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6.1 INTRODUCTION

Contemporary research shows that female participants in the current primary and secondary educational milieus may experience acute stress reactions as well as chronic long-term stress response and stress-related disorders. Thus, female stress is a problem for current female caregivers whose mental health affects others in the learning situation. Yet, their educational role is vital because the successful leading of children and adults to self-actualisation is often dependent upon adequate 'nurturing' and 'caring'. Moreover, women and girls are naturally and traditionally nurturers and caregivers. However, stress is also a problem for female learners for whom stress prevents adequate self-actualisation. It appears, in fact, that many girls as well as adult women experience stress today. Furthermore, according to population statistics, there are more females than males in South Africa. For example, there are approximately 21.5 million males and almost 22.5 million females (South Africa Population 2002: 1; National Institute for Mental Health 2003: 1-3; Wolcott 1991: 4; Moch 1997: 30-32).

Most teachers are female in South Africa and teacher stress is a well-researched contemporary problem in the country. South Africa is both a developed and developing country where many individuals lead a life that is both Westernised and traditional (Adams 1999: 1-14; UNESCO Institute for Statistics. 2002, s.v. "South Africa"; Kyriacou & Sutcliffe 1987: 1-6). Moreover there are as many girls at school today in South Africa as boys because education is compulsory for all children from the beginning of the year in which they turn seven until either they reach the age of fifteen (Grade 9). There are also increasing numbers of female enrolments at high school and higher education level, although the pass rate is lower than for males (De Koker 2002: 8). This suggests still greater financial and parental support for male participants in the secondary educational milieu. Here the age-old basic stressor of female marginalisation continues in a society grounded in a negative perception of natural and traditional female sociopsychobiological identity as in past civilizations. This attitude to women and girls in the primary and secondary educational milieus is a stress vulnerability factor, along with the other gender-related biological, psychological and social factors that made females stress prone in the past when faced with time-related stressors. These are often also linked to eternal diathesis factors, such as female biology, psychology and related social roles (Patel 1991: 13; Canadian International Development Agency 2002: 9-10; Bennet 1993: 174; De Koker 2002: 8).

In addition to the eternally present female diathesis to stress, due to negative societal perceptions and the stressful nature of the age-old female biological, psychological and social role of nurturer, stressors peculiar to contemporary South Africa may face female educators and learners who may be experiencing a particularly difficult time. However, many time-bound stressors are rooted in the reality of eternal female oppression (Bureau of Africa Affairs 2002: 6).

In the second reading of the Mental Health Care Bill, South African Minister of Health, Manto Tshabalala-Msimang pointed out that mental health is a crucial issue in South Africa today (Tshabalala-Msimang 2002: 1). In addition, Dr Salduker, spokesperson for the South African Society of Psychiatrists, maintains that one to five million people in South African suffer from a psychiatric disorder of which a large percentage is female (Dresner 2002: 4). Since ‘developing countries’ give evidence of a ‘massive burden of suffering resulting from mental health problems’ and where ‘even today, people with mental illness are badly discriminated against, stigmatised and abused’, the problem of female stress should be urgently dealt with (Tshabalala-Msimang 2002: 1).

According to psychologist, Oliver James (in Williams 1998: 96), research has shown that symptoms of stress have increased since the 1950s. This affects 40% of women and girls in contemporary Westernised society that James calls the *advanced capitalist society* that promotes unrealistic life expectations for women and girls (James in Williams 1998: 96). This appears to be a continuation of the similar situation for females of the industrial era. The World Health Organisation predicts that the stress disorder, *depression* to which females appear most vulnerable will be the ‘second greatest single cause of disability and death in the world’ by 2020 (Dresner 2002: 4).

Although an apparent Western female phenomenon, stress disorders like depression are manifested in traditional South African cultures despite variations in stress response and stressors (Mazure *et al.* 2002: 10, 26; Shannon 2002: 5). Research in this area should take cognisance of a transcultural perspective and ‘indigenous categories’ of affective disorders like *stress*, a Westernised concept systematically developed and analysed since the start of the latter half of the twentieth century. However, as this research has shown, female stress was prevalent in different cultures in the past despite varying stressors, manifestations and coping strategies. Thus it is a universal and eternal phenomenon that is, moreover, grounded in basic psychobiosocial factors

common to all human females (Ensink & Robertson 1996 137-172; Al-Issa 1995: 42-46; Moch 1997: 30-32); Bangla 2000: 2002: 1; Blumenthal 2003: Dresner 2002 :4; BehaveNet 2002b, s.v. “stress-diathesis”; Medical Research Council 2002: 1; Szasz 1975: 859-861; Foreman 1996: 25).

Indigenous categories and traditional perceptions of affective disorders influence the lives of many female participants in the primary and secondary educational milieus in South Africa. For example, as Salduker, media spokesperson for the South African Society of Psychiatrists maintains, symptoms of depression range from headaches to spirit possession in black females, as opposed to Westernised symptoms such as sadness, listlessness and eating or sleep disorders. However, Salduker adds that in ‘a fast urbanising black African population some of the typical symptomatology is seen’ (Dresner 2002: 4).

In an unstructured interview (1) conducted in April 2000 with T. Batyi a female South African university lecturer with traditional roots, it was mentioned how stress makes many traditional female teachers believe that they are spirit possessed and are becoming a medium. Harriet Ngubane in her 1977 book *Body and Mind in Zulu Medicine* outlines traditional African perceptions of what may be attributed to stress disorders in contemporary Westernised thinking. According to Ngubane (in Al-Issa 1995: 42-46), indigenous categories distinguish between diseases of African people and universal illness. One of the former is female possession by evil spirits, called *amafufnyane* in the Zulu language. A manifestation of this disorder that Al-Issa states is ‘associated with social stressors’ would be talking in an African mother tongue in a male voice. Traditional healers would be consulted for a cure to the female stress disorder attributed to bewitchment and a negative relationship with ancestors. These healers would be either a herbalist doctor (*inyanga* in Zulu/ *ixhwete* in Xhosa) or a spirit mediator, diviner and intuitive dreamer (*isangoma* in Zulu/ *igquira* in Xhosa) who has him/herself been through spirit possession. Up to 60% of South Africans consult traditional healers of which there is an estimated 200 000 (Al Issa 1995: 43; Van Wyk , Van Oudtshoorn & Gericke 2000: 10).

The initiation of a Xhosa diviner is founded on the belief that the individual has been troubled (*inkathaza*) by what is conceptualised as an *illness* found more often in females. This disorder, symptomised by visions and dreams, is viewed as a gift from ancestors (*amthonga*) that only admission and initiation can cure. In other words, the ancestors cause the illness but also heal it by allowing the diviner to use her powers to interpret the will of the ancestors, identify witches and treat and counsel victims of illness and misfortune (Hunter 1979: 320-348).

Simon (1997: 13) maintains that research conducted by the Pietermaritzburg Institute of Natural Resources discovered that 84% of the South African population consults herbalist doctors more than three times a year after or in lieu of the Western medical doctor or clinic. Although this figure differs from that of 60% quoted by Van Wyk *et al* (2000: 10), the data show how traditional conceptualisation of illness may impact upon perceptions of stress experienced by women and girls in contemporary South Africa.

Ensink and Robertson (1999: 23-43) examine how indigenous names are still used in a study of 62 African psychiatric patients and their families who used Westernised psychiatric facilities, with which they were generally satisfied, as opposed to traditional diviners (not herbalists). Research with South African Xhosa-speaking psychiatric nurses in the year 2001 investigated how these health workers manage to reconcile Western psychiatry with traditional healing perceptions. Interviews showed that nurses do not when questioned admit to reconciling both paradigms and proclaim the superiority of Westernised psychiatry as superior to traditional stress medicine (Kahn & Kelly 1999: 5-9).

South African female participants in the primary and secondary educational milieus manifest stress disorders that can be interpreted from a Westernised psychological perspective regarding causes, manifestations and coping mechanisms. However, researchers need to be aware of culturally embedded perceptions of the stress phenomenon. This will allow those suffering to be offered effective solutions to the problem according to what is functional in both Westernised and traditional understanding.

The following paragraphs will investigate the problem in current society bearing in mind differences with regard to the Westernised and traditional female stress experience with the aim of understanding the universally valid essentials observed in the past. A comprehension of the latter underpin recommendations regarding educational solutions to the problem of stress experienced by the female participants in the primary and secondary educational milieus.

6.2 CAUSES OF STRESS IN THE FEMALE PARTICIPANTS OF THE CONTEMPORARY PRIMARY AND SECONDARY EDUCATIONAL MILIEUS

Women and girls who participate as teachers or caretakers or learners in South Africa may be vulnerable to stress for the same reasons as those living during the eras discussed in the previous chapters of this study. Nevertheless, particular stressors that faces them at macro, meso and micro-level need to be surveyed to fully understand the problem from a contemporary perspective, even if many of these time-bound stressors are related to eternal psycho-biosocial factors.

6.2.1 Stressors at macro-level in society and culture

Many stressors face South African women and girls in a society where dire challenges such as female oppression, poverty and disease are rife. Research has shown that women are three times more likely than men to experience depression in response to a stressful event, and South African culture is a breeding ground for many traumatic circumstances (Mazure *et al.* 2002: 15; Mindwaves Institute 2002: 1).

6.2.1.1 Female oppression

Although taking on a time-related outward appearance in some cases, female oppression may be a contributing factor to stress experienced by women and girls in the current South African Westernised and traditional formal or informal educational milieus as in the past. Seen as second-class citizens, South African females may run the risk of low self-esteem, a psychological stressor, predictor and manifestation of distress (Snyders, Pretorius & Strümpher 2002: 142).

Despite the attempt to follow mainly Westernised twentieth century trends in order to transform the female social position and establish gender equity made by recent formal legislation in South Africa, female participants in the current South African Westernised and traditional primary and secondary educational milieus still encounter ‘discrimination and disempowerment’ (Kaplan 1992:16; Jonker 2002: 9; Good Shepherd Sisters 2002: 8). Jean Ngubane, president of the Women’s National Coalition in South Africa, maintains that female oppression in South Africa is ‘the worst form of oppression there is’ (Page 1995: 2). Ngubane sees this oppression as deeply rooted in both South African traditional and Westernised society. Ngubane believes ‘many levels

of oppression ... still exist' that spring from patriarchal attitudes in a society where male leadership is the norm whether it involves 'the father, the tribal chief ... husband's permission for absolutely everything, even using contraceptives' (Page 1995: 2). Munro (2002: 3) highlights traditional gender oppressive 'controversial cultural practices'. These include the dowry system, female-child marriages, genital mutilation and, sexual abuse of women and girls. Botha (in Page 1995 2) mentions female oppression in South African white Afrikaner culture. She maintains this starts in the primary educational milieu of 'the home' and continues in the secondary educational situation of 'a limited and prejudicial education'. South African females have 'colluded' in their oppression in patriarchal structures. For example, women and girls abused by male family members remain silent because of economic and emotional dependence (Sex News 2002: 2). Sixty percent of rapes 'take place in the home' (SpeakOut Legal Services 2002a: 1). According to Smith, a rape victim, patriarchal attitudes are often responsible for sexual violence. Smith (in Sex News 2002: 3) mentions:

... the despicable attitudes towards women and children ... of men and boys who rape; who believe they can have sex with anyone they want whether it is a woman walking in the street, their non-consenting wife or their daughter ...

Sexual exploitation of poor South African girls by 'sugar daddies', who pay their school fees, is another stressful reality and includes the emotional and physical risk of AIDS transmission. Rape, sexually transmitted infections and AIDS comprise stressful gender-related threats to virgins in particular, whom infected men rape in the hope of a cure prescribed by urban mythology (Sex News 2002: 2). Under pressure, teenage girls are often coerced into having sexual intercourse. Yet interviews with 26 000 Johannesburg high-school pupils revealed that about half did not believe that 'forced sex' was 'sexual violence', thus perpetuating the cycle of violence with their acceptance of the status quo (SpeakOut Legal Services 2002b: 1).

6.2.1.2 Loss of traditional female status

A Westernised life-style has left traditional female participants in the current South African primary and secondary educational milieus in a stressfully confusing cultural void. During unstructured interviews with girls and women during the period 1996–2002 in the Eastern Cape, the researcher observed feelings of tension due to a sense of loss in many individuals. Although females led oppressed lives in traditional African society, they were respected for their albeit

subservient female role. The status quo granted them social, familial and self-respect for fulfilling their natural, nurtured role as nurturers in a way similar to that experienced by females in early society. No longer respected according to this traditional perception, post-modern female participants in the primary and secondary educational milieus struggle to find a realistic and positive self and social cognitive appraisal of or respect for their role (Cf. Interviews 4-7).

6.2.1.3 Effect of violent crime and abuse on females

Although all ages and people of both gender are victims of non-natural death including murder, transport-related deaths and suicide in South Africa, women and girls are most at risk at the hands of their partners (Padayachee 2003: 9).

Violence is in general a problem in the crime-ridden environment of South Africa. However, females are particularly vulnerable victims of violent crime because females are generally physically weaker than males (SpeakOut Legal Services 2002c: 1; Van Lingen 2001b: 1). Since 1990, the South African crime rate has soared. Crimes include the drug trade, property crime, murder and other violent crimes. Professor Mahomed Dada, head of the Department of Forensic Medicine at the University of Natal states that South Africans are ‘twelve times more likely to be murdered than the international norm’. His statement is based on research by the Department of Forensic Medicine at the University of Natal (SpeakOut Legal Services 2002c: 1)..

Data gathered in 1999 and 2000 in South Africa indicate excessive violence towards female adults and children in particular. Seedat (in SpeakOut Legal Services 2002c) maintains that gender discrepancies could be responsible for the high death rate from violence for South African children under the age of 19 which Marais (in SpeakOut Legal Services 2002c) claims is 41%. Violence devastates the lives of women and girls in South Africa today (Ford 2002: 17; Jurgens 2002: 1). Furthermore, resulting long-term physical (including reproductive and AIDS related) health problems, as well as chronic psychological stress experienced by female participants in the primary and secondary educational milieus may be ultimately debilitating for all stakeholders (Heise, Pitanguy & Germain 1994: 17). Simpson (1993: 3) views women and children as casualties in a ‘culture of violence’ as the State President of South Africa described the situation in the country in 1990 before political transition to a democracy. Yet since democracy dawned in South Africa in 1994, women, mostly female children and the elderly, as the least assertive members of society, have continued to be victims of abuse (Simpson 1993: 4; Vogelmann & Eagle

1991: 209-229). Simpson (1993: 5) maintains that violence against women and girls in particular is the norm in South Africa, where it is 'subtly sanctioned by society'. In the words of Simpson (1993: 5-6):

The dramatic experiences of rape, wife battery and other forms of physical abuse are merely at the most extreme end of this spectrum. Violence against women is a much more pervasive and comprehensive problem, which intrudes on the social, sexual and psychological dimensions of most women's lives. For this reason, solutions to the problem must go well beyond a legal process, whether punitive or preventative. Women need to be empowered. This is primarily a social and educational process.

One in four women and girls are physically, emotionally or sexually abused in South Africa today (FAMSA 2002). An estimated third of all females encounter a progressively increasing rate of violence, sexual abuse, rape and forced prostitution (Good Shepherd Sisters 2002: 8; Ndhlovu 1995: 1, 4). A UNISA report in 1999 maintains that one in two South African females will be raped, the rape graph rising steeply at age 11 and peaking from ages 13-25. A Childline report also released in 1999 maintains that one in four female children will be sexually molested (SpeakOut Legal Services 2002a: 1). Furthermore, statistics represent only those cases reported to the police of which only a small portion 'get turned into cases by the police, (and) fewer still are referred to court' (Martin 2002: 3). The SA Law Commission reported that only one in 35 rapes were reported in 1998. Yet, Interpol maintains that South Africa hold 'an undisputed first place' with regard to reported rape cases (SpeakOut Legal Services 2002a: 1).

Female participants in the primary and secondary educational milieus either fear abuse, are currently victims or have been abused in the past. This violent stressor is a source of ongoing stress resulting in maladaptive psychological response, including distancing and denial as well as incapacitating stress disorders (Simpson 1993: 6-9; Good Shepherd Sisters 2002: 8). Martin (2002: 1) quotes the example of Soweto resident, Lerato Molo, who is frightened each day of 'getting raped' owing to the rape of her teenage sister, Mpho who, thus 'joined the growing number' of South African female rape victims. Mpho, once 'an outgoing girl' has 'become a recluse whilst the perpetrator 'remains at large'. Martin (2002: 1) describes the 'terror in the hearts of township women' due to the threat of what is 'perversely called' *jackrolling* or *recreational rape*, 'where victims are abducted and repeatedly assaulted'.

Bennett sees violence, abuse and harassment of females today as similar to the case of African-American female slaves. Simpson (1993: 7-8) views it as part of a 'framework of a male dominated' South African society where (especially black) females are 'taught to be subordinate and submissive'. Moreover, according to Simpson (1993: 8), black men have had to 'deal with ... inferior status' in an apartheid society, 'compounded by deteriorating social and economic circumstances'. This is often accompanied by unemployment and a sense of gender-related failure resulting in 'reassertion of masculinity and control' via violence against disempowered females (Simpson 1993: 8).

Post-traumatic stress is a particular repercussion of this victimization together with feelings of shame, guilt and pressure placed on victims by peers or family members. Moreover, gender oppression may be perpetuated because both Westernised and traditional cultural norms and myths are often used to protect perpetrators of gender violence. The traditional lobola (dowry) system, rare cases of female circumcision and the Westernised patriarchal and overworked criminal justice system are gender related structures that underpin South African society to a greater or lesser degree (Jackson 1997: 1-13; Vogelmann & Eagle 1991: 209-229).

An 'unregulated pornography market' is another cause for the stressor of violent and sexual crimes against women and children in contemporary South African society according to Deputy President Jacob Zuma at the 2001 conference, *16 Days of Activism against Gender Violence* (Oliver 2001: 14). According to Zuma (in Oliver 2001: 14):

... the easy availability of pornography had contributed to the mindset responsible for the escalation of sexual crime.

Fear of rape carries the anxiety of possible HIV infection in contemporary South Africa. Rape clinics reported in 1999 that one in three women are infected when raped; yet antiretroviral medication is unavailable to them ((SpeakOut Legal Services 2002a: 1).

Two studies undertaken by the South African Medical Research Council studies the reality of violence in teenage sexual relationships. The first survey involved 24 pregnant Xhosa teenage girls aged between 14 and 18 years of age in Khayalitsha in the Western Cape (Wood, Maforah & Jewkes 1996: 1-17). The second investigation involved 30 Xhosa youth aged between 18 and 24 years of age from two township schools in the Eastern Cape and mothers and policemen (Wood

and Jewkes 1998: 1-48). Both studies highlighted the violent nature of heterosexual adolescent relationships. Moreover they quoted similar findings made by other research projects. The reports draw attention to the excessive emotional stress that girls and women experience because of marital and non-marital sexual relationships fraught with victimisation, conflict and violence in contemporary South Africa (Wood & Jewkes 2001: 1-17).

6.2.1.4 Social stereotyping that is oppressive to females

Westernised society perpetuates stereotypical myths regarding gender differences that support stressful negative perceptions of female participants in the primary and secondary educational milieus. Examples of these myths are: girls are more gullible than boys; girls lack motivation to achieve; girls are better at rote learning and simple tasks; and boys are more analytic than girls. Although studies of Westernised populations have indicated gender differences with regard to abilities such as verbal, visual, spatial and mathematical ability and personality traits such as aggressiveness, other discrepancies have not been convincingly proved. These myths are sources of negative pressure in the lives of girls and women engaged in learning, teaching or guiding children towards adulthood (Campbell & Storo 2003: 1-8). Moreover, research has shown that girls learn 'negative attitudes about math and the technical fields from their mothers' (*Girls Do Well* 2002: 1). Career and school subject choice stereotyping begins in the primary educational milieu of the home (Geyer, Watson, Foxcroft and McMahon 2002: 1). More males tend to study science and technology in higher education than females who tend to choose the humanities, health sciences and business (De Koker 2002: 8).

Gender stereotypes are also firmly rooted in traditional African culture where men and boys tend the cattle and women, the fields. In the Westernised world of work, males tend to choose engineering, business, sales, science, agriculture and religious work; females choose nursing, secretarial work, home economics, teaching and medicine (Cloete 1980: 35.). Females may feel the stress of negative perceptions of their role in stereotypical fields to which they may actually be suited in individual cases.

Girls and women are under pressure in most cultures to adopt stereotypically female linguistic behaviours such as: talking at a higher pitch; allowing themselves to be interrupted more; listening more; disclosing more personal information; being polite in their speech and less assertive. These patterns start in childhood and are reinforced, as girls grow older. This further

contributes to stereotypically female unassertive behaviour and the stress of learned helplessness. The phenomenon of learned helplessness phenomenon involves maladaptive passivity and emotional numbing that also follows victimization (Tannen 1996: 341-344; Seligman 1972: 407-412; Seligman 1980: 123-142; Seligman & Peterson 1986: 223-249).

Contemporary society often stigmatizes many female physical ailments including pain as not psychosomatic and therefore, not in need of medical care. However, similar symptoms in men are considered as genuinely biomedical in cause. In addition, many stress disorders manifested by females are not taken seriously and labelled in terms of female stereotypes as opposed to those exhibited by males (Hoffmann & Tarzian 2001: 13-28; Cormack & Furnham 1998: 235-248).

6.2.1.5 Effect of poverty on females

Brown, Bhrolchain & Harris (1975: 225-254) believe that poverty is a gateway to stress disorders because poor women and girls are more likely to experience stressful life events than other sectors of the community. Poverty, along with discrimination is a strong mediator for stress. Moreover, tensions linked to poverty cause family breakdown that is a stressor in itself (Mazure *et al* 2002: 16; Jonker 2002: 9). In addition, female marginalisation is linked to poverty: A UN Population Fund report in October 2000 highlighted gender inequity as a cause of poverty (Holste 2002: 1). Females earn less than males, perform menial jobs and are often single parents without the benefit of a male breadwinner. At the World Food Summit held in Rome on 10 – 13 June 2002, the United Nations Population Fund (UNFPA) urged the international community to take practical steps to reduce poverty and hunger by lifting the female participants in the primary and secondary educational milieus out of oppression. Kunio Waki, Deputy Executive Director of the Fund, stated (in Holste 2002: 1) that the world should:

Empower the largest disenfranchised group on earth-and that is women ... providing them with access to credit, markets and technical advice, as well as education and health care, and enforcing their right to own and inherit land could both improve the food supply of the world's poorest people and help them escape from poverty.

Millions suffer daily from hunger and malnutrition in Sub-Saharan Africa including South Africa in rural areas and townships (Holste 2002: 1; Wooden 2002: 1; Rassool 2002a: 3; Interview 3; Munro 2002: 3). Adler, Boyce, Chesney, Cohen, Folkman, Kahn & Syme (1994: 15-24) maintain that socio-economic inequity and not simply poverty causes serious negative stress disorders. In

other words, discrimination regarding salaries, financial status and social standing based on gender or race can raise stress levels in women and girls due to gender inequity.

6.2.1.6 Witch-hunts

Although this occurred some time ago in 1986, an anti-witchcraft attack on five old women in Mapulaneng, a rural area in South Africa, manifested a possible stressor in the lives of women and girls in traditional rural South African society. In this particular vendetta, five women were accused, whipped (*sjambokked*) and four were burnt to death for supposedly causing malevolent supernatural circumstances such as lameness among infants. In the wake of the attack, seven more women and one man were punished (Ritchken 1989: 2). According to Ritchken, at a seminar held at the University of the Witwatersrand on 29 June 1989, a witch is often a 'symbolic object' of 'all that is unnatural and anti-social to a particular society' (Ritchken 1989: 2). The women believed to be witches were representative of unacceptable attributes of a rural household. A study made by Ritchken of each of the women revealed a socially unacceptable aspect in the personal history of each, such as alcoholic husbands, adultery, dead grandchildren, inter-household conflicts, abortion, miscarriage or marginality in the younger village community. Whatever the reasons for labelling and persecuting the women, Ritchken maintains that the witch-hunt was a 'warning of a potential punishment for all involved in relationships that the youth define as anti-social' (Ritchken 1989: 12). In particular, the youths rejected overassertive females, difficult female neighbours, miserly female pensioners, female adulterers, those who performed abortions and female nonconformists. Knowledge of this and similar events elsewhere in rural South Africa may cause stress in the female participants in primary and secondary educational milieus where traditional and indigenous perceptions abound (Van Wyk *et al* 2000: 10).

6.2.1.7 Female transgenerational stress

In an interview with Batyi in March 2002 (Cf. Interview 1), the researcher learnt that traditional South African individuals sometimes believe that problems in life are not only due to ancestral intervention but also ancestral wrongdoing. For example, Mrs Batyi's had recently lost two dogs. One had wandered away from home and not returned; the other had been run over by a car in front of their house. According to tradition an extended family gathering would have to be held where various activities would take place to appease the ancestors.

A similar story was told in a SABC television show entitled *Mamepe*. In this case, a traumatic life event had caused feelings of anxiety and stress. This was accompanied by a belief in ancestral influence and the individual interviewed expressed a need to atone for the sins of a female ancestor, who was in fact his deceased mother. Male and female participants in educational milieus may experience this transgenerational stress. Thus, like Mrs Batyi's family they may take part in various rituals to appease the ancestors and restore the aberrant ancestor to a right relationship with the Creator. In this way, emotional stress due to the stressful event will be relieved. However, while resolving inner conflict in traditional South Africans who simultaneously follow Westernised customs, guilt is experienced for neglecting traditional roots and customs. By atoning for ancestral sin, they may feel that they can find inner peace (*Mamepe* 2002; Louw & Edwards 1993: 688; Schützenberger 1993: 81; Interviews 1, 3).

6.2.1.8 Westernised expectations

In Westernised and traditional South African society, there is pressure on girls and women to conform to unrealistic expectations regarding physical appearance, educational achievement, jobs, material surroundings and family role. In addition, the ideal of the superwoman is flaunted in the media and in contemporary social ideals of gender equity that propose adopting masculine attributes for success. These ideals portrayed via the American media in particular are unattainable by many females whose ambitions remain frustrated in a patriarchal country that does not allow many women to break through gender inequity at home, in the school, university or workplace (Williams 1998: 96).

6.2.1.9 Frustrated self-actualisation in the workplace

Feelings of frustration and stress may be felt by those female participants in the primary and secondary educational milieus in South Africa, who are unable to actualise their particular talents and career needs (Snyders *et al.* 2002: 141). Although South Africa has followed Western societies in showing an increase in the female workforce since 1960, especially in some fields such as legal and medical areas, change is slow. Female career paths still mostly involve traditional female work in nursing, teaching, sales, clerical spheres where there is wage inequity and under-representation in management (Lemmer 1993: 23). Recent statistics indicate that only 50% of the females are economically active compared with 87% for men (Canadian International

Development Agency 2002: 3). At a workshop dealing with the issue of equality in South Africa (MacArthur 1999), various delegates made the following statements:

- Despite apparent equity in South Africa, women and girls are still more likely to be unemployed than men and boys;
- Female workers more likely to earn less in a particular position of employment;
- Women network, but are still unlikely to find employment if a man is also in line for a job.

Worldwide, but especially in poorer countries like South Africa, women are still oppressed when it comes to the world of work. As the often quoted United Nations report of 1980 states:

Women constitute half the world's population, perform nearly two-thirds of its work hours, receive one-tenth of the world's income and own less than one-hundredth of the world's property.

Professor Stella Nkomo perceives South Africa as more than thirty years behind the US with respect to equity especially with regard to female managers. Researcher of the Year for 2001 at the SA School of Business Leadership for her work regarding race, gender and women's empowerment, Nkomo maintains that, unlike government (approximately a third of MPs are women), the private sector has relegated female employees to 'administrative and support positions' as opposed to decision-making positions. Moreover, the work place is not female friendly with regard to accommodating 'women's family responsibilities' (Bennett 2002: 8). Frustration at the glass-ceiling phenomenon may contribute to stress not only in adult participants of the primary and secondary South African educational milieus but also in girls growing up in a society that offers few female career role models in male-dominated fields. Furthermore, women who work are at risk for stress disorders like depression, especially if they manage dual roles as mothers, wives or caretakers and workers. This will impact on their on their role in the primary educational milieu and the secondary educational milieu if they are teachers.

According to a study conducted by Howell, Carter and Schied, women do not deal with stress in the workplace where levels of both emotional and physical stress are increasingly high. This high level of stress affects the primary educational milieus of the home as well, where female workers must be caregivers as a second job, so to speak (Howell, Carter & Schied 2002: 118, 122, 123).

Moreover, women are not willing to cope by being assertive for example in the workplace. They are, instead, expected to be compliant and always in good spirits (Howel *et al.* 2002: 119). Thus, females are not actualising themselves in the workplace. In fact, they are suffering debilitation stress instead and manifesting symptoms of ill health as a result that affects their functioning both at home and in the workplace.

6.2.2 Stressors at meso-level in the home, peer group and school

The time context in which stress disorders occur is important in understanding the female stress phenomenon rooted in universal gender-related factors. As noted earlier at macro-level, poverty and discrimination are examples of contextual factors in society causing stress in female participants in the primary and secondary educational milieus. However, both these stressors are related to the stressor of social oppression that seems to be common to all eras. At meso-level, stressors such as family situation; being a worker in the family without recognition; maternal mortality; single mothers; gender bias in education and stress in female teachers may also appear to be particular to contemporary South African society on the one hand, but grounded in eternal factors in some cases too.

6.2.2.1 Family situation

Stress in female participants in the primary and secondary educational milieus in contemporary South Africa may be directly due to a dysfunctional family primary educational situation. Studies have shown that many depressed mothers were raised in dysfunctional families and are themselves dysfunctional parents, a pattern prevalent across generations. Moreover, stress disorders like depression are often linked to marital discord with partners who also have affective disorders that affect interpersonal functioning. Thus, socio psychobiological inheritance takes on a particular contextual shape in specific time zones (Mazure *et al.* 2002: 17)

When families are poor, violent, affected by parental AIDS or substance abuse, as is often the case in contemporary South Africa, girls generally remain in stressful primary educational situations because of the child-caring and domestic roles they are expected to fill. Yet they also go onto the streets, especially if orphans, a frightening reality for South Africa where there are an estimated 4,8 million AIDS sufferers (SpeakOut Legal Services. 2002d: 1; SpeakOut Legal Services. 2002e: 1; Gebers 1990: 11-14).

Female orphans are especially vulnerable to abuse, especially sexual abuse and related problems (Munro 2002: 3). If the family disintegrates, neighbours and relatives, however, usually take in girls because they assist with household tasks and look after small children. This new primary educational situation may also prove stressful for orphaned girls, who may be overworked and victims of further abuse. Those, who drift onto the streets, generally become prostitutes to survive which leads to further sexual exploitation (Swart 1998: 34; Gebers 1990: 11-14; Le Roux 1996: 423-431; Keen 1990: 11-12; Fall 1986: 47-53).

What should be a haven from the stressors of life, the family, is actually a source of violence for many females in South Africa. One in four South African women in rural areas, townships and cities is a victim of domestic violence. These statistics would be higher if it were not for the silent suffering of battered women in abusive relationships. The organization, POWA (People Opposing Women's Abuse) maintain that many rich, poor, educated or illiterate South African black females believe that they have no rights in South Africa within the primary educational situation of the family or in the secondary educational milieu of the school, where female abuse also takes place. Therefore, they collude in their own oppression by remaining behind a wall of silence (Day 2002: 1-2). The payment of *lobola* adds to this feeling of subordination in many traditional female participants. *Lobola* passes control of a girl or women from her father or male guardian to her husband who, thus, buys his wife who has no rights and is expected to keep domestic issues under 'a veil of secrecy' (Day 2002: 3).

Dr Elizabeth Musaba-Mphele who operated the Empilisweni Woodlands Centre for Aids Prevention in the Eastern Cape, places ill treatment of women and girls at the centre of the actual breakdown of the family unit. In other words, the primary educational milieu for many South African females is in itself stressful and its resulting breakdown comprises another stressor to face. Dr Musaba-Mphele (in Steele 2002: 2) maintains that 'South Africa has the highest statistics of violence in the world for a country not at war'. This reality may be largely due to domestic violence. Dr Musaba-Mphele indicates that sexual partners that include husbands have infected 80% of HIV positive females in sub-Saharan Africa. Thus, marital infidelity and infection of marital partners is another stressor within the primary educational milieus. This leads to the death of many female participants especially mothers, hence the orphan crisis which Dr Musaba-Mphele says is a 'woman crisis' that can be partially solved by 'empowering women in a culture where women are socialised to be subservient to men' (Steele 2002: 2).

A seminar instigated by the MEC for Health in Gauteng, South Africa, Dr Gwen Ramokgopa identified disintegration of the family combined with peer pressure as a significant stressor in the lives of Gauteng girls leading to teenage pregnancy, HIV, AIDS or STDs, gender-based violence, sexual abuse, unemployment and drug abuse (Rassool 2002d: 3).

South African females often experience powerless sexual relationships that take place in the primary situation of the home between marital partners. This is especially so in situation of sexual abuse of girls by family members. Under pressure from those who demand sexual intercourse within the home and often at school as well, South African women and girls face the frightening prospect of death due to AIDS in a country that has 'the fastest rate of HIV infection in the world (Jonker 2002: 9).

6.2.2.2 Family worker without recognition

According to Ngubane (in Page 1995: 1), although females generally form the bedrock of homes that depend on their input, 'women are not entitled to make any decisions'. Ngubane states (in Page 1995: 1):

I am a worker, an organizer, a director, an administrator, an adviser, a doctor, a nurse, a cleaning woman, a gardener, a painter, a carpenter you name it! I am the handyman, the jack-of-all-trades.

The traditional female role of mother, wife, employee and caregiver to young, old, ill or disabled relatives may make female adult and even child participants in the primary educational milieu of the home and the secondary educational milieu of formal education succumb to negative stress because of work overload and because their role is deemed second-class. A US research project showed that the 296 female participants, who filled all these roles experienced stress exacerbation when confronted by additional stressors while fulfilling these roles (*Psychology & Aging* 1997: 376-386).

6.2.2.3 Maternal mortality

Although often only valued for their reproductive role in Sub-Saharan Africa, women and girls face their most stressful experience in the role of motherhood that is not really granted the esteem it is due (Holste 2002: 1). As in the past eras, the emotional, social and physical complications of the female biological, social and psychological reproductive role may underpin stress in the lives of many female participants in the current primary and secondary educational milieus.

According to estimates made in 2001, Third World including Sub-Saharan African women and girls have a one in thirteen chance of dying as a result of childbirth and its complication compared with a one in 1,400 chance in industrialised societies (World Health Organization 2001: 14; South African Broadcasting Corporation: 2001). Over 250,000 adolescent and adult females die in Southern Africa every year owing to poor obstetric care, which statistics show has not improved significantly in South Africa (World Health Organisation 2001: 14-15; Flanagan 1998: 1). Moreover, severely stressful conditions following childbirth, such as torn tissues, infections and incontinence may develop in underage South African mothers, sometimes 14 or even 10 years as a result of 'underdeveloped pelvises' (Flanagan 1998: 2).

6.2.2.4 Single mothers

There are many single mothers in South Africa today owing to teenage pregnancies, men who have multiple sex partners and abandoned women (Good Shepherd Sisters 2002: 8). In 1996, South Africa had the highest teenage pregnancy rate in the world. In 1990, four out of every ten births resulted from teenage pregnancies and in 1993, 4,6 % of all babies born with AIDS were delivered by teenage mothers (Shisan 1996: 5). This brings emotional and financial strain into the lives of the females concerned, including the reality of child and female abuse that underpins the situation. The single mother family is often the victim of male attitudes of disrespect towards females and children that manifests itself in violence, abuse, rape, multiple sex partners, neglect and lack of paternal responsibility (Mandela in Heinemann South Africa 2002: 4).

6.2.2.5 Gender bias in education

Despite extensive research into gender bias in education in Westernised post-industrialized society in the US, Western Europe and Australia, since the 1960s, prejudice against female

learners in many countries and especially South African society prevails (Kelly 1989: 548, 558; Kelly & Slaughter 1991: 4; Jonker 2002: 9; Page 1995: 2; Lemmer 1993: 20). Furthermore, as Lemmer (1993: 20, 23) maintains, gender and racial equity concerns, particularly in education, were 'marginalized in South Africa' prior to the dismantling of *apartheid*, after which research and legislation for reform became possible. Yet, there is still a great deal of room for change.

A report issued by the Gender Equity Task Team, led by Annemarie Wolpe in 1997 pointed out that, although 53 % of all South African university students were female in 1996, percentages were lower in technikons, science, technology, law and most of all, in post-graduate courses. With regard to the latter, interviews revealed pressure on these women and girls to discontinue their studies, which were felt to be 'inappropriate' (Wolpe 1997: 144). Gender inequality is prevalent among academic staff in many South African institutions of higher education (Wolpe 1997: 141).

According to Biraimah (1999: 11), even well-educated South African women and girls are discouraged from pursuing higher levels of education, research and promotion in many institutes of higher learning, especially the historically disadvantaged ones. Disheartened by 'gender-differentiated staffing patterns', inequitable promotion, unreasonable teaching loads in junior positions, family responsibilities, a lack of effective gender equity policy including gender sensitive protection and security, 'reinforced by a lack of self-confidence and lack of role models', female participants in the secondary educational milieu of higher learning experience stress due to gender differentiation, harassment, victimisation and violence (Biraimah 1999: 13, 17). In the words of Biraimah (1999: 13):

If South African HDI's truly wish ... to ensure equal access while providing the nation with a large cadre of well-trained professionals, they must not only attend to access and field of study issues, but also the many social and psychological issues that can keep even the most dedicated student from achieving their academic goals.

Not only are female participants in formal education part of an unequal power struggle in South Africa, they are often marginalized with regard to curricula, educational material, teaching styles, scientific and technological knowledge, subject choice, division of classroom tasks, educational management and personal safety issues in the secondary educational milieu that are traditionally patriarchal and/or Eurocentric (Biraimah 1999: 12, 15; Lemmer 1993: 19-24; De Koker 2002: 8).

Moreover, ‘differentiated gender role socialisation’ may have already begun in the primary educational milieu of the home and family, where patriarchal stereotypes are communicated (Lemmer 1993: 9; Geyer *et al* 2002: 1).

6.2.2.6 Stress in female teachers

The teaching situation in most contemporary South African schools is particularly stressful. According to Adkins (2002: 1), schools are in ‘continuing chaos’. Female participants may be affected greatly by this situation because of being stress-prone in a society that cognitively appraises females negatively because of the age-old marginalisation of natural and nurtured female uniqueness as society’s nurturers, tenders and carers.

Over the last 20 years there has been ‘a wealth of research ... published on the phenomenon of teacher stress – focussing on various subgroups of teachers including females’ (Adams 2002: 1-7). For example, female teachers were identified as having a higher level of stress than male teachers in a research report presented at the International Special Education Congress 2000. The study identified stressors for a particular group of South African teachers. The project involved 92 female and 115 male Grade 0 to Grade 12 teachers (aged 26 to over 55) from Gauteng and Western Cape Province. The investigations proved that the mean of the seven stress level factors identified in the sample indicated a higher level of stress for female than for male teachers (Engelbrecht, Eloff, Swart & Forlin 2000: 3, 9).

Research in Westernised societies has concluded that teachers are under greater stress than in the past with negative effects on teacher effectiveness and learner success (Kyriacou 1987: 146-152; Anderson 1989: 1-10). Since most teachers are female in South Africa, this may be a problem for participants in the secondary educational milieu as well as the primary educational milieu that is often affected by what happens in the former (Okebukola & Jegede 1989: 23-36). Kyriacou (1987: 146-152) defines teacher stress as a negative emotional experience as a result of teaching work leading to manifestations of stress (such as nervous tension, anxiety, frustration, anger, and depression) and to poor teaching.

Stressors identified for teachers are: inadequate working conditions and educational resources (Okebukola & Jegede 1989: 23-36; Smilansky, 1984: 84-92); misconduct or negative work ethic in learners (Kyriacou 1987: 146-152) and a lack of resources for teaching, overload with non-teaching duties and time pressure (Payne & Furnham 1987: 141-150). Cox and Brockley (1984:

84) maintain that ‘work appears as a major source of stress for working people, with teachers appearing to experience more stress through work than non-teachers’.

Kyriacou and Sutcliffe (1978: 1-6) see teacher stress as manifestations of various affective, behavioural and physical disorders due to stressors in the teaching environment. However, factors, such as subjective perception will affect the individual teacher’s particular stress response (Handy 1988: 351-369). Thus, because of possible female stress diathesis female teachers may be particularly vulnerable to the negative effect of stressors in the teaching environment of, for example, the Eastern Cape in South Africa that is in crisis and ‘currently caught up in a quagmire of appalling matriculation (final school examination) results, non-payment of teachers, absence of school books, corruption and general sloth’ (Adkins 2002: 1).

The teaching situation in South Africa has been particularly exacerbated by AIDS that is claiming the lives of many (mainly female) teachers, as reported by the SA Democratic Teachers Union during 2001. In five of the nine provinces, more women than men were dying at primary school level where teachers are mostly young women (Govender 2001: 5).

6.2.3 Stressors at micro-level in the individual female self

Although female biology and psychology rooted in the reproductive role (negatively influencing social status) may be a contributing factor in stress vulnerability in women and girls in the South African primary and secondary educational milieus, who are psychobiolosociologically the same as their earliest ancestors, stressors at micro-level peculiar to South Africa may evoke negative stress in female participants in the primary and secondary educational milieus.

6.2.3.1 AIDS and Sexually Transmitted Diseases (STDs)

AIDS and STD’s impact socially, physically and psychologically upon many female participants in South African primary and secondary educational milieus (American Jewish World Service 2002: 14). The biopsychosocial status of females is at the root of the stressor of AIDS and STD’s owing to female victimisation in the form of sexual abuse in and outside of home and school. Most South African girls are sexually active by the age of ten and over ten million HIV positive South Africans are aged between 18 and 24 (CNN News: 2002; MTV News: 2002).

Many more females are infected with HIV or AIDS infection than men (Jonker 2002: 9; Good Shepherd Sisters 2002: 8). In parts of South Africa up to 40% of females of childbearing age are infected (Bureau of Africa Affairs 2002: 9). Moreover, one in four women between the ages of 20 and twenty-nine are infected (*South Africa scales* 2002: 2). ‘The debilitating effects of stigma and discrimination’ against infected individuals cause considerable stress and related disorders; especially since children of AIDS women and girls are sometimes infected in the womb and through breastfeeding (Munro 2002: 3).

At a 2002 seminar attended by youth from 250 organisations in Gauteng, South Africa, Simon Zwane speaking for Health MEC, Gwen Ramokgopa, stated that about four million South Africans develop STD’s annually and 35% of teenagers fall pregnant or have a child by age 19 (Rassool 2002d: 3). The Department of Health announced in March 2000 that two out of every ten South African girls between the ages of 13 and 19 are HIV positive (Sex News 2002: 2). Adolescent girls are twice as likely to become infected with HIV as boys. This is a reflection of increased sexual activity, often unwilling, with older men or infected males who either seek revenge and/or believe that sexual intercourse with a virgin will effect their own cure for HIV (Murphy 1998: 8). Chidonza-Gordon (in Jonker 2002: 9) points out that:

Gender-based inequalities mean that women are more vulnerable to HIV infection because they have little power to insist on safer sex, while men often do not inform their partners about their HIV status.

Women and girls battle to access health care and social services in some areas of South Africa, where the 1999 estimated AIDS deaths were 150 000. Estimates made in 2002 gave 60% of the population infected (Jonker 2002: 9; MTV News 2002).

6.2.3.2. Abortion

Many unwanted pregnancies are terminated by means of abortion, which has been legalised in South Africa. Moreover, pregnant girls and women are often forced to abort their babies, which is a stressor in addition to the unwanted pregnancy, which is often due to rape (Good Shepherd Sisters 2002: 8).

Traditional rural society victimises mothers who have natural or deliberately induced miscarriages or abortions. According to Hammond-Tooke (1981: 115), rural communities fear that misfortune such as drought, illness or death may affect the future sexual partners of these women or girls. They believe that the abortions or miscarriages might cause disaster if these females have not undergone the prerequisite community cleansing rituals. Social control of female fertility issues weighs heavily on the rurally rooted female participants in the primary and secondary South African educational milieus in addition to the stress of the actual loss of the foetus.

6.2.3.3 Emasculation of natural female identity

Not only are women and girls in patriarchal societies marginalized as in most Westernised and traditional society, they may suppress their feminine identity even further by trying to find positive social and personal cognitive appraisal by becoming ‘masculine’ and adopting typically male identity characteristics such as aggressiveness, competitiveness and even physical muscularity through exercise. They may, thus, suffer from the stress of conflicting gender role identity because ‘clinical judgements of mental health’ in females are often according to male norms (Cekelis 2002: 1).

Female participants in the primary and secondary educational milieus may experience inner conflict, guilt, worry and dread of success by displaying the socially esteemed traits of success in a man’s world such as boldness, confidence, aggression, competitiveness, objectivity and success in mathematics and science, traditionally male career paths (Cekelis 2002: 1).

Literature in the early 1970s examined the link between gender and mental health and resolved that double standards existed in psychological assessments that judge individuals by traditional gender norms. In other words, female mental health and life skill success were judged against male health parameters of socially highly valued items of competence and individual achievement (Pyke & Stark-Admec 1981: 38-54).

Mixed feelings at not portraying traditional feminine characteristics that are opposite to typically male traits may cause inner tension. Female non-aggressive, tending, caring and sharing tendencies are not truly respected in patriarchal contemporary South African primary and secondary educational milieus (Kimball 1975: 121-142; Woolsey 1977: 66-88; Broverman, Broverman, Clarkson, Rosencrantz, & Vogel 1970: 1-7).

According to a television documentary entitled *Science of Beauty*, Westernised females tend to want to be superwomen to win social esteem. The irony is that the more women and girls seek the perfect physique, intellect and financial status, the more men and boys will seek supremacy in similar areas, such as by strenuous exercise to develop bigger muscles and even using perfumes and cosmetics (*Science of Beauty* 2002).

6.2.2.4 Low self-esteem

Low self-esteem may be another factor at micro-level in female participants in the South African primary and secondary educational milieus. In a society that does not value girls and women, females are not likely to value themselves highly (Blehar 1997: 3-12; Blumenthal 2003: 1). Moreover, self-blame is a severe mediator for negative stress disorders such as depression in abuse and rape victims in particular. Beliefs and event-related appraisals can predict the outcome of a stressful life event (Mazure *et al* 2002: 15). This may be the case with South African female participants who are biopsychosocially predisposed to stress like their ancestors who viewed themselves as second-class citizens in patriarchal societies and manifested various stress disorders.

According to Northrup (1998: 28), ‘our central nervous systems and sense organs ... process *only those stimuli that reinforce what we already believe about ourselves*’. In other words, women and girls who are ‘conditioned’ to being oppressed and even abused ‘have difficulty recognizing loving people and environments’, unless they consciously change their perceptions based on ‘the seeds’ of stress disorders sown earlier in their lives.

6.3 MANIFESTATIONS OF STRESS IN THE FEMALE PARTICIPANTS OF THE CONTEMPORARY PRIMARY AND SECONDARY EDUCATIONAL MILIEUS

Although stress symptoms patterns and expression of psychological distress may vary in individuals and cultural groups, the following paragraphs survey a few manifestations that are apparent in Westernised and traditional South Africa today. These impair the emotional, physical, behavioural and cognitive functioning of female participants in the primary and secondary educational milieus (Mazure *et al.* 2002: 34).

6.3.1 Physical illness

Western medicine concedes that physical disease may originate in the mind. In other words, emotional disorders such as stress in females for example may ultimately lead to bodily dysfunction. A South African health professional and leading academic stated this during an unstructured interview conducted in September 2002 (Cf. Interview 13). In March 2003, an American holistic health professional and expert on stress management expressed support for the mind and body connection in health issues and in particular, the link between stress and physical illness (Cf. Interview 17). For example, sudden trauma or even chronic duress such as a continually and stressfully lonely or busy life might harm the body. Chronic or acute stress could even affect the immune system thus 'opening the way for illness' (Chopra 2001: 116 –117; Northrup 1998: 710). The interview with the South African Westernised health expert mentioned above provided the researcher with more information regarding the mind body relationship. The interviewee is also a holistic healer influenced by Eastern medical practices that have supported this paradigm for centuries. During the interview, the medical practitioner mentioned revealed that many women patients suffering from breast cancer had faced some form of stress disorder earlier in their lives. Many were members of a Catholic religious order and had, like many females during the Middle Ages, suppressed their hormonally and culturally inherited femininity. The same practitioner spoke of how the physical and psychological stressor of unnatural female fashions in shoes and clothing could cause disease. He mentioned the stress caused by wearing heavily wired brassieres and girdles of the 1950s and 1960s, designed to contort the female body according to socially prescribed norms of female attractiveness (similar to those of the industrial era). These may have also caused physical disorders later in life including cancer (Cf. Interview 13). According to Northrup (1998: 28), scientific research into the mind and body connection, or psychoneuroimmunology (PNI), has shown that:

Subtle electromagnetic fields around and within the body form a crucial link between the cultural wounding, which we think of as *psychological* ... and the ...problems women have, which we think of as *physical*.

An unstructured interview with a forty-four year old South African woman, in April 2003, revealed that stress could have caused this woman to develop a tumour on her adrenal gland. She described how she had led a pressurised life prior to the growth of the tumour as a teacher and

full-time working wife in a particularly difficult marital situation. After the tumour had been removed, the women consulted an Indian holistic healer in the hope that the practitioner could help her prevent future physical ill health due to stress to which she felt that she was prone (Cf. Interview 20).

Traditional South African healers also perceive physical illness and non-physical causes by trying to ‘understand why the patient became ill in the first place’ before applying ‘specific therapies to alleviate the signs and symptoms of the condition (Van Wyk *et al* 2000: 10).

Stress is a risk factor for cardiovascular disorder in females that may be related to stress. One in four Westernised and traditional South African women will suffer from cardiovascular disease before they reach the age of 60. South African women have a greater chance of suffering heart attacks than ever before, ten times more likely to die of a heart attack than of breast cancer. Females are especially at risk because of reduced estrogen levels during the pre-menopausal years that may set the stage for heart disease later in life. Moreover, stress disorders such as anorexia nervosa can reduce estrogen levels (*Stress could increase* 2002: 1; Frazer, Larkin & Goodie 2002: 244-253; *Cardiac* 2002: 1; Collins 2002: 1; Interview 23).

6.3.3 Visions and dreams

When traditional female participants in both formal and informal educational milieus in South Africa claim to have seen a wild animal in a waking vision or dream, they are believed to have succumbed to possession by ancestral spirits or are spiritual mediums (*igquira* in Xhosa). The creature (*ityala* in Xhosa) is believed to be an incarnation of the ancestor (*ithongo* in Xhosa) who stays with female spiritual medium her whole life (Hunter 1979: 320-348). A female afflicted with these visions is considered seriously ill and in need of traditional healing by admitting to the visions of the *ityala* and becoming a novice spiritual healer herself in an elaborate initiation ceremony lasting several days (Hunter 1979: 320-348).

Batyi (Cf. Interview 1) echoes the belief of many contemporary traditional South Africans that these ancestrally possessed women and girls are actually ‘under stress’ in the Westernised sense of the phenomenon that they manifest via visions, dreams and nightmares.

6.3.4 Post-traumatic stress disorder (PTSD)

Female victims of violence and other traumatic events sometimes experience chronic stress manifested as *post-traumatic stress disorder* (Arambasic, Kerestes, Kuterovac-Jagodic & Vizecvidovic 2002: 135-146). A 2000 study of children affected by violence and torture in South Africa concluded that girls manifested more post-traumatic stress disorder symptoms than boys (Mokutu & Thomson 2000: 70-77). Another study by the Department of Psychiatry at the University of Stellenbosch, of 307 grade 10 adolescents (57.5% female) in secondary schools in the Western Cape found that girls responded with more PTSD symptoms than boys after witnessing or experiencing violence at home or school and in the neighbourhood including street violence (Seedat, van Nood, Vythilingum, Stein & Kaminer 2000: 20-38).

Social workers at the trauma centre of the Centre for Violence and Reconciliation in the Western Cape believe female children display symptoms of PTSD a year or two after a violent incidence and are more psychologically at risk than adults when exposed to violent crimes such as sexual abuse, rape and prostitution (Jackson 1997: 4). PTSD is often a consequence of an abnormally distressing experience. It may include many manifestations of stress such as: severe panic, shock, powerlessness, flashbacks, dreams, emotional numbness or, over-reaction, sleep disorders, memory impairment, inability to concentrate and aggressive behaviour, eating disorders, substance abuse, frigidity, promiscuity, low self-esteem and 'avoidance of activities associated with the event' (Vogelman & Eagle 1991: 209-229). In addition to vulnerability to stress because of oppression of their natural and nurtured female biopsychosocial identity as were their earliest ancestors, female participants in the contemporary primary and secondary South African educational milieus face many traumatic life events in the general climate of violence, poverty and disease (Louw & Edwards 1993: 701-702; Butler & Moffic 1999: 524-531; Victims 1996: 11).

6.3.5 Maladaptive coping mechanisms

Alcohol and drug abuse is a problem amongst women and girls today. It is often a way of trying to counter and compensate for the negative effects of stressful life events in the face of little family support (Parry & Plüddemann 2002: 1-24; Interviews 4 – 8 & 21). Substance abuse that may begin as apparent experimentation is often actually used as a panacea for stress because many substances temporarily raise levels of serotonin in the brain that produce a sense of

wellness. Serotonin is the brain neurotransmitter associated with mood, sleep, appetite, aggressiveness and sexual behaviour. Excessive carbohydrate foods eaten alone also raise serotonin levels briefly, but these can become abused like alcohol (Williams 1998: 96). Overweight has been linked to stress in a study that found that women and girls who cope with stress, reduced overweight as well as 'task and avoidance oriented strategies' (Oginska-Bulik & Juczynski 2001: 23-31).

Sexual promiscuity is another possible maladaptive coping mechanism that is a manifestation of stress. Unstructured interviews with female primary and secondary school pupils as well as higher education students in the Eastern Cape during the period 1996-2002 revealed that many Westernised and traditional girls felt obliged to offer sexual favours in a search for social acceptance by male participants in a patriarchal society. The result is further stress due to unwanted pregnancies; further sexual abuse; single parenthood; complications as a result of birth control or abortion and sexually related infections (Cf. Interviews 4-8).

6.3.6 Acne as a physical stressor for adolescent girls

The term *acne vulgaris* denotes an outbreak of red pimples on the face, neck and other parts of the body. This is often a problem for teenage girls and boys because of chronic skin inflammation and irritation that accompanies the eruption of spots and swellings. However, Westernised and traditional South African adolescent girls are more vulnerable than boys are to 'psychiatric issues associated with acne'. These include symptoms of negative stress such as: low sense of self-worth withdrawal; depression; anxiety; aggressiveness; relationship problems and disordered thinking (Altam, Ozman & Scedilanli 2000: 3).

Adolescent girls are more prone than boys are to suffer the negative psychological consequences of *acne vulgaris*, which usually starts in adolescence and frequently resolves by the mid-twenties'. Moreover, emotional stress can exacerbate acne', which is thus both a cause and symptom of stress (Altam *et al.* 2000: 3).

6.3.7 Eating disorders

People suffering from eating disorders such as *anorexia nervosa* and *bulimia*, most of whom are adolescent girls and young women, feel constantly under acute stress as well as experiencing the

fight or flight response and continual anxiety (Cf. Interview 21). This may be due to heightened levels of the neurotransmitter (brain chemical) serotonin, according to a study by doctors at the Maudsley Hospital, London that maintains that anorexics possibly have variations in the gene for serotonin receptors, part of which helps to determine appetite (Frizzell 2002: 1).

Affective disorders that may result from stress, such as *anorexia nervosa* (refusal to eat and obsession with losing weight) and *bulimia* (food fixation, gorging and self-inflicted vomiting) prevail amongst female participants in the primary and secondary educational milieus of Westernised and traditional South Africa. Brizer (1993: 167) and Frizzell (2002: 1) maintain that these eating disorders are grounded in self-absorption and preoccupation with body image that predominate in today's First World. Brizer (1993:167) compares these possible manifestations of stress to Industrial Era *hysteria* that was a psychological outcome of a society that idealized human achievements and technological perfection. This attitude is still very much in evidence in today's Westernised and capitalist societies.

The American Psychiatric Association claims that eating disorders are particularly widespread among women and girls in First World countries and most prevalent in US, Canada, Australia, Europe, Japan, New Zealand and South Africa, although not limited to specific ethnic groups and depend on biochemical, genetic, environmental and personality factors (Frizzell 2002: 1).

6.3.8 Mass hysteria

Psychologists in South Africa and the US have stated that teenage girls are especially prone to displaying symptoms of mass hysteria due to stress and tension (Rataemane & Rataemane 2002: 53-59). In 1995, such an event occurred in Kokstad, South Africa, leading to the murder of women suspected of witchcraft. Moreover, manifestations similar to those of epileptic fits were evident in groups of girls at a high school in Umtata, Eastern Cape who, according to a psychologist were experiencing examination pressure and/ or cultural transition. In reference to the school authorities' appeal to non-Westernised traditional religious assistance in what was believed to be *demon possession*, the psychologist believed that a traditional paradigm brings stress-symptom relief if 'concordant with the girls' cultural attributions of their stress experience' (Carlisle 1999: 10).

Although the true cause of the problem was not ascertained, a diagnosis of *Anxiety Mass Hysteria* or *hysterical contagion* was also given to a group of 1430 female learners at Mangaung and Heidedal schools in the Free State, South Africa. These teenage girls manifested what could be classified as typical stress symptoms such as intense itching following other symptoms such as anxiety, pain, numbness, dizziness, headaches, hyperventilation, nausea and chest tightness with no physical or organic explanation. The symptoms were classified as psychological in origin and treatment, although it was not clear what caused the psychological problem. The girls tried to attribute their symptoms to organic causes. In a similar South African study in 1991, mass hysteria had been attributed to witchcraft (Rataemane & Rataemane 2002: 53-59).

Elaine Showalter, an English professor in 1997 at Princeton University in the United States, maintained that the US in particular, had 'become the hot zone of psychogenic diseases, new and mutating forms of hysteria amplified by modern communications and *fin-de-siècle* (end of century) anxiety...' (Showalter in Gleick 1997: 56). Showalter believes contemporary hysteria includes contemporary chronic fatigue syndrome and the large amount of repressed memories of child abuse that many males and females are claiming to suffer today. According to Showalter, these stress disorders are modern versions of the hysteria manifested in earlier eras such as the witch-hunts of the Middle Ages. Another example of past symptoms of female hysteria is the so-called hysterical 'coughs, panics and headaches' of the industrial era. Physician Charcot (1824-1893) and his disciple Freud (1856-1939) made a particular study of this stress disorder (Gleick 1997: 56; Cf. paragraph 4.2.1.6; 5.5.3).

6.3.9 Somatoform disorders

Somatoform disorders are ailments or syndromes that have physical symptoms but are actually rooted in psychological and affective disorders. Contemporary studies of somatoform disorders have revealed that they are five times more prevalent in females than in boys or men. Moreover, current thinking views somatisation disorder as beginning in young women and mostly adolescents who are often genetically predisposed owing to its occurrence in female relatives. Symptoms such as bodily pain, gastrointestinal problems, sexual symptoms and neurological conditions such as blindness or paralysis may be a manifestation of stress and cause further distress to the girls or woman participants in educational milieus today (National Institute for Mental Health 2003: 1-16; Rataemane & Rataemane 2002 :53-59).

6.3.10 Anxiety

Cassidy (2002: 1) identifies anxiety or fear that is both a manifestation and a stressor for female participants in the primary and secondary educational milieus today. He mentions the excessive increase in female anxiety and stress levels in South Africa today that accompanies with dissatisfaction with life, painful life events and stressors such as mental torment, work overload, crime, violence, financial problems, divorce, poor parenting, abuse, sexual diseases and substance abuse. Cassidy describes a survey of 20 girls in a Western Cape school in Grade 11, who said

Fear was a major issue...fear for the future... unemployment... failure in life...marriages...
break down...staying on in South Africa

(Cassidy 2002: 1)

6.4.11 Major depression

Major (clinical or unipolar) depression is a stress disorder that clusters together many other stress disorders such as mood swings, a lack of concentration, insomnia, appetite, eating disorders and feelings of loneliness. Twice as many contemporary females as males suffer from clinical depression in the US and elsewhere in the world. One out of every seven women will probably suffer from clinical depression in the course of their life. Moreover, women experience higher rates of seasonal affective disorder and dysthymia (chronic depression). Females do not experience bipolar disorder (manic depression) more than males. However, women experience the depressed phase of manic depression and rapid-cycling bipolar disorder. Females are twice or three times as likely as males to develop clinical and chronic depression simultaneously. Moreover, symptoms may sometimes differ between males and females. Females tend to manifest anxiety, somatisation (the physical expression of mental processes such as aches and pains with no physiological cause), increases in weight and appetite, oversleeping, and expressed anger and hostility (Blumenthal 2003: 1; Ferketick, Schwartzbaum, Frid, & Moeschberger 2000: 1261-1268).

Various factors contribute to the prevalence of clinical depression in contemporary females. Biological factors that contribute to clinical depression in contemporary females include reproductive factors, thyroid function, neurotransmitter activity, the effect of the hormone estrogen and circadian rhythm patterns. Genetic factors cause a greater

prevalence of clinical depression in first-degree and second-degree female relatives. Psychosocial factors that may cause female vulnerability to depression include multiple work and family responsibilities, sexual and physical abuse, sexual discrimination, lack of social support, traumatic life experiences and events, and poverty (Blumenthal 2003: 1; Cowdry 2003: 1; Blehar 1997: 3-12).

6.4 COPING MECHANISMS

Westernised and traditional women and girls use mental health services both within and outside of the South African primary and secondary educational milieus more than men and boys. However, traditional females are less likely to seek Westernised professional help with regard to stress disorders (Mazure *et al.* 2002: 29, 33-34; Interview 10, 12, 15, 21 & 25). Nevertheless, in South Africa various traditional mechanisms are in place aimed at stress prevention. Some of these address time-related stressors at macro/meso/micro-level. Other stress coping mechanisms attempt to manage stress due to eternal factors such as society's negative perception of natural and nurtured female psychological, biological and social identity as nurturers. A brief study of a few of these stress coping mechanisms may shed light on strategies to take in future with regard to addressing the problem of stress experienced by females. Some strategies may be similar to those used in the past, whereas others may be unique to the current era. Examples to be discussed are: gender empowerment; anti-porn lobbying; sexuality training; access to AIDS intervention; traditional customs; access to crime prevention strategies; support groups or centres; rural background; access to literacy; westernised coping strategies and indigenous healing therapies.

As in previous chapters, the researcher has attempted to identify stress coping mechanisms and strategies not only used by the individual female, but also adopted by the larger social group of the family, society and culture. In South Africa today, there is a conscious awareness at macro, meso and micro-level of the harmful effects stress may have on female participants in the primary and secondary educational milieus in particular. Perhaps some coping mechanisms already in use could be useful in the future too.

6.4.1 Awareness of attempts to realise gender empowerment

Although discrimination is still a problem for female participants in the South African primary and secondary educational milieus, there has been confrontation of social structures that

discriminate against females since the mid-nineties. This may be of some comfort in the face of this stressor. Various South African bodies, including those at governmental level, have explicitly addressed the issue of gender equity that, along with race and class equity, has been historically suppressed. In the area of higher education for females, organizations like the United States Agency for International Development in South Africa (USAID/ SA) and projects such as the Women in Development Technical Assistance Project have done research and made recommendations. The latter suggested practical ways 'to enhance women's opportunities in education' based particularly on needs of Historically Disadvantaged Institutions with regard to staff, curriculum, students, management and research development (Biraimah 1999: 7-9; Chidonza-Gordon in Jonker 2002: 9).

South Africa's Employment Equity Bill has attempted to address the stressor of gender discrimination in South Africa in respect of unemployment, salaries, work status, management positions and training opportunities. Gender inequity has historically been the lot of South Africa's black women in particular (Mills 1998: 1-7). The Empilisweni (*healing place* in Xhosa) Woodlands Centre for Aids is an example of an attempt to empower females through job skills training. The centre opened in 1999 with the view that if women are financially independent and have knowledge regarding AIDS and other health issues, they will be in control of their family situation and primary educational milieu. By learning how to operate small farms, learn other skills and how to prevent AIDS, they would no longer be victims of violence and abuse and AIDS infection by sexual partners or husbands that accounts for 80% of female contagion in sub-Saharan Africa. The centre hoped that girls and women would become strong in the face of stressors and, thus, be better nurturers of their family. The centre also has a school for children, aged 9 – 14. In this way boys and girls are taught in a secondary educational milieu about issues that could lead to female (and family) empowerment (Steele 2002: 2).

There is a move towards equity in the workplace as well in South Africa. More women and especially black women are studying for higher educational qualifications such as MBL degrees according to Nkomo, a professor at the UNISA Graduate School of Business Leadership. Thus, Nkomo, concludes 'change will occur'. She feels that a 'workplace culture' of gender equity will develop over time with 'dialogue between black and white women managers' (Bennett 2002: 8).

6.4.2 Knowledge of anti-porn lobbying

Since 1996, the organisation, *Standing Together to Oppose Pornography (STOP)* has been protesting the pornography industry that contributes to sexual crimes and violence. The organisation suggests that the Film and Publication Board and South African Broadcasting Corporations examine sex literature and films before release (Oliver 2001: 14).

6.4.3 Empowerment through sexuality training

One third of babies in South Africa are born to teenage girls, who start to have intercourse as young as 10 or 12 or by the time they are 15. Thus, there is a growing awareness that sexuality education is vital to ensure protection from the epidemic of STDs and AIDS, as well as the large number of unwanted pregnancies and related problems including that of 'children being brought up by children' who are single mothers, as well as that of ongoing female abuse (Heinemann South Africa 2002: 1; MTV News 2002).

National School curriculum courses for school children such as the *Life Orientation, Arts and Culture* course in Grade 4, encourage children to be aware of the personal physical, emotional and social consequences of early sexual activity. The South African school curriculum requires that children be made aware of their bodies and emotions as they enter puberty. Girls, in particular, are taught an understanding of the concepts of *coercion* and *rape* in a contemporary society where girls sometimes begin menstruation as early as nine years old (Heinemann South Africa 2002: 4).

In traditional South African society, adult women in the community have always played a role in advising girls with regard to their future reproductive and nurturing roles. Grandmothers (*ogogo* in Xhosa) and unmarried female guides (*amqhikiza*) are still vital in educating girls about sexual issues in light of the stressors of sexually transmitted diseases, AIDS, unwanted pregnancies and female sexual abuse currently facing South Africa girls and women (Heinemann South Africa 2002: 5). Research has highlighted this need for sexuality training as well as education for violence and other gender-related stressors (Wood *et al* 1996: 1-17; Interview 15).

6.4.4 Access to AIDS intervention

Women and girls in South African may feel the pressure of the HIV and AIDS situation less stressfully when they hear of various responses to AIDS in contemporary South Africa. For example, the Mandela AIDS Council under the patronage of the mayor of the Nelson Mandela Metropole in South Africa was formed in January 2002 to assist AIDS orphans in their educational needs. This is 'a growing problem' according to Councillor Maphazi, as the area reported 776 HIV and AIDS victims in September 2001 of which 639 were adults aged 29 years old on average. Moreover, the AIDS Training Information and Counselling Centre based in Port Elizabeth maintained that there were 6201 HIV infected individuals in the Western Region of the Eastern Cape in November 2001. Various religious and charitable organisations are assisting the orphan aid council in their attempt to address the social stressor of abandoned children of AIDS victims in South Africa, estimated at 420 000 in 1999 and predicted at 1.6 million in 2008 (Nelson Mandela Metropole 2002: 3; SpeakOut Legal Services. 2002d: 1).

Africa has the highest percentage of the world's AIDS victims, (about 28 million out of 40 million). Yet, only 1,6% of world funding has been allocated since 1987 to African Aids research. Only R 403, 4 million has been granted to Africa out of a total of R 24, 6 billion. South African Medical Research Council chief, Malegapur Makgoba, stated these facts at a 2002 congress at Somerset West near Cape Town. Delegates included scientists, politicians including South African Health minister, Manto Tshabalala-Msiman, industry representatives, donor agencies, representatives of research organizations and AIDS activists. The 2002 meeting was organised by the World Health Organization (WHO) together with the UN (United Nations) AIDS secretariat, the United States National Institute of Health, the International Aids Vaccine Initiative, the French Agency for Research on Aids, the World Bank and other institutions. The meeting called on funders to accelerate research for the development of an AIDS for Africa initiative, make a plan of action for the next 7 years and raise over two billion rands for African Aids vaccine research (Rassool 2002c: 2).

The congress notes that as long-term preventative measure, current vaccines tested in Asia or the US are not appropriate for Africa where some HIV strains are different. The meeting also pointed out the need for more expertise in Africa. Fifteen West African countries officially pledged support and R500 000 a year. Thus, initiatives are being realised to help South Africa where

many victims are female potential mothers; one third aged between 15-24 and do not even know of their HIV positive status (Rassool 2002c: 2).

The commercial sector is sometimes prepared to help the population cope with a disease that causes particular stress for female participants in the primary and secondary educational milieus. For example, Daimler-Benz Chrysler pays the medical bill for AIDS victims employed at Atlantis Diesel Foundries in the Western Cape (Cf. Interview 22). However, such initiatives are few and financial considerations prevent victims, especially female individuals who are infected because of rape, from receiving antiretroviral treatment for example.

A conference at Yale University Divinity School in New Haven, Connecticut in the US examined the link between 'gender and faith in a quest for new responses to HIV/AIDS in Africa'. Delegates discussed how loss of traditional values regarding sexual relationships, as well as female status and poverty, were factors in the escalating and overwhelmingly female STD's and AIDS infection risk (Rassool 2002b: 2). In fact, 80% of the response to AIDS in Africa has been offered by religious communities who are already assisting and intend to intervene further in addressing the problem, which is 'essentially a moral issue fuelled by poor socio-economic conditions' (Munro 2002: 3). Nevertheless, in April 2002 a revival of the HIV/AIDS program was proclaimed by the South African Cabinet with considerable financial support augmentation planned for the period 2003-2004. This may comfort South Africans (Bureau of Africa Affairs. 2002: 9).

6.4.5 Traditional customs

Belief in traditional rituals is a South African coping mechanism for various social, family and personal problems. These rituals succeed in providing comfort to groups and individuals who feel that they have done their best to meet traditional and ancestral demands according to particular cultural customs. Until they have fulfilled these expectations according to what they view as their *roots*, feelings of stress and its long-term effects may overwhelm them. For, the stress of living with 'two hats', one traditional and the other Westernised, may become unmanageable for females in the South African primary and secondary educational milieus who may be particularly vulnerable to stress-disorders (Cf. Interviews 10-12). As a result, they may seek both Westernised and traditional coping strategies, the latter finding a prominent place in the lives of many South African women and girls (Cf. Interviews 1 &16).

In an unstructured interview with B. Mpini, a former social worker and university lecturer in 2002, the researcher learnt that funerals provide stress relief for traditional males and females. Not only is the deceased mourned and the stress of grief dispelled, but an opportunity is also provided for the extended family and friends to meet and receive social support for issues that extend beyond the actual burial and death. Extended family get-togethers abound at times of crisis or celebration, thus giving all family members a sense of identity based on their cultural roots in a time of great transition and confusion especially for females (Cf. Interview 11).

In 2001, an unstructured interview with T. Batyi, a teacher and university lecturer, revealed that traditional family reunions are called to celebrate various occasions. For example, they could celebrate a boy's initiation and circumcision, or a young girl's coming of age in a Westernised sense (21 years old), or a need to appease the ancestors owing to some misfortune in the traditional family (such as the accidental death of a domestic animal). The occasion is marked by traditional customs such as the slaughtering of a goat and a social setting where men and boys sit apart from girls and women. At such events, females may find comfort in their traditionally esteemed if marginalized and accepted familial and social roles. Generally, the women prepare beer and other traditional food and drink for days in advance. At the actual event, the men will sit apart from the women and children (Cf. Interview 1).

Another unstructured interview with Batyi in April 2003 revealed that women and girls with traditional cultural roots seek stress release in music, singing and dance. This may be at funerals and weddings for example, or other formal occasions such as graduation ceremonies and church services and religious ceremonies (Cf. Interview 1).

Many traditional girls and women will jump at the opportunity to wear traditional female dress. For example, after marriage the traditional headscarf 'doek' and apron are willingly worn to please husbands and society in general. Thereby, the new wife finds stability and comfort in a western social and family environment (Cf. Interviews 1, 3, 11 & 14).

Interviews with girls revealed that although demeaning and oppressive to the Westernised mind, the system of *lobola* (paying of dowry for the bride) is welcomed by many traditional female participants in the primary and secondary educational milieus as a sign of social and personal esteem. This traditionally positive perception of the feminine role as valuable pervades and

influences the mindset of many traditional girls and women. The latter crave this positive cognitive appraisal often lacking in Western society that appears to want girls to adopt masculine psychological (aggressive and achieving) and even physical attributes (dress and body image) in order to be accepted (Cf. Interviews 4-7, 9).

6.4.6 Access to violent crime prevention strategies

According to Jackson (1997: 1), since 1994 and the installation of a new political structure in South Africa, the South African government and Police Service have been showing an increasing 'commitment to victims' of crime 'particularly women and children'. Legislation, as well as training projects in the Police Service has furthered the aims of crime reduction especially with regard to gender-related misdemeanours (Jackson 1997: 1-13). This may offer some stress relief to female participants in primary and secondary educational milieus who are often crime victims.

6.4.7 Support groups and centres

In the Eastern Cape, mechanisms exist for South African female victims of domestic violence to help them cope run by FAMSA, Life line, Nicro and the Department of Health and Welfare who formed the counselling sub-committee of Women's Empowerment Bureau in 1996 (Support Groups 1996: 7). Support mechanisms such as the Ncedo centre at Dora Nginza Hospital in Port Elizabeth offered a safe environment for women and children who were victims of sexual abuse and violence (Victims 1996: 1). Likewise, the *Mother of Hope Resource Centre* in Port Elizabeth provides holistic help for victims of abuse with women's empowerment as a leading principle. Other NGOs involved in similar measures are the Yokhuselo Haven for victims of family violence, Legal Resources Centre, the Women's Empowerment Bureau plus police and provincial social services (Aim of city 1996: 4). In the Western Cape, in Chapel Street, Woodstock Cape Town, there has been established a Trauma Centre for Survivors of Violence and Torture especially adolescent girls who respond with more Post Traumatic Stress Disorder symptoms than boys do (Mokutu & Thomson 2000: 70-77).

A University of California, Los Angeles research report on animal and human studies released in May 2000 discussed what similar studies have shown: females deal with stress by being sociable, seeking contact with others or caring for others. Research linked the hormone *oxytocin* released during stress to tendencies in rodents, primates and humans regarding feelings of calm, less fear

and sociability. Shelley E. Taylor, a University of California, Los Angeles, psychology professor, maintains that male hormones reduce the effect of oxytocin, but the female hormone estrogen amplifies it (Bangla 2000: 1).

Females tend to admit their pain, share with others, seek help, solve problems and attempt to understand their feelings. Unlike women and girls, men and boys do not readily consult medical professionals when they are ill and do not obtain early treatment for either physical or emotional disorders (Cf. Interview 12). Thus, female life expectancy 'has increased faster than that of men because of their attitude to healthcare'. In other words, although research reveals that females may suffer more from stress disorders than males, it is possible that they also do not deny their problems (DeNoon 2001: 1). The female tendency is to be involved in personal growth, spirituality and all that can nurture life and healing. Other natural and traditional characteristics of females are a need to feel cherished, to find solace by sharing feelings and problems rather than seeming competent, a traditional male trait, and to use communication to explore feelings, organize thoughts and clarify priorities (Gray 1992: 29-41). Females focus on emotions and seek adaptive 'instrumental and emotional social support more frequently than men and boys' who opt for maladaptive coping tactics of 'denial and mental disengagement' (Gurnakova 2002: 75-86). In addition, females who tend to express feelings, solve problems or seek social support, find owning a pet such as dog or cat a buffer for stress (Arambasic *et al.* 2000: 135-146)

Harvard psychiatry professor, William Pollack, believes that men and boys in contemporary Westernised society are actually 'in crisis from emotional under nourishment' (Barovick 1998: 64). Michale Gurian, a US therapist, theorises that this particular culture is rooted in patriarchal ideas of masculinity. Gurian maintains that males evolved from hunter-gatherer primates are geared for survival as well as quick solutions. They tend to be dominant and physically aggressive and are not hormonally suited to dealing with feelings like females (Barovick 1998: 64). This means, according to Gurian, that adolescent boys in Westernised society are destined for emotional pain, loneliness and other stress disorders owing to their suppression of emotional stress that society only allows them to express via rage and anger (Barovick 1998: 65). The researcher agrees with the views of Gurian and Pollack, which imply that Westernised and traditional South African female participants in the primary and secondary educational milieus are able to deal appropriately with stress through social support, unlike men and boys in patriarchal

Westernised and traditional South African society whose aggression is often directed towards females (Cf. Interview 11).

6.4.8 Rural background

Research carried out by Stellenbosch University in 2001 revealed that the communalistic and caring philosophy of life supported by rural Black South Africans, known as *ubuntu*, could be a panacea for stress among Black South African adolescents from a rural background. A total of 102 Black South African adolescents at a high school in Cape Town completed a demographic questionnaire, the Perceived Stress Scale, Adolescent Stress Scale and Adolescent Coping Orientation for Problem Experiences. Under greater stress than other samples in research literature, these teenagers experienced mostly school and vocation stress. Seeking solutions to family problems was preferred to Westernised professional help and expression of feeling was the preferred coping strategy used by these pupils, whether of urban or rural roots. Family support was a successful management technique for those of rural roots, especially women and girls for whom caring and sharing is a useful stress management technique (Spangenberg & Henderson 2001: 77-90).

The researcher observed the same trends in observing Black female scholars as well as their teachers in Western and Eastern Cape schools and higher educational institutes from 1992-2002. Girls and women who adhered more to a traditional and rural world-view seemed to show less symptoms of stress than those who chose to observe Westernised customs. There were instances when the latter suffered from depression, sexual promiscuity, scholastic under-achievement, social withdrawal, sleep and eating disorders and substance abuse (Cf. Interviews 4-7).

6.4.9 Access to literacy

Female literacy has been improving in South Africa for some years and this may have reduced female stress vulnerability in many instances. However, there is still room for improvement. In his opening address to the International Literacy Conference in Cape Town on 13 November 2001, Professor Kader Asmal MP, Minister of Education said:

The female literacy rate in South Africa is the highest on the continent, which makes us very proud of our women, who are at the forefront of literacy work. But we still have an adult literacy rate of only 85%.

(Asmal 2001)

In 1997 the illiteracy rate among the population was 15% for males over 15 and 16.5% for females in the same age group (Canadian International Development Agency. 2002: 9). Thus, there are still slight inequities at higher educational level, despite progress in this regard. The National Plan for Higher Education, published by the South African Ministry of Education in February 2001 pointed out that one province had a proportion of female higher education students, which was considerably lower than the national averages: only 43% compared to a national average of 50% (Ministry of Education 2001: 44). This indicates that inequities of access to female literacy still exist in South Africa although much has been done to alleviate the situation.

6.4.10 Westernised stress coping strategies

Many Westernised and traditional South African girls and women who experience stress make use of Western (allopathic) biomedicine including pharmacotherapy. However, biological gender related factors moderate response to some therapies such as antidepressants (Cf. Interview 12; Leibenluft 1999: 25-33). Moreover, according to Mazure *et al.* (2002: 35), there is growing evidence that psychoactive drugs are metabolised differently in different ethnic groups. Thus, both gender and ethnicity are factors in Westernised psychopharmacological treatments for stress, although an oft-used coping strategy.

In treating stress disorders, many contemporary psychologists and psychiatrists recognise the medical model of abnormal behaviour that has a two-pronged approach to treatment: drug as well as talk therapy. This model integrates other models (biological, psychoanalytic, learning theory, cognitive, humanistic-existential, socio-cultural) and 'recognizes the uniqueness of the individual' with regard to stress reactions and manifestations that are influenced by gender or genetic predisposition, early life experience, chronic illness, substance abuse and diet. Thus, neurobiology plays an important role in this model that acknowledges that one may be more or less stress-prone depending on various factors (Louw & Edwards 1993: 697; Mann 2002: 1; Interview 12).

Mazure *et al.* (2002: 18) maintains that 'there is no doubt that psychotherapies are currently available that are effective interventions for women and girls' suffering from stress disorders,

particularly depression. Some contemporary psychiatrists use an eclectic approach (Cf. Interview 12).

Aerobic exercises are popular with females in Westernised South African society such as cycling, swimming, dancing and walking to produce the body's natural antidepressants *endorphins* to relieve feelings of tension and to energise them (Williams 1998: 97; Bloomfield & McWilliams 1996: 114; Snyders *et al.* 2002: 144; van Lingen 2001a: 1; Mazure *et al.* 2002: 20).

Increasingly, Westernised females in particular favour the use of alternative therapies for stress disorders including those derived from Eastern traditions. These include various forms of bodily manipulations such as acupuncture, the Japanese therapy termed *reiki* and therapeutic touch. Another example of current stress-coping trend amongst First World females is aromatherapy that is the application of concentrated oils directly to the body by means of massage, soaking in an oil-diluted bath, or inhalation, as a lotion or fragrance to relieve tension. Most plant-based oils are believed to generally have calming and stress relieving effects. For example, the musk oil *Cistus* is noted as a treatment for insomnia, anxiety and nervousness, *Sandalwood* or *Jasmine* for depression and *Rosemary* for concentration problems (Staying Alive 2000: 2-4; *Aromatherapy* 2002: 1; Friedman 2003: 1-2; *A World of Aromatherapy* 2002: 1).

Apart from aromatherapy and other forms of external mediation, many alternative self-help methods originating in the East emphasize internal stress control methods. These include mental meditation techniques and physical exercises are popular amongst Westernised South African females to combat stress. An unstructured interview with a teacher of Eastern meditation techniques to a mainly female group of learners conducted in March 2003 gave the researcher some insight into mind control strategies aimed at stress prevention (Cf. Interview 19). However, there is a need for further research to examine efficacy effectiveness and safety of these therapies specifically for women in different age groups (Mazure *et al.* 2002: 20-21).

Loewenthal (1997: 173-176), Dein and Loewenthal (1998: 5-10) and Loewenthal & MacLeod (2000: 355-374) have investigated the issue regarding religion and coping in Westernised women. Although these studies challenge the assertion that females are more religious than males, they do examine the effect that religious and cultural factors have on beliefs regarding various treatments for affective disorders. However, a study of Westernised American society, published in the April 4 2002 edition of the *International Journal of Psychiatry in Medicine* supports the theory that

religious faith promotes a feeling of being able to cope with tension. Doug Oman, main author of the research report and lecturer at School of Public Health, University of California-Berkeley, believes that regular church attendance, for example, leads to 'inner peace' and less stress. In fact Oman points out that the Bible (Mark 13:18; Matt. 24:20) speaks of excessive distress as being part of the end-times as it is typical of contemporary Westernised society (International Bible Society 1984: 929; Liu 2002: 7).

Another issue on which Westernised South African female participants in the primary and secondary educational milieus focus in order to cope with stress is nutrition. Low levels of certain vitamins and acids in women and girls such as folic acid, Vitamin C, B2 and B6 are believed to make them stress prone. Moreover, excess sugar, white flour, alcohol, caffeine and smoking are thought to contribute to stress diathesis leading to disorders such as mood swings and sleep disorders, especially in females (Bloomfield & McWilliams 1996: 112; Williams 1998: 97; Snyders *et al.* 2002: 142, 144).

6.4.11 Indigenous African healing therapies

Traditional African healers use medicinal plants to cure stress disorders such as insomnia, anxiety, asthma, indigestion, hysteria and even rheumatoid arthritis and cancer. Traditional healers usually consult with an ancestral spirit before beginning to collect medicinal plants. Via dreams or whilst praying, the healer will be told a suitable time for collecting plants and even told about specific plants for particular patients and their source. Various taboos and other factors known to the healers influence the gathering of medicinal plants for therapeutic effect (Van Wyk *et al* 2000: 14; 290-291).

6.5 SUMMARY

A great number of stressors face contemporary girls and women. Life is often oppressive for them in cultural milieus that still discriminate against females. The age-old stressor of society's negative perception of females still exists today in various ways. The list includes: female oppression; loss of the status traditionally granted to females; violent crime and abuse directed specifically to females; social stereotyping; poverty that seems to affect females in a particular way; witch-hunts; female transgenerational stress as a result of years of oppression; not receiving recognition for domestic work; gender bias in education and low self-esteem (Cf. paragraphs

6.2.1.1 – 6.2.1.7, 6.2.2.2, 6.2.2.5). The eternal stressor of female biology still affects females today including maternal mortality in Third World societies in particular and abortion. Age-old female psychological vulnerability to stress due to unassertiveness is often replaced in Westernised society by typically masculine assertive and even aggressive attitudes, feelings and behaviour. Ironically, this attempt to cope with society's negative perception of women and girls by becoming more masculine can become a stressor in itself that appears to be unique to the contemporary world (Cf. paragraph 6.2.3.3). Other stressors may be unique to the era but eternal female vulnerability may still be a cause of stress in overworked female teachers today, in an era where universal and educational opportunities are available in much of the developed and developing world (Cf. paragraph 6.2.2.6). Another time-related stressor is the frustrated actualisation of females in the workplace. Even though contemporary girls and women are brought up and educated to function in the public sphere beyond the domestic milieu and expect equity, gender inequity persists in many employment situations (Cf. paragraph 6.2.1.9). Single motherhood may be a stress peculiar to many current Westernised societies in particular, where the traditional marital and family status quo is not always maintained (Cf. paragraph 6.2.2.4). In addition, the presence of sexual diseases is another stressor particular to contemporary society. Although, there have always been contagious diseases and sexual diseases, the current epidemic of AIDS and other sexually transmitted diseases appear to be unique to this era (Cf. paragraph 6.2.3.1).

Depending on their vulnerability to stress (that may be a general female rule due to inherited and eternal psycho biosocial factors), contemporary women and girls manifest stress symptoms when confronted by time-bound stressors with which they may attempt to cope using mechanisms available in current society. In this chapter, the researcher focussed on a few physical manifestations such as bodily illness, acne vulgaris and somatoform disorders (Cf. paragraphs 6.3.1, 6.3.5, 6.3.8). Certain paragraphs described behavioural manifestations including visions and dreams, maladaptive coping mechanisms, mass hysteria and eating disorders (6.3.2, 6.3.3, 6.3.4, 6.3.6, 6.3.7). Emotional manifestations explained were post-traumatic stress disorder (PTSD), anxiety and clinical depression (Cf. paragraphs 6.6.3.3, 6.3.9, 6.3.10).

In chapter six, the researcher listed and explained some coping mechanisms used by contemporary women and girls. Stress caused by a negative perceptions of female socio psychobiological identity and may be relieved in South Africa and other places by experience and awareness of gender empowerment mechanisms in society, anti-porn lobbying, sexuality training,

access to AIDS intervention, access to violent crime prevention strategies and literacy (Cf. paragraphs 6.4.1, 6.4.2, 6.4.3, 6.4.4, 6.4.6, 6.4.9). Knowledge of and awareness at various levels of society including governmental and non-governmental levels, of the need to perceive female identity in a positive and realistic light, may be of comfort to women and girls and, therefore, contribute to their formation of a realistic and positive self-concept. Adequate mental and physical health management may be a way that contemporary female participants in the primary and secondary educational milieus cope with stress disorders. In this chapter the researcher briefly outlined some Westernised stress management techniques that include eastern methods. These alternative therapies sometimes involve relaxation strategies (Cf. paragraph 6.4.10). There was also a description of indigenous African healing therapies in particular (Cf. 6.4.11). In the case of many contemporary females, stress release may be derived from the comfort gained in attending support groups and centres, awareness of traditional and rural roots as well as the observance of traditional customs. These include rituals, music singing, dance and the wearing of traditional clothes. By sharing and caring as well as relaxing in various creative ways, many contemporary women and girls feel a sense of peace (Cf. paragraphs 6.4.5, 6.4.7, 6.4.8).

Stress levels are high in women and girls today despite awareness of the problem and attempts at solutions. There is a need for further analysis and recommendations regarding a solution to the problem. This was the general aim of the previous six chapters of this research project where the researcher attempted to examine the problem from a historical perspective. In the following chapter of this study, the researcher will evaluate the problem by comparing and contrasting the stress experienced by female participants in the primary and secondary educational milieus of the past and present eras that was discussed in the previous chapters. By means of this final analysis of the data, the researcher hopes to identify generally valid essentials regarding the problem to make recommendations for the future of education. Thus, through the act of education individuals may learn ways to effectively manage female stress.