"We have come out of one place: it is called Omega"

An ethnographic study on the role of context in understanding mental suffering among the !Xun and Khwe of South Africa

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Citation for published version (APA):
den Hertog, T. N. (2018). 'We have come out of one place: it is called Omega': An ethnographic study on the role of context in understanding mental suffering among the !Xun and Khwe of South Africa.

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Introduction

Figure 1: taking the exit road from the R31 near Kimberley, this kilometre long entrance road takes you to the centre of Platfontein, the township of the !Xun and Khwe. Photo by author.
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Introduction

The high incidence of domestic violence and alcohol abuse... may be an expression of an underlying collective trauma that could eventually undermine efforts to create a cohesive and empowered community (Robins, Madzudzo, & Brenzinger, 2001: 23).

This quote about the !Xun¹ and Khwe communities in South Africa emphasises the need to understand and address the complex dynamics of social and mental despair among the !Xun and Khwe. The collective trauma mentioned by Robins and colleagues (2001) encompasses decades of exposure to violence during the Angolan war of independence from Portugal (1961-1974) and the South African border war (1966-1989), and then forced displacement, and marginalization.

The !Xun and Khwe are San or Bushman² communities and have been positioned at the very bottom of local social hierarchies throughout history, at times considered more animal than human being (for detailed historical reflections see Gordon and Sholto-Douglas, 2000). During the Angolan war of independence, the Portuguese sought to capitalize on the oppressive relationship between the San and Bantu groups by incorporating the San into their army (Battistoni & Taylor, 2009). After Angola’s independence, the !Xun and Khwe fled the country in fear of retribution from local communities (Battistoni & Taylor, 2009; Brinkman, 2005: 120-121; Robbins, 2007). The South African Defence Force (SADF) stationed in the Caprivi area of then South West Africa, now Namibia, recruited many of them and additionally recruited local Khwe. In the SADF, the !Xun and Khwe were grouped together in so-called Bushman battalions (Sharp & Douglas, 1996), the !Xun and Khwe in Platfontein primarily come from Battalion 31. There are sources that claim the !Xun and Khwe were grouped in different units (Hitchcock, 2012). The memoires of a former commander of Battalion 31 (Linford & Venter, 2015) revealed that although grouped together in one battalion, they were placed in separate rifle companies during their military operations into Angola. Battalion 31 was stationed at the military base Omega.³ Originally the base was named Alpha, after the Combat Group Alpha. It was renamed ‘Omega’ to signify the end of an important time, as operation Savannah, the counter insurgency operation into Angola, came to an end in late 1975 (Linford & Venter, 2015). During their time under the auspices of the SADF, the !Xun and Khwe became fully dependent on the SADF in many aspects of life such as employment, housing, schooling, and provision of services (Gordon & Sholto-Douglas 2000). In many ways, their time at Omega shaped their current living conditions and future in South Africa, as will become clear in this thesis. Although Omega refers to ‘the end’, it was for the !Xun and Khwe currently living in South Africa very much the beginning of a new life.

¹ The symbol ‘!’ here refers to an alveolar click.
² The naming of ‘San’ or ‘Bushman’ communities is under continuous negotiation. Both ‘San’ and ‘Bushman’ have actively been taken up by communities and were at other times considered to be fraught with derogatory connotations. In this thesis I prefer using specific names that refer to linguistic groups such as !Xun and Khwe. When referring to the broader cultural group, I will use ‘San’.
³ In the title of this thesis: ‘We have come out of one place: it is called Omega’, Omega is used by a Khwe community member to indicate a place and time-period in which the !Xun and Khwe were bound together.
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After Namibia’s independence in 1990, many of the !Xun and Khwe retreated to South Africa along with the SADF. Here they lived in a tented camp on a military base in the Northern Cape. After nearly thirteen years they were again forced to relocate, as a local community won a land claim covering the land of the military base (Douglas, 1997). In early 2004, the !Xun and Khwe relocated to Platfontein, a township near Kimberley (Northern Cape), where they currently reside. Life in Platfontein is in many ways an improvement from their previous location, for example, in terms of housing and proximity to a large city. Nonetheless, their history of violence, displacement, and marginalization continues to affect the !Xun and Khwe in many ways. Poverty and unemployment are major concerns, with 97% living on less than 1 dollar/day and an unemployment rate of 95% (Dalton-Greyling & Greyling, 2007; South African San Institute, 2010). Consequently, households are mainly run on social grants, at times supplemented by growing vegetables. The !Xun and Khwe often explain these circumstances in terms of discrimination. In addition, feelings of marginalization and neglect by local government are fuelled by poor provision of municipal services, such as electricity, water, and good quality housing (Tempelhoff, 2014).

![Figure 2: housing structures in Platfontein with on the far left a pit toilet. Photo by author.](image)

Although reliable statistics are not available, tuberculosis and HIV/AIDS severely affect the communities (Govender, Miti, Dicks, & Ewing, 2013; Letsoalo, 2010). Violence and substance abuse mentioned by Robins and colleagues (2001) continue to be the order of the day and exemplify the state of social despair. These living conditions and their effects on mental well-being should be understood as an interrelated whole, considering the widely acknowledged social and mental effects of traumatic events, such as war and displacement, and the interwoven nature of mental health with socioeconomic conditions in general (De Jong, 2002; Kirmayer, Macdonald, & Brass, 2001; Miller & Rasmussen, 2010; Patel & Kleinman, 2003; Vega & Rumbaut, 1991).

Although the above presents a rather bleak image of the situation in Platfontein, the resilience of its inhabitants and determination to build a life in South Africa should not be underestimated. The studies in this thesis shed light on the way in which people persevere under difficult circumstances. In addition, local farming projects have taken shape, and new economic opportunities are being explored by community leaders in the form of solar farms.
and tourism ventures. Furthermore, a better future was envisioned and written down in a community development plan in collaboration with the South African San Institute (South African San Institute, 2010). Aside from SASI, other NGOs also invest in the future of Platfontein such as Isibindi, Red Cross, Love Life, and Aids Foundation South Africa. In addition, there is much scholarly interest in the !Xun and Khwe, and San communities in general. However, despite the involvement and interest of many individuals and organizations, mental well-being is an area that has received little attention: no research on the topic has thus far been done, and trauma-focused or psychosocial interventions have been nearly absent among the !Xun and Khwe. This thesis hopes to contribute to understanding the complex dynamics of social and mental despair among the !Xun and Khwe by exploring local understandings of mental suffering and its embedment in local contexts. In so doing, the thesis aims to contribute to our understanding of the multidimensional nature of mental suffering and specifically in relation to marginalized and displaced communities. In the following sections, I describe the main research themes, research background, and study site, concluding with the research questions and an outline of the thesis.

**Research themes**

To foreshadow the studies presented in chapters 2-5, this section describes the main research themes and concepts of the thesis. Firstly, I explain how I use concepts referring to mental suffering throughout this thesis. Secondly, I reflect on the role of context and how the concept is applied in this thesis. And thirdly, the influences that various contexts have on mental suffering are described in terms of causal pathways related to war, displacement and marginalization, subjective experiences, perceptions, and help-seeking strategies.

**On concepts of mental suffering**

Many diverging concepts are used to refer to negatively appraised mental states such as psychological pain, emotional pain, suffering, mental despair, and distress. Many of these concepts may actually refer to the same phenomenon (Meerwijk & Weiss, 2011). In their conceptual analysis, Meerwijk and Weiss (2011: 410) defined psychological pain as ‘a lasting, unsustainable, and unpleasant feeling resulting from negative appraisal of an inability or deficiency of the self’. Of importance is the emphasis on the negative appraisal and the unpleasantness or anguish or pain, as this reflects the core experience. Additional characteristics encompass the fact that this is not a short-lived experience but ‘lasting’, and that it is untenable; severe negative consequences (e.g. suicide, depression) may develop when the condition is endured over a long period of time. A further specification of negative mental states may be found in severely debilitating conditions, meticulously described and defined as mental illnesses or disorders. The research presented in this thesis aims to explore local perceptions of mental suffering; the concept of mental suffering is therefore a research question rather than a condition to be defined beforehand. Throughout this thesis I therefore use diverse concepts to refer to negative mental states or specific aspects thereof to match local understandings. For example, in chapters 3 and 4 I make an analytical distinction between emotional and cognitive aspects of mental suffering. In addition, I use specific concepts to provide methodological focus. In chapter 3, for example, the disorder
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construct ‘depression’ provides a useful focus point to study perceptions on a specific set of mental states.

The matter of context

Throughout this thesis ‘contextualization’ is a recurring approach used to situate research findings in local contexts. Contextualization has a long tradition in anthropology, with the underlying idea that we should direct attention to ‘features and characteristics surrounding a phenomenon in order to illuminate it and to understand or give sense to it’ (Dilley, 1999: 1). This implies that decisions are made concerning what is and what is not relevant in order to understand a certain phenomenon. The resulting process of interpretation and reinterpretation is common among anthropologists but relatively new in other research fields. Andersen and Risør (2014) argue that qualitative health research is often lacking in terms of degree of contextualization and thereby misses the underlying dynamics that would be able to explain behaviour or make sense of what was said by respondents. As an example, the authors reflect on studies on patient delay in healthcare seeking. In one of the studies a patient mentioned that he didn’t want to bother the general practitioner with his symptoms. The authors of the study did not reflect further on the explanation provided. Andersen and Risør suggest underlying meanings may be uncovered by reflecting on how healthcare systems inform sociocultural assumptions about ‘what are normal bodily experiences and what are signs of illness’ (2014: 350). Similarly one may reflect on sociocultural norms and masculinity in relation to healthcare seeking (Addis & Mahalik, 2003) in order to provide additional meaning. This thesis takes note of the call for contextualization by explicitly paying attention to diverse contexts such as sociocultural, social, socioeconomic, and socio-historical contexts.

Contexts of mental suffering

To shed light on the interwoven nature of mental suffering with diverse contexts, the following paragraphs explore causal pathways of war, displacement, and marginalization to mental suffering, subjective experiences, perceptions, and health-seeking strategies.

War, displacement, and marginalization are often interrelated and co-occurring; their effects on mental suffering are therefore explored together. Two broad distinctions are made in pathways from exposure to violent conflict to mental suffering: direct effects of exposure to violent conflict (i.e. trauma) and exposure to indirect effects of war in terms of environmental stressors (e.g. poverty, displacement, adjusting to a new environment, loss of social connections) (Miller & Rasmussen, 2010). The former concerns past traumatic events that continue to exert mental strain on individuals, whereas the latter describes ongoing circumstances that cause states of distress. Direct effects of war on mental suffering have been well documented in trauma literature (De Jong et al., 2001; De Jong, 2002; Johnson & Thompson, 2008; Steel et al., 2009). Research indicates that exposure to torture and other potentially traumatic events increases the risk of developing posttraumatic stress disorder (PTSD) and other mental health problems such as depression (Johnson & Thompson 2007, Steel et al. 2009). Identification of risk, and protective factors and development of sophisticated models (e.g. De Jong, 2002) have uncovered the complexity involved in the direct effects of exposure to potentially traumatic events. Many factors are involved that influence the development of mental suffering in the wake of exposure to violent conflict (De Jong et al., 2001). The second pathway from violent conflict to mental
suffering relates to environmental stressors. War disrupts entire populations and generates a myriad of environmental stressors, as people flee from violence and become refugees. Through displacement, social connections and support networks are lost, as family and friends are dispersed, missing, or killed. Furthermore, local means of subsistence and economic self-sufficiency are lost as well as access to healthcare and education (Miller & Rasco, 2004). In exile, people have to rebuild their lives and redefine lost social roles in an often unfamiliar surrounding. This is a daunting task in and of itself and is further complicated by the discrimination of host communities and high rates of unemployment (Miller & Rasco, 2004). A meta-analysis by Porter and Haslam (2005) revealed the importance of environmental stressors experienced among post-conflict populations on mental health outcomes. In doing so, they make an explicit case for understanding mental health problems among refugees as a product of their economic, social, and cultural contexts rather than being largely determined by traumatic events of the past. In addition to marginalization brought about by war and displacement, marginalized groups such as people living in poverty, indigenous people, and ethnic minorities are known to face numerous environmental stressors that affect mental health outcomes (Cohen, 1999; Desjarlais, Eisenberg, Good, & Kleinman, 1995; Kirmayer et al., 2001; Patel & Kleinman, 2003; Vega & Rumbaut, 1991). Post-conflict, displaced, and marginalized communities, such as the !Xun and Khwe, are therefore likely to have an increased risk for mental suffering.

In addition to the causal pathways described above, sociocultural contexts shape experiences, perceptions, and help-seeking strategies related to mental suffering. These aspects of mental suffering are embedded in the sociocultural world of an individual. To clarify this idea, Kleinman, Eisenberg, and Good (1978) distinguish between disease and illness. The former consists of ‘malfunctioning or maladaptation of biologic or psychophysioligic processes in the individual’ and the latter describes ‘personal, interpersonal, and cultural reactions to disease or discomfort’. Sociocultural contexts shape the illness experience and, for example, produce labels, symptomatic expressions, meanings, and coping strategies for mental suffering. In the case of symptoms and labelling, mental suffering experienced in Euro-American cultures have been grouped together in sets of symptoms to be able to distinguish mental states. These sets of symptoms are described in classification systems such as the diagnostic and statistical manual of mental disorders (DSM) and the international classification of diseases (ICD). The conditions described in these classification systems are commonly known as mental health problems. Studies in diverse world regions have revealed that certain ‘mental health problems’, such as mood disturbances, affect, and anxiety, may in certain cultures be labelled as social problems (Kirmayer, 2001). In addition, sociocultural contexts determine appropriate responses to mental suffering, for example, the extent to which distress is expressed in emotional or physical symptoms (Kirmayer, 2001). Labels and symptomatic expressions of mental suffering are therefore part of the language of distress. Application of Euro-American classification systems in other sociocultural contexts is therefore problematic (Kleinman, 1977; Parry, 1996; Sweetland, Belkin, & Verdeli, 2014). As illustration, the use of depression as a label in South Asia would be as relevant as diagnosing white European males with semen retention syndrome, a condition present in South Asia (Jadhav, 2007). The application of labels across cultures is meaningless because they are detached from their sociocultural context: what it means to experience depression or semen retention syndrome is embedded in a specific sociocultural context. Systems of meanings of mental suffering in diverse cultural settings have been explored using idioms of distress (De Jong &
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Reis, 2013; Nichter, 1981, 2010), semantic network analysis (Good, 1977) and explanatory models (Kleinman et al., 1978; Weiss, 1997). Such studies revealed how mental suffering may be understood as personal, interpersonal, psychological, physical, spiritual, and/or political problems. Sociocultural influences also play a role in the dynamic process of help-seeking pathways (Cauce et al., 2002; Rogler & Cortes, 1993). The first steps toward help seeking are recognition and interpretation of the problem. Sociocultural norms and prevalent belief systems determine whether something is considered a problem, how severe it is, and possible explanations. If, for example, a form of mental suffering is interpreted as spiritual in nature, and the use of spiritual or traditional practitioners is common in that setting, it is likely that initial help is sought in terms of spiritual intervention. This is often reported to be the case in South Africa (Burns, Jhazbhay, & Emsley, 2011; Burns & Tomita, 2014; Sorsdahl et al., 2009). Sociocultural contexts may also prevent individuals from initiating help-seeking behaviour for mental suffering; stigma associated with mental illness is an illustrative example of this (Corrigan, 2004).

Research background and study site

In this section I provide background information on the research process and the study site to enable a sense of place in which to situate subsequent chapters.

The origin of the research presented in this thesis is rooted in my first visit to South Africa in 2007, whilst conducting a study for my Master’s degree. The sharp contrasts of rich and poor, privileged and unprivileged, stemming from South Africa’s apartheid past shook my inner world and unconsciously directed my future studies. In 2011, I discussed possibilities for a doctoral research with Harry Wels, a colleague at the time as well as supervisor during my master’s study, and South Africa therefore soon became a topic of discussion. Following my interest in how the apartheid past continues to affect people of South Africa I was drawn to the San as a highly marginalized group of people in southern Africa. My institutional context at the time was very much involved in mental-health-related research. With these markers in place, I started exploring possible avenues for research. It was not until my first fieldwork visit in 2012 that the research took on a more definite shape and direction. Throughout the three fieldwork visits (2012, 2013, 2014) the research followed an iterative design in which new insights and problems encountered informed the consecutive studies. To provide contextual depth, a socio-historical analysis of the !Xun and Khwe communities was conducted in the first study (chapter 2). Considering the paucity of research on mental suffering among San communities, the empirical studies (chapters 3-5) had an explorative approach using qualitative methods such as interviews, observations, and in-depth case studies. For detailed information on methodological approaches used, you may refer to the methods sections in the papers presented. Data collection was done in collaboration with two or three master’s students from VU University at a time. Some of these were also co-authors in the articles presented in chapters 3-5.

Conducting research among San communities is challenging, as the overwhelming interests in San communities by filmmakers, photographers, scholars, and the like have had dramatic impacts. The image of San people was turned into a commodity in forms of live displays, books, photographs, movies, and scientific publications (Bregin, 2001; Gordon & Sholto-Douglas, 2000). As a consequence, issues of representation, knowledge ownership, and distribution of benefits are fiercely debated and negotiated in the field (Tomaselli, 2003,
Although research is often done with the best intentions, it remains a thorny field in which mistakes are easily made (Bregin, 2001). Attempting a research project among these communities as a foreign white researcher, I was received with much suspicion. During my first visits to the !Xun and Khwe, community leaders and a local NGO South African San Institute (SASI), functioning as gatekeeper, thoroughly questioned me on the research project, process, and its potential revenues. Through these deliberations conditions for the research project were agreed upon. Specific attention was paid to sharing information, by holding meetings, airing on the local radio station, and returning publications to the community. In addition, Keyan Tomaselli from the University of Kwazulu-Natal, who has decades of experience working with San communities, facilitated the research in ways that allowed me to navigate the field of competing interests and build trust relationships with local parties. Additional codes of conduct developed in the field, as we, the research team, reflected on events with community members, research facilitators, and community leaders. Ethical clearance for the research project was obtained at the University of KwaZulu-Natal; however, it was the thorough discussions with local parties and reflexive processes in the field that contributed most to the ethical grounds of the project.

The !Xun and Khwe in Platfontein are estimated at 4500 and 1700 people, respectively (South African San Institute, 2010). Although part of the Kimberley municipality, Platfontein is relatively isolated from Kimberley, approximately 12 kilometres from the city centre (see figure 3). Unlike other townships, Platfontein is not attached to a city but was instead built about one kilometre inland from a provincial road. Taking the exit to Platfontein, a large sign welcomes visitors to ‘the footprints of the San’, reminding them of the cultural background of its inhabitants. The township itself resembles other South African townships in terms of RDP (Reconstruction and Development Plan) houses and general facilities such as a primary healthcare clinic, a combined primary and secondary school, shops, and ‘shebeens’ (informal liquor stores/bars).

Figure 3: overview of Platfontein, upper-left corner, in relation to the provincial road (R31) and Kimberley centre, starting at the bottom-right corner (image captured from Google Maps, 23-11-2017).

The primary healthcare clinic, run by the provincial health department, plays an important role in healthcare for the !Xun and Khwe. The clinic provides various types of care such as antenatal services, family planning, tuberculosis (TB) screening, HIV counselling and testing, and mental healthcare. If needed the clinic arranges transportation to the general hospital in Kimberley. In addition to the general hospital, Kimberley has a combined TB and mental healthcare facility called West End Hospital. This is the only in-patient psychiatric facility in
the Northern Cape. The facility suffers from staff shortages (Cullinan, 2006), as is typical for the country as a whole (Petersen & Lund, 2011). Development of an extensive mental health facility is expected to improve conditions, however construction has been delayed; scheduled for completion in 2007 (Evans, 2012), it was still under construction during my last visit in 2014. Aside from using biomedical healthcare facilities, the !Xun and Khwe also utilize traditional forms of healthcare (De Jager, Prinsloo, & Joubert, 2010; Letsoalo, 2010). The combination of biomedical and traditional healthcare is not uncommon in South Africa (Gqaleni, Moodley, Kruger, Ntuli, & McLeod, 2007). In Platfontein a few traditional practitioners remain, however, they struggle to continue their practices due to lack of medicinal plants and strict regulations for importing them. It is therefore common for people to travel to Namibia or Angola for traditional healing.

Figure 4: the medical clinic located in the centre of Platfontein. Photo by author.

Research questions and thesis outline

The aim of this thesis is to contribute to understanding the multi-dimensional character of mental suffering in displaced and marginalized communities. The following research questions form the core of the thesis.

Main research question:

- How do the !Xun and Khwe understand, give meaning to, and cope with mental suffering, and how is this embedded in local contexts?

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4 ‘Traditional’ or ‘alternative’ healthcare or ‘healing’ are commonly used in the literature to refer to a collection of non-biomedical forms of healthcare. They are, however, fraught with negative connotations of supposed dichotomies such as ancient-modern and uncommon-normal. For lack of a suitable and intelligible alternative, I use ‘traditional’ here to refer to healthcare practices typically found in San cultures.
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Sub research questions:

- How may the current living conditions and marginalized position of the !Xun and Khwe be understood from a socio-historical perspective?
- How do the !Xun and Khwe understand and give meaning to mental suffering, and how is this embedded in local contexts?
- How do the !Xun and Khwe cope with mental suffering, and how are coping strategies embedded in local contexts?

The studies, described in chapters 2-5, highlight different aspects related to the research questions. Chapter 6 provides an overall discussion and conclusion.

Chapter 2 takes a socio-historical approach in order to provide insight into contextual dynamics that have shaped the current living conditions of the !Xun and Khwe. In particular, it aims to explain how these two communities were bound together despite their wish to go separate ways. In this way, the chapter provides insight into dynamics (e.g. marginalization, displacement, and war) that 1) may be a source of distress and increase the risk of mental suffering; 2) disrupt social fabrics and thereby cause personal/interpersonal distress, and threaten social dynamics that could inhibit negative effects of distress; and 3) shape experiences and meanings attached to mental suffering. In addition, it provides the necessary contextual depth to situate the research findings of chapters 3-5.

In chapter 3, local perceptions on mental suffering are studied using a depression vignette. Twenty semi-structured interviews were conducted to explore causal interpretations and coping strategies for depressive conditions. This approach proved valuable because it allowed respondents the space to draw on personal experiences and salient issues in the community. The stories of respondents thereby function as mirror of the sociocultural context. Ethnographic data was additionally used to make sense of the findings. The study provides insights into the multi-dimensional understanding of depressive conditions in which cognitive, emotional, and socioeconomic dimensions are central. Perceptions on coping strategies have identified local strategies and sources of support. Furthermore, a paradox was revealed in which social relations are causing distress as well as being the primary source of support. In addition, the results of this study initiated the study of chapter 4, as a local idiom of distress ‘thinking a lot’ was uncovered.

Chapter 4 studies local meanings of the idiom of distress ‘thinking a lot’. Twenty semi-structured exploratory interviews were conducted among the Khwe. The main topics included use of the idiom in social settings, content of ‘thinking a lot’, and key characteristics such as symptoms, timeline and duration, causal explanations, consequences, and coping strategies. The results of the study provide detailed insights into local understandings of distress states. Key characteristics of local ethnopsychology and ethnophysiology in relation to distress states are made tangible. Meanings of ‘thinking a lot’ are in particular situated in social, socioeconomic, and political contexts. Although the idiom is used in diverse world regions and commonly grouped together, the results of this study make differences visible and emphasise the importance of paying attention to local contextual meanings.
Chapter 5 takes a case-study approach to study the social dynamics of informal care for people with chronic psychotic symptoms. Four case studies were conducted encompassing observations, along with a total of 33 interviews. The results of this study emphasise the pivotal role of informal care for the well-being of persons with mental health problems in low-resource settings. It further reveals how local care structures are shaped by sociocultural, socioeconomic, and socio-historical contexts. Local care structures prove to be especially valuable in terms of their adaptability. Simultaneously, the case studies illustrate the precariousness of informal care in poor socioeconomic contexts such as Platfontein.

Chapter 6 concludes the thesis by discussing the separate sub-studies and reflecting on the above-outlined research questions. In addition, methodological reflections and implications of this research are discussed.
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References


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