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subjective life expectancy:  
Understanding young adults'  
perceptions of (in)-vulnerability**

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# Exploring Concepts of Death and Subjective Life Expectancy: Understanding Young Adults' Perceptions of (in)-vulnerability

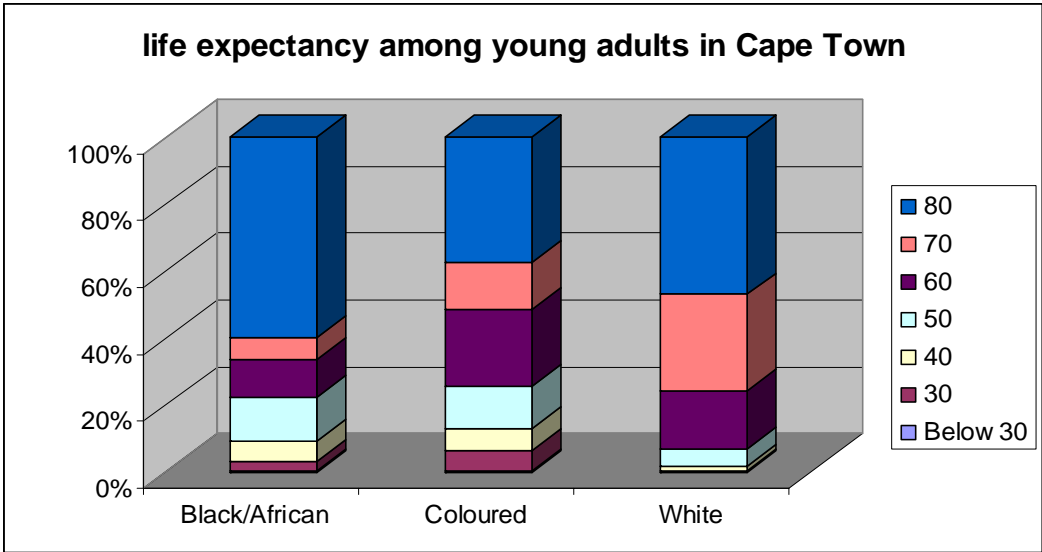
## Abstract

*This study contributes to the understanding of young adults' concepts of death and subjective life expectancy, especially in an era when HIV and AIDS significantly raise morbidity and mortality levels and lower life expectancy. It was meant to inform theory building about subjective life expectancy and its potential impact on individual decision-making. The sample for this specific paper consisted of ten African adolescents aged between fifteen and twenty-two, all of whom living in areas of Cape Town most heavily affected by the AIDS pandemic, as well as by other environmental factors, such as high poverty and crime rates, and high levels of violent deaths especially among young men. Findings show that young people are extremely aware of high death rates in their environments, especially deaths of a premature nature. Causes indicated were HIV and AIDS, but even more prominently crime and violence. Although confronted with the daily reality of death, participants did not consider these high death rates to be part of "a normal life", yet related them often to a general feeling of social and moral chaos in the townships. Different psychosocial mechanisms of dealing with the threat of death showed, with often very high levels of resilience and a focus on the future, but also fear and lack of clarity about that future in general. Subjective life expectancy (SLE) for oneself, however, was generally high and not influenced by the uncontrollable threat of violent deaths; Instead, the motivation behind SLE showed young adults' belief in personal choice and control exercised within their environments characterised by the complex interaction of poverty, crime, HIV and AIDS, peer pressure and modernisation. HIV and AIDS was mostly taken into account as a factor of influence that one had control over and therefore did not influence SLE. Peers' SLE, however, was rated far lower than their own, taking into account those factors that participants considered controllable.*

# Introduction and background

In light of the frequent and increasing confrontation with illness and death, it has been hypothesised that young adults would lower their own subjective life expectancy, which would then, in turn, impact negatively on their actions and decisions. Some suggest possible rising levels of delinquency and criminal behaviour and will even go as far as to hypothesise a threat to democracy in affected countries (Barnett and Whiteside 2002; Schonteich 1999; Pharoah 2005). In South Africa, recent years have seen a steady increase in (young) adult morbidity and mortality levels, especially among the previously disadvantaged population groups. Mortality rates among young women aged 25 to 29 have more than tripled over a period of about fifteen years, and doubled among men between the ages of 30 and 35 (Bradshaw *et al.* 2003, 2005; Hosegood *et al.* 2004; Kahn *et al.* 2007). It has been estimated that life expectancy at birth in the country has decreased from approximately 62 years in 1990 to 46 in 2005 (UNICEF, 2008), largely as a consequence of the HIV and AIDS pandemic.

Apart from HIV and AIDS, homicide or “unintentional”, i.e. violence related injuries have been identified as leading causes of death among the population, contributing to rising numbers of both infant and young adult mortality. In fact, homicide has been identified as the leading cause of death for Cape Town male youth aged fifteen to nineteen (Bradshaw *et al.* 2003, 2005; Groenewald *et al.* 2007). However, when asked to estimate their life expectancy, the majority of African youth in the greater Cape Town Metropolitan Area expressed the overly optimistic belief to still be alive at the age of 70 (analysis of Cape Area Panel Data collected in 2005), more so than their Coloured and White peers.



Such findings of quantitative data analyses point at a gap in understanding, and at the necessity to contextualise the way in which young adults make sense of their realities. Despite the enormous impact that health and death must inevitably have on lives of South African youth today, very little is known about how they construct a meaning of death in their environment, whether or not such understanding would influence their life expectancy, and consequently their decision-making on any level of their lives. Research that looks at, for example, how children and young adults cope with high levels of death caused by violence and war shows mixed results. Studies have pointed at increased levels of distress, anxiety and posttraumatic stress disorder (See, for example, Straker *et al* 1996; Ward *et al.* 2007). Younger children have been found to “restrict their activities, pretend not to care about anything, chronic worry about safety, anxious attachment to mothers, counter-phobic display of bravado...” (Osofsky *et al.* 1993). A more recent study into the impact of violence on the psychosocial adjustment of South African children found that “ambient community violence was significantly and directly correlated with attention problems, aggression and anxious-depression” (Barbarin *et al* 2001: 7). The negative impact on children was, however, mitigated by levels of individual child resilience, maternal coping and positive family relationships (*ibid*: 1). Still other research on resilience has indicated that, in fact, the daily confrontation with violence and death might increase levels of resilience in youth and children.

Studies into the impact of HIV-related death on young adults have mostly focused on parental bereavement or HIV-infection in young adults themselves. Findings have pointed at increased levels of emotional distress, depression, anxiety, conduct problems, academic difficulties, etcetera (Rotheram-Borus *et al* 2001), but it has also been found that environmental and personal factors can be protective elements in adolescents’ adjustment (Rotheram-Borus *et al* 2005; Rotheram-Borus *et al* 2006). Longitudinal research has, for example, indicated that parental bonds at the baseline year would reduce emotional distress and increase future expectations among adolescents (*ibid*). Individual coping strategies have also been found to be moderators of psychosocial adjustment, with children who adapted more problem-focused coping strategies showing less emotional and behavioural problems than those who used emotion-focused coping strategies (Steele *et al* 2007).

Research into subjective life expectancy (SLE) then has mostly been conducted in more of the developed world, and seems mostly of a quantitative nature, focusing on adult SLE. Findings illustrate that socio-economic status, educational attainment, current health, feelings of control in life, anticipation of future risks to health and survival, all have a significant and positive impact on SLE (Ross and Mirowsky, 2000; Wardle and Steptoe, 2003; Popham and

Mitchell, 2007; Fang *et al.* 2006). Others have found that parental age at death has large and significant effect on SLE, as does exposure to same sex early death, especially for female respondents (Nelson and Honnold 1980; Fang *et al.* 2006). Strikingly, however, one study into “estimates of life expectancy by adolescents and young adults with Congenital Heart Disease” (CHD) found that patients rated their SLE far above the expected longevity for people with their heart condition, and just below that of their peers without CHD, indicating again a gap in understanding how SLE is constructed. Frequent reference has also been made to the fact that “survey questions presumably measure subjective life expectancy with considerable error” and that more work has to be done to understand how exactly people rate their life expectancy and how such ratings may change over time (Reid *et al.* 2006; Fang *et al.* 2006).

This study therefore attempts to gain a deeper, more contextualised understanding of how young people living in impoverished, heavily HIV-affected areas of Cape Town understand death, and how they subsequently estimate their own life expectancy.

## Sample and methodology

In 2006, twenty young adults from the stretch of the impoverished “Cape Flats” townships just outside of Cape Town were selected as participants in a broader study about educational decision-making and the potential impact of HIV and AIDS thereon. Individual in-depth interviews of approximately one and a half, to two hours were conducted with the research participants, focusing especially on their life histories and the choices about schooling they had made in the past few years. Approximately half of the sample was not enrolled in any type of formal education at the time of interviewing in 2006; also approximately half self-identified as being closely affected<sup>1</sup> by the AIDS pandemic. The analyses of collected narratives focused on potential differences in the stories about educational decision-making based on this AIDS-affectedness.

Following the first round of interviews and during the course of 2007, phone calls and talks with either the respondents themselves or their friends and family members, allowed for a certain degree of follow up on their lives and choices they were making with regards to their present and future lives. At the end of 2007, a “wrap up” round of contacting was conducted to see how all were doing,

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<sup>1</sup> In the original sample and analysis of 2006, a narrow definition of “affected” used, i.e. those who were either infected, living or had lived with a primary caregiver who was HIV positive or who had died of AIDS-related illnesses.

and a subsample of ten young adults was invited to take part in discussion groups focusing especially on the concepts of death and subjective life expectancy. In the final discussion on life expectancy, one of the female respondents had to leave the group for personal reasons, so findings in the second part of the paper are based on a sample of 9 young adults. 6 of original 10 respondents had lost at least one of their biological parents; Also 6 self-identified in this round of talks as being affected by HIV and AIDS; everyone had had someone in their close family structure who had been or was seriously ill, and all said to have been confronted with violent deaths within their families of communities.

The discussion groups were organised by gender with two female and one male group; I had intended to also select participants into the groups on the basis of school enrolment, but the majority of those who were last year not in any secondary or tertiary educational institution, had this year returned to school.

The groups were kept deliberately small to elicit more in-depth discussion about the topics. They can perhaps not be considered “traditional” focus groups in the sense that respondents would not have known each other (see references on focus group work in, for example, Bernard 2000): all participants had been part of previous research and some had met during certain participatory activities. Nevertheless, all respondents were asked to sign another consent form agreeing also on confidentiality and respect towards each other’s stories. The aim of the focus groups was to understand not only the young adults’ concepts of death and life expectancy, but also of future and aspirations, and of the interaction between the two. The discussions deliberately started with a broad exercise about “future”, leaving the option to mention death, illness or age up to the young adults themselves. Later stages of the talks were led intentionally into discussions about subjective life expectancy, understandings of death and risk behaviour.

Expert interviews with a priest, a nurse, teachers and a group of home based caregivers were conducted in addition to the discussion groups to add an extra level of understanding and some manner of verification of the youth’s stories.

## **Research Setting**

The townships that are home to the participants of the study are representative of the most densely populated, poverty-stricken areas in the Western Cape. The Census 2001 data record 40 to 60% of the houses in the Cape Flats area as informal dwellings or shacks. The same data indicate that 35% of all households

do not have access to piped water within their dwelling or yard, and that approximately 22% of all households live without electricity. Unemployment rates in “the Flats” are estimated to range between 50 and 60%. The vast majority of the households in the Cape Flats are living on less than R1600 per month (Census 2001).

Leading causes of death in the area indicate the high prevalence of HIV and of violent crime. According to the Western Cape Government, the leading cause of death over the period of 2002 to 2005 in two of the largest townships, Khayelitsha and Nyanga, was HIV/AIDS (24% and 16% respectively), followed by assault of any nature (13.5% and 16% respectively) (City of Cape Town, Health Services, 2007).

## **Key findings**

This section teases out young adults’ understanding of death as a concept in life in general, but more specifically, as a reality within their complex and fragile living environments. It first sketches not only the youth’s daily anticipation of, but also the lived experiences with death and bereavement, as well as the possible causes quoted for premature deaths in their environments. The analysis then looks at the effects on young adults’ aspirations and expectations, including expected longevity of life or “subjective life expectancy” (SLE). It will become clear that, even amidst the social, economic, moral and cultural complexities shaping their world, these young adults maintain the belief that they are able to exert at least a certain degree of control over their lives, therefore allowing them control over their life expectancy and futures. More importantly even, the analysis shows that they indeed also try to act upon that belief. Individual decision-making and resultant actions become part of a broader strategy that is meant to escape or at least mitigate the destructiveness of their environments.

### **“It happens all the time”- the reality of death in young people’s lives and futures**

I had planned to wait and see whether the respondents would themselves raise the topic of death in the first half of the discussions, before introducing it in the second half of the interviews. I therefore invited the participants to make a list of anything that came to mind when thinking about “future”: “people, emotions, places, and events, positive or negative... anything that you might associate with



‘future’’. Some would have rather abstract lists referring to “what you will do in your life”:

‘I...I said future is about you, your life, just everything around you, it’s about how you’re going to live your life in the couple of days coming or in a couple of years coming. It’s about money and who do you choose to live your life with, at what place would you like live and what kind of things you would do’ (Noxolo, female group two).

However, most of the replies were baffling: alongside happy thoughts and grand aspirations to have, for example, “a family, kids, success, a (usually high level) job” and to go “travelling” were, almost casually interjected, references to HIV and AIDS, death, loss of faith in the future of youth around them, and difficulties to overcome. Some were really dramatic, with hardships preceding aspirations:

‘HIV/AIDS, poverty, crime, rape, success, 2010 worldcup, husband and kids’ (Thobeka, female group one).

Most, however, were more subtle mixtures. Nobuzwe, for example, read out her list as follows:

‘Okay for me, its success, a big house, marriage, three children, happiness, independence, money, love, death, a car, business, charity, changes, improvement, love, station [stage] manager, producer, documentaries, theatre making, and health.’

The fact that death appeared as a possibility in many of the youth’s lists, and that it was during all discussions accepted as universal (“everyone will die”, “you can always lose someone”...) does not have to be surprising. Research within the discipline of psychology has tried to understand children’s and young people’s definitions of death and their understanding of various aspects of it, such as irreversibility, causality, etc. (see for example Smilansky and Weissman 1978; Orbach *et al* 1996). It has been shown that young people develop an understanding of “death as a universal, inevitable process by which life as we know it terminates” and that adolescents understand “physiological, psychological, and religious or spiritual aspects of death” (Morin and Welsh 1996: 586). Yet, when explaining why she had included ‘death’ in her list, Nobuzwe not only referred to the universality of death, she includes the thoughts of wanting to be prepared: taking the possibility of death into account becomes a coping mechanism for dealing with the daily insecurity that

‘... you never know what’s gonna happen the next day [A: uhu]. You never know if you gonna wake up with your mom still there or your father still there or your family members still there’ (Nobuzwe, female group one).

I will return to the topic of coping mechanisms in later parts of the paper, but first want to describe in more detail the concept of death as it was discussed among the youth in my sample. What was most striking in the participants’ understanding was not so much death as a universal *possibility*, but always as a *daily reality*. Even those who had not placed thoughts of death explicitly on their lists would, in the group discussions, clarify some of their references to future in terms of death, violence and the fear of losing those around them. As soon as the subject was touched upon, the equally resigned manner in which all of the participants were able to describe several examples of encounters with death, and the way in which each would add onto the others’ stories with one of their own, was striking. The various narratives illustrate the fragility in these young people’s lives: there were stories ranging from people dying of AIDS, of violent attacks or robberies, rape, witchcraft, or, more generally, of poverty. Respondents immediately understood and clarified one another’s references. Nandipha, for example, added to Bulelwa’s reference that “people are dying of AIDS and poverty” with the following story of people being punished to death by community members<sup>2</sup> after having committed a crime *because of poverty*:

‘Like say for instance, the poverty she has there on her list... [A: uhu], sometimes, maybe her family is poor, then maybe the son will go out and go steal from his neighbours or his peo... from other people... then he will be caught and in the community will be like, you know, like beaten [A: uhu], and if they beat you, they beat you to death. [A: uhu]. Yes. If you get caught [A: uhu]. So... maybe she’s talking about such poverties because it happens all the time’ (Nandipha, female group one).

In the young men’s group, an extensive, very lively discussion developed about witchcraft, illustrating the complexity of these young people’s lives. Here too, other respondents immediately understood and helped clarify what the others meant:

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<sup>2</sup> Only very recently, another such case of community outrage against crime resulted in the “necklacing” of a young suspect of armed robbery: he was assaulted with sticks and stones by community members, “after which several tyres were put on him and set alight” (Cape Times 2007). One of the young men in another discussion group mentioned a similar case of death by community “revenge”, wondering “what good that does for this guy’s future”.

Nezile: Sometimes you could get that the neighbour that stays in the far corner hates the neighbour that's next door (laughter) so there's 'black magic', there's witchcraft in the community. They also take a part in the community, going back to the gangsters, some of them say 'no, it's the lady that lives next door that has done this to me so I can't go back, I can rob, that's the only thing I can do'.

Siya: Ja...recently there where some boys found at a house, not far from where I live and I don't think it's far from where he lives. There people had died many years ago but they where found in some wardrobe. It is not known what they were doing there.

Thando: And they were alive.

Nezile: That's what they say; they say they keep the people there.

Siya: They keep them in wardrobes so that they can do stuff.

...

Importantly, death as it featured in the first exercise about future mostly referred to the possibility of *premature deaths* of themselves, their peers or their loved ones, i.e. not the kinds of deaths that would, for example, be linked to old age, but those that happened at younger ages. Respondents would thereby clearly make a distinction on the basis of agency. They would portray themselves mostly in a potential *victim* role, those who run the risk of being killed or raped, or of losing someone close because of "others". "The other" young people could be either victims or perpetrators.

Interestingly, however, within this discourse of agency, it seemed everyone could be the victim of witchcraft. It is not this paper's intention to extensively discuss the importance of witchcraft in these youth's stories, but it is necessary to see such references within what Ashforth called "the witchcraft paradigm": "Discourses of witchcraft can... be represented as modes of posing and answering questions about evil; about the beings, powers, forces, and modes of action responsible for causing suffering in the world." (Ashforth 2002:127). In his work on the meaning of death, Davies (2005) refers to premature deaths as conceived by most societies as "useless deaths" – it is exactly in such context

that paradigms of witchcraft are to be situated as well. As one of the respondents clarified: it is about “trying to understand” what is happening to individuals within a context that, as Ashforth describes it, is one of spiritual, physical and financial insecurity (Ashforth 2002):

A: Does it live in your minds though? I mean...do you guys believe the possibility that there is witchcraft around?

Thando: There is witchcraft but people are saying that...

Siya: They want to understand it: like if something is happening in the home. Like if there are quarrels, umm... some divines... something that you can't really see because something is happening in the spiritual right; so there is no way that you can understand it just by looking around, you see so I would say it is but I won't entertain it. I won't put that much...I wouldn't really look at it... when it's happening... if my neighbour is doing it for whatever reason, they must do it for themselves, I don't care about that nonsense but it is there. I've heard many stories of people flying at night and stuff like that.

In contexts not related to witchcraft, however, “the others” were often described as those who made a conscious choice, who would “do stupid things” or “risk their lives”. Examples of that were to join a gang and thereby either run the risk of getting shot or killing others; or to go out to clubs, drink and smoke and thereby risk being raped or killed; or to give in to peer-pressure “to have a baby” and thereby forgetting the risks of unprotected sex.

One of the young men, for example, explained these choices of others as a risk to his own life. His list read:

‘Okay, I've said... I will play professional rugby (A: Mhh), be educated, be able to support my family, maybe I can be killed or lose my close friend’ (Thando, male group).

He clarified:

‘Maybe I can get killed because my gym starts at 6 o’clock and I live in the ghetto. I have to cross New Cross Roads to reach Nyanga East; I come at about... my gym take 2 hours, sometimes 3 hours so I will come about 10:00. So I walk home because I don’t have transport so it’s dangerous for me, late in Gugulethu. One day I was robbed and they took my rugby boots and all my kit; they left with my bag, that’s why I wrote negative things because I can be killed and it’s not that they don’t know me. They know me because I go to gym, they know me... they want me to be like them [to become a gangster like them].’

This possibility of premature death was seldom related to physical problems, yet always portrayed within the social and moral circumstances shaping life of South Africa’s township youth with references to poverty, envy, gangsterism, lack of parental control over or understanding of children, youth who are trying to decide what choices to make within their fragile worlds:

Alutha: Ok, by next generation, like in my township there are these gangsters which are called Palestines and they are also those big guys and they are called the ‘Mashimane’ but those big guys, they are not like doing that thing in the community, like... robbing people in the community, in the streets or whatever. So like I’m... there are also those little boys which are growing in front of them: like when they’re robbing, they are... they see those things. Even when they’re playing on their own, they’re like playing as if they are those gangsters so like I’m wondering about them. What would happen like... what do they think about their future. Do they want to become those... those Palestinians or what in their minds.

A: So you wonder about the next generation of young people?

Alutha: Yes, maybe those...those kids...they’re those kids that will do the same thing even in front of their parents, you see. And then their parent will just look at them and not even umm...try to stop them doing those things

because it's something that is happening everyday so the parents don't care about it.

These stories and reasoning of the respondents were certainly not told in isolation. During my fieldwork time, many stories, whether they were on educational decision-making, gangsterism or some form of risk behaviour would centre on the multiplicity of choice, and the absence of guidance and support structures in young people's lives. Instances such as these explicitly bring to mind Giddens' theory on identity construction in a post modern society (1991). However, the specificity of South African society is not one where all guidance of culture or religion would be lost. Yet one where the official discourse of "freedom" and "opportunity for all" is so pervasive that it seems to lead to chaos and to a consistent interpretation of certain outcomes as the result of individual responsibility rather than as influenced by circumstantial factors.

Thumsani, a priest in Khayelitsha, spoke of the problems of youth putting themselves at risk by participating in gangsterism and multiple or unprotected sexual relationships. His explanation referred to both parents' and youth's struggle with "the issue of democracy and human rights" in present day South Africa: the fact that the gained freedom of choice confuses both parents and children. It is, according to Thumsani, a liberty unknown to parents who grew up under a strict apartheid regime that allowed little or no free choice and within community structures where, for example, "every parent was a parent to every child in the community":

'The problem with today's parenting is that... definitely children have got choices which is a good thing, they can make those choices but those choices the unfortunate thing is that coming from those situations like apartheid, we were in a box, in a cage kind of thing, once you set free that bird out of that cage, that bird is definitely hit, if its in a house its going to hit everything in a house because it does not know this environment. So now in an environment that is new to us and now we as parents today we don't know how to handle it. And the children who are growing up they are finding us in this confusion because one parent is saying something else to their children and the other parent is saying something else to their children, so that brings more confusion.'

Strikingly, a study into the understanding of death among residents of a rural region in South Africa's Limpopo Province that was heavily affected by AIDS-related illness and morbidity found very similar references (Posel *et al.* 2007). Respondents were interviewed more specifically about their understandings of

“the acceleration of death amongst the young and middle aged” and of HIV and AIDS specifically (ibid). Researchers found that explanations for AIDS-related deaths referred “first and foremost (to) a symptom of a cultural and moral condition”. The heightened levels of morbidity were linked directly to the “erosion of cultural norms and traditions”, the rejection of parental guidance by youth, for example, and the “practicing of freedom” gained in the new South Africa, also on a sexual level (ibid: 141-142).

## **“It distracts you a bit” – does death become “normal”?**

I asked the young adults in the groups to tell me more about how they deal with this presence of death in their daily lives. The small sample of the study does not allow making generalised statements, but the mixed reactions reflect findings of studies into the effects of violence and war on young people, as mentioned earlier. Some researchers have hypothesised that “high exposure to violence leads to the experience becoming normalised such that it ceases to be a source of concern for youth” (McWhirter and Trew 1983 in Straker *et al.* 1996), and indeed, some of the reactions of the participants do remind of such normalisation:

‘You see there’s a lot of stuff that is going on in the areas that we live in. At time you’re like studying at night and you hear some noise out and you notice that someone just got robbed or someone just got shot and so... you look for means, that that person could be helped. In that situation you either call the police or an ambulance and that distracts you a bit’ (Siya, male group).

It is important, however, to distinguish between the “normality”, the *reality* of death in their environment and what youth would consider a *normal* life. None of them, for example, thought it normal to always have to take precautions to protect themselves, yet large parts of the discussions were exactly about that.

Nobuzwe: Cause like if you live in a townships, you always feel.... Like you always wake up and they say “so and so was raped” (other agreeing on the background), “so and so was killed”, “so and so is dying of HIV and AIDS”, “so and so ... was a victim of crime”, whatever [A: uhu]. *So like you... you can’t... you can’t... you can’t help it but think about it.*

Noxolo: *I really have it on the back of my mind everyday because I'm not gonna walk around with a phone. I can walk around with a phone in my community because we don't usually get stuff...gangsters that much. Now when I'm in other... communities, then it comes, you know and disrupt...but then if you go to their communities then eventually you gonna get robbed and stuff, you know. And you can get killed over a cell phone or just money, like they can say 'give us money' and then you say 'no I don't have money' and you can get killed over such little things, you know.*

The stories of youth in this study remind of those in McIntyre's study about the impact of violence on the lives of African American urban youth (McIntyre 2000). The researcher conducted participatory research in 1997, with youth in an American "inner city public school" to investigate "community issues that were of concern to young people" and to develop an action plan to help deal with these issues. Violence was one of the main topics to be dealt with. McIntyre refers to work by the Latin-American psychologist Ignacio Martin-Baro and his concept of "normal abnormality" (1994): "a state of being/ living where people come to anticipate living with multiple forms of sanctioned and unsanctioned violence, marginalisation, and oppression, all of which inform and shape their daily lives" (McIntyre: 126). Other Latin American researchers on children's experiences with violence, such as Lykes (1994) in Guatemala and Quesada (1998) in Nicaragua, have pointed at the fact that experiences with unpredictable violence have "despite their clear abnormality, come to be accepted as normal" (Lykes, 1994: 7). The researchers state that children and youth growing up under such conditions face "existential dilemmas": the need to choose between picking up arms or running away, resisting or giving in" (Quesada, 1998: 57).

The daily confrontation with death was one such 'normal abnormality' in my participants' lives. They too struggled with dilemmas: the need to explain for themselves that the level of death they experienced was "normal", next to the wish to escape. This is again in line with the seemingly contradictory findings of the South African Youth Victimisation Study that large numbers of youth wished to move from their communities, regardless of 'being fond' of them (Leoschut and Burton, 2006). All of the participants would have liked the dying to stop, many of them expressed their concerns of wanting to help and save those they considered at risk. Yet many of them also express the wish to "get away", be out of the "ghetto" and go live "a better life".



‘Yoh...so many people have died, many people that are close to me. Now I’m no longer surprised. If someone died I’m just like ‘I’m sorry to hear that’, it’s like something that happens everyday; I’ve gotten used to many people dying. I lost my mom at a very very young age and my father and after that followed my cousin, friends. People...I can tell you in the entire street someone has died in each and every house. In fact in my life time, about 2 people have died, at least, in each and every household so I’m used to seeing that happen and I think the sooner I leave that place, the better because I just can’t take it anymore. Guys, I mean people dying like flies’ (Siya, male group).

These are remarks also noted in earlier interviews with the youth. Many had previously expressed the wish for a life like the ones lived in the city, or overseas. Some would word their dreams for the future in terms of “wanting to get out of the country”. Not all would act upon those wishes. But strikingly, many would in fact look for some way to take up agency and give direction to their lives. The next section describes how aspirations and acting upon them can become a coping mechanism in a context of adversity.

## **“We will grow old” – aspirations as a coping mechanism and a drive behind personal decision-making**

Although many expressed fear and some would hold back their behaviour – e.g. “you cannot walk to the shops”, “I don’t go out”, “Sometimes I get scared” - when thinking about the risks they are faced with in their environments, most of the participants showed incredible resilience in the midst of their chaotic and fragile worlds. For Nobuzwe, for example, who had lost her mother to AIDS a couple of years ago, the possibility of death is always “at the back of (her) mind”. Yet, as mentioned earlier, she described it almost as a coping mechanism, a way to be prepared, to have a plan ready if ever the confrontation with death would happen to her again:

Nobuzwe: Ja, for me it’s always at the back of the mind. Cause like even if I, I think of “okay, tomorrow I’m gonna wake up and, and do something productive, I always think that there might be something that will prevent me from doing that. Cause like, that’s how life is. You can’t say, like you can’t clear your way like “it’s okay, I’m gonna climb my way up to the top” without

considering the things that might prevent you from getting there. [A: uhu]. So for me it's always there, I always think "what if tomorrow I wake up and my aunt is dead, then what am I gonna do". [A: uhu].

However, even after having been confronted with death and considering the possibility of loss almost daily, Nobuzwe continues to take very conscious decisions with an eye on the future and fulfilling her aspirations. In 2006, she decided to take a "gap year" to prepare for rewriting her matriculation exams and better her results. In 2007, she enrolled at the University of Cape Town, and this year (2008) she started her second year of tertiary education. She found a part time job that would allow her to pay for her books and other schooling and living expenses, and to contribute to her household's income, while maintaining her focus on her studies. She decided to apply for a room in a university residence so she wouldn't lose time by travelling back and forward to the townships every day and so she could be "in the quiet" and better able to study than in the busy township environments.

Others in the sample chose a different way of dealing with the constant confrontation with death: it is simply not a possibility they wish to focus on. In an earlier quote, Siya described how he lost his mother at a very young age, how his father was shot a few years ago – which led to him dropping out of tertiary education - how he lost a cousin to HIV, and frequent other encounters with violent or HIV-related deaths in his community. Yet, about the possibility of his own death, he states:

Siya: A person...there is a possibility that it might happen right? I don't consider it; I don't plan it around my life. It's more on the things that I want to attain while I'm still alive; that's where I'm pushing towards. There other stuff, if they catch on with me, I guess it will be some plan; maybe something that God decided, that it should happen and there's nothing that I can do about it but for those that I think I can do something about, then I'm gonna make sure that I do that.

Whatever the coping mechanism adopted to deal with the daily hardships, Siya too has been choosing very consciously to remain faithful to his aspirations in the midst of all the turmoil and loss. His individual decisions allow him to further his life in the direction of his aspired future. When I spoke to him in 2006, he had dropped out of tertiary education because of his father's death and the consequent loss of resources to fund his education. In 2007, however, he was back in school, combining part time work with study.

Somewhat to my surprise, Nezile agreed with Siya's approach of "not thinking" about death:

Nezile: I also don't think of dying... (All laugh) I seriously don't wanna die. I wanna see myself like in 50 years from now, I don't know. Looking at myself in the mirror, even if I am a grandfather or something and just tell myself that I have made it; and then see that I can actually die now. But at this moment *hayi* [No]...

Nezile is one of the young people who at one point in their lives choose to follow a path of crime. In the individual talks in 2006, he stated that he did not know whether he was going to live "another 10 years", as he was scared of the consequences of his choices and saw no way of escaping the risks. Yet in 2007, he had decided for himself to "turn a page", to move on with his life and focus on activities that would keep him away from the townships and his former gang-related friends as much as possible. He is now able to state he wants to see himself in fifty years time, an element that will be discussed in more detail in the section of this paper that will deal specifically with life expectancy.

Some of the above quotes already illustrate how some manage to maintain aspirations and hopes next to thoughts of death, crime, and HIV and AIDS. All three respondents quoted above had in the course of their lives either lost someone within their close family structure to AIDS, or had just found out one of their siblings was HIV positive. Yet such confrontations with the pandemic did not seem to have any different impact on their reactions and actions as the confrontation with death by other causes.

Maintaining a focus on their goals for the future is an element that has been identified by psychologists as helping to build and maintain resilience (see, for example, Ahern, 2006; Rutter, 1987). It was a clear coping mechanism identified by many of the participants. Others would give more chaotic accounts of how they attempted to "manage" the impact of threats on their dreams, but none seemed to question the fact that they would, in fact, "grow older" and complete the various stages of the lives they dream for themselves. Below is an excerpt of a discussion about the influence of the threat of gangsterism on their lives. Noxolo had said sometimes the violence affects her dreams for the future, Alutha disagrees and in the passage quoted below, Noxolo continues in an attempt to clarify:

Alutha: For me... for me I don't think crime can ruin my dreams because... crime is there, you can go to school

even if crime is there. Everyday you can wake up and go to school and get a taxi and go to school and come back and do your thing. I don't think it can... just for me.

A: You wouldn't let it?

Noxolo: Ja, it wouldn't ruin our lives like... I mean, it can ruin what you have. You can have what you wanna have: you can buy a car if you want, you can buy your house but then one day, something will happen, something bad could happen like some gangsters shoot you and just take your car and highjack you and stuff like that. You know stuff like that can happen, it's just part of our lives, it's just gonna happen.

For Noxolo, the idea of gangsterism and the fact that “it will always be part of our lives”, does not keep her from stating in the same matter-of-fact way that growing older is “part of our lives you know, just growing up and... it's just what the future holds”. Her reaction is interesting in showing the duality that exists in these young people's minds, their ways of juggling the possibility of death with the certain belief of one day reaching their goals and ambitions. Next to their feeling of helplessness when it comes to fighting the uncontrollable threat of violence, is the conviction that they will “live their lives”, they will “grow older”. It shows the almost daily balancing exercise between various coping mechanisms, between uncertainty and dream in their worlds.

Their contradictory attempts to describe how death and aspirations live alongside, again strongly remind of what McIntyre reported on the youth in her sample: “The world that the young people described in this book inhabit, is a world of despair and hope, chaos and silence, violence and peace, struggle and possibility – a world in which they expend a great deal of energy surviving violence while simultaneously negotiating the psychosocial, economic, raced, gendered, classed and sociocultural borders that inform and influence their lives” (McIntyre, 2000: 126).

In fact, the youth's narratives seem to reflect methods of psychological protection against the idea of “life's meaninglessness” as described by Davies in his “Brief History of Death” (2005). According to philosophical theories touched upon by the author, for the young adults to let go of their aspirations, would be equal to giving in to a fear of death: “Many philosophers... have seen that attitudes to death are closely related to our sense of identity, to the way we

live and to the meaning we sense in the life we lead. With this in mind I would argue that fear of death is related to fear of life... In particular, the fear of life is the ultimate fear of life's meaninglessness" (ibid: 141). For the young adults in my sample, giving in to a fear of death, would be to give up the idea of possibly accomplishing their goals and ideals, an idea that is simply not acceptable as a valid option for their lives. In a similar way, the author refers to the necessity of *hope* in contexts characterised by adversity: "There is optimism in hope that fosters human endeavour in a committed search for solutions to problems even when they may appear insoluble... There is survival value in hope" (ibid: 11).

Perhaps the contradictions and confusions in the young adult's concept of and stories about death already reflect part of the answer to the paradox of their high subjective life expectancy: all of them live the realities of death in their communities, family or caregiving structure. Yet they understand their own choices to be those that keep the chance of dying under control as much as possible. Maintaining the belief in their own agency, in their own personal decision-making in order to secure a longer life seems their "survival value". It is their way of dealing with the 'chaos' and destructiveness that is encountered daily in their environments, and of not giving in to hopelessness and resignation. Subsequent chapters in this dissertation will illustrate that this belief is upheld in very much the same way as the one in which many are seen to try and exercise agency with regards to education, in a context that seemingly leaves very little room for it.

## **Subjective life expectancy in a South African context**

One aim of the discussion groups was to better understand how respondents would reply to the survey question on subjective life expectancy (SLE) as used in both the Cape Area Panel Study (CAPS) and the Cape Area Study (CAS). The survey question asked respondents whether they expected to still be alive at the ages of 30, 40... up to 80. A total of 60% of young adult respondents of the Cape Area Panel Study optimistically estimated to reach at least the age of 70, compared to an estimated national life expectancy at the age of 20 of just over 56 years of age (ASSA 2003 full model). Life tables calculated by the South African Actuarial Society do indicate a higher life expectancy of 65 at the age of 20, for the Western Cape. Even in this province, however, declines in LE are noticeable with a loss of one year in a period of just three years time (LE of 66 at the age of 20, as estimated in 2002; 65 as calculated in 2005; ASSA 2003).

Optimism in SLE was highest among African youth with close to 60% expecting to still be alive at the age of 80 (analyses of 2005 Cape Area Panel data). Yet it is especially these young people that are most likely to be confronted with higher levels of illness and death in their close environments. Little or nothing is known as to how exactly respondents expressed their life expectancy. Hence this round of more in-depth fieldwork in order to try and understand better what the underlying reasons for these positive responses to SLE might be.

US based researchers Thornton and Lam (2007) point at the necessity to look into possible correlations between numeracy levels and SLE responses. In general, however, African respondents have been found to express very positive or even more optimistic beliefs about their present and future lives than their White or Coloured peers, which may not necessarily be related to numeracy levels in all cases (see, for example, data on educational expectations, De Lannoy 2008 forthcoming; but also data collected by the World Value Survey). Hence, I decided to conduct a round of more in-depth fieldwork in order to try and understand better what the underlying reasons for these positive responses to SLE might be.

Participants in the qualitative work were presented with the same scale of SLE and asked to reply to the question firstly for themselves, and secondly for young people in their community in general. They were asked what factors they took into account when replying.

Taking into account the participants elaborate stories about the daily experience with death, the high replies on SLE in the qualitative work may seem surprising, yet were similar to the findings in the CAPS sample. Only one of the male participants expects to no longer be alive from the age of 60 onwards, the majority of the others said they didn't know as of the age of 70. There is, however, a striking difference with their own subjective life expectancy and that for "youth in their community": much higher levels of uncertainty exist on whether or not their peers will live up to the age of even 40 and no one believes they will reach the age of 60.

Obviously, with a small sample like this it is not our intention to quantify replies, but rather to look in more depth at the logic behind the answers. Respondents were asked to clarify the factors they took into account when estimating their own and their peers' life expectancy.

Subjective life expectancy for self				Subjective life expectancy for peers			
Do you expect to still be alive at the age of	Yes	No	Don't know	Do you expect to still be alive at the age of	Yes	No	Don't know
30	8	0	1	30	7	2	0
40	8	0	1	40	3	3	3
50	7	0	2	50	1	4	4
60	5	1	3	60	0	4	5
70	1	1	7	70	0	7	2
80	0	1	8	80	0	7	2

**“This is how I want to live my life” - Controlling the controllable**

Without any exception, participants based their high SLE on the belief that one has control over “how one lives one’s life”. Reaching older ages, in other words, is dependent on one’s own choices in life:

‘Ok, I can go first. Ok for me I’d say that the questionnaire wasn’t that hard because of the way I want to live my life and then things like accidents and...ja things like accidents would be things that I didn’t expect, like in my life but things like HIV/AIDS and stuff like that, I can be like more protective not to get those things so it’s the way I want to live my life. *I want to live a better life by taking good responsibilities*’ (Alutha, female group 2, SLE of at least 70).

This feeling of control was always mentioned with regards to *physical* aspects of health and death: one can look after one’s health, go to gym, eat healthily, not smoke or drink or use drugs, etcetera. This relation between SLE and feelings of control and perceptions of current health is in line with earlier mentioned findings of quantitative studies:

Nobuzwe: Like obviously you consider your life style. [A: uhu] Now. Cause I think like everything you do now, you’re your future depends on what you do like at the present moment [A: uhu]. It’s like if you lead a healthy life, you lead a healthy lifestyle and you, you don’t smoke, you don’t drink, maybe occasionally drink, occasionally,

and you know you're not a regular smoker, you don't have unprotected sex if you have sex, and... and ja, just keeping yourself healthy.

A: How bout you girls?

Nandipha: Ja

A: Same thing?

Nandipha: Ja, and to know your status [giggles], ja.

Bulelwa: It depends on how your life... [Cl: hm] how you are...  
[A: on how you...?] how you live your life [A: uhu]

Importantly, the chances of contracting HIV were also considered controllable by practicing safe sex, or even abstaining. This resonates findings of a small ethnographic study at the University of Cape Town in students' perceptions of and attitudes towards HIV and AIDS, which found that respondents "would argue that individuals are responsible for their own health, particularly in relation to sexual practices" (Levine and Ross 2002: 8).

In other words, for the participants in my sample, this idea of "living one's life" in what is considered the *right* way, implies choosing to stay away from risk behaviour that would compromise their chances of ever reaching the lives they aspire. This is again described as a personal, *moral* choice to go against what is described as the dominant "risk culture" of their peers, an element that is described in more detail in a following section of the paper. Again, this is a slightly gendered choice, which for men also implies staying away from gang-related or other criminal activities, and for women "looking after oneself".

This idea of an individual moral choice influencing life course and outcomes thus persists. It was also found in earlier work around educational decision-making (De Lannoy 2007). It also mirrors findings of a study on sexual abstinence among young women in a Coloured area within the greater Cape Town Metropolitan Area, who were found to abstain in "an attempt to challenge and counter destructive sexual norms operating within their community". Kahn described the participants' sexual decision-making as "rooted in their frustration with, and desire to counter or avoid being absorbed into the destructive attitudinal, relational and behavioural cycles at play in their immediate social worlds" (Kahn, 2005: 23-24).



When asked what led respondents to reply they “didn’t know” whether they would still be alive at a certain age, most referred to physical causes like illnesses or genetically inherited conditions that could occur at such later ages – not to the possibility of perhaps contracting HIV or dying of a violent attack:

‘Oh for me? I think my decisions maybe... the way I live my life. I think it is taking me to age 60 or probably 70 but I’m saying I don’t know [as of 70] because there are a lot of sicknesses that go on. You can get sick from the food that you eat, there’s a lot of stuff attached to it. And if you’re not following the necessary precautions you die. But I would like to live until the age of 60 without having any sicknesses and then start to have some sicknesses between the age of 60 and 70. Ja... I think by 80 maybe there’s nothing left for me but I would love to live until the age of 60’ (Siya, male group, SLE of at least 60).

‘... If you look at maybe at your family history. I have got my granny living and she is 81, she is still alive, she is healthy. She is...she is you know...she is going everything for herself and also my other grandmother she is 62 and she is also very healthy and my father is still alive and has nothing and my mother. So if I look at my family history, I would say ok there no one who has done of heart disease or something and then you carry that in your system and then maybe you live longer because usually that’s what doctors say. They’ll ask you, did you have a family related illness, you know. Maybe that’s why you have diabetes at this age because it’s family related. So if I look at them and they’re still alive, maybe I’ve also inherited that, that gene that maybe at 80 I will also be alive because my granny is still alive but maybe I will die of a car accident or maybe I’ll get stabbed, if I die, you know at this young age. (A: Mhh) So I would also say the same thing that I might be 80 (A: So) looking at my life, looking at how I live my life: if I don’t smoke, I avoid all these things that...that lead to your system not being healthy and stuff’ (Noluthando, female group 2, uncertain SLE).

Respondents’ high SLE was thus based on their belief in their ability to control the outcomes of their lives. This belief did, however, not exclude the awareness of factors that could lead to an early death that one has *no* control over. Indeed, there was the awareness that they could get involved in an accident, or again the reference to certain social, moral and economic aspects of township life that might lead to an early death: being the victim of a robbery or of witchcraft for example, having no money to buy healthy food, or unintentionally contracting

HIV. It is, however, important to note that those non-controllable factors were almost never the ones that were taken into account when spontaneously estimating one's SLE:

Ja, like accidents, you don't have control over accidents, they just happen. [other: uhm]. If you are, if .. if it's your time to die, then you'll die. [A: uhu]. And if you are like in a critical state then you'll die, but then there are, there are stuff that you have control over. Like, like you can prevent, I know that in some cases you can get raped and get HIV [A: uhu]. But then there are like things that you can do. [A: uhu] Like having safer sex or abstaining, not having sex at all...' [Nobuzwe, female group 1, SLE of at least 70].

The seemingly contradictory inclination to recognise the risk of HIV-infection without taking it into account when estimating one's own (high) SLE mirrors findings of other studies. US based study into "patterns of associations among psychological distress, anticipated mortality and perceived vulnerability to HIV among urban multiethnic samples of adolescents", for example, found no significant relations between anticipated mortality and perceived vulnerability to HIV infection (Langer *et al* 1998: 1).

I wondered why uncontrollable risks hardly ever feature in the way in which my respondents calculated life expectancy for themselves. When probing further into their conviction to live a long life, one of the male respondents clarified:

Siya: I think maybe it's because I want to live... *I want to live until those ages*. I think the decisions that I've made maybe... ja I think I should still be around at that time. I don't think I have made stupid decisions, I don't everything... anything like this you know, I should live until I get to 60. If I don't then...

A: What will be the causes you could die of earlier?

Siya: It would be something drastic happening... something like a car accident, get shot; a cross-fire, something that was intentional or contract HIV or stuff like that. Those would be the things that are likely to...

His peers all agreed with him: the ages they had expressed in their answers were an aspiration, they would "love to live" until that age. However, they assumed

their aspiration a real possibility as it was based on the belief that they controlled most of the factors to live up to those ages.

Very similar trends were found when analysing previously collected data on educational expectations and decision-making. Young adults were found to express very high expectations with regards to the level of schooling they would achieve. Just as in this case of SLE, those educational expectations seemed, in fact, aspirations: these were the levels of schooling they would *love* to achieve, expressed in the understanding that if one remains focused enough and makes the *right* decisions in life, these aspirations would in fact become reality, no matter how high the economic or other constraints (De Lannoy 2007).

However, a lot of “othering” was noticed in that context of educational expectations, with their peers being depicted as those that made all the “wrong” choices in life: those who would fall pregnant, chose the path of gangsterism and hence drop out of school (De Lannoy 2007). Similarly, when it came to estimating their peers’ life expectancy, the majority of the participants expressed a very different, more negative reasoning than they had for themselves. Similar to the youth in Kahn’s study, the participants of this study presented themselves as the “exceptions” within their broader environment (see Kahn 2005: 24).

## **The others’ life expectancy – “they will see if they get to tomorrow”**

Clearly, the belief in longevity of life for the “other” youth in their communities is much more pessimistic than for themselves. Two of the respondents were very negative and expressed the thought that most youth around them would not live until the age of thirty. Only three believed they would definitely live up to forty years of age – compared to eight of them expressing the belief they would definitely still be alive at that age. In line with their previously described thoughts about death, the main reasons for the belief in lower longevity of life for their peers were risk behaviour: for young men, the involvement in gangsterism and violent crime; for both men and women, multiple sexual partners and the possibility to contract HIV, the use of alcohol, smoking and drugs; and for women especially, the kind of behaviour that might increase their risk of being raped or contracting HIV. One of the male respondents mentioned witchcraft as a possible reason for death among young people. In general the loss of hope for their fellow youth was overwhelming. Below is an extract of the young men’s discussion:

Nezile: I'm... I would say that in my community there are people that have passed, that are already... and passed 30 and 40. And now let's say... let's not include the elders and the people that are passed 40, let's live the young stars. I think they won't reach it because they've seen enough in their world, you see. (Ariane: mhh) What they've seen is... can actually kill them, you see. So... the reason I've said no, that's why I've said no but still... but some of them die even much younger because of... well some of them it's tragedies. Some of them it's gang-killings, some of them it's just illnesses. (Ariane: Mhh) So I said no to 30 and 40 and 50 and 60 and... besides the older people and... They would actually... I'm not being... I'm not being cool or anything but they would die.

A: What are the... if would make a list, what are the main reasons that would cause young people not to live up to the age of 30 or 40?

Siya: HIV is one of them.

Nezile: Ja...

Siya: Drinking.

A: Drinking?

Siya: Drugs and the environment, just crime in general and accidents. I've already lost a friend of mine to a car accident, I've lost my sister to HIV and my father got shot so... ja and witchcraft as well. There are some people that die of witchcraft; they get poisoned and stuff.

When asked whether they thought that young people in general were aware of the things that might lead to earlier deaths, no clear cut answers could be given. There was a general feeling of "not understanding" their peers, but also the belief that most of them were only living "for today":

Nobuzwe: I don't think they are aware. [A: uhu] I don't like... like they know that HIV is there, [Nandipha: but they do] I

don't know what's the problem is, I don't know if young people in general actually think about their futures. I think they have that attitude of living for today [Nandipha: today, ja]. [Bulelwa: they want to experience] And then they will see what they what if... if they get to tomorrow.

A: They want to experience... like what?

Thobeka: Like I dunno, like, when you are like being told that there's HIV and AIDS and what... I wanna like experience it myself [A: uhu], to like to see if there is HIV and AIDS.

Again, the overall agreement between the participants on “others”’ risk behaviour was overwhelming. Interestingly and alarmingly though, when probed about their own risk behaviour, many of the respondents had stories to tell of how they had “not always” been careful. One of the men, whose own life expectancy was to live until at least fifty, admitted having had unprotected sex with multiple partners. Another one had had a drinking problem. The third one had been a gang member until very recently. Among the girls, one admitted to having had unsafe sex, another one to going out and drinking, one to sometimes feeling tempted to drop out of school and “hanging out”, etc. Yet all had expressed for themselves higher life expectancy than for their fellow peers.

This resonates with findings from psychological and psycho-social studies into what has been called “positive bias” or “illusions of invulnerability” among both adults and adolescents. It is not unusual to find (young) people expressing the risks for their own lives as lower than others and their understanding of the probability of experiencing positive outcomes as higher (Cohn *et al* 1995). Studies have indicated that indirect exposure to trauma (e.g. higher levels of death in the broader society rather than in one's immediate environment) affects “how one estimates risk of death in relation to the average other but not in relation to oneself” (Roe-Berning and Straker 1997). This could explain why the respondents' stories of daily confrontations with death do not seem to correlate with their SLE. Moreover, even those who have been more directly confronted with higher levels of illness and death, who are sick themselves or who themselves choose risk behaviour have been found to express the belief that they will live longer lives than their peers (Cohn *et al* 1995; Reid *et al* 2006). Numerous studies have, for example, looked into the risk perception of smokers for their own health. Smokers have been found to be more likely to doubt that they will die from smoking, even though they would agree on the fact that

smoking is addictive and that it causes “most people” who smoke to die (Arnett 2000: 625; see also Greening and Dollinger 1991; Weinstein *et al.* 2005). Similar beliefs about invulnerability have been found to exist also with respect to disease, pregnancy, driving and crime (Quadrel *et al.* 1993). It has been assumed that adolescents’ perception of invulnerability is higher than that of adults, but findings about those hypotheses are contradictory (Cohn *et al.* 1995).

Importantly, however, the likelihood to express what some have termed “unrealistic optimism” among adolescents has been found to increase when events are judged to be “personally controllable” (Quadrel *et al.* 1993). It is evident from the stories of the participants that they consider most the choices about their health controllable, and that they take little notice of the chances of what is not controllable to express their SLE. In the case of Noluthando, as presented below, however, the traumatic experience with an event she had no control over, left her unable to predict her life expectancy. Nezile, on the other hand, regained some sense of control over life after breaking away from gang-related crime; whereas he was unable to estimate whether he would still be alive “by 2010” in our talks of 2006, this time he was able to express an SLE for himself without doubting. As an illustration of the impact of changing circumstances and feelings of control on SLE, the following section of this paper will describe these two case studies of a young woman who has very recently been involved in a traffic accident, and of a young men who last year still described himself as being involved in “bad stuff” and wanting to move away from gangsterism, but who this year told a very convinced story of how he had chosen to “move on with his life”.

## **Losing and regaining feelings of “invulnerability”**

It has been suggested that people would feel less invulnerable after having had experience with a certain traumatic event (Quadrel *et al.* 1993). Noluthando, a twenty year old woman, was the only respondent unable to reply clearly whether or not she expected to be alive even still at the age of thirty. Only weeks before the interview, she had been involved in a serious accident with a minibus taxi. She describes the experience as highly traumatising and explains she has had anxiety attacks since that time and “thinks about death” much more now than she had before:

‘I was in taxi travelling from Gugulethu to Cape Town and the taxi that I was travelling in had a tire burst, it was right in N2, you know when you curve... from De Vaal and you go straight down to Cape Town by the... what’s that hotel? (Alutha: City Lodge?) Garden Court.

(A: City Lodge?) Garden Court (A: Mhh) the one in N2, so you know when they curve, you know the speed is very high. So it had a tire burst, it was the back... so at that moment I really was in the changes, I was like 'God, this taxi is gonna roll now, I'm dying now'. So at that moment I think... then I started becoming very scared of death and as a result I've been getting anxiety attacks. It's like I'm, I'm... I'm taking everything seriously. I'm like you know, what if get into a taxi... ever since then, what if I get into a taxi and it's... you know the tire bursts and I die now. So something like that, that's why I say I don't know if... when, at age 30 I'll be still alive because there's so many things that are going on and it has affected me too much.'

However, when she later joins in the discussion about what one takes into account when estimating one's life expectancy, her rational is very similar to that of her peers, distinguishing as well between what she can control in her own lifestyle and what she cannot. It is Noluthando's awareness of the fact that there are those factors one cannot control has made her feel less "invulnerable" than the others and led her to express an uncertainty about the possible length of her life:

'I think firstly I would say I agree with what Wendy is saying, like if you have a choice that you want to make and you say 'this is how I wanna live my life' and you make a plan. (A: mhh) You say 'ok, sexually-wise, I'm going to use a condom' so you know that you're not gonna get these transmitted diseases, so that's safe on that side. But then there things that you cannot make a choice in, you cannot say 'I won't die'... 'I won't die of an... I won't die of a car accident' or something so there are things that are not controllable, that you cannot predict whether you will be alive by this age. You can maybe those choices, continuous-wise if you wanna live your life like, you're not gonna smoke to avoid heart-disease, you're not gonna drink to avoid...to avoid you know cancer or something. But then there are things that happen, that just happen like accidents: like you get robbed or...you know, things that you can't control.'

When I spoke to Nezile in 2006, his story had been one of high aspirations but no plans as to how to ever fulfil the dreams. He had been involved in gang-related crime and had been expelled from school several times; he finally dropped out in grade 10. Nezile expressed very high doubts about his future. He told me he was not sure if he would even make it to 2010 "*because I know one of these days something is gonna happen*". His sense of control in life seemed completely shattered, and he made reference to possibly having been bewitched

and therefore being unable to “stay out of trouble”. The only way he could picture things getting better for himself was “*to get away, to take my mother along and get away*”, but he had no idea on how to ever do that. One year later, during the focus groups, Nezile talks about how he decided after our talk last year that it was time to turn a page. His choice to move on was a very fragile one, not guided by knowledge and security, but by doubt on whether or not his life was going to get any better. Yet he decided to “*try something different and see what’s gonna happen*”. He talked about how difficult it was in the beginning when trying to move away from all the influences in “*the ghetto*”, but that he now makes a living of DJ-ing, an activity that takes him out of “*the location*” as much as possible, and thus away from possible trouble. Interestingly, today Nezile refers to other youth using witchcraft as an explanation for their involvement in gangsterism:

‘... going back to the gangsters, some of them say ‘no, it’s the lady that lives next door that has done this to me so I can’t go back, I can rob, that’s the only thing I can do.’

For himself, he now claims he does not believe in witchcraft and thinks it “*is all in the mind*”.

Nezile’s story is oppositional to that of Noluthando and shows that one can not only lose one’s belief in longevity of life, but also regain it. By regaining at least some degree of self-efficacy and agency in his life, Nezile’s insecurity today is no longer in longevity of life: he can now say he believes he will live until the age of 50, as he has removed himself from the most immediate threat of gangsterism in the township. Yet his story does still indicate a really great insecurity about “the future”: he is not able to picture a future for himself, but refers to the lost chances for the youth around him. His SLE is based on the wish to live long enough to see what will happen to those around him. When I ask him to tell me more about whether he sometimes think about growing older he replies:

‘I just want to be able to see... when I grow I just wanna be able to see what happened to those that didn’t listen to what I said and those who actually succeeded in life. I just... that’s the only thing I want. I just wanna see what’s gonna happen if I still live there e-Khayelitsha and see, when I’m old that this is progressing and that’s going away.’

Important about both these stories is the understanding that SLE is fluid in time, and that SLE as measured at one given point in time does not portray an individual’s full story. When trying to understand SLE, and when thinking about



the impact of illness and death thereon, one needs to also take into account all other contextual factors that can impact on such expectancy but that are often not captured through survey work. There are, moreover, also more individual ways of interpreting the SLE question that can create skewed results when analysing the data without being able to take such individual interpretations into account.

## **Individual differences in interpreting the SLE question**

When taking a close look at the various replies to the SLE scales, it is clear that there are, apart from the general noticeable belief in one's own invulnerability, also other, perhaps more individual differences in replying to the question. This is easily illustrated by M.'s interpretation of the question on "other" youth's subjective life expectancy. His rating of others SLE is one of the highest found in this sample. He clarifies as follows:

Siya: Ok I'll start. The reason why I would like them to live 'til the ages 30, 40 and 50 it's because I still have friends out there, if they die where am I gonna stay? So they must be there but I'm accepting you know, between the ages of 50, 60 because I've seen many people die at that age so it makes me not sure if ever they're gonna live until the ages of 60 and 70 and 80. *I would like them to live, like myself; I would like to live until that age* but I don't know, maybe what's gonna happen in the future.

The fact that he interprets "other youth" in this question as his "friends" leads him to wish them longer lives as well, which, again, should not be a surprise. "Social distance" is another factor found to influence optimism: greater differences in risk levels are expressed when asking adolescents to compare their own risk with that of peers in general than with that of a close friend (Quadrel *et al.* 1993).

Another individual difference, it seems, was found in Nezile's interpretation of the question. He was the only respondent to answer "no" to an SLE scale for himself. He believed that by the age of 60, he would probably have accomplished everything he had wanted to and "there was nothing more to live for". Again, however, this reply seems reflects an aspiration rather than a certainty, Nezile almost wishes not to "be around anymore":

- Nezile: I said no... ja I don't that I will be around.
- A: You said no; what makes you change from...what makes you say that at 60 you won't be around anymore?
- Nezile: *Well you see maybe there's nothing for me to live, at 60 I'll be...there's nothing that I will be seeing except that I'll be sitting at the old-aged home, just staring at the TV day and night. Sitting on a wheelchair and doing nothing, you see so I don't...I don't think that at 60, 70 and 80, I will be there but 30, 40 and 50, especially 40.*

## Conclusion

Findings of this in-depth study indicate that the assessment of risk factors to young adult's decision-making should always be conducted taking into account the context of their broader socio-economic environment. The understanding of death of the young people in this sample was based always within their complex living realities. All expressed the daily confrontation with premature deaths in their communities or families; deaths caused certainly not only by HIV and AIDS, but also – or, according to their testimonies, even more so – by crime and violence, poverty, accidents or witchcraft. Their stories reflected the findings of leading causes of premature death and victimisation in their areas of residence (Groenewald *et al* 2007). No one thought such confrontation to be “normal” but rather caused by a level of social and moral disorder within the townships. Many described the wish to escape such reality.

Different coping mechanisms to deal with the omnipresence of death were identified, with some taking the possibility of loss of a loved one into account almost daily, and others trying to keep their thoughts away from such possibility, maintaining a firm focus on the present. Apart from that, however, all maintained high aspirations for their future lives and in fact consciously looked for ways to act upon these aspirations: Nezile, a young man who had previously been involved in gang-related crime, had now decided to focus on his work that took him “out of the location” and thus away from trouble; Nobuzwe had over the last few years made several positive decisions about her education and was staying in a university residence to allow her to focus on her studies; Noxolo, who had dropped out of school in 2006, went back to repeat her grade and move on with her schooling; Siya, who had dropped out of tertiary education after losing his father, was back in school trying to pass his first year of Engineering at the Cape Town “Technicon”; Noluthando was well on her way to complete her final year in agricultural studies; Thando was in his matriculation year

preparing for the exams and had planned to leave straight afterwards to start the cultural initiation rites; Alutha, who had passed her matric but did not manage to get into a tertiary institution had looked for short-term courses that could help her prepare for the next round of application, etcetera. Clearly, the presence of death and of HIV and AIDS was not keeping these youth from *hoping* for a better life, and – more even more importantly - from *acting* upon such hope.

Furthermore, the young adults in the sample did not express a lowered subjective life expectancy for themselves because of the threat of HIV, or even of premature death as a consequence of the rampant violence and gang-related activities in their neighbourhood. Most constructed a concept of subjective life expectancy based on their belief in agency to make the right choices even in a context where many of the threats to life may seem uncontrollable. Although many of them admitted to some *momentary* instances of risk behaviour, by depicting themselves as those who would nevertheless still make the right *moral* choices, these young adults distanced themselves from the dominant peer culture that they described as being one of *general* involvement in risk behaviour. Maintaining a focus on the future (“it’s all about dreaming”) and finding ways to act upon that, becomes a self-corrective behaviour that keeps one “from doing something stupid” (Alutha, female group 2).

Respondents’ high SLE was thus based on the belief in their ability to control the outcomes of their lives. This belief does not, however, exclude the awareness of aspects that might not be controllable. Only, maintaining the belief in their agency, in their ability to take control of their lives, is these young people’s ‘survival strategy’. It is their way of not giving in to hopelessness and resignation in a context characterised by ‘chaos’ or fragility.

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