals may also respond to traumatic events by decreasing use. This may be, especially, likely for individuals who have received training or education warning them about the problematic associations between alcohol use and coping with affective distress.

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Respondents on this study were found to have increased their drinking pattern following their trauma exposure. The main of this increase aim was to cope with their overwhelming experiences. Simmons et al., 2005 confirm these findings by stating that there is a functional relation accounting for high comorbidity between PTSD, alcohol use and related problems whereby individuals increase alcohol use in an effort to cope with trauma symptomology. Moreover, it appears that increasing alcohol drinking usually comes as a consequence rather that an antecedent of PTSD and is used in an effort to alleviate symptoms.

This increased pattern of alcohol use (using alcohol to cope with distress) is associated with increased risk of negative alcohol consequences and alcohol dependency.

5.8 Effects of alcohol

The findings revealed that respondents experience feelings of irritability, anger, isolation, poor concentration and poor sleeping patterns which are also in line with the criteria for the diagnosis of PTSD. Matsakis (1992) in his study also found that alcohol use and intoxication also increase emotional numbing, social isolation, anger and irritability, depression, and the feeling of needing to be on guard. This study also revealed that respondents now depend on alcohol, whereby, they drink it on a daily basis as a way of dealing with their problems. This behavior could lead to them developing alcohol-related problems. Tarrier et al. (2003) observed similar results that there was a strong evidence of a link between PTSD and alcohol problems, with a higher risk of alcohol-related problems for those with PTSD following trauma, compared with those exposed to trauma but without PTSD or those not exposed to trauma.

The study also revealed that work performance for some respondents was suffering. Setlalentoa et al. (2010), state that any working environment has certain expectations of its employees. They have to be productive in order for the company to realize profit and that those employees who use or abuse alcohols

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are not likely to perform well at work. Some of the problems identified are absenteeism, low production (inability to meet deadlines, inability to follow procedures) and proneness to job- related accidents. This could lead to dismissal that would affect the person and his or her family. The disruption caused by alcohol use or abuse on different societal levels, ranging from family breakdown to crime, remains overwhelming.

Individuals experiencing stressful life events may use alcohol at higher rates and are at increased risk for developing alcohol-related problems. Alcohol use has been linked with both general life stresses as well as symptomatology associated with traumatic experience. Alcohol has physiological effects that may serve to dampen symptoms such as exaggerated stale and other hyperarousal symptoms (Simmons et al., 2005). Excessive use of alcohol can cause several bodily changes that might increase illness and death rate and can also impair one's ability to sleep restfully and to cope with trauma memories and stress, Lowenfels (1982).

The findings show that respondents have PTSD and were using alcohol. Evans and Sullivan (1995) report that alcohol use and intoxication also increases emotional numbing, social isolation anger and irritability, depression and feeling of needing to be on guard (hypervigilance). Respondents were also found to be now becoming over dependent on alcohol as a way of coping. Kaysen, Pantalone, Chawla, Lindgren, Clum, Lee & Resick, (2008) attest that poor health behavious such as alcohol use that can be associated with PTSD may independently lead to increased health concerns. Furthermore, heavy alcohol consumption has been associated with multiple health problems including coronary heart diseases, injuries, various cancers, hypertension and liver diseases.

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5.9 Relationship between PTSD and alcohol use

The study has revealed that all respondents have posttraumatic stress disorder and were drinking alcohol. As they have PTSD, they resorted to alcohol use as a way of trying to cope. PTSD and alcohol use commonly co-occur in the general population and this co-occurrence has been linked to impairment in a myriad of functional outcomes (Read, Brown & Kahler, 2004). The findings show that respondents became over dependent on alcohol because they want to overcome their overwhelming experiences. Although respondents were also using other strategies in dealing with their experiences, alcohol has become the primary source of defence. Trauma literature suggests that there are many different reasons why individuals with PTSD engage in alcohol or substance use. Chilcoat and Breslau (1998) attest that individuals with PTSD engage in alcohol and substance use as a means of self-medication to regulate painful emotions.

Rheingold, Acierno and Resnick (2004) confirm this result by saying that individuals with PTSD may engage in risky health behaviours as an attempt to cope with high levels of emotional distress related to PTSD. Literature further states that alcohol use may temporarily regulate emotions or relieve some of the prevailing PTSD symptoms. However, it does not eliminate or resolve the primary trauma issues that the person is struggling with. Respondents also reported that they are aware that alcohol can only temporarily regulate their emotions.

Dixon, Leen-Feldner, Ham, Feldner and Lewis (2009) stated in their study that trauma – exposed individuals with or without PTSD may demonstrate an enhanced motivation to drink alcohol to cope with negative effects. Back, Sonne, Killeen, Dansky and Brady (2003) observe that alcohol use disorders have been related to more severe posttraumatic stress symptoms in trauma- exposed samples both with or without PTSD diagnosis. Despite evidence of the relation between posttraumatic stress symptoms and coping motives for alcohol use, the potential mechanism underlying this association remains unclear (Vujanovic, Marshall-Berenz & Zvolensky, 2011).

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5.10 Strategies for coping with Posttraumatic experience

Findings in this study show that respondents who sought for help were subjected to individual therapy. Trauma is an event outside normal human experience and it generally leaves one feeling powerless, helpless, and paralyzed. As a result of this, coping strategies are required to deal with these overwhelming experiences. One cannot think clearly during and after a severe trauma; at the same time, one is forced to be conscious in an attempt to deal with the situation. PTSD is difficult to treat, even difficult to diagnose. This diagnosis carries an especially strong stigma of dishonor and moral weakness. During the first and second world wars, people called some soldiers suffering from PTSD and stress – breakdown, cowards or deserters. Since PTSD is actually the body's natural response to an injury, it is not really an illness in the same sense as depression. It is however often accompanied by depression and other mental illness.

Persons with PTSD usually need a therapist to help them deal with their problems. There are varieties of reasons for this; the nature of PTSD leads the person to avoid the very issues that they need to address. The person can possibly be re-traumatized just by remembering the events which created the PTSD. The two most common treatment approaches are group and individual therapy. The findings of the study revealed that respondents have applied other different ways of dealing with these experiences, which includes exercise, alcohol use, counseling, social and spiritual support.

5.10.1 Exercise

Apart from using alcohol as a way of coping, respondents had other ways to deal with their horrific experiences. Respondents reported that they engaged in different exercises and it seemed to be working well for them. They felt that it makes they feel more relaxed and at ease. They further reported that apart from relaxing, it makes their bodies strong. Medina, Vujanoic, Smits, Irons, Zvolensky and Bonn-Miller (2011) provide some convergent evidence that aerobic exercise

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may be helpful in reducing emotional distress and problematic alcohol use among trauma-exposed populations. Brown, Abrantes, Read, Marcus, Jakicic, Strong (2009), add that it is possible that exercise may serve as an emotion regulatory tactic for trauma-exposed alcoholic persons.

Stewart, Mitchel, Wright, and Loba (2004) also found in their study that the relation between vigorous-intense aerobic exercise and alcohol use as coping motives was found to be significant above and beyond the effects of current alcohol consumption; co-occurring alcohol use motives posttraumatic stress symptoms severity and anxiety sensitivity.

5.10.2 Behavioural coping or alcohol use

Findings of the study have discovered that respondents were relying largely on behavioural way of coping; they felt that it was the only way that they could face the real world. They could not even go a day without engaging drinks as a behavioural way of coping. Alcohol was seen as a source they used for coping. They reported that it makes them to feel much better about their trauma experience and it makes them temporarily forget about these experiences. A similar study attests that in an attempt to change one's perception, individuals take action such as using alcohol or substance as a way of reducing the effects of stress (Walsh, Fortier & Dilillo, 2010).

Self-medication was found to be the main defence used to deal with the painful experience by respondents. Respondents' intentions were to look for better health outcome. Waldrop, Back, and Verduin (2007), observed that people with PTSD are more likely to use substance or alcohol in response to negative emotions and that cues of traumatic experience lead to alcohol and drug craving among people with PTSD. These authors, they maintain that individuals who self-medicate with drugs have significantly higher rates of comorbid psychopathology and a higher likelihood of suicidal behaviour. Self-medication in PTSD is also associated with lower mental health-related quality of life. Leeies, Pagura,

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Sareen and Bolton (2010), observed similar results in their study that using drugs may exacerbate the distress incurred by PTSD symptoms, exactly the opposite intention of self-medicating behaviour.

5.10.3 Social support

The findings show that respondents were also getting support from their family members and friends. Respondents felt that it was easy to share their painful experience with their social support as they appeared to trust them. Although it was not in all cases, respondents felt that it was easy to relate to them and families even suggested that they should see professionals so that respondents could get proper help. Ozer et al., (2003) proved in their study that seeking social support is another active coping strategy in dealing with traumatic stress. More specifically, beneficial effects of disclosing or discussing the event have consistently been reported among individuals who have experienced a wide range of traumatic events, from natural disasters to combat to sexual assault (Ullman & Filipas, 2001; Bolton, Glen, Orsillo, Roemer & Litz, 2003).

5.10.4 Counselling

The findings have revealed that respondents had received counselling as a way of dealing with their experiences. They indicated that that they have attended some sessions with counsellors in the hospital; they agreed that counselling was helping although some did not honour the next appointments given. Gamble, Creedy, Moyle, Webster, McAllister and Dickson (2005) observed in their studies that brief counselling intervention reduced trauma symptoms, depressive symptoms, stress, and feelings of self-blame on people with PTSD. Bowley et al., (2004) state that the responsibility to provide counselling for respondents injured after taking alcohol or drugs lies not with specialised treatment centres but with the physicians and other health care staff in general hospital settings who should be trained to provide brief intervention. Respondents reported that they were referred to the hospital by family members and friends. Other findings show that

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it is not only counselling that can help in dealing with these experiences but debriefing assists both victims and their families. Several studies have shown that brief intervention or counselling for alcohol problems among respondents involved in alcohol-related injuries are effective in reducing drink – driving offences and alcohol – related injuries (Gomez – Talegon & Alvarez, 2006).

It is clear from this study that respondents were using many different types of coping strategies simultaneously, making it difficult to isolate their unique effects. It is well established that respondents use all these coping strategies in order to avoid painful traumatic experiences that they went through.

5.10.5 Spiritual support

The findings of the study show that respondents also relied on social support through the involvement of spiritual communities as they are known to be caring. Litz, Stein, N., Delaney, Lebowitz, Nash and Silva, (2009); Trevino, and Pargament (2007) observe that spirituality may improve post-trauma outcomes through: 1) reduction of behavioural risks through healthy religious lifestyles (e.g. less drinking or smoking), 2) expanded social support through involvement in spiritual communities and activities, 3) enhancement of coping skills and helpful ways of understanding trauma that result in meaning-making, and 4) physiological mechanisms such as activation of the "relaxation response" through prayer or meditation (5). Feelings of isolation, loneliness, and depression related to grief and loss may be lessened by the social support of a spiritual community. Being part of a spiritual community places survivors among caring individuals who may provide encouragement and emotional support, as well as possible instrumental support in the form of physical or even financial assistance in times of trouble.

The findings of the study also show that spiritual support was used in order for respondents to cope with their overwhelming experiences. Spiritual beliefs may influence the trauma survivor's ability to make meaning out of the trauma

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experience. The meaning drawn can have a significant impact on the survivor's symptoms and functioning. Recovery of meaning in life may be achieved through changed ways of thinking and involvement in meaningful activities. Spirituality might be defined as an inner belief system providing an individual with meaning and purpose in life, a sense of the sacredness of life, and a vision for the betterment of the world, Delaney, Miller and Bisonoa (2007).

Ano and Vasconcelles (2005) state that evidence suggests that trauma can produce both positive and negative effects on the spiritual experiences and perceptions of individuals. For example, depression and loneliness can lead to feelings of abandonment and loss of faith in God. These effects may change as time passes and a person moves further away from the acute phase of trauma recovery. On the positive side, some individuals experience increased appreciation of life, greater perceived closeness to God, increased sense of purpose in life, and enhanced spiritual well-being even following devastating events such as disasters and rape. For others, trauma can be associated with loss of faith, diminished participation in religious or spiritual activities, changes in belief, feelings of being abandoned or punished by God, and loss of meaning and purpose for living. However in this study, findings show that the events had positive effects on their lives as they continuously attend church.

Park (2005) states that spiritual guidance following a traumatic event can be challenging; pastoral professionals should keep up to date with the latest in research and treatments for trauma and PTSD. Being knowledgeable about the effects of trauma would enable pastoral professionals to better serve those seeking care.

Because PTSD symptoms seldom disappear completely, coping with PTSD symptoms and the problems they cause is usually a continuing challenge for survivors of trauma. Often is it is through receiving treatment for PTSD that many learn to cope more effectively. Recovery from PTSD is an on-going daily gradual process. It doesn't happen through sudden insight or cure. Healing doesn't mean

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forgetting war experience or having no emotional pain when remembering them. Healing may mean fewer and less intense reactions but it also means greater ability to manage trauma-related emotions and greater confidence in ability to cope. When a trauma survivor takes direct actions to cope with problems he or she often gains a great sense of personal power and control.

Positive coping actions are those which help to reduce anxiety, lessen other distressing reactions and improve the situation in a way that does not harm the survivor further and which improves things not only today but tomorrow and later. Trevino, and Pargament (2007) state that positive methods to improve may include, learning about trauma and PTSD, talking to another person for support, talking to your doctor about trauma and PTSD, practicing relaxation methods, taking prescribe medication to tackle PTSD, and calling a counsellor for help. However findings from this study show that respondents were engaging in negative coping actions. Trevino and Pargament (2007); Park (2005) state that negative coping action helps to perpetuate problems. They further state that these actions may reduce distress immediately but cause later problems. Negative coping methods can include isolation, use of drugs or alcohol, violent behaviour and different types of self-destruction behaviour.

5.11 Conclusion

The aim of this study was to investigate the relationship between Posttraumatic stress disorder and alcohol use among out-patients. The results show that the objectives of the study were achieved. The study revealed that respondents were using alcohol as a way of self-medicating. It will be important for future research to come up with prevention strategies against alcohol use following trauma exposure that will help to reduce what may become escalating patterns of risky behaviour.

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CHAPTER 6: LIMITATIONS, RECOMMENDATION AND CONCLUSION

6.1 Introduction

The following chapter attempts to summarize the salient points found in the results and make recommendations based on these findings. The recommendations are aimed at assisting respondents suffering from PTSD and who use alcohol as well as those that can provide professionals with sufficient knowledge and skills to help the victims. The chapter ends with a look at the limitations of the study.

6.2 Summary of Key Findings

The aim of this study was to investigate the relationship between PTSD and alcohol use among PTSD out- patients.

The study was guided by the following objectives;

- To explore traumatic events experienced by out - patients suffering from PTSD;
- To identify the types of beverages containing alcohol and patterns of use by the patients;
- To identify patterns of alcohol use by the patients;
- To describe effects of alcohol on out-patients suffering from PTSD;
- To explain the relationship between trauma and alcohol use among out-patients; and
- To explain the coping mechanism used by PTSD out-patients in dealing with traumatic experience.

The aim and objectives of the study were achieved through the use of the following research questions:

1. Which traumatic events did the patients experience?

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2. What experiences did PTSD patients have after exposure to traumatic event?

3. What are the types of alcohol beverages that PTSD patients use?

4. What are the effects of alcohol on PTSD patients?

5. What is the relationship between traumatic experience and alcohol use?

6. What coping mechanisms do PTSD out-patients use?

The findings show that respondents were exposed to different traumatic events and the major ones experienced includes motor vehicle accidents, sexual assaults, robbery, rape, seeing someone hurt and killed, and fire; most of these events were found to be individual traumas

Themes that emerged show that respondents were not exposed to a single event but multiple events that led to the development of PTSD. Due to respondents' inability to control some of the factors leading to the trauma, events such, as sexual abuse, respondents continued to leading to the respondents feelings of powerlessness in their lives. Respondents reported reacting differently after the trauma; reactions include a combination of fear, feelings of helplessness and horror and some reported that they have also developed a shame. The study also discovered that some respondents had feelings of being bad and at fault for the assault.

Beer was found to be the most beverage containing alcohol that was used by respondents due to its availability in their respective communities. Some respondents started drinking before and others started following the exposure to the traumatic experience. Those who had been drinking increased their drinking patterns in trying to be emotionally stable. However, due to the nature of trauma, some respondents had decreased their drinking patterns because of fear that they may have a repeated experience of trauma. The study also revealed that

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some of respondents' areas of functioning were suffering, areas such as occupation and social functioning.

The findings also show that all respondents were suffering from Posttraumatic stress disorder and were all using alcohol. They reported that they had resorted to alcohol use as a way of trying to cope with the traumatic events and now they find that they are becoming too dependent on alcohol as a way of coping. Self-medication through alcohol was found to be the main defence used to deal with the painful experience by respondents. Apart from alcohol use, respondents have also applied other strategies in dealing with these experiences which include, exercise, social support, counseling and spiritual support.

6.3 Limitations

This study had some limitations;

The present study focused on respondents who were suffering from both acute and chronic PTSD. The findings cannot be generalised because the experiences of acute and chronic PTSD might be different. Future studies should at least concentrate on either acute or chronic PTSD to examine these conditions' relationship as well as finding the difference on the two.

The study focused on respondents who reported to have increased and decrease alcohol use following an exposure to traumatic events; patterns of alcohol use and experiences must be investigated so as to see the differences on those who have decreased and those that had increased.

6.4 Recommendations

Based on the findings of the study, I would like to make the following recommendations;

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Wellness programmes at workplace

It was seen from this study that people who were suffering from PTSD were finding it difficult to perform their duties at work and they could no longer concentrate this shows non – availability and non – access to services due to them from employers and schools. For this reason I, as a researcher, feel that there is a need for employee assistance practitioners in any work environment. This will help, greatly, in the wellness of employees in cases where the employees are vulnerable to overwhelming circumstances.

Education about the basic symptoms of PTSD

It was discovered that respondents did not understand what was going on with their lives following trauma exposure and they did not know that those experiences warrant professional help. Although some reported attending a few counselling sessions, it came out clear that they do not understand the importance of interventions following an overwhelming experience and they don't really know about the implications of PTSD can have on them. I feel as a researcher that there is a need for education about PTSD to be provided to the members of the community. This would make them aware of the symptoms, effects, and possible ways of dealing with PTSD.

Awareness campaigns on alcohol use

Respondents were found to be using alcohol on a daily basis as a way of coping with their painful experiences. Some started drinking after the trauma while others who used to drink increased their drinking amounts. This shows that respondents relied on the self-medicating way of coping which at the same time is harmful to their health and at some point, it may also hamper the treatment. It will be important for campaigns on alcohol use to take place so that such people may in future, not use alcohol because it might complicate their situation should they find themselves with PTSD.

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Attendance of both psychological and physical health symptoms

Respondents were found to be always consulting medical doctors due to some physical ill – health complications but it appears that doctors were not attending to all the issues apart from what the respondents were complaining about. Medical practitioners should carefully assess for trauma histories as they may be the first line of defence in screening and referral for trauma survivors. It is therefore recommended that medical practitioners need to attend to both their clients psychological and physical health symptoms as they both critically affect every day functioning. This may also help in making proper referrals.

Need for training of educators

It was clear from the data collected that some respondents were still at school when they experienced the trauma and it was so painful that they could not concentrate at school. This has resulted in them having to dropout from school because of their poor performance. It is imperative to provide educators with training that would enable them to see if the learners in their respective classes have emotional problems. By doing so, they will be able to refer the learners to the relevant health practitioners.

Treatment of trauma respondents

Many traumatized respondents are reluctant to seek help for their symptoms, especially from mental health professionals. Respondents should be made to understand that anyone may develop PTSD symptoms in response to extreme trauma and that the diagnosis is not a reflective of a character flaw or personal weakness. Education, supportive counselling and providing a safe and supportive environment for tears and concerns should ideally be provided to all respondents with PTSD. Respondents can be treated with medication, psychotherapy or a combination of these modalities.

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Urine test

Future studies need to also look at measures that will confirm alcohol use by respondents. For example, urine tests. This will enable a researcher to determine the level of concentration of alcohol in the respondents' body. This will also assist the researcher to categorise respondents with low and high concentration of alcohol intake. The researcher will then be able to look at the difference in terms of experiences of respondents at both levels. This will also help the health care providers to know exactly the type of treatment modalities for both levels.

6.5 Conclusion

The aim of this study was to investigate the relationship between posttraumatic stress disorder and alcohol use among out-patients. The results show that the objectives of the study were achieved and it was found that there is a strong relationship between exposure to a traumatic events and alcohol use. The study revealed that respondents were using alcohol as a way of self-medicating. It will be important for future research to come up with prevention strategies on alcohol use following trauma exposure that will help to reduce what may become an escalating pattern of risky behaviour. Some of the limitations include the usage of PTSD checklist civilian version as the only measure to verify PTSD, and also lack of consistency in the profile of the respondents since some reported increased or decreased alcohol use following an exposure to traumatic events, and inability to generalize because of drawing respondents from a single geographical location.

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APPENDIX 1

INTERVIEW SCHEDULE FOR PTSD PATIENTS

1 What kind of trauma did you experience?

1. Was it a repeated traumatic experience?
   If yes, please specify the nature of the event.
2. What were your experiences after the traumatic event?
3. What type(s) of beverages containing alcohol do you use?
4. When did you start drinking? Was it before or after the trauma?
5. If before, did you increase or decrease drinking after the trauma?
6. What is the relationship between PTSD and alcohol use?
7. How have you mainly been dealing with the traumatic experience?
8. How else have you been coping with the incident?

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APPENDIX 2

Consent letter

Dear Respondent,

I am Manganye Leslie from the University of Venda. I am conducting a research regarding the relationship between Posttraumatic Stress Disorder and alcohol use. You are kindly requested to participate in this study by responding to the few questions that I would like to ask you. The study is conducted for educational purposes.

Please note that participation is voluntary and you do not have to take part in this study. However, I would really appreciate it if you would share your thoughts with me. If you choose to participate you may still quit at any time, there will be no penalties and you will not be prejudiced in any way.

I will not record your name and the information you provide will remain confidential and there will be no repercussions from the answers you give. The interview will last around 15 – 20 minutes. I know that you cannot be absolutely certain about some of the answers but I ask that you be as open and honest as possible in answering these questions. Some questions may be personal in nature and I will also ask some questions that may involve thinking recalling the past or thinking about the future. I hope that does not make you feel too uncomfortable

Thank you.

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Appendix 3: Consent Form

Consent form

I hereby agree to participate in the research on the relationship between Posttraumatic Stress Disorder and alcohol use. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can quit at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the interview and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to me and my community on the results of the completed research.

Signature of Respondent Date: ----------

Signature of Researcher Date: ----------

Telephone Number: 015 962 8667

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Appendix 4: PTSD Checklist – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2	Repeated, disturbing *dreams* of a stressful experience from the past?					
3	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8	Trouble *remembering important parts* of a stressful experience from the past?					
9	Loss of *interest in things that you used to enjoy?*					
10	Feeling *distant* or *cut* off from other people?					
11	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12	Feeling as if your *future* will somehow be *cut short*?					

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13	Trouble *falling* or *staying asleep*?					
14	Feeling *irritable* or having *angry outbursts*?					
15	Having *difficulty concentrating*?					
16	Being *"super alert"* or watchful on guard?					
17	Feeling *jumpy* or easily startled?					

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Appendix 5: Transcriptions

Respondent 1

Gender : Male (Venda)

Age : 24

Occupation : Employed

1. What kind of trauma did you experience?

I have been involved in a motor vehicle accident 2 years ago while I was going to buy bread from nearby shop. I didn't see it coming; all I can remember is when I was taken to the hospital.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

Yes, I also witnessed someone being killed by a mob in Orlando few months ago. This person was accused of doing house-breaking in the local township.

3 What were your experiences after the traumatic experiences?

Life has never been the same again. I started to have difficulty falling asleep. I had been unable to concentrate at work and my supervisor had also given me verbal warning because I had not been doing my work properly. These days I don't even feel comfortable watching action movies on TV because I fear that I may see motor car accidents.

4. What type(s) of beverages containing alcohol do you use?

I usually drink beer. My favourite one is Hansa but if my friends bring wine or brandy I do drink. Drinking almost every day helps me feel a bit relieved about what happened to me in the past.

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5. When did you start drinking? Was it before or after the trauma?

I had not been drinking in the past months but after the accident I realised that I needed something to cope with, that's when I started drinking. I just thought that drinking will make me overcome bad memories about the accident. What even made drinking to be worse was when I witness someone being killed.

6. If before, did you increase or decrease drinking after the trauma?

Yes, I think I increased because in the past I used to drink mmmmh maybe Once or twice a week but now, hey things have changed. I increased drinking more especially after I have witnessed someone being killed

7. What is the relationship between PTSD and alcohol use?

I think it makes a person to feel more vulnerable to the situation because you keep thinking about what happened and if you don't find necessary support one may turn to drink alcohol. I personally had an increase of alcohol intake because I wanted something that will make me forget about the traumatic experience

8. How have you been dealing with the traumatic experience?

So far talking with friends has being the option that has been available to me and of course drinking makes me try to forget. That kind of support system, it seem to me that it is not enough because I seem not to get over what happened.

9. How else have you been coping with the incident(s)?

I sometimes listen to the pastors over the radio on Sundays. At least I sometimes feel that my spirit has been lifted high.

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Respondent 2

Gender : Female (Venda)

Age : 19

Occupation : Learner

1. What kind of trauma did you experience?

I have been sexually assaulted by my uncle a year ago. Both of my parents have passed on. I and my young sister are always sexually assaulted by my uncle but as of now my young sister is no longer staying with us. We even tried to involve our relatives but nothing has changed.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

Yes it was repeated because he used to do it in many occasions and he was always threatening not to buy food for us. Because we had no other source to provide us with food and shelter we were forced to live by his commands.

3. What were your experiences after the traumatic experiences?

Hey, I don't even want to talk about it. I feel like a worthless person you know. Right now I can't even maintain a good relationship with my partner. I don't enjoy being with him because each time he touches me I feel like is him (uncle). When I sleep at night, I usually have nightmare about him. So far I have moved to my friend's place, I don't want to be near him, am very afraid of him, in fact I don't want to hear anything from him. He is a cruel man. I am still angry at him. Even if he dies I don't think I can go to his funeral. I repeated several grades a school, because I couldn't concentrate well at school.

4. What type(s) of beverages containing alcohol do you use?

Please don't judge me, I drink any alcohol except sorghum beer, I prefer drinking beer, wine, brandy etc. it depends on what is available for the day and whether I have enough cash or not. But mostly my friends do buy for me.

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5. When did you start drinking? Was it before or after the trauma?

I started drinking after the horrible experience I had. I needed to get something that will bring my life back. I feel better when I am drunk. At least I wouldn't be thinking about my miserable life. You know what, I even drink more often so I can feel better with friends.

6. If before, did you increase or decrease drinking after the trauma?

n/a

7. What is the relationship between PTSD and alcohol use?

It appears to be related in that if you are coping with horrible experiences you tend to use alcohol as a means of coping because it makes one to feel more relaxed. Honestly I feel a bit happy if I drink.

8. How have you been dealing with the traumatic experience?

So far I have not done anything because I have not told anyone about this. I think it is very embarrassing to tell anyone but drinking has kept me going for some time now.

9. How else have you been coping with the incident(s)?

Nothing else

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Respondent 3

Gender : Male (Venda)

Age : 28

Occupation : Technician

1. What kind of trauma did you experience?

I have been robbed of my items at a gun point while I was on my way home with a friend of mine. I was also severely beaten because I was not cooperating and it was really bad. Although I feel that I am feeling better now but I still feel that the whole situation was so overwhelming. I even feel that indeed it was the end of my life. I was really hopeless thinking that I will not make it.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

No it was not repeated. But eish….. My mind keeps thinking about this event.

3. What were your experiences after the traumatic experiences?

Ever since that traumatic event, there so much that has changed. I find myself avoiding to walk in the evening because I feel like the same thing will happen again, more especially using that same road I used by that time of the event. I also find it hard to recall every aspect of the trauma. In fact I don't even want to discuss this because it makes me go through the same experience again. I now have difficulty maintaining sleep at night and am always hypervigilant wherever because I have learned not to trust anyone.

4. What type(s) of beverages containing alcohol do you use?

I often drink beer with my friends. I seem to get a bit of peace of mind. It makes me to feel more relaxed.

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5. When did you start drinking? Was it before or after the trauma?

I started drinking long time ago. It was before this traumatic event and I was a casual drinker.

6. If before, did you increase or decrease drinking after the trauma?

I found myself increasing drinking as I was not coping with what happened to me. I never thought I could be so helpless or even desperate to save my life. What made me increase drinking was that I was overwhelmed with the traumatic experience. I felt like mentally I was not functioning well. And again at work things were not shaping up and the only thing which could make things better was to get something like beer to pump me up.

7. What is the relationship between PTSD and alcohol use?

You know if your life becomes miserable just like with my situation one is tempted to do things that you would do if things were fine. If you have experienced trauma, alcohol becomes the first thing to use so that one feel a bit of relief from the experience. Alcohol refreshes your mind and you may end up temporarily getting rid of the experience.

8. How have you been dealing with the traumatic experience?

Apart from alcohol use there has not been any other support. I feel like friends are useless because I drink with them and there is nothing good that can come out of them.

9. How else have you been coping with the incident(s)?

I often find myself busy with reading books and playing soccer so that at least I can try to forget about this traumatic event.

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Respondent 4

Gender : Female (Venda)

Age : 18

Occupation : Learner

1. What kind of trauma did you experience?

Hey it is tough my man, you won't believe if I told you what happened. I am someone who drink alcohol, so this other day a group of boys bought lot of liquor, it was nice, they later took me to a nearby bush and they gang raped me. Since I was drunk, I had no power to neither resist nor scream.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

No, it wasn't, this was the only experience I had.

3. What were your experiences after the traumatic experiences?

You know what I feel that I have lost a value in life, am now a worthless person; who do you think can marry someone who have been gang raped? I have no future. Whenever am surrounded by people, I feel like they talk about what happened and it makes me not to be in social places. So far I no longer spend much time in bar because am scared the same experience will repeat itself. I don't even want to meet the perpetrators, I hate them and I no longer enjoy my sleep, sometimes I even have nightmares about the same event. This traumatic event has also destroyed my love affairs with my boyfriend.

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4. What type(s) of beverages containing alcohol do you use?

I am someone who does not really choose, anything that is on table I drink. But I prefer drinking beer a lot. It makes me feel relaxed and I turn to forget my experiences easily. These days I drink with caution though.

5. When did you start drinking? Was it before or after the trauma?

I started drinking long time ago while I was 17 years old and of course it was before this traumatic experience. The time I started I was still young but u know that sometimes if have a bad company you end up doing things that you wouldn't do if you were given a second choice of living. But it is life and we all learn from our mistakes.

6. If before, did you increase or decrease drinking after the trauma?

Yaaaaaa, ever since this experience I told myself to decrease my drinking patterns because I am scared that other people may want to take advantage of me again. I used to drink a lot, a lot yaaaaa……., sometimes I will even comeback home around 4 in the morning because of drinking. And again I want to be more vigilant of my surrounding because I no longer trust this people.

7. What is the relationship between PTSD and alcohol use?

PTSD is something that normally leaves you overwhelmed, and as such one is tempted to do whatever it takes to deal with it, many people that I know prefer dealing with it using alcohol, thinking that it will permanently go. Alcohol is something that after drinking it you will feel pleasure and it makes one to forget everything that is troubling you so as a result of that, many people who find themselves in life – threatening events prefer using alcohol so that they can get relief from their overwhelming experiences.

8. How have you been dealing with the traumatic experience?

So far I have not be doing anything I only went once for counselling in the hospital. I now feel very scared about illness. I think I might have contracted

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some diseases form that encounter. I tried to speak to some of my friends but they continue judge me, and they think I have wanted it to happen. It's not true; I never wanted it to happen. I think it's not worth it to share with friends. Sometimes talking with my mother does help because she does not judge me. She is someone who listens to me at all time though I sometimes think that I have let her down.

9. How else have you been coping with the incident(s)?

I sometimes find myself reading the bible and always keeping myself busy with family chores. I normally do this on the daily basis.

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Respondent 5

Gender : Female (Tsonga)

Age : 18

Occupation : Learner

1. What kind of trauma did you experience?

Hey my brother life is bad out there. You wouldn't believe if I told you that I have been repeatedly sexually assaulted by my stepfather. For four years now. This matter is traumatising me and I hate him.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

Yes, like I said before, it was a repeated experience. He kept doing it for several times. He always promises to kill me if I tell people and that he will stop buying food in the family. And I feel bad whenever he abuses my mother, I always witness that.

3. What were your experiences after the traumatic experiences?

All I want now is to move out of that place, I don't want to see him again. Whenever I see him, everything he does to me and my mother keeps coming. Am now feeling scared to be in that house, more especially that room. I always feel like he can come to my room and do it. I am getting old and I feel not ready for a relationship any time soon. I even divorced the man I loved because each time he touched me I used to feel like it is my stepfather. So far I did not even go far with my studies because of the assault and the abuse I witnessed on my mother. I couldn't concentrate while at school and my sleeping patterns were always disturbed due him regularly visiting my room. The most painful part that my mother couldn't say a word because if we were evicted we wouldn't have a place to go and that she is not working.

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4. What type(s) of beverages containing alcohol do you use?

I always drink what is available, I normally drink beer, and I drink any type of beer. So far I think I do enjoy drinking because once I drink I turn to forget about my painful experience. I don't think I would be functioning well without beer. There is nothing I can do, my friend.

5. When did you start drinking? Was it before or after the trauma?

I didn't drink before; I only started after this painful experience. I was not coping at all. I had no one to turn to. I had to do something that would console myself. And I didn't want to bother my mother as she was also experiencing difficulties from her marriage.

6. If before, did you increase or decrease drinking after the trauma?

N/a

7. What is the relationship between PTSD and alcohol use?

Hey yaa, there is a lot one can say about this. As people we are facing difficulties in our families. Some of these terrifying experiences leave us in situations wherein we cannot cope. As a result of this, we end up in need of something that can make us feel strong, and be able to face the world. Alcohol makes individual to feel more at ease in times wherein people are not coping in with difficulties in their lives. Because of its availabilities in our respective communities, we turn to use it as way of trying to face the world and to get back to reality as trauma takes that away from us. Once I use it, I feel like I am the real old person. I think there is a relation between traumatic experience and alcohol use.

8. How have you been dealing with the traumatic experience?

I tried to talk about this with my friends but they don't seem to take me serious. As for the family and relatives is much better although their support is not enough. I appreciate the fact that they do listen to me sometimes and they also

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suggested that I must see the counsellor but the challenge is that since am not working I don't always have the money to travel to the hospital.

9. How else have you been coping with the incident(s)?

Apart from what I told you. There is nothing more serious that I have been doing. Perhaps one may also say going to church is helping because my soul is being uplifted day by day.

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Respondent 6

Gender : Female (Tsonga)

Age : 40

Occupation : Self employed

1. What kind of trauma did you experience?

I have witness three of my close friends being knocked down by car. Two of my friends died on the scene and the other sustained the very serious injury. One of those friends was my boyfriend. I always cry when I think of him.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

Of course it was, it happened in three different occasions and I had witness all those accidents. It was the very same motor car accidents.

3. What were your experiences after the traumatic experiences?

Eish….. My friend, life is tough. I feel like the world is against me. I feel so helplessness; those that I trust are no more. I always avoid thinking about how they died, and I think it may take time to get friends like those. I can't even think of getting a new boyfriend now. I now have difficulty to finish my work on time because I can no longer concentrate on my work. I easily get irritated when people talk about things related to the trauma I experienced. As I speak now, I feel very scared to walk along the road. I feel like the same thing would happen to me as well. Some people don't even want to be friends with me because of all these accidents. They feel like they will be the victims as well.

4. What type(s) of beverages containing alcohol do you use?

Yaa nee, I am a cheap lady, am not an expensive person. I drink beer a lot. It is really nice. It gives me more energy. But at times I do drink brandy if has been bought by others. I enjoy beer though because it is cheap and I can afford it.

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5. When did you start drinking? Was it before or after the trauma?

I started drinking alcohol occasionally long time ago but right after the traumatic experience things turned otherwise. It was so bad loosing those friends of mine. The pain was so unbearable and I felt that I needed something to bring my life back. Right now I can't imagine myself sleeping without having one or two and I think it is even taking control over my life.

6. If before, did you increase or decrease drinking after the trauma?

I think things changed from bad to worse. I used to drink occasionally but I found myself having to increase drinking due the overwhelming experience. It is tough because if I don't drink, I always think about overwhelming. I see no life if I don't drink.

7. What is the relationship between PTSD and alcohol use?

Yoooo, if one has been traumatized and nothing seem to go the right way, may turn to use certain available mechanism in trying to deal with trauma. Alcohol serves as a means to entertain persons and at the same time those who may seem to have problems get to forget their problems. Those who are overwhelmed by traumatic experiences may want to use alcohol as way of trying to deal with their problems. I just don't know if it really works.

8. How have you been dealing with the traumatic experience?

So far alcohol has been keeping me going. I just don't know if am really doing the right thing but I believe it is making me to cope with all that I went though. The family is there for me but I can't really seem to get rid of this overwhelming experience. I always prefer being alone because it also gives me more time to think about my life

9. How else have you been coping with the incident(s)?

Hey, there is not much more that I do, but just to be myself.

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Respondent 7

Gender : Male (Tsonga)

Age : 31

Occupation : Unemployed

1. What kind of trauma did you experience?

Hey my man, I got arrested six months ago. So while I was in prison things got tough. As you may know that some of the inmates form groups, this other day things got out of hand when I refused to be sodomized. I was severely beaten wherein I ended up fighting for my life.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

Yhaaa, it was a repeated experience because few days after that traumatic experience, I had to be sodomized by the very same group. And this time I couldn't say no because of the fear of what happened to me last time. I have also seen terrible things happening to other fellow inmates which are very life threatening. Life is really tough there.

3. What were your experiences after the traumatic experiences?

Things are bad my friend. I think I have lost my real sexually orientation. I think am no longer a man any more. I feel like everyone now that am out knows that I have been sodomized. People no longer feel my presence and am always by myself, so as such I have lost interest in all things I used to enjoy. I feel like I have no future anymore and each time I sleep, I can't seem to maintain my sleep because am always thinking about the bad experience I had. Sometimes I feel like whenever I meet a group of people they can do bad things like those in prison. These days it is even easy for me to get irritated out of small things and this makes me feel bad. I don't even have someone to talk to about this, am just all by myself.

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4. What type(s) of beverages containing alcohol do you use?

I only afford beer. It is the one that I drink most often, as you can see, I have nothing to do except drinking. I think it is the one that brings back my senses. I think I can't function without beer. If I don't get two or three quarts I feel like I have no life.

5. When did you start drinking? Was it before or after the trauma?

I used to drink before I got arrested but it was just a sensible drinking pattern. But now things have changed, I find myself drinking everyday none stop. If I don't drink I think I will go crazy. Man I can't just imagine myself as a man being raped or sodomised, and in addition, in front of other inmates.

6. If before, did you increase or decrease drinking after the trauma?

Yaa like I told before, I think I have increased drinking due to the overwhelming experience. Am going through a lot of painful experience. I forced myself to that because I was not coping with the trauma I experienced. My friend it is bad.

7. What is the relationship between PTSD and alcohol use?

Hey ....mmmmmh, an overwhelming experience makes a person to loose in touch with reality, and as a result of that one may want to get something to relieve himself. And the only thing which is common in our society is alcohol. Alcohol makes people to forget their problems and to get back to their senses. So if you feel overwhelmed and nothing seems to come right in your life you turn to use alcohol as a way of dealing with the traumatic experience and trying to get back to your normal senses as well as getting vibe in your life

8. How have you been dealing with the traumatic experience?

So far I have been drinking beer, which I believe that it had been doing the good job. My family has not been supportive. As I told you before I have no friends around so it's me and beer that keeps me going.

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9. How else have you been coping with the incident(s)?

There is no other specific thing that I do but now someone has referred me to counseling but I don't know whether things will go back to normal.

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Respondent no 8

Gender : Male (Venda)

Age : 37

Occupation : Employed (shop keeper)

1. What kind of trauma did you experience?

I have been involved in a robbery wherein my colleague ended up being shot on the head in front of all staff members in the shop. Three men came in pretending to want to buy some items in the shop. They then took out their big guns and started demanding cash, airtime and cigarettes. Right after one of them shot my colleague, he then pointed me with a gun.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

No, it was not a repeated experience, but eish, this experience keeps tormenting me almost every day.

3. What were your experiences after the traumatic experiences?

So far many things have been happening and I think am now losing my mind. I always have recurrent distressing dreams and intrusive images about this trauma. This has been disturbing in my life because I can no longer maintain my sleep and when am at work things have now changed because am always hypervigilance (I always look out on who is coming in the shop) and this makes me not to concentrate on my work. Lately my boss has also been complaining about my performance. I must confess to you that I really hate to talk about this and I believe this would be the last time. Whenever I walk on the street, I feel uncomfortable when I meet someone who appears like those people

4. What type(s) of beverages containing alcohol do you use?

I drink beer and wine, but due to the fact that beer is available everywhere and it is also cheap as compared to wine, I tend to use it more often than wine. Without

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it I don't see myself going to work, it keeps me strong. I always prefer not to go to work, if I didn't get something to give me strength.

5. When did you start drinking? Was it before or after the trauma?

I started drinking alcohol few years back and of course it was before this traumatic experience. I use to drink maybe weekends and sometimes when we are in the party. I used to drink but it was not excessively.

6. If before, did you increase or decrease drinking after the trauma?

Hey man, I really don't know what is happening; so many things have changed about me. I drink almost every day, and I don't even care whether it is in the morning of later in the day. I think I have increased drastically. Due to what happened to my life, I don't think I can get to that place again without something to elevate my mood.

7. What is the relationship between PTSD and alcohol use?

Let me just talk about myself. I used to know and understand myself but due to the stressful experience I don't think am still my own. I turned on to use alcohol as result of alcohol. The experience was so overwhelming in such a way that I felt I needed something to bring myself back to normal life. I just could not imagine myself being pointed with a gun and seeing someone being shot and seriously injured. That was a very painful experience that resulted in me now starting to use alcohol excessively because I was not coping.

8. How have you been dealing with the traumatic experience?

So far the thing that kept me going is counselling sessions that I have attended. I must admit that things are getting better as compared to before. Friends have been also playing their roles of giving support and being there for me. The family has always being there for me at all times and I appreciate all that.

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9. How else have you been coping with the incident(s)?

My other coping strategies is that whenever am not at work, I try to engage myself with other activities that which will keep me busy. i always want to be around other people because when am alone I tend to think a lot about my traumatic event.

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Respondent no 9

Gender : Female (Venda)

Age : 22

Occupation : Student

1. What kind of trauma did you experience?

I had a very serious traumatic event ever in my life. One day while I was with my boyfriend two men broke in our room and they were carrying knifes. They demanded our belongings including money, phones, laptops, jewellery and dvds. My boyfriend was not cooperative and he was stabbed several times and this other threatened to kill me if ever I will scream.

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

No, not at all. But I still feel that I have been robbed of my loved one since he later died due to incident.

3. What were your experiences after the traumatic experiences?

I was in a very bad situation wherein I felt that hopeless that I will ever live again. That was a horrible experience, having to see someone fighting for his life. Right now I can't cease to experience intrusive images of those two men. Each time I sleep, I experience difficulty staying asleep and these days i become easily irritated. I can't seem to have peace with what happened. You know what? Am now at school, but nothing is coming my way. I often find myself absent from school, if am there I can't really concentrate, eish. I feel like I have no life again.

4. What type(s) of beverages containing alcohol do you use?

The cheapest one that I afford is beer. That's the one that makes me feel relieved of the traumatic experience. It tries to lift up my spirit and am now starting to enjoy every moment of it. I can concentrate a bit at school when I have taken it.

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5. When did you start drinking? Was it before or after the trauma?

I started drinking three months back. I used to hate drinking because of what people do when they are drunk but life got tough on me and the only thing that I thought of was alcohol. I started drinking after this horrifying experience because I wanted it to make me cope. I wanted to forget about experience. I felt that I don't deserve that.

6. If before, did you increase or decrease drinking after the trauma?

N/A

7. What is the relationship between PTSD and alcohol use? I think the two are *related in that when someone is overwhelmed by a horrifying experience may tend to use alcohol as a means of trying to deal with trauma. Most people like me might have done this as a way of trying to cope because I believe it does. I believe there is a strong relationship between the two. Since it is available everywhere, sometime if one has been traumatized and there is nothing in terms of support that is coming your way, u tend to think that alcohol can make u cope and forget about everything.*

8. How have you been dealing with the traumatic experience?

My friends suggested that I go to counselling of which I did and am still on it. So it is the one that kept me coping with this pressure. My family is also supporting me.

9. How else have you been coping with the incident(s)?

Yhaa my friends always keep on telling me that I need to be strong. They have been supportive as well and I think it is good to be always around them.

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Respondent 10

Gender : Male (Venda)

Age : 27

Occupation : Self employed

1. What kind of trauma did you experience?

It is quite a sad or perhaps emotional experience. I used to live in a two roomed house, so this other day it happened that the house caught fire. It appeared that there was no way out since the fire was huge and a lot of smoke. Three of us were all screaming for help and at the same one of my younger's clothes were starting to burn. And we felt so hopeless that will survive

2. Was it a repeated traumatic experience?

If yes, please specify the nature of the event

No it was not a repeated experience. It happened once but it left a gap that no one else can fill because after that incident, one of those brothers that I was with finally died due to the smoke that he inhaled.

3. What were your experiences after the traumatic experiences?

The incident happened three month ago, and since then I feel really worthless. I can't think straight and I sometimes feel like am the one to blame since am the elderly brother. I can't even remember exactly what happened that made the fire to occur. I used to work but now I can't because the supervisor says I can't concentrate and am not productive. When I sleep, I often experience recurrent distressing dreams. This thing have affected me very bad you know, I used to play soccer but now I just need to be alone

4. What type(s) of beverages containing alcohol do you use?

I started to drink a month ago. The pressure was too much. I was not really coping. I felt that I must get something to boost that was an awkward experience that it shouldn't be experience by a human being. That was a horrific experience.

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5. When did you start drinking? Was it before or after the trauma?

My brother, the only drink that I use is beer, but not always because I don't work. I seem to enjoy it because it helps me to temporarily overcome this traumatic experience. Had it not being for it, I think I would be mad by now.

6. If before, did you increase or decrease drinking after the trauma?

I wouldn't say because this was my first experience and I started drinking a day before the funeral. It was tough.

7. What is the relationship between PTSD and alcohol use?

The pressure is too much. Without someone or something you won't survive. I feel there is a relation though the other may seem to be a dependent on the other. Due to this pressure you may feel that you need something to boost yourself and the most available aspect will be alcohol. Since it can make you at ease, alcohol helps one to be able to cope with the overwhelming experience. I think that due to this overwhelming experience one is tempted to use alcohol.

8. How have you been dealing with the traumatic experience?

I have being drinking alcohol which I believe it had been making me cope and I have also referred to the counsellor who is also helping me. One of my relative has also been supportive to me and my other brother who survived.

9. How else have you been coping with the incident(s)?

I think one of my long-time friend has also been trying to support me.

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