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CHAPTER 1

BACKGROUND TO THE STUDY THE STUDY

1 INTRODUCTION

Jomo*, one of the research participants, did not know who his mother was until he was six years old. His family were poor and he was left in the care of relatives. However, he was deeply unhappy.

Jomo: My mother was living somewhere, in fact she was a domestic worker, so for most of the time, she was not [living] with us. She was at work and my father, stayed with my mother. He didn't come [to see me] often and at that time he had not married my mother. I remember I didn't know my mother until one day she came there [where I was staying] and they said, "This is your mother here."

When I was a little boy, maybe about eight to ten years old, somewhere there, [my uncle] used to sjambok us [beat with a rubber rod]. Actually in those days a man would just come and whip boys. No one would want to know why he was whipping these boys, no! No one would want to know. There was this thing that "every child is my child" and every man could just go in the veld [fields] and find boys and just whip them. It was acceptable in those days in the rural communities, in the villages, definitely it was like that. Women could not interfere in such things, when boys were whipped. They could not, they could not. If they did that they would really fail the love of the husbands.

Jomo however stood up to the beatings the only way he could, by swearing at his uncle, the perpetrator**.**

Jomo: I felt that this person was not fair with us, and he was just imposing everything on us and because I was young, I could not fight. But if I had been strong enough, I would have fought him, so I just swore at him. It was never acceptable that a child should swear at the older person, an adult. That was not acceptable, no matter what the conditions were, it was not acceptable… I could not just submit to that situation, so the only thing I could do was to swear at him. Maybe if I could have had poison, I would have poisoned him, or something like that.

The whipping, was unfair, I had to deal with it… but another pain was the reaction of all the family members, who said "Jomo is not respectful, he doesn't respect adults, this is a disrespectful child," so I was labelled that way, I was treated that way. I wasn't happy, but I didn't really want to be like any other person. I was just unhappy about myself, but I wanted to be happy, just to be free like them in the family. But how could I be happy in that kind of situation? It was difficult actually. I could not fit.

*Not his real name

Jomo was sent to another branch of the family when he was around eight years old. However, he was regarded as a burden and the abuse continued.

Jomo: This uncle complained "this boy, we are feeding this boy here and his mother doesn't bring anything home. Why should we keep on keeping this boy here, feeding him? His father is… having nice time there, but we are feeding this boy here, we have to protect him.

He looked different, being taller and lighter skinned than his cousins. His sense of isolation was profound. He noted that there was no-one to help.

Jomo: There is no therapy for that. No one would ever consider that this child might be traumatised or, no, no, no. It is something that you have to deal with [researcher] – How did you deal with it? [Jomo] Actually, I didn't deal with it, I just left it and I think it went away; it didn't stay with me for long, only, memories… I'm glad that I fought back, that I didn't submit to that treatment. I fought back. Now I'm proud about it, but in that fighting, it was bad, but now I feel good that I fought back.

Jomo developed a keen sense of justice because of these experiences. He also longed to be a man, not because it would give him a sense of power over others, but because it represented freedom:

Jomo: I wanted to be a man one day, I wanted to be free – actually to be free – not to be like my uncle there and abuse other people, but freedom, to be understood, treated kindly with respect.

Finally Jomo was re-united with his parents, but the relationship was not good.

Jomo: [My father] wanted [his] way: "You can't do this, you should do this." He didn't give me any space where I could be myself… Most of my problem with him was that he wanted to be authoritative and that is what doesn't go well with me. Maybe I'm [so] stubborn that I cannot take instructions, but in most things, that is my conflict with other people, they are trying to be authoritative and in the process, I feel that this is unfair to me that they want me to be like this, to act like this, but I don't feel like being that way. So my father beat me sometimes. …He beat me several times. Yes, several times and in some instances, I think he was unreasonable. I don't think I was a person who should have been trained by being beat up, – no; I think I'm a person who can cooperate. Yes. Definitely. I want to cooperate with many people and though I wanted to cooperate with him, it was just difficult. I had to compromise my integrity, just to deal with him, so I could not take it.

Violence was commonplace in the township where he lived.

Jomo: There was a time when I felt that to be strong, to be able to fight, was a good thing, but this doesn't only come from what happened

within my family, but because of our community. In those days, there was lots of fighting still. Fighting was normal. There were streets which I could not go through. Those were no go streets, because boys in those other streets would not allow boys in other streets to pass through. Even if they met you at the shop, or somewhere in the veld [fields] or at the river, they would definitely beat you. So they were fighting, fighting, fighting…. I think this fighting, I might be wrong here, but I think that this fighting was not a way of trying to make other people to accept me, but I had that longing to be accepted. [Fighting] gave me some kind of respect among boys, yes, but definitely I needed to be accepted, that was the main thing.

Jomo remained lonely and isolated. He became an avid reader. This exposed him to a new world.

Jomo: I remember I developed a habit of reading a lot. I read novels and other books, but the problem was that [my parents] did not want me to read any [type of] book. The only books that they allowed me to read were the books that were prescribed for me at school, but nothing more. I wanted to have knowledge. I read in order to have knowledge and books were just interesting to me. I just loved reading – reading – reading… As I read newspapers, I came to know about the ANC and the Pan African Congress, about all those stories and then somehow I became politically conscious, then I liked politics.

The tide was rising against the Apartheid policies of the ruling Nationalist Party. The ANC (African National Congress) was still banned but other resistance movements such as the UDF (United Democratic Front) were gaining momentum. The resistance to the ruling Nationalist party became known as “the struggle.” The values of justice and non-discrimination resonated with Jomo’s ideals and he became a political activist, to the dismay of his family.

Jomo: I got into politics when I was in standard eight. I was very active in politics. I joined the UDF –At that time the ANC was banned, but there was the UDF So I got involved with this political group…

In those days, riots were just relevant – according to how we have perceived our struggle .We had this thing that we should make the country ungovernable. It was announced by the ANC in many ways that we should make the country ungovernable, so it was good for us that there should be riots everywhere – everywhere – everywhere. They were just conscientizing people about the situation there… It was, exciting… My life changed. I was connected to many people and we had a common goal. I thought I was doing something good and I had something that gave meaning to my life. I belonged somewhere, and I had something to do …I still see it that it was a good thing to do.

[My parents] were not pleased with me – my father used to tell me that "no, you are a disgrace to our family." Yes, he told me things like "no, in my time, I was never troublesome to my parents and there were never police men in our home or in our house, no there were never police men. These things come with you now; you are just a disgrace to the family."

Although his involvement in the struggle gave Jomo a sense of meaning and purpose eventually it deepened his isolation and alienation. These were dangerous times. However, Jomo's fears were drowned by his sense of purpose:

Jomo: We always had a fear of being – I don't know whether I should say, assassinated, because there were people who just disappeared and people who were killed. Later on, there was this agency, the security branch [of police]; those were people who were a threat to us. For instance, even when there was no chaos, no riots in the townships, they still hunted us in the township, they came to our families…I've met people who were being tortured, who were detained for a long time, released and detained within minutes – things like that – mm – so, there was fear, but there was no ways any thought of retreating could have crossed my mind. No, I was in it. There was no way that I could think twice about it. I was in it. I didn't want to quit… I was in it and somehow I was enjoying it. I think I thought it was right to be there and I really wanted to be there, but at the same time, there were those dangers of being kidnapped. We were always afraid that one might be kidnapped and be killed, or maybe be caned and tortured. We always thought about something… There was fear, but the hatred of the unjust system overrode all those fears. I think I was more determined to deal with that unjust system than with my fear. My fear was secondary, but to deal with apartheid and the whole unjust system, was a big thing to me, so everything else was secondary. I was prepared to die. … Our dream of freedom was paramount.

I remember one time, this security branch came to my home. Then I had to run away. It was in the night. I went to the home of one of my comrades. We used to call ourselves comrades. Unfortunately it seems they had been watching me, so they came to his home and then I had to run … When I got home I the morning, I found my father burning books that I was reading about the struggle, about liberation… I found him burning them and really angry with me, threatening me that he would move me out– you see – and it was so bad that I was running from one danger, but here someone again was fighting me – there was no support here – so it was so difficult. Then people around me, knowing that the security branch were looking for me, did not want to be around me, because they knew that once they were around me, they might be suspected of being part of my political activities. So people ran out of my life… Even some parents told their children, "avoid Jomo. The, police are going to kill him. Just avoid him."

Jomo was arrested and interrogated. After his release he felt hunted.
I wasn't sure that I was going to live long and I knew that there are lots of dangers awaiting me. I knew that anything could happen. I was vigilant, knowing that a car might come – in fact, with every car that passed me, I had to be sure – sure – sure that it wouldn't be dangerous to me, so I was so vigilant.

Jomo is aware of being deeply wounded by his experiences. An event took place that was too painful for Jomo to disclose to anyone. However, it had a profound impact on him as a person and he retired from politics.

Jomo: Before this, I had a feeling that I was not just going to be this ordinary Jomo, but I was going to be a certain great man. To me it was obvious that I was on that path. But after that, everything just collapsed…Maybe, I lost confidence in myself… psychologically, I was no longer that Jomo. I think I had some kind of psychological problems and for some few years, I could not really socialise the way I did before. It was bad... I was just hiding myself –I was avoiding people…– I had no focus, I didn't really know what I should I be, who and who I was, … Sometimes I didn't know exactly what was right, what was wrong. It was like I was really mad. I think any person in that situation should get some kind of professional attention.

Jomo did not find the help he needed.
Jomo: I didn't know there was [professional help] and even if I knew, I could not afford it. I didn't know I had to get that kind of help, I thought it was my whole issue. I've never talked to anyone about it. I don't know what it is like and what is going to happen after I've talked about it. So that I don't feel comfortable to talk about it. I can't bury it – it's with me – I don't know how I can just take it and bury it somewhere…It just that this killing me inside.

Disillusioned with politics and disappointed with himself, Jomo considered his options. He decided to find a profession and live a quiet secluded life. He considered philosophy, science and social work. He did not meet the entrance requirements for science and he realised that he could not earn a living from philosophy. He chose social work because he could support himself in the profession. He met the entrance requirements, which excluded maths and science. He also believed it was an occupation in which he could remain relatively hidden. He grew passionate about it. He registered in 1998. Ten years later he still does not have access to a career in social work. In spite of passing all the theory, Jomo has tried unsuccessfully to pass the practical component three times. He has difficulty implementing the skills

inherent in the person-centred approach [a theory used in social work]. He concluded:

Jomo: What was stopping me? I believe that I know what the person-centred approach is. I think I have the potential or capability of being a Social Worker. I think I could be a good Social Worker. But to pass at Unisa in the practical work – it's so difficult…Now in a way and I have this fear, because already I'm over 40 and I don't have a family...I can't say I have a girlfriend or someone I can marry and I know I want to have my own family – I want to have children and at my age, that tells me that no, you've failed in many respects. At 40 you are not married you have no family. Academically you have not achieved anything. I'm nowhere; so I've failed in may respects. I'm a failure.

This thesis is the story of Unisa social work students' trauma, the effect it had on them and on their work as social workers. Jomo's story is told to illustrate how traumatic experiences may hinder a person's progress. It also shows that people have the capacity to grow and persevere despite the obstacles presented to them.

2 MOTIVATION FOR THE STUDY

Concern about students like Jomo is what motivated this research. Unisa is an open distance learning (ODL) institution located in Pretoria, South Africa. It offers tertiary education to anyone wanting to study, provided the entrance requirements are met. Students may complete their studies on a part-time basis, making it possible to study whilst employed or meeting other responsibilities. This makes Unisa an attractive option for, amongst others, previously disadvantaged people. Unisa may be a more affordable option than residential universities. Unisa also makes tertiary education available to people with disabilities as well as those living in remote areas, who may not have access to residential universities. The focus is on career orientated learning opportunities, academic excellence and graduating individuals of sound character and versatile ability (Schenck 2008). One of the programmes offered by Unisa is a degree in Social Work. The theory underpinning this training is the person-centred approach first formulated by Carl Rogers. An essential feature of this approach is its faith that people have the ability to strive towards health, growth and adjustment (Van Dyk 2000:32). Rogers initially formulated his ideas as a way of conducting psychotherapy, but later

his propositions were extended to other contexts such as teaching (Rogers 1969), working with groups, families and communities (Grobler, Schenck & Du Toit 2003; Louw 2007).

Certain core conditions are considered fundamental to the person-centred approach. Firstly, an attitude which stresses the significance and worth of each person is central to it (Rogers 1951: 21). Secondly, emphasis is placed upon congruence or sincerity on the part of the helper. The third core condition is empathy. Empathy is the ability to understand and imaginatively enter into another person's feelings and perceptions and convey such understanding to the person (Grobler et al 2003: 152). The Department of Social Work at Unisa strives to implement the principles of the person-centred approach in the learning environment, as lecturers and supervisors interact with students.

Due to the person-centred, participatory nature of workshops and supervision sessions attended by social work students at Unisa, lecturers and supervisors frequently become aware of distressing events and circumstances in students' lives because students often use these opportunities to disclose their experiences. Some students write about things that have happened to them in written assignments. These experiences include poverty, abuse, exposure to crime, combat (in the army or as activists in the struggle against apartheid), domestic violence and loss of family members. Such stories alerted the Unisa lecturers and supervisors that Unisa social work students are being trained to deal with people in such circumstances, while many of the students are wrestling with such difficulties themselves (Schenck 2008). Like Jomo, many students struggle to obtain their qualifications and the throughput at Unisa is disappointingly low. Only 6% of students who register in first year actually complete their degrees (Schenck 2008). Schenck, one of the senior staff members at Unisa, expressed concern that many social work students are academically strong, but struggle with the practical component of the course, where interpersonal skills have to be implemented. In particular, supervisors note that many students seem unable to express empathy, a skill that is central to social

work. Other students seem overwhelmed by strong emotions when working with clients.There are also those who struggle academically.

The researcher and Schenck wondered if there is a connection between possible trauma in the students' history and emotional numbing, a well-established response to trauma. On the other hand, they thought students may be overwhelmed by trigger reactions in response to their personal trauma (Friedman 2006:10; Matsakis 1996:21-24; Naparstek 2006:82; 88). Many researchers state that unresolved personal issues may interfere with the student's ability to interact therapeutically with clients (Earle 2008:123; Clark 2006:84; Adams & Riggs 2008:31).

Black, Jeffreys &Hartley (1993:179) indicate that students with a history of trauma may struggle with residual anger, frustration, a need to "care take" or sense of personal failure as a result of past experiences. They state: "This constellation of characteristics may well interfere with the students' ability to learn and understand the nature of the helping process."

Black et al (1993:178) propose: "On the one hand, a background of personal distress may render a practitioner more insightful, sensitive and empathetic to the distress of others. Practitioners who have worked through their traumatic experiences may be in a position to more effectively reach out and engage clients. On the other hand, failure to resolve a problematic background may result in a "wounded healer" with counter transference biases that can be harmful to the therapeutic relationship and may prevent the therapist from attending appropriately to the needs of the client… Therefore it is essential for social work educators to investigate the extent of psychosocial trauma among social work students."

This implies that trauma is not necessarily an obstacle, but can be an opportunity for growth, if it has been worked through. Amir & Sol (1999:152) suggest that the effects of trauma are mediated by personal constructs and the meaning which an individual assigns to their experience.

Becoming a social worker in South Africa requires the completion of a four-year degree and registration with the South African Council for Social Service Professions (SACSSP). The SACSSP is responsible for ensuring ethical professional conduct and maintaining the standards of the profession, including setting criteria for training (Earle 2008:38).

The Unisa Department of Social Work has a responsibility to deliver a competent professional to society. If students are hindered in their ability to develop the required skills, it is important to investigate this so that interventions may be put in place if needed. Schenck had already conducted a small preliminary study during a workshop that suggested that many Unisa social work students had encountered multiple incidents of trauma but had not been able to find help in dealing with these experiences. Amir & Sol (1999:151) found that exposure to multiple incidents of trauma makes coping harder. Schenck suspected that many students had enrolled for social work *both* to become equipped to help others *and* as a way of dealing with their own unresolved issues.

Although the Unisa Department of Social Work strives to implement the principles of the person-centred approach, no opportunity had deliberately been created to hear students' stories. The extent of students' trauma was unknown. Little was known about what helps them to cope and what hinders them. It was not clear whether, like Jomo, other students felt that they are struggling with unresolved issues.

It has been noted that almost all the theory and research on trauma has been generated by European, American, Israeli and Australian researchers and professionals who share Western cultural traditions (Marsella, Friedman & Spain 1996c: 116). This implies that there is a risk of ethnocentricity in trauma research. Mokgalthe (2001:31) states "it would be simplistic to over generalise and accept that Western psychology is applicable to Africa in all its aspects". Predominant definitions of trauma used in research thus far may have limited value in populations that do not *necessarily* share the premises and concepts on which the research was based. However the way that

trauma is conceptualised by Unisa social work students was not known. It should be pointed out that students engaged in the future occupation of social work will encounter traumatised clients, but it was not known what they viewed as trauma. Therefore, understanding social work students' perceptions of trauma has widespread implications for social workers and their clients.

It is plausible to assume that South African social work students' experience of trauma is similar to that of others in the society in which they were raised. This has ramifications for the profession and client population – indeed for society as a whole. Therefore it was viewed as important to find out how students conceptualised trauma. It was considered necessary to find out whether the students are traumatised and if so, whether anything had been done to enable them to cope. Schenck was looking for a researcher who would explore the issue and make the Department of Social Work aware of whether students were exposed to trauma that was unresolved with a view to seeing if further research or interventions were called for. These questions gave direction to the study.

3 RATIONALE FOR THE STUDY

The rationale for the study was to conduct research in order to provide information to the Department of Social Work about trauma in the lives of students. South Africa is a multicultural society and, with students scattered throughout the country, this diversity is reflected in the student population. South African culture is unique and it was expected that the experiences of students parallels that of the society in which they were raised. Students would have access to knowledge about specific perceptions of what constitutes trauma and of ways of dealing with trauma that would be unknown in other parts of the world. Within the context of the culture of violence, poverty, HIV/AIDS and family break-up in this country, the study has widespread implications for the country as a whole. An understanding of how students are affected by a history of trauma would provide a basis for intervention for students and the public to prevent the deleterious effects of exposure to direct and vicarious trauma. The study could help to focus

attention on possible positive effects of trauma and improve the quality of support offered to traumatised people.

The study was exploratory in nature. It is hoped it will lead to further investigations and the design of relevant interventions to support and encourage students working with traumatised clients.

4 THE AIMS OF THE RESEARCH

The aims of the research were formulated as follows:

- To provide a context in which students' frame of reference regarding trauma could be explored, heard and respected.
- To gain increased knowledge about the nature and extent of students' traumatic experiences.
- To provide information about the perceived impact of students' trauma on the developing self as a social worker.
- To contribute to students' well being by making this knowledge available to the Department of Social Work for use in developing training and/or services that could promote students' well being and professional development, if needed.
- To transform the finding into a theoretically relevant description, exploring contradictions and commonalities with published research as noted in the literature survey.

The study was expected to produce a description of trauma, a picture of the effect of trauma and the coping strategies that are employed. However, a study such as this would not offer an explanation of the causes of trauma.

The researcher aimed to explore personal meanings as provided by the students themselves. This is in keeping with the person-centred approach where the client is best understood from his or her own frame of reference (Rogers 1951:494). The research was designed to respect students' own perspectives.

Based on these aims the research question was formulated as follows:

What are the experiences and effects of trauma in the lives of Unisa Social Work Students?

The guiding question was broken down as follows:

- How do Unisa students describe or conceptualise trauma?
- What experiences have students had that they regard as traumatic?
- How have students coped with these experiences?
- Are these traumatic experiences perceived to impact their work with clients?
- How do these experiences impact the self as a social worker?

5 THE THEORY

The person-centred approach of Carl Rogers was the theoretical perspective adopted for this study. The theory is discussed in detail in chapter 2. This theory was chosen because it is the perspective adopted by the Unisa Department of Social Work, so it was possible that students would relate their experiences in the language and terminology of the person-centred approach. It was believed that using the same theory would facilitate communication between the researcher and the Unisa Department of Social Work. It is also important to note that the research arose from concern about the needs, well-being and growth of the students. This may be considered indicative of the person-centred values underpinning the study.

The person-centred approach was described in the form of nineteen propositions (Rogers 1951). It focuses on a person's ability to grow and actualise the self. It is a view that sees people as unique and of value. It states that a person is best understood from his or her own frame of reference. The values of respect, individuality and self-determination are central to this approach.

6 DESIGN

The study comprised both a literature survey and a practical component. A literature search was conducted. Numerous data bases were searched

(Oasis, Unisa library online, psychINFO, Academic Search Primer, NEXUS database and BiblioLine). Because no existing literature on trauma in the lives of South African social work students could be found, the study was designed to be exploratory in nature. Traditionally a literature survey is undertaken to generate hypotheses (Neuman 2006:446). This is not consistent with the person-centred stance adopted in this study. Instead, the literature study was undertaken to sensitise the researcher to themes and to provide an alternative perspective to that of the research participants. The literature study was compared with emerging themes as the study progressed. The purpose was not to confirm or validate these themes, but to offer different perspectives on the topic. The purpose of the practical component was to give students an opportunity to express their ideas and tell their stories as well as developing a profile of the extent of the trauma to which they may have been exposed.

The researcher was working from a person-centred approach, with its emphasis on the centrality of a person's unique perceptions. This theory holds that a person is best understood from his or her own frame of reference (Rogers 1951: 494). Therefore existing definitions or ideas about trauma were not imposed upon participants. Instead, a context was provided in which participants could give their own description and examples of trauma, using both quantitative and qualitative methods.

The study was exploratory in nature and focused specifically on South African students. It was anticipated that the study would produce results that are relevant to this group, filling and important gap in the understanding of trauma. (No previous research on trauma amongst Unisa social work students could be found). However, results cannot be generalised to other groups. A detailed report is provided to enable others to assess the transferability of the findings of this study to other groups.

Quantitative methods were employed together with descriptive statistics to generate a profile of students in terms of demographics, the incidence of trauma and level of distress. Qualitative data yielded a rich description of the

meaning of trauma from the viewpoint of participants themselves. These views are offered as an extension or alternative to the literature survey. The effect of trauma, coping strategies, nature and usefulness of help received was also explored, using both quantitative and qualitative methods.

7 TIME FRAME OF THE RESEARCH

The study was implemented in two phases, a preliminary study in July 2006, and a follow-up study in January 2008.

8 SAMPLING AND SELECTION

A case-study approach was adopted in which students registered for the fourth level study in social work were participants. Convenience sampling was used and participation was voluntary.

9 DATA COLLECTION

Surveys and focus group interviews were used to gather research material. Surveys are useful in both exploratory and descriptive research (Bless & Higson-Smith: 1995: 43-44). The survey was presented as a self-administered questionnaire. The questionnaire also contained open-ended discovery-oriented questions to enable participants to reveal their perceptions. Focus group interviews facilitated the generation of a thick description of students' perceptions of trauma and its effects.

10 DATA ANALYSIS

Quantitative data was analysed with the aid of a statistician using SPSS for Windows. Descriptive statistics provided a profile of the participants. No inferential statistics were used. The qualitative data was analysed using an interpretive method known as hermeneutics. Hermeneutics focuses on discovering meaning using empathy and considering the meaning in context using distanciation (see chapter 11 for more details). Thus both the unique individual perspective and wholeness are taken into account. This fits with the person-centred approach with its emphasis on individuality (proposition 1 & 2) and wholeness (proposition 3), as discussed in Chapter 2. The researcher became immersed in the text and then identified themes.

Excerpts from the texts are used to illustrate these themes. Thereafter, a comparative analysis was undertaken to explore commonalities and discrepancies with existing research and to consider the implications of these themes.

11 MEANING OF TERMS

The following terms were used in this report:

- **"Trauma"** has been described as "violent encounters with nature, technology or humankind' (Goodman, Corcoran, Turner, Yuan &Green 1998:522). It has also been noted that, by definition, traumatic events evoke intense fear, helplessness or horror (APA 2000: 467-468). Although these descriptions predominate in the literature, this thesis will explore the description of trauma from the perspective of participants themselves.
- **UNISA** refers to University of South Africa.
- **Department of Social Work** refers to the Department of Social Work at Unisa.
- **Student or students** refers to a person who was registered for the course in casework (SCK 402-B) in Department of Social Work at the fourth level of study in either 2006 or 2008 when the research was conducted. These students were participants in the study.
- **Participants or respondents** are students who took part in the study in 2006 or 2008.
- **Self** refers to the perception a person has of himself or herself. It is the image one has of oneself. It is created through experiences as well as interaction with others (Rogers 1951: 497).
- **PCA** refers to person-centred approach.
- **PTSD** refers to posttraumatic stress disorder as described by the American Psychological Association.
- **APA** refers to the American Psychological Association.

12 FORMAT OF THESIS

Relevant theory will be discussed. The way that the theory was applied to the research appears in *italics*. Verbatim quotations from participants are shown

in **bold** type. All names have been changed to preserve the anonymity of the participants.

CHAPTER 1 introduces the study with an overview of the background to the study, aim and rationale. An overview of the design, methods and data analysis is presented.

CHAPTER 2 describes the person-centred approach as the conceptual framework for the study.

CHAPTER 3 discusses research paradigms and presents reasons for the use of a mixed paradigm. Hermeneutics and its coherence with PCA are discussed. In this method of analysis, the research phenomenon is considered in light of the broader cultural, historical, social and political context. These considerations guided the literature study, which follows the chapter.

CHAPTER 4 is a review of ethnocultural considerations in the study of trauma. It includes an overview of the African Worldview.

CHAPTER 5 discusses the biomedical view of trauma. The biomedical model is presented as a perspective on trauma that is founded on a Western worldview. The focus of this model is on the effect of trauma on an individual. These effects touch the person as a whole. Links between the biomedical model and the PCA are highlighted.

CHAPTER 6 considers trauma in society, vicarious trauma, secondary traumatic stress and burnout. The focus of this chapter is on how trauma affects those who are not direct victims, but who hear about or see trauma of others. The use of trauma as a means of coercive control is discussed. The effects of war on veterans and their children are described. These are relevant to the study in view of the history of South Africa, which recently experienced the struggle against apartheid and the bush war. The person-centred approach suggests that the self is formed in interaction with significant others so the influence of the wider context is considered crucial in understanding the context from which participants come.

CHAPTER 7 describes South Africa as the context in which most participants grew up. The context in which research participants are studying

is described. This description relates to the society in which most participants will practice social work.

CHAPTER 8 discusses the research process. It describes how the questionnaires were developed, how focus groups were conducted and how the data were analysed. Attention is also given to ensuring that the study was ethical.

CHAPTERS 9 & 10 present and discuss the results.

CHAPTER 11 comprises a review of the research. Limitations are acknowledged and recommendations are made in this chapter.

The value of the study will be presented in this chapter Issues surrounding reliability and validity are addressed.

APPENDIX An appendix containing the questionnaires used in the research, consent forms, as well as covering letters to the students and supervisors is available on request from the researcher (olivebranch@telkomsa.net).

13 SUMMARY

Unisa is a university that offers training in social work. It is an open distance learning institution that makes tertiary education available to a wide range of students. The person-centred approach is the theoretical foundation for training in social work at Unisa. Due to the interactive nature of workshops, students frequently disclose personal, distressing experiences to lecturers and supervisors. At other times, accounts of personal trauma are disclosed in written reports. There was a need to find out more about the nature and effect of trauma on the lives of these aspiring social workers. It is possible that such experiences may deepen and enhance a person’s compassion and empathy, or they may have deleterious effects on the helping relationship. The study was introduced in this chapter together with an overview of this report.

CHAPTER 2

THE PERSON-CENTRED APPROACH

1 INTRODUCTION

The Department of Social Work at Unisa uses the person-centred approach (referred to as the PCA) of Carl Rogers in the training of social work students. The researcher studied at Unisa and subsequently became involved in the training of social work students at the institution, so this model became part of her outlook on life and influenced her interactions with people in general, whether dealing with clients, family, friends, students or colleagues.
Staff at the Unisa Department of Social Work strive to implement the principles of the PCA in their relationships with their students. As mentioned in the previous chapter, many students disclose personal problems to the facilitators during the workshops or in written assignments that form part of the course. The researcher and her colleagues began to wonder how these experiences were being organised in relation to the students' self as social workers, which gave direction to this study.

To understand how the researcher approached and implemented the research, as well as how she came to her conclusions at the end of the study, the reader needs to understand the PCA as the theoretical framework from which she worked. This is the theoretical framework of the Unisa Department of Social Work as well as the students, so the researcher thought it may facilitate communication to stick to that framework. The theory underlying the PCA is discussed in this chapter.

2 BASIC PRINCIPLES OF THE PERSON-CENTRED APPROACH

The person-centred approach to people is a way of being in human interactions. An essential feature of this stance is its faith that people have the ability to strive towards health, growth and adjustment. This is based on the premise that people are trustworthy, capable of self-direction and are able to become effective and fully functioning (Van Dyk 2000:32). This is referred to

as self-actualisation. The person-centred approach is, therefore, a philosophy about people, in which the value of respect is central.

Carl Rogers (1902-1987) formulated the person-centred approach from his clinical experience as a psychotherapist, as well as from his own personal experience. Consequently, much of his writing refers to the facilitating role of the helper in relation to clients. For the sake of clarity, this discussion refers to the "client" and "facilitator" and focuses on the individual, but the person-centred approach extends beyond the realm of therapy and has found wide application in teaching (Rogers 1969), working with groups, families and communities (Grobler, Schenck and Du Toit 2003; Louw 2007).

Rogers' work is also considered to be a theory of personality development. Moore (1994: 377) states that Rogers occasionally expressed surprise at the idea he may have created a personality theory in the process of formulating his approach to therapy. Nevertheless, one chapter of his book, "*Client Centered Therapy",* is entitled *"A Theory of Personality and Behaviour"* (Rogers 1965: 481-533).

Rogers' theory is presented in a tentative manner as a series of propositions or assumptions. These propositions suggest a way of understanding oneself and others and, in turn, guide interactions with people from a person-centred stance (Rogers 1951: 481-533).

The person, referred to as the "organism" in Rogers' propositions, occupies a central position in his theory. The whole field or world of experience, including inner subjective experience, is referred to as "the phenomenal field." The approach emphasises the centrality of a person's subjective experience. It explores how a person experiences his or her internal and external world.
A person's perception of himself or herself is referred to as "the self- concept" or simply "the self". The self-concept is an individual's perception of who he or she is. The self represents the picture which one has of oneself and the value one attaches to oneself (Moore 1994: 377).

An important concept in the PCA is that experiences may be “symbolised” or “unsymbolised.” Experiences are made intelligible to ourselves and others by attaching symbols to them. Symbols are concepts, expressed in language, words, pictures, gestures and so forth. Concepts are conveyed by means of symbols. Symbols make it possible to share our experience with others, provided the conceptual meanings of the symbol, such as words, are shared. Attaching symbols to experiences makes them understandable to ourselves and also makes the experience available to us on a conscious level. Unsymbolised experiences are beyond conscious awareness. Regardless of whether experiences are symbolised or not, they are proposed to impact the self-concept. The person’s responses to his or her experiences reveal something about the self.

Faith in a person’s constructive potential and intrinsically goal-directed behaviour is fundamental to the person-centred approach (Moore 1994: 377). The basic thesis of Rogers’ theory of selfhood that appears in his book *“Client Centered Therapy”* is reviewed here (Rogers 1951: 481-533).
Rogers (1951) formulated his theory in the form of 19 propositions. The researcher has grouped these propositions into themes for the purpose of discussion. These themes are as follows:

Propositions relating to experiences, namely:

- Proposition 1 – unique experiences.
- Proposition 2 – unique perceptions.
- Proposition 3 – holistic response to experiences.

Propositions that relate to the self, namely:

- Proposition 8 – forming of the self.
- Proposition 9 – The self and others.
- Proposition 10 – Experience of values taken from others, or evolved from one’s own experiences.
- Proposition 4 – Preserving, enhancing and actualizing the self.
- Proposition 5 – The self and motivation for behaviour.

- Proposition 6 – Emotions as a clue to the significance of experience to the self.
- Proposition 11a – Experiences that fit the self that may be symbolised.
- Proposition 11b – Experiences that are irrelevant to the self may be ignored.
- Proposition 12 – Experiences that fit the self and their relationship to behaviour.
- Proposition 11c – Experiences that do not fit the self may be denied.
- Proposition 11d – Experiences that do not fit the self may be distorted.
- Proposition 13 – Unsymbolised experiences may motivate behaviour.
- Proposition 14 – Experiences that generate stress.
- Proposition 16 – Defending the self against threatening experiences.

Propositions relating to change in the self, namely:

- Proposition 17 – Creation of a facilitative climate.
- Proposition 7 – Understanding the person from the frame of reference of the client.
- Proposition 15 – The symbolisation of unsymbolised experiences.
- Proposition 18 – The outcome of change in respect to the self and others.
- Proposition 19 – The development of a new value system.

3 PROPOSITIONS RELATING TO EXPERIENCES

3.1 Proposition 1

Every individual exists in a continually changing world of experience of which he is the center (Rogers 1951: 483).

3.2 Proposition 2

The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality" (Rogers 1951: 484).

The person-centred approach is a phenomenological approach. These propositions suggest that a person's world of experience is made up of perceptions. These propositions imply that we do not respond to absolute reality, but to our *perceptions*. What is perceived depends on the vantage

point or perspective of the observer (Rogers 1951:485). When one's perceptions change one's reactions change as well (Rogers 1951:486). These propositions suggest that each person's experiential world is unique, personal and changing. These perceptions are available only to the person him or her self. No one else can know the vividness with which an experience is perceived by another. No one has access to the experiential world of another person, unless he or she shares it with them.

Some experiences are said to be symbolised. This means that they are available to conscious awareness. Others are unavailable to conscious awareness and are said to be unsymbolised. (Grobler et al 2003: 45).

3.3 Proposition 3
The organism reacts as an organized whole to this phenomenal field (Rogers 1951: 486).

People respond as a whole to experiences. All the dimensions of a person, - feelings, thoughts, values, needs, physical attributes and so on – form an organised whole, so change in one part of the self influences the whole self (Moore 1994: 379).

Relevance to the research

These propositions imply that each person is unique. Therefore it is not possible to generalise the findings from this study to another group. The world of each participant is changing and participants and the researcher may experience change as an effect of taking part in this study. The experiences of each person are both conscious and unconscious. The data were gathered from participants' conscious responses. They shared their perceptions and experiences as they perceived them at that moment.

There is a large body of literature concerning trauma. However, perceptions of the meaning of trauma in these studies may not coincide with that of participants because people's perceptions are unique. It will become apparent that much research in the field has been conducted overseas. The researcher

wondered if South African students' perceptions of the meaning of trauma differed from those gathered elsewhere. The researcher was also aware that each participant would experience trauma differently. Perceptions of what constitutes trauma in each person's unique life would be different for each person. The extent of trauma in the life of participants could vary widely. Whether an experience was perceived as traumatic or not would depend on the perceptions of the individual concerned.

4 PROPOSITIONS RELATING TO THE SELF

The self is a central concept in the PCA. Rogers describes the self and its development in terms of 4 propositions, namely, proposition 8, 9, 10 and 4. Motivation, behaviour and emotions are described in propositions 5, 6 and 12.

4.1 Proposition 8

A portion of the total perceptual field gradually becomes differentiated as the self (Rogers 1951: 497).

From infancy, as one interacts with the environment and with other people, one builds up perceptions about oneself, the environment and oneself in relation to others. Such concepts may be non-verbal and unsymbolised, but this does not exclude them from functioning as guiding principles. No person lives in isolation, but as we interact with others, perceptions of these interactions become part of our picture of who we are. Rogers (1951:498) refers to the self as "awareness of being, of functioning." As a person interacts with the world, part of the private, subjective world is recognised as "I" or "me." Rogers (1951: 497) suggests that whether or not an object or experience is regarded as part of the self depends largely on whether it is perceived to be within the control of the self. For example, a paralysed limb may be perceived as alien and disconnected from the self (Rogers 1951:497).

A great deal of research has focused on the self subsequent to Rogers' writing. Baumeister (1995 :52) defines the self as one's identity, composed of:

- An awareness of the body.
- Group membership.

- Interpersonal roles.
- Traits.
- A concept of one's personality.
- A structure of one's values and priorities.
- The active agent in making decisions.
- An active agent determining one's motivation.
- An idea of the possible or ideal person one could become.

Clearly the self is a complex entity. It embraces awareness of one's physical being. It embraces the idea of the type of person one is e.g. "I am friendly." It includes roles e.g. "I am Susan's father, Mary's husband, Marks employer and Martha's son". It incorporates group membership e.g. "I am a white South African." Cultural affiliations are part of the self. One's values are part of the self.

Baumeister (1995:53) indicates that the self does not only function as an entity that is aware, but it is also an active, decision-making entity. It also guides and motivates behaviour. This aspect of the self is discussed in propositions 12 and 13 of Rogers' (1951) theory. The self has a picture of the ideal self that is linked to one's values. It has an idea of what one could become, known as the possible self. These notions may be a powerful source of motivation. The self also has a picture of its own worth. Research indicated that the wider the discrepancy between the self as it is perceived to *actually be* and the *ideal* self, the lower self esteem. The smaller the discrepancy, the higher self esteem (Baron & Byrne 2000:174).

Relevance to the research

This proposition is significant for this research because each participant has a unique perception of self. Each comes from a different context with its own culture, each has unique significant relationships, and each has grown up in a different world with unique experiences, relationships and people.

4.2 Proposition 9

As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is

formed – an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me," together with values attached to these concepts (Rogers 1951: 498).

Although the self consists of a relatively stable pattern of integrated perceptions, it is flexible and changeable. Self perceptions emerge from the totality of a person's experiences and, since experiences change, the self-concept is open to modification and change. Perceptions that make up the self-concept are organised as a whole, so change in one part of the self-concept influences the whole self-image. The individual determines what his or her self-perceptions are (Grobler et al 2003: 10). Interaction with significant people in one's life influences self-perceptions. For example, if one experiences affection and affirmation from other important people in one's life, one tends to develop a picture of oneself as "lovable and acceptable." Roles in relation to others also influence our picture of ourselves. Whether or not one accepts these roles as part of the self depends on the meaning the individual assigns to the experience. For example, generally one sees oneself a parent in relation to a child, whether the child is one's own, adopted or a foster child. The "I" as a parent is defined in interaction with the child. This is not fixed. One may relate in a parental way to a grandchild or pet, or one may reject the role of parent, for example. It is the person's perception of who he or she is in relation to others that defines the self in this regard. Similarly, one is only a leader in relation to those who follow one. Leaders and followers define each other. In other words, our perception of self evolves in interaction with others (Grobler et al 2003: 13). Such perceptions are varied and include many facets, such as caretaker, nurturer, responsible one, disciplinarian, student, teacher and so forth.

Relevance to the research

The self emerges from our perceptions of our experiences. Seeing that each person's experience is unique, the impact of trauma will not necessarily be the same for everybody. Although the impact of trauma was explored, the researcher cannot state that all the participants would experience all these effects, or that trauma would affect each person in the same way. The

researcher could only identify themes and patterns in the data and present her perceptions of these.
Participants may have been subjected to trauma imposed by others. In this case the perpetrator would be a significant other in relation to the victim. Perceptions of this interaction may have implications for the way the person has come to view him or herself and others.

4.3 Proposition 10

The values attached to experiences, and the values which are a part of the self structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in a distorted fashion, as if they had been experienced directly
(Rogers 1951: 498)

Values and a sense of worth are attached to one's perception of self. The value one attaches to oneself, or any of one's experiences, may be shaped by one's own direct experience. For example, if a child wins a number of races at school, he or she may conclude "I am a good runner." Together with this conclusion, he is likely to feel good about himself. Other significant people may influence perceptions of one's worth. If one experiences, for example, affection and affirmation from other important people in one's life, one tends to develop a picture of oneself as "lovable and acceptable."

Rogers (1990:172-174) postulates that these values emerge initially from our direct experience. However, he believes that as humans grow from infancy to adulthood an internal rift develops that separates immediate awareness from deeper experiencing. He suggests each person has a need to be regarded positively by himself or herself and also to be regarded positively by others. He believed that as we grow up, our need to receive approval and love causes us to suppress those urges and experiences that are deemed unacceptable to the important people in our lives. Rogers (1990: 163) explains that as infants, the locus or evaluation is firmly embedded in us. As infants we live in our experience. We trust it. When a baby is hungry he neither questions his experience of hunger, nor doubts whether he should make an effort to get food. The tendency to preserve and enhance the self leads him to act in line

with his experience. He will do what is needed to satisfy his hunger. This is true of all our experiences in infancy. As we grow, significant people may say or imply, “if you feel that way I won’t love you.” So we are proposed to build up a self that is based in part on what we believe we *should* experience, not what we *do* experience.

Values attached to the self, one’s behaviour or other experiences may be taken over from others and internalised as part of the self, as if they had been experienced personally. When significant others impose standards or values on another, these imposed standards are known as “conditions of worth.” It is important to note that it is not the specific behaviour of the significant other that is crucial here, but the one’s perception of it. As we grow up we are prepared to assume the values of significant others as our own. These values are known as “introjected values.” We are proposed to introject the evaluations of others until we are largely unable to distinguish between our own internal values and evaluations and those we have assumed from others. Rogers (1951:498) suggests that values taken over from others are perceived in a distorted way, as if they had been experienced directly. To illustrate this point, suppose a boy hits his baby brother and experiences satisfaction, but his parents express disapproval. The accurate symbolisation of this scenario would be “I perceive my parents as experiencing this behaviour as unsatisfying to *them*.” The distorted symbolisation is “I perceive this behaviour as unsatisfying.” Thus the evaluation of significant others is taken over as if it is the boy’s own value. It is out of these dual sources – direct experience and the distorted symbolisation of experiences introjected from others – that the self- concept, or self evolves.

Rogers (1990: 171) suggests that the valuing system of the infant is flexible. He likes or dislikes food for example, depending on whether he is hungry or not. He values security, but leaves it for the sake of new experiences. His values depend on whether an experience tends to enhance and develop the self or not. In the infant, these values are based on experience, mainly a gut-level experience, not intellectual, conceived values. The locus of evaluation is in himself, not others (Rogers 1990: 172). Slowly the infant learns that what

“feels good” to him may be seen as “bad” in the eyes of others. It seems he takes the same attitude of others towards himself. He tries to behave in terms of the values of others. The criterion on which these values are set seems to be the degree to which they will earn love and acceptance (Rogers 1990: 173-175). There is often a discrepancy between his experience and introjected values. Such values tend to be held rigidly. The locus of control resides with others. Consequently the person feels shaky and easily threatened in his or her values (Rogers 1990: 176).

This does not imply that all our values and perceptions are taken over from others. The self and values attached to it can be formed from our own experience, independent of others. However, values assumed from others tend to be held rigidly and do not always match personal, inner, gut-level, experiences. Such values tend to create inner tension and are frequently unsymbolised. The discrepancy between one’s inner, gut-level, organised experience and values taken over from others is known as “incongruence.” Incongruence refers to the discrepancy between the actual experience of a person and the self-concept (Rogers 1990: 221).

Relevance to the research

Each participant has his or her own personal value system and has been exposed to the value system of the PCA. The researcher made an effort to apply person-centred values throughout the research process. The research was implemented during a workshop. The students had been part of the workshops since second level. Values of respect, self determination, and individuality seemed to be part of the group norms. The researcher believes that the norms within this person-centred climate gave participants freedom to express themselves without fear of rejection. Participants were able to talk about personal and cultural differences freely in the permissive climate of the workshop and the researcher was conscious of their respect for each other.

4.4 Proposition 4

The organism has one basic tendency and striving – to actualise, maintain, and enhance the experiencing organism (Rogers 1951: 487).

This proposition suggests that each person has the urge to maintain, express, actualise and develop the self as he or she experiences it (Grobler et al 2003: 4). The person-centred approach relies heavily upon this belief in the tendency of people towards self-enhancement and growth, which is a central tenet of the PCA. This approach emphasises the release of people's potential for self directed change and growth. Rogers (1967: 33) states: "If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and changes and personal development will occur." This statement captures the positive stance of the person-centred approach with its inherent trust in the person's innate potential.

Relevance to the research

Participants were given the option of participating in this study or not taking part. No – one was purposely persuaded or coerced into it. They did not all take part eventually, and some took part by filling in a questionnaire, but not taking part in the focus groups.This shows that self-determination was allowed and accepted.

The nature of trauma was defined by participants themselves. They shaped the questionnaire that was used in the study. They determined which experiences and examples should be included. The researcher chose to use the questionnaire they developed, rather than imposing an existing questionnaire with perceptions that other researchers had developed upon them.

The researcher exercised self determination by exploring areas that she considered crucial to the research and by posing questions in the focus group.

4.5 Proposition 12

Most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of self (Rogers 1951: 507).

This proposition suggests that behaviour is directed mostly by the self-concept and that a person behaves according to the image he or she has of him or herself.

Relevance to the research

Participants were free to disclose as much or as little information as they wished. All information was gathered on a conscious level with no deliberate attempt to explore unconscious experiences. The research relied heavily on participants' perceptions and memories of trauma and its effects. Participants were asked how their own traumas have affected the self and their interactions with others. These responses relate to effects of which the participant is consciously aware. This suggests that participants responded in terms of their personal symbolised story about trauma. Proposition 12 implies that a person will normally be able to accept behaviour or responses to trauma that are consistent with the self.

4.6 Proposition 5

Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived (Rogers 1951: 491).

In terms of this proposition, behaviour may be understood as a purposeful attempt to satisfy perceived needs. Behaviour, therefore, has a motive or purpose. This implies that the facilitator should aim to understand the person, not judge or evaluate him or her.

Relevance to the research

If a person took part in the study, he or she was motivated by a need, possibly a need to be heard. It will be seen that the response rate was high (92%-93%), suggesting that the research seemed relevant to the participants.

4.7 Proposition 6

Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism (Rogers 1951: 492).

Behaviour may be facilitated by emotion; for example, strong feelings of fear may facilitate an escape from danger. The intensity of emotion correlates to the importance that the person attaches to the experience in terms of the preservation, enhancement or enrichment of the self (Grobler et al 2003: 61).

Relevance to the research

The need of some participants to be heard seemed higher than others in that some were very vocal in the focus groups and others were not. Some participants gave long written responses, others did not. Some participants expressed themselves using strong emotional terms, such as "I harshly hate him," indicating the intensity of emotion that the person felt. Focus groups gave the researcher the opportunity to see and hear strong feelings that were expressed.

4.8 Proposition 11

As experiences occur in the life of the individual, they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self (Rogers 1951: 503).

In this proposition Rogers suggests that one deals with experiences by:

- Ignoring them.
- Symbolising and being aware of them.
- Suppressing or denying them so they remain outside conscious awareness.
- Distorting them, or allowing a distorted version of the experience into consciousness.

We use symbols to attach meaning to our experiences. Whether I see a picture of say a "car," speak the word or read it on a page, the meaning is the same. Symbolisation allows us to make sense of our experiences and convey meaning to others, to the extent that meanings are shared. Experiences that are symbolised are available to our conscious awareness. They are experiences that become part of our life story. They are experiences that we "understand."

Whether or not experiences are symbolised, ignored, denied or distorted is influenced by both the person's needs and self-concept. Experiences may be ignored because they are irrelevant to one's needs. At another time, such experiences may well be allowed into consciousness. Experiences may be symbolised if they are relevant to a person's needs or fit the self. For example, a traumatised person seeking help is likely to spot a trauma centre. Such a person may have passed the centre previously without paying attention to it when it was irrelevant to the person's needs and self.

Experiences that do not reinforce the self-concept may be ignored, whereas experiences that meet a need or reinforce the self-concept may be accepted into consciousness. (Moore 1994: 382).

If an experience is inconsistent with the self-concept, such an experience presents a contradiction to the self. Such experiences may be distorted to reduce the contradiction so that the self-structure does not change. Alternatively, the contradictory experience may be "tuned out." When experiences are threatening to the self, we may not allow ourselves to attach symbols to them. Rogers (1990: 412) suggests that when an experience is perceived as threatening to the symbolised self, it is temporarily rendered impotent by being distorted in awareness or denied to awareness (proposition 11 c and d). A large part of the helping process is enabling the client to acknowledge or own these experiences.

Relevance to this research

Participants were free to disclose as much or as little information as they wished. Participants were free to ignore or deny traumatic experiences if they wished. All information was gathered on a conscious level with no deliberate attempt to explore unconscious experiences.The research relied heavily on participants' perceptions and memories of trauma and its effects. However, the researcher was aware that reflecting on personal traumatic experiences could trigger past feelings and memories. She took care to explore the ethics of the study and to provide de- briefing if needed.

4.9 Proposition 13

Behavior may, in some instances, be brought about by organic experiences and needs which have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not "owned" by the individual (Rogers 1951: 509).

Unsymbolised needs and experiences may motivate behaviour, even though the person may not be consciously aware of those needs or experiences. The person may feel "I don't know what made me do that." The self is not experienced as being in control and the experience or behaviour is not regarded as part of the self. This may be expressed in statements such as "I was not myself," or "I had no control," or "I don't know why I do it. I don't want to, but it happens." In such cases Rogers suggests that the behaviour is based on experiences that have been denied symbolisation and therefore have not been brought into any consistent relationship with the self (Rogers 1951: 510).

For example, values taken over from others do not necessarily have a relation to the self. The person may express this as "I have lost myself. I am always trying to please others." The discrepancy between the world of experience and the self may be distressing. Similarly, unsymbolised thoughts, needs, emotions or other experiences that are at odds with the symbolised self may trigger inner conflict or tension. Facilitators may trigger stress if they introduce or impose change that is in conflict with the client's self-perception and values (Grobler et al 2003: 39).

When behaviour is triggered by an unconscious need, conscious control over the behaviour is hindered because one is unaware of the underlying need. Although one may consciously resolve not to repeat the behaviour, when the unconscious need resurfaces, the behaviour is likely to be repeated. As long as the underlying need remains unsymbolised it cannot be handled in a direct, less stressful way.

Relevance of proposition 11 c & d and proposition 13 to the research

Participants may be motivated to protect the self from threatening material. If a respondent for example says that they "were fine" after a horrific experience, or "it did not affect me at all," it may be a response born of a need to keep the self intact. This in no way implies that the person is lying – he or she may simply not be aware of the experience or the implications for the self. Respondents who find certain experiences too painful may not have wished to disclose the experience or its effects. It was important therefore to respect the person's right to withdraw at any time.

4.10 Proposition 14

Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension (Rogers 1951: 510).

Experiences that are denied symbolisation or that are symbolised in a distorted way are proposed to create stress. The person is not aware of the source of the tension because it relates to unsymbolised experiences.

Relevance to the research

Answering the questionnaire or participating in the study could trigger an awareness of unsymbolised experiences or effects of trauma that are inconsistent with the self. It was important to the researcher to ensure that follow-up therapy was available for any participants who may have been stressed by reflecting on trauma. (See Chapter 8, the research process).

4.11 Proposition 16.

Any experience which is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself (Rogers 1951: 515).

Experiences that are in conflict with the self, as the person perceives it, are considered as a threat. The person is likely to try to protect the self, that is, to

maintain the structure of the self. The person is likely to deny or distort the experience. This can reduce awareness of the discrepancy, but does not reduce the threat itself. The greater the number of discrepant experiences, the more intent the self-structure becomes on self-preservation.

Relevance to the research

*If the self is threatened, one is motivated to preserve the self. In this study it was essential that responses could **not** be linked to a particular person. It was important nothing about the research could be used against the them in any way. Participation or non-participation should in no way influence their marks. No disclosure would stigmatise the person by attaching a diagnosis, (such as post traumatic stress disorder) or label, (such as rape victim) to them. Rogers (1990:231) believes that attaching a diagnosis or label to a person reduces him or her to an object, rather than a person. In this study, all responses were anonymous and confidential. Anonymity means that no name appeared on the respondents' questionnaire. In the case of person-to-person contact in the focus groups, the researcher could link responses to particular people in her own mind, but undertook not to do so publicly. Seeing that participants were registered student social workers, they have a legal and ethical responsibility to maintain confidentiality. Students are exposed to sensitive information from clients on a regular basis so it was expected that confidentialitywhould not be violated be members of this group.*

Participation in the study was voluntary and had no bearing on students' marks or course requirements. Participants could decline answering any items that they wished to avoid.

5 PROPOSITIONS RELATING TO CHANGE

The person-centred approach focuses on facilitating change or growth in a person. Rogers described the process of change in some detail, as well as the conditions that bring change about. Although the aim of this research was not to bring about change in the participants, just being part of the process could trigger change in both the participants and the researcher. This may happen

because the self emerges from our experiences, including the experience of being part of the research.

Participants were social work students who were learning how to facilitate change using the PCA. According to the PCA, it is the quality of the relationship, rather than specific techniques that brings about change (Rogers 1967: 135). The focus is on growth in the client as a person, rather than the problem (Rogers 1990: 87). In his view, the relationship should be experienced as a person-to-person encounter (Rogers 1990: 409). For this reason, the self of the facilitator is a crucial part of the equation. According to the PCA, the facilitator needs to be sufficiently free of his or her own defences to establish such a relationship. The conditions for facilitation are described in propositions 7 and 17.

5.1 Proposition 7

The best vantage point for understanding behavior is from the internal frame of reference of the individual himself (Rogers 1951:494).

People respond to perceptions which are unique, individual and private, that is subjective experiences that are available to no one, except the person himself or herself. This implies that people can only be understood from their own internal frame of reference.

Relevance to the research

The emphasis in this research was on the perceptions and frame of reference of the participants themselves. It was an exploratory process and the researcher modified the course of the research as participants' frame of reference became clear to her. She worked from data itself and did not use pre-existing questionnaires or definitions of trauma because she believed that they may limit her openness to the students' frame of reference, or that she may distort the data to fit such pre-conceived ideas. The questionnaire for the research emerged from participants' frame of reference. The researcher's frame of reference has been disclosed in this report. The literature review presents an alternative frame of reference. Focus groups and the

questionnaires provided a context in which the participants' frame of reference could be disclosed. This report is presented as the researcher's perception of the participants' frame of reference. Another researcher may have structured and interpreted the data differently.

5.2 Proposition 17

Under certain conditions involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences (Rogers 1951: 517).

When the self is accepted, one has no need to fight for the preservation of the self (Grobler et al 2003: 72). In a person-centred relationship between the facilitator and the client , one gradually realises that one is accepted as one is. Experiences that have been denied can be symbolised and explored; no matter what it is that the client brings out into conscious form, the self is accepted by the facilitator. Experiences that are contradictory to the self can be explored and integrated. The self is accepted in every step of its exploration and each change is treated with the same unconditional positive regard. The client sets the pace. The client is allowed to become acquainted with facets of the self that may be threatening to the symbolised self. This implies that change is possible in the context of the relationship between the person and facilitator (Rogers 1951: 519). According to the PCA, it is the quality of the relationship that is more important in facilitating change than specific techniques (Rogers 1990: 67).

Rogers (1967: 35) believes that every person has a tendency to move towards growth and that this tendency is latent, if not evident. He believed that this potential is unleashed in the context of a relationship characterised by empathy, congruence and respect.

- **Empathy**

Empathy is a way of being. It enables the facilitator, as far as he or she is able, to assume the internal frame of reference of the other, to perceive the world as the other perceives it and to perceive the other person as he or she

views him or her self. Importantly, empathy entails communicating this understanding to the person (Grobler et al 2003: 152).

Empathy involves laying down perceptions from an external frame of reference and understanding the other person from his or her frame of reference (Grobler et al 2003: 68). Empathy is incompatible with judgment, criticism, approval, disapproval or stereotyping. It is a way of reaching an understanding of another person and conveying that understanding in a manner that is accepting and non-threatening. Empathetic understanding is experienced in a tentative manner because one can never enter another's private world completely, but the facilitator does so as far as he or she is able.

Empathy means that the facilitator is able to understand what it is like to be the other person. It is the ability to understand the client's feelings and experiences. It is the ability to feel what the client feels or experiences and to communicate that understanding to the client (Rogers 1967: 34).

When the facilitator is sensing the feelings and personal meanings which the client is experiencing, when he or she can perceive them from "inside" as they seem to the client and communicate that understanding, the condition of empathy is fulfilled. It is only when the facilitator can communicate how things seem to be to the client that empathy is experienced. The helper can experience the client's world without losing his or her separateness in the empathic process.

Empathy suggests that the facilitator is at home in the private world of the client so much so that he or she can clarify meanings of which the client is aware as well as those that are just below the surface of awareness (Rogers 1990: 136).

Empathy involves sensing a client's fear, anger, or confusion, or other experience, without getting bound up in it. The client's experience is sensed by the helper, without confusing the helper's own experiences with those of the client.

- **Congruence**

Congruence is the state of realness or genuineness that emerges when one has explored the experience of one's own self and has accepted the truths that have been discovered in the process (Van Dyk 2000 a: 34). Congruence is shown in genuineness or sincerity. A congruent person is at home with him or herself and can be authentic in interactions with others. It means being at home with one's own feelings and experiences (Rogers 1967: 33). The opposite, "incongruence," is pretence, hypocrisy, or "wearing a mask" in relating to others. Congruence is being real (Rogers 1967: 33). Therefore, congruence requires self-awareness and self-acceptance. Congruence is the foundation of trustworthiness. Van Dyk (2000a: 35) explains that congruence does not necessarily mean that one always speaks one's mind or expresses one's feelings, but that, when one does so, it is in a spirit of realness or genuineness. Rogers (1967: 33) concluded that the more genuine or congruent a facilitator is, the more helpful the relationship. Rogers (1990: 409) describes the optimal relationship between a facilitator and client. This quotation describes the stance of the facilitator:

"It would mean that the therapist has been able to enter an intensely personal and subjective relationship with the client – relating not as a scientist to an object of study, not as a physician expecting to diagnose and cure but as a person to person. It would mean that the therapist feels this client to be a person of unconditional self-worth: of value, no matter what his condition, his behavior or his feelings. It would mean that the therapist is genuine, not hiding behind a defensive façade but meeting the client with the feelings which organically he is experiencing. It would mean that the therapist is able to let himself go in understanding this client, that no inner barriers keep him from sensing what it feels like to be the client at each moment of the relationship and that he can convey something of his empathetic understanding to the client. It means that the therapist has been comfortable in entering this relationship fully, without knowing cognitively where it will lead, satisfied with providing a climate which will permit the client the utmost freedom to become himself."

Rogers (1967: 51) suggests that it is unhelpful to the client when the facilitator fails, because of his or her defensiveness, to hear what is going on in him or her self. One cannot be congruent if certain inner experiences are denied to awareness.

- **Unconditional positive regard**

Unconditional positive regard refers to prizing the other person. It entails accepting all a person's experiences in such a way that no experience can be viewed as less worthy of acceptance than another. When unconditional positive is practiced, one extends understanding to another, whether or not one approves of the other person's behaviour, ideas, feelings or any other experiences. This does not mean that the facilitator becomes incongruent or gives up his or her own values, but that the facilitator's values are not imposed on the other person. The facilitator suspends his or her own values temporarily, in order to understand those of the other. Unconditional positive regard entails acceptance and an effort to understand and value or prize the other person (Van Dyk 2000a: 36).

Rogers (1967: 41) is convinced that the attitude or values of the helper make a relationship growth-promoting or growth-inhibiting. The PCA is known for its non-directiveness. This conveys respect to the client. Being trusted, being free to make choices and being understood by the helper were found to be the major elements that make the interaction helpful (Rogers 1967: 43).

Rogers (1967: 54) asserts that when the facilitator's acceptance of a client is conditional, the client cannot change and grow. He believes that a positive evaluation is as threatening to a client as a negative one. The facilitator should permit the client to reach the point where the locus of evaluation is within him or her (Rogers 1967: 551). To enable the client to grow and discover his or her own solutions, the facilitator adopts a non-directive approach.

Rogers (1951: 21) believes a helper can be non-directive only to the extent that he or she has respect for the other person. The facilitator refrains from giving advice or imposing his or her ideas on the client. Decisions about the direction of the interview, the topic discussed and solutions to problems rest with the client. The facilitator maintains a stance that the client has inner resources to grow and deal with life, so the responsibility is left with the client. This does not mean that the facilitator is passive or that he or she adopts a

laissez faire policy (Rogers 1951: 27). On the contrary, the helper is actively involved in creating a relationship.

The facilitator does not attempt to analyse or diagnose and label the client. Rogers (Rogers 1990:231) believes that these activities are unnecessary, reduce the person to an object and hinder the person-to-person encounter that is the hallmark of a person-centred approach.

Relevance to the research

The research took place in the context of a workshop at Unisa. From first to fourth level, these workshops have been structured by the Department of Social Work with the ideal of implementing congruence, empathy and respect as group norms. Participants were encouraged, throughout their training to adopt an empathetic and respectful stance towards each other. Participants seemed to implement this stance quite spontaneously in the study.

At the same time the researcher made an effort to create a safe, facilitative climate by listening to the participants in an empathetic way, treating them with respect and being genuine in her approach. Participants who had experience of trauma were respected as experts in understanding what it means to be traumatised. The researcher adopted the role of a learner in the research context and tried to convey, by listening empathetically, that participants were accepted and respected as people who had something of importance to convey to her and to the world at large.

The hermeneutic method chosen for this research involves adopting an empathetic stance towards the research participants and striving to understand what it is like to be that person. This was viewed as coherent with the person-centred approach. At the same time, it takes the context and theory into account, which is coherent with proposition 3 concerning wholeness.

In keeping with the principle of congruence, the research involved no deception. Participants were fully informed of the purpose of the research. The right to participate or not was emphasised, as well as the right to withdraw. The participants were aware of the researcher's background and role in the department. In this report, the researcher has disclosed her orientation and background, as well as her own perceptions of the process and how it affected her. It is hoped that the reader will glean not only a picture of the participants, but also of the researcher as a person.

6 HOW CHANGE MANIFESTS ACCORDING TO THE PERSON-CENTRED APPROACH

The goal of change is described in proposition 15:

6.1 Proposition 15

Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self (Rogers 1951: 513).

When experiences are symbolised they are available to consciousness. This does not imply that they are in one's consciousness all the time, but they can be called into awareness. When unsymbolised experiences are symbolised and are integrated in relation to the self, tension drops. Experiences that are perceived negatively or positively are integrated with the self. When behaviour is no longer motivated by experiences that are not symbolised (and therefore beyond conscious awareness), it is possible to express and respond to these experiences in a controlled way. Ironically the PCA suggests that behaviour tends to become less guarded, more spontaneous and that the drive to actualise the self can be released (Rogers 1951: 514-515). When experiences that were unsymbolised or given distorted symbolisation are allowed symbolisation, various possibilities are created. On the one hand, the self may be restructured to be congruent with the experiences. On the other hand, behaviour may change to fit with the self. To illustrate, Baron and Byrne (2000:174) note that the greater the discrepancy between the "actual" self and

the “ideal self,” the lower one’s self esteem. The discrepancy may be reduced in a number of ways: One may become more like the ideal self by changing one’s behaviour to reduce the discrepancy. Secondly one may perceive the self as more like the ideal, thereby changing the self. Alternatively, one may reduce the standards of the ideal self to be closer to the actual self. This also involves a change in the self.

Rogers (1967: 103) proposes that one often acts in terms of the expectations of others. One may act in ways that are consistent with expectations of others or so as to contradict them, but one is still influenced by expectations from outside oneself. He believes that one of the outcomes of the person-centred approach is that one begins to act in terms of one’s own inner experience.

6.2 Proposition 18

When the individual perceives and accepts into one consistent and integrated system all his sensory and visceral experiences, then he is necessarily more understanding of others and is more accepting of others as separate individuals (Rogers 1951: 520).

When one has integrated one’s experiences into a total self-concept, there is no need to defend oneself against perceived threats to the self, so there is no need to attack. In contrast, when discrepancies are part of one’s world, words, behaviours, and values in others may represent or resemble threatening experiences and in turn trigger defence of self. When a person’s experiences are symbolised and integrated in relation to the self it is as if the person has a sense that “I am myself and I am different from others and that is okay.”

6.3 Proposition 19

As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system-based so largely upon introjections which have been distortedly symbolized-with a continuing organismic valuing process (Rogers 1951: 522).

As a person comes to perceive and symbolise his or her experiences, his or her value system may form part of this field of exploration. Values taken over from others are symbolised and may be discarded and replaced by his or her

own norms and values. The person may *choose* to retain some values, but then they are his or her values, not introjected values because they have been freely chosen. The individual decides for him or herself what is important. One becomes less dependent on others and becomes more and more reliant on one's own judgement, trusting one's own experiences. One comes to trust the valuing process rather than a system of values (Rogers 1951: 523). Such a value system is unique and personal and serves the maintenance, growth and development of the self.

Rogers' faith in people is evident in his description of optimal personality development. He believed that the wider the range of experiences that can be allowed into consciousness and organised in relation to the self, the better one will know oneself and be able to use one's abilities, talents, make constructive choices and release one's potential. He referred to this as becoming "fully functioning" (Moore 1994: 387). He also called it "the good life" or "becoming the self one truly is" (Rogers 1967: 115). Based on his clinical observations, Rogers (1967: 115; 1990: 241-243) believes a fully functioning person displays the following characteristics:

- **A growing openness to experience**

One can be open to experience, both internal and external because one has moved away from defensiveness and is willing to embrace experiences that were previously perceived as threatening. Distorted and denied experiences are symbolised and are integrated. Defences are dropped. Rogers (1967: 64) believes that the person moves away from fixity and rigidity. He points out that becoming oneself is not a fixed goal. It is a continuing way of life and one is willing to be "a process." By this he means open to constant growth and change (Rogers 1967: 181). The good life is a process, not a state, a direction, not a destination and it is selected by the person when there is freedom to move in any direction (Rogers 1967: 186). He expresses the fluidity that is present by saying the self emerges from experience, rather than experience being twisted to fit a pre-conceived self (Rogers 1967: 188).

- **An increasing existential lifestyle**

Rogers (1967: 115) believes that, as defences are dropped, one is more open to one's own immediate "gut-level" experiences, rather than experiencing the introjected values, feelings and perceptions of others (see proposition 10). Such a person is more openly aware of his or her own feelings, as well as reality outside him or herself. Stereotyping tends to be reduced (Rogers 1967: 189). He believes the person is able to live with more vivid experiences whether pain or joy, anger or love, and so forth (Rogers 1967: 195).

- **Increasing trust in self**

Rogers (1967: 167) suggests that a person who emerges from a person-centred relationship shows a tendency to move away from facades and defences. The person no longer strives to be what others expect him or her to be. The self is regarded as the best reliable guide to satisfying behaviour. Such a person can choose not to rely on existing norms, codes or the prescriptions of others. He or she develops his or her own value system (Rogers 1967: 65). The person begins to trust him or herself and is more open to all experiences. Therefore, he or she has more "data" available for making choices. Because of openness to changing experience, if things turn out to be unsatisfying, the person will readily perceive this and take corrective action. The person increasingly accepts that the locus of evaluation is within him or herself (Rogers 1967: 119).

- **Freedom of choice**

The fully functioning person, as described by Rogers (1967: 177) is able to choose and take responsibility for his or her choices.

- **Creativity**

The person who is open to a wide spectrum of experiences and who is able to live flexibly and spontaneously within these experiences, is able to live in a creative, non-conformist way.

- **Basic reliability, trustworthiness and constructiveness**

The PCA is built on basic trust in people (Rogers 1990: 136). It places high value on the right of every person to be an individual (Rogers 1990: 87). Rogers (1967: 177) was often confronted with people who expressed the fear that a person who becomes what he or she truly is would turn out to be evil.

He assents that nothing can be further from the truth. He states that in his experience, when a person can experience feelings fully, including hostile, sexual or lazy feelings, they take their place in the total harmony of feelings and hostile, aggressive or other feelings, in his experience, are balanced as they mingle with other emotions such as tenderness, zeal, or joy and so forth. Various tendencies and urges have harmony within the person. Rogers (1967: 177-178) is convinced that a person who is open to his or her own experiences, including his or her experience of the environment and society, can be trusted to admit and accept all his or her needs and maintain a balance between them. He believes that symbolising one's experiences enhances one's self-control and enables a person to work out the most constructive way of living in harmony with oneself and others.

A rich full life

Rogers (1967:188) maintains that the life of a fully functioning person is rich and full. He suggests that the person is able to embrace all of his or her emotions, whether joyous, painful, frightening and so forth in their full intensity. He believes such a life involves stretching and growing. A fully functioning person is said to be willing to embrace challenge and change. More and more of one's potential is proposed to be actualised. "It means launching oneself fully into the stream of life" (Moore 1994: 388-389).

Relevance to the research

No effort was made in this study to help participants to integrate their own trauma. Nevertheless, the researcher did explore what experiences participants had gone through and what participants had done to deal with these experiences and whether they sought help. If help was sought, was it useful? The researcher kept the growth-orientated perspective of the PCA in mind and explored whether participants had grown in response to their encounter with trauma.

7 CHAPTER SUMMARY

Social work students at Unisa are trained in the person-centred approach. This approach relies heavily on people's capacity for self-directed change.

Such change is possible in a climate of respect, congruence and empathy, where there is no threat to the self of the person.

The theory was formulated by Carl Rogers in the form of nineteen propositions. It is a phenomenological approach in which a person's subjective experiences, including the subjective experience of him or herself plays a central role. Experiences may be symbolised or unsymbolised. The process of change entails the symbolisation of previously unsymbolised experiences and the integration of such experiences in relation to the self. The outcome of change is growth towards a rich, full life, in which the person becomes increasingly congruent and open to experience.
This research was informed by the person-centred approach. The person-centred approach is lived out by putting respect, congruence and empathy into practice as an intrinsic part of the research relationship. The implications of each proposition with respect to this study were reviewed in this chapter.
It is suggested that people who have experienced the process of person-centred facilitation may become "fully functioning people." Such people are said to be open to experience, flexible, creative, self-reliant and responsible and are able to embrace growth and change. It is proposed that they are able to actualise their potential and "launch themselves into the stream of life" (Moore 1994: 389).

The person–centred approach has been applied in a wide range of contexts. Rogers' principles have been applied in educational settings (Rogers 1990:304-323). The approach is used in the training of social work students at Unisa and the principles of the PCA were integrated in this research study.

CHAPTER 3

RESEARCH PARADIGMS

"Science exists only in people"
(Rogers 1955: 274).

1 INTRODUCTION

This chapter explains how assumptions influence research and why a particular approach has been adopted in this research. It will become apparent that the approach chosen for this research, in turn, influenced the choice of topics in the literature review.

Research is about producing knowledge. It is possible to produce multiple accounts of reality, depending on one's frame of reference and the background assumptions on which the research is built. Rogers (1955: 275-277) points out that the claims of the so-called scientific method only hold up among people who subjectively agree on the ground rules on which these claims of "truth" and "knowledge" rest. In social science the background assumptions that make a research account believable are referred to as "paradigms". A paradigm is an all-encompassing system of thinking and practice that defines the nature of enquiry along three dimensions. These dimensions are ontology, epistemology and methodology.

- Ontology specifies the nature of reality.
- Epistemology specifies the nature of the relationship between the researcher and the object of enquiry.
- Methodology specifies the practical means by which the researcher may go about studying the topic of interest (Terre Blanche & Durrheim 2006:6).

"A paradigm is a generally accepted view of the nature of the scientific discipline; the paradigm defines the discipline in question and sets limits on enquiry"

(Castillo 1997:12). Researchers and practitioners working from a particular paradigm generally assume that the paradigm is an accurate description of how they perceive their field. The assumptions and premises on which the paradigm is based tend to go unquestioned (Castillo 1998:12). The paradigm provides a foundation of knowledge, the limits of knowledge and defines what problems are relevant, what methods can be used and what solutions are fitting and acceptable (Castillo 1997:12).

A person is prepared for admittance to a community such as the scientific community by formal study of a paradigm. During this process, the person learns how to apply the rules of a paradigm and operate within its boundaries as well as what constitutes deviance. Knowledge is structured within a paradigm by models, theories and hypotheses. Models are general theories that explain a large part of the field within a scientific discipline (Castillo 1997:13). Theories are more specific explanations for particular unanswered questions. Hypotheses are testable propositions to explain a particular problem. Within a paradigm, models, theories and hypotheses must be logically consistent with the paradigm. Therefore a paradigm determines the nature of the questions asked, how questions will be tested and answered and what constitutes a valid answer (Castillo 1997:13).

If it could be demonstrated that one ontological/epistemological/methodological system was superior to others, there would be no disagreement about how to practice science. However, the rules of science are human constructions (Guba & Lincoln 1990:132-133). Controversies abound about how scientific research should be conducted. Research may generate and analyse quantitative and/or qualitative data. These types of studies are based on different paradigms. Both quantitative and qualitative methods were used in this research. Quantitative and qualitative research will be compared briefly to elucidate the rationale for the use of mixed methods in this study.

2 QUANTITATIVE RESEARCH

From an ontological perspective, quantitative and qualitative research methods are based on different assumptions about the nature of reality. They also have different research goals. Broadly speaking, quantitative research is based on a positivist philosophy. In positivism, the assumption is made that the social world has a real existence “out there” that can be discovered. Positivists assume that social reality is patterned and exhibits regularity that can be observed, measured and replicated. Hypotheses are stated in advance and subjected to testing under controlled conditions where efforts are made to control influences from the environment and context to avoid biasing or confounding the results. This philosophy assumes that it is possible to adopt a detached, objective stance from which social reality can be observed. Reality is assumed to be unaffected by the scientists’ act of observation. When results are reported, care is taken to convince the reader that the researcher was objective, detached and unbiased (Guba & Lincoln 1990:135).

Positivists assume that knowledge about people can be accumulated by observing what is seen or measured. The belief is held that reality is stable and unchanging and there is one universal truth. This view of science holds that incorrect theories are rejected over time, leaving more and more correct theories, which draw closer to the truth. The methods adopted by positivism generally produce numerical data that can be analysed statistically. This type of research method is referred to as “quantitative research.”

Several objections have been raised against the positivist approach to research. The claim of objectivity has been questioned. Rogers (1955:275) points out that all decisions regarding research are made subjectively by the scientist. He challenges the notion that any research is objective in the sense that any researcher can be detached. He points out that research itself is carried out by persons, who hold a set of assumptions and make subjective decisions, based on their own interests, beliefs and values. Atkinson and Heath (1987:12) argue

that the rhetoric used in research may obscure the “perspectival” nature of knowledge. “Research is generally seen as one method used by scientists to persuade one another regarding the legitimacy of their theoretical conclusions” (Atkinson and Heath, 1987: 12). Typically, scientific writing from a positivist perspective avoids emotion or ornamentation to convince the reader of the writer’s disengagement from the analysis. In a typical quantitative research report, language describing the design and instrumentation persuade the consumer of research of the validity of the writer’s claims by showing how bias and error are eliminated in the study. A common objection to the claims of positivism is that a positivistic stance disguises the influence of the observer’s perspective on the nature of the knowledge produced (Terre Blanche & Durrheim 2006:6).

According to Becvar and Becvar (1996: 312-313), researchers in the field of psychology initially adopted the philosophy and methods of the natural sciences in an effort to gain credibility as a scientific discipline. These methods are quantitative in nature and are based on the philosophy of positivism. According to Neuman (2000:347), this approach to science held sway from the end of World War two until the 1970’s. During this period, Carl Rogers, founder of the person centred approach was conducting research. Rennie (2007:5) states that he worked within a positivist framework. It seems Rogers became increasingly disillusioned with a positivist approach to people. He challenged several notions of the dominant paradigm of his day (Rogers 1955:267-278). He was not alone. According to Neuman (2000:347), during the 1970’s and 1980’s field researchers began to reflect on the philosophical assumptions and epistemological roots of social science and to develop paradigms that were coherent with the subject matter of their research. Kelly (2006a: 346) calls this “the interpretive turn” in social science, which refers to a turn towards “contextual” research that is less concerned with discovering universal law-like patterns of human behaviour and is more concerned with making sense of human beings from within the context and perspective of human experience.

Despite the dominance of positivism at the time, Rogers published an article entitled “persons or science?” in 1955, in which he reflected on the limits of positivism. He states: “It should be clear that, no matter how profound our scientific investigation, we could never by means of it discover any absolute truth but could only describe relationships which had an increasingly high probability of occurrence. Nor could we discover any underlying reality in regard to persons interpersonal relationships or the universe” (Rogers 1955:269). With respect to the study of persons or the interactions between client and therapist, he concluded that positivism is inadequate. He suggested positivism is one way of knowing, but not the only way (Rogers 1985:13). This view has gained wide acceptance today as, qualitative paradigms have achieved increasing credibility (Neuman 2000:347; Rubin & Babbie 1997:27). The person-centred approach is the theory underlying the study and many of the concerns raised by Carl Rogers (1955:267-278) have been echoed by the researcher as the study was designed.

3 QUALITATIVE PARADIGMS

Several researchers argue that the subject matter in social science is fundamentally different to that of the natural sciences, focusing as it does on persons. Rogers (1985:10) states: “We must see the person from within and recognise that this is a person with a choice and a will”. Whereas the physical sciences deal with inanimate objects, social science focuses on the products of the human mind with its inherent selectivity, emotions and values, in short, the person’s subjective world. From an ontological point of view, this reality is not objective, but consists of the internal world of the subjective experience. In response to the assumption that reality is subjective, an alternative paradigm, the interpretive approach has been adopted by many social scientists.

The interpretive paradigm rests on the assumption that reality consists of subjective experience that can be understood as meaning is negotiated. Rogers (1985: 16) states: “It is obvious that an important aspect of life, the meaningfulness of experience cannot possibly be studied by conventional

empirical methods. The approach must be from within." An interpretive view requires the researcher to adopt an empathetic, interactional stance, using empathy or participant observation as a means of enquiry (Neuman 2000:71). Data acquired in this way is usually linguistic in nature. Research in this tradition is, therefore qualitative. There are several varieties of interpretive research, including hermeneutics, constructionism, ethnomethodology and phenomenology among others (Neuman 200:71).

The goal of the interpretive approach is to develop an understanding of social life and discover how people construct meaning (Neuman 2000:71). The researcher aims to see things through the eyes of the research participants. The researcher him or herself is the primary "measuring instrument" in the interpretive research approach (Krefting 1991:220). Terre Blanche, Kelly and Durrheim (2006b: 277) state, with respect to an interpretive analysis, "subjectivity is not regarded as the enemy of truth, but the very thing that makes it possible for us to understand personal and social realities empathetically". When the research report is written, an effort is made to show how the researcher used his or her (subjective) capacity for empathy. Several methods of analysis have been developed for this type of data, including content analysis, hermeneutics and narrative analysis.

4 COHERENCE BETWEEN AN INTERPRETIVE PARADIGM AND THE PERSON CENTRED APPROACH

No literature detailing the coherence between an interpretive paradigm and the person-centred approach specifically could be found. The researcher's own ideas about the fit between Roger's propositions and values and an interpretive approach are presented here.

Positivists believe that everyone shares a meaning system and experiences the world the same way, while interpretivists argue that human action does not have inherent meaning. The interpretivists argue that people possess an internally constructed sense of reality (Neuman 2000: 71-72). From an ontological point of

view, the interpretive paradigm and the person centred approach are coherent. Rogers proposition 1 states: “Every individual exists in a continually changing world of experience of which he is the centre” (Rogers 1951:483). Proposition 2 states: “The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, ‘reality’ ” (Rogers 1951:484). These propositions imply that every person’s experiential world is central, unique and changing. Multiple realities exist. Thus the interpretivist paradigm and these propositions are coherent.

The goal of the interpretive approach is to develop an understanding of social life and discover how people construct meaning (Neuman 2000:71). The researcher aims to see things through the eyes of the research participants. This is consistent with Roger’s proposition 7: “The best vantage point for understanding behaviour is from the internal frame of reference of the individual himself” (Rogers 1951:494).

Interpretivists emphasise that multiple interpretations and multiple realities exist because meaning is constructed and interpretations are created. Key questions for the interpretive researcher are “how do people experience the world? Do they share meaning?” It is assumed that meaning is acquired among people who share a meaning system and that is what makes the interpretation of human action or communication possible (Neuman 2000:71-72). Participants in qualitative studies become co-researchers and collaborators (Moon, Dillon & Sprenkle 1990:364). These assumptions fit with the respectful stance inherent in the person-centred approach.

In keeping with this idea, proposition 9 states: *“*As a result of interactions with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed – and organised, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with values attached to these concepts” (Rogers 1951:491).

As people interact, perceptions of theses interactions become part of who we are. The “self” of the researcher and research participant evolve in interaction with each other. As stated, participants in qualitative studies become co-researchers and collaborators (Moon et al 1990:364). Interpretive researchers believe that it makes little logical sense to make deductions about people from abstract theories that may or may not relate to the participants’ world (Neuman 2000:72-73). These assumptions fit with the respectful stance inherent in the person centred approach. The person-centred approach does not engage in labelling or diagnosis but sees behaviour as a goal directed attempt to satisfy needs. Proposition 5 states: “Behaviour is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.” The interpretive approach seeks to understand people and notions of predictability, replication and social control are abandoned (Rogers 1951: 491).

Rogers (1955: 277) has emphasised the need to find ways of accessing the inner, subjective world of people participating in research. He states “Science as well as therapy, as well as all other aspects of living, is rooted in and based upon the immediate, subjective experience of a person. It springs from the inner, total, organismic experiencing which is only partially and imperfectly communicable. It is one phase of subjective living”. Rogers (1985:13) advocates “indwelling” in the perceptions, attitudes feelings, experience or behaviour of the participant as a means of enquiry. This suggests that empathy, a central tenet of the person-centred approach, would be a means of data collection that is coherent with both the person-centred theory and the interpretive paradigm adopted as a basis for the study.

Relevance to the research

The person-centred approach suggests that each human being occupies a unique place with his or her own relationships, aspirations, personal history, goals and experiences. Viewed this way, when trauma is encountered, it becomes part of a unique context. The meaning of trauma to a person is

subjective and available to no one but the individual concerned. Consequently it cannot be measured. Although quantitative methods of research can provide insight into the incidence of trauma, they say nothing about what it is like to be traumatised, or the meaning an individual attaches to his or her experience. This study differs from conventional quantitative studies in terms of its objective. The aim is not to find an explanation, cure or treatment for trauma and its effects. Neither does it seek to define relationships between societal, psychological or other variables or factors. Instead, the meaning of trauma is described from the perspective of research participants themselves. One of the goals of this research was to understand the meaning of trauma as defined by the respondents. Another goal was to understand how these experiences were perceived to impact the self of the research participant. It was necessary to view these experiences from the frame of reference of the participants themselves. Therefore a qualitative, interpretive approach that gives access to these experiences was deemed an appropriate paradigm for this study. This paradigm was also held to be coherent with the person centred theory underlying the research.

An interpretive report aims to give the reader a feel for the reality of the participants. This is achieved by providing a “thick description” of the participants’ world. A “thick description” means that the processes, transactions and context of a phenomenon are included in the description. However, the aim of an interpretive account is not simply to summarise what people already understand about their reality. Qualitative research constructs new ways of understanding (Kelly 2006a: 350). A research report comes to conclusions that exceed what subjects understand about their own world (Kelly 1997:413). This is achieved by analysing the data. Many approaches to analysis of qualitative data exist including hermeneutics, constructionism, ethnomethodology and phenomenology, among others (Neuman 2000:71). Hermeneutics was chosen as a means of analysis which is coherent with the person-centred approach, for reasons that will be clarified. First a description of the process will be provided,

followed by arguments in favour of the use of this method in a person-centred study.

5 HERMENEUTICS

The term “hermeneutics” is derived from the name of the Greek god, Hermes who had the task of communicating the desires of the gods to mortals. His task was to interpret the messages and make them intelligible to humans (Addison 1999:148).

Hermeneutics is the interpretation of written and oral texts about matters that include human experience and social conduct (Rennie 2007:3). The task of hermeneutics is to make something that is unintelligible meaningful and understandable (Addison 1999:148).

A text is a cultural product of any sort which is held over after the event of its creation for later comprehension (Kelly 1997:406). When a cultural product or text is displaced from its context, human scientists usually assume the task of understanding to involve “re- contextualization”. It is assumed that if the cultural product is placed back in its original context, its meaning will become evident. This principle is followed in hermeneutics. The assumption is made that the meaning of a text can be ascertained through knowledge of the inner life of the author and knowledge of the socio-historical and linguistic context in which the author worked. Both an empathetic understanding of the participant’s world and a more distant understanding of the participant’s context are required for a hermeneutic analysis.

In a hermeneutic analysis the meaning of parts of the text should be considered in relation to the whole and the whole should be understood in respect to its constituent parts. This is conceptualised as a circular movement between parts and the whole and the implicit and explicit and the particular and general. This recurring cycle is referred to as the hermeneutic circle. In hermeneutics tension is

maintained between describing the particular and general and giving a detailed account verses and abstract account. The emphasis in a hermeneutical analysis is on meaning-in-context. The following example given by Kelly 1997: 417) may illustrate this concept.

Imagine that a person was lost in a cave. The person may sense that if she had a map she would cease to be lost and could use the map to get out. In terms of a hermeneutic analysis the immediate subjective experience could be apprehended by empathy. However, equally crucial to deriving the meaning of the experience is the broader context in which it is through not having a map (or broader perspective) that the experience of "being lost" is defined. In a hermeneutic analysis, the view from without, (from the perspective of an outsider), places experience in the orienting perspective of a context, such as a life story, culture or history. "This breaks out of what is known to the experiencing subject and orients the subjectivity of experience in a broader context" (Kelly 1997:417). Therefore, both subjective experience and context are included in a hermeneutic analysis. The researcher's engagement with each of the two perspectives are described respectively as "empathy" and "distanciation."

Empathy is the process whereby the first-person perspective is derived. The perspective of the experiencing research participant is adopted and described (Kelly 2006a: 348). On the other hand, the researcher seeks to understand the participants' context from outside that context. This is known as "distanciation". Distanciation adds to understanding by pointing to the contextual limits of understanding (Kelly 2006a: 348). When something is viewed from a distance we can say things about it that we cannot say from within (Kelly 2006a: 348). In a hermeneutic analysis attention is given to both the particular and general.

5.1 Steps in a hermeneutic analysis

From the following discussion, it is apparent that a hermeneutic analysis is a circular rather than a linear process. It is as if the researcher “zooms in” on an aspect of the data and then “steps back” to view the instance in context.

5.1.1 Reflexivity

Not only does the author or originator of the text influence the meaning that is constructed, but the questions and concerns that emerge from one’s encounter with the text, as the researcher, also influences the meaning developed in the research report. This echoes Roger’s (1951:498) view that the self of the researcher and research participant, and the self of the reader and writer evolve in interaction with each other. He says: “As a result of interaction with the environment, and particularly as a result of evaluational interactions with others, the structure of self is formed – an organised, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with values attached to these concepts.”

“The values attached to experiences and the values which are a part of the self structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as if they had been experienced directly” (Proposition 9 and 10) (Rogers 1951: 498).

Therefore the researcher should reflect upon and disclose his or her orientation and how he or she influenced and was influenced by the research process. This process is known as “reflexivity”(Miller & Crabtree 1999 b: 131). Specifically reflexivity refers to self-reflection and self-criticism. This self-reflection occurs throughout the research process. The process of the research is described in detail. Once the researcher becomes aware of his or her preconceived notions and views, these are actively set aside or “bracketed” to allow the data to speak for itself (Terre Blanche et al 2006a 322).

Data in the form of texts are acquired from written field notes, transcripts of interviews or from participants themselves in the form of drawings, diaries, journals or other products.

In qualitative research, data gathering and analysis frequently occur together. Data collection gradually fades out as analysis becomes the dominant process (Miller & Crabtree 1999 a: 24; Terre Blanche et al 2006a: 321).

The hermeneutic method does not have a prescribed set of techniques but the following approach has been set out by Rapmund 2000 : 140-142) and Terre Blanche et al (2006a: 321-327). Data analysis is not a linear process but proceeds in a circular fashion, moving between the explicit and implicit, general and particular, part and whole. It is presented here as if it is a step by step process for the sake of clarity.

- **Step 1. Immersion**

The researcher makes an effort to bracket his or her perceptions and becomes immersed in the data. The texts are read and re read to enable the researcher to come thoroughly familiar with the material. The texts are reviewed several times.

- **Step 2. Developing themes**

Data needs to be organised. Some approaches to qualitative research use a pre determined structure or code book to organise the data. This is known as a template organising style. However, in a hermeneutic analysis, a more flexible style, namely the editing organising style is used more commonly (Miller & Crabtree 1999 a: 21). In this style, the researcher approaches the text like an editor, searching for meaningful segments of data that can be grouped together. The text may be cut, pasted and re arranged until categories are discerned. This style of organisation is known to be useful in exploratory studies (Miller & Crabtree 1999 a: 23-24). Hermeneutics is a bottom-up approach. Structure is not imposed on the data from outside but organising principles that emerge naturally

from the data are sought and used. As categories are discovered they are labelled, preferably using the language of the participants. The researcher should not merely summarise the data but should actively seek and note contradictions, tensions and functions that can be discerned in the text. In this way themes are developed, grounded in the data.

- **Step 3. Coding.**

As themes are being developed, the data is simultaneously coded. Different segments of data are marked as being relevant to a theme. This may be done with coloured pens, or by cutting up printouts of the text or with the aid of computer programmes such as Atlas Ti.

- **Step 4. Elaboration.**

The activity of developing themes has the effect of joining disparate segments of the text together. Connections are made within the text and between the theme and context. The themes are explored more thoroughly so that commonalities and discrepancies within the theme can be uncovered. The purpose is to capture nuances of meaning. The process of coding and developing themes may be revised. The process is not to devise one correct way of structuring the data but to provide a thorough analysis. The process is repeated until no new insights emerge.

- **Step 5. Interpretation and Checking.**

A written account of the phenomenon is compiled. The account is checked for examples that contradict the interpretation. The report should be more than a summary, but should provide a general account of the phenomenon. The researcher should reflect on his or her discoveries and actively interpret them for the reader. The researcher should reflect on his or her role and influence in the research process. The research report must be legitimised by showing how standards of credibility, trustworthiness and interpretive validity have been met (Miller & Crabtree 1999 a: 20-21).

Kelly (2006a: 346) suggests that the final account is a “situated” account. This means that the researcher provides the reader with enough detail to allow him or her to imagine the situation as it was experienced by the participant within the relevant theme. Individual accounts are integrated into a general account. The extent to which the account is given in terms of the contextual details that surround the events of interest is the extent to which the account is situated (Kelly 2006a: 364).

5.2 The meaning of interpretation

A hermeneutic analysis begins with lack of understanding. When something is missing, wrong or does not make sense, the analysis must address the issue that is *not yet* understood (Addison 1999:150). Meaning does not only lie in what is verbalised, but also in action and practices. Meaning gains greater focus when the background conditions such as the immediate context, social structures, personal histories, language, shared practices and economic conditions are illuminated. Data is interpreted and analysed with these background conditions in mind (Addison 1999:150). Hermeneutics goes beyond a mere description of research participants’ experiences. The research report comes to conclusions that exceed what subjects understand about their own world (Kelly 1997:413). It does so by re-contextualising the text. When a text or any cultural product is displaced from its context, its meaning may be obscured. Researchers assume that reaching understanding involves placing the text back into its context. It is assumed that when the text is viewed in context its meaning will become evident (Kelly 1997:406). This principle is followed when the research is interpreted and the outcome is discussed. The assumption is made that the meaning of the text can be ascertained through knowledge of the inner life of the originator and knowledge of the social, historical, political and/or linguistic context in which the author worked. Hermeneutics suggests that people do not always know why they act as they do. Many motivations are unconscious and can only be understood through interpretation (Kelly 1997:412). These principles are similar to Roger’s proposition 13: “Behaviour may, in some instances, be brought about by organic

experiences and needs which have not been symbolised. Such behaviour may be inconsistent with the structure of the self, but in such instances the behaviour is not “owned” by the individual” (Rogers 1951:509). When texts are viewed at a distance, or with the benefit of hindsight, meaning emerges that may not be apparent to those within the context or immediate situation. Therefore an interpretation is written using distanciation. Interpretations may not always be recognised by the subjects themselves. The subjects of research may not confirm the researchers interpretations, but are well placed to confirm his or her descriptions (Kelly 2006b: 305). However, interpretations are always grounded in the data.

The degree to which an interpretation provides the perspective of an insider or outsider depends on the theoretical orientation of the researcher and the research question. These poles create a degree of tension. Phenomenological and participatory action research studies lean towards the insider perspectives while social constructionism, with its emphasis on discourses and grand narratives, lean towards a more distant sceptical discussion of the context (Kelly 2006a: 346).

5.3 Steps in writing an interpretation

Writing an interpretation can be regarded as another phase of data analysis (Terre Blanche 2008: personal communication). The process is similar to that described previously, but interpretation leads to the production of a more general account of the research topic. The stance of the researcher tends towards distanciation rather than empathy and the emphasis leans towards context rather than specific instances. Particular instances are explained in terms of broad principles, although distinct and unique features of social phenomena are respected.

- **Immersing, unpacking and associating**

There is a saying that a picture paints a thousand words. This implies that the meaning of images is not fixed, and there is no one-to-one correspondence

between the image and a specific meaning. This principle applies to language as well. A single word or symbol may refer to many overlapping meanings (Barrell, Aanstoos, Richards & Arons 1987: 433). For example, the meaning of the word “black out” changes between the context of a hospital, where a patient faints frequently, and that of a frustrated student trying to write a report when the electricity supply has been cut. Symbols and language may convey content, connotations, associations and emotions and be vivid, carrying many overlapping meanings. Language is said to be overdetermined with respect to meaning (Kelly 2006a: 356). Metaphors are forms of language where words from one context are used to impart meaning in another. To “unpack” or “lay-out” or become conscious of the many meanings of certain images and texts, it is necessary to gain an intuitive sense of the data and freely associate or muse over the symbols, connections and emotional overtones. Also, to unpack or understand the meaning of certain texts, it is necessary to understand the *history* of their creation.

As the task of interpretation is undertaken, the researcher needs to become familiar with the images in the text. Note is taken of respondents’ characteristic use of language and metaphors. Themes may be listed (Kelly 2006a: 356-357). One of the tasks of interpretation is to understand the general principles that emerge from the data. Predominant themes and sub themes are mapped out, for example, using tree-like diagrams. This enables the researcher to examine themes that are packed with dense meaning and examine how meaning is structured.

Sometimes one thing may be symbolic or stand for another. A flag is an example. Words, actions and phrases may have particular historical and cultural references. For example, the connotation of the term “settler” referring to “white people” cannot be understood without reference to association with a context. Use of the term “boer” for “Afrikaans speaking people” is another example where the overtones of the word can only be understood in a particular political and

historical context. The process of associating while writing the research report involves interpreting the material in relation to a broader theoretical, historical cultural or/and political framework and making these associations explicit (Kelly 2006a: 358).

- **Themes discourses and the research question**

One of the goals of qualitative research is to uncover regular patterns, known as "themes" or "discourses" in the data. It is also important to note ways in which data resists incorporation into a theme. This may lead to new research questions. Miller and Crabtree (1999 b: 142) say: "Celebrate anomalies. They are the windows to insight." It is important to exhaust the data and acknowledge the unexplained. They caution against premature closure of enquiry but acknowledge that an analysis will never be perfect.

Developing themes is a process of finding patterns in the data. A pattern is identified by virtue of repetition. In a phenomenological study, patterns may be identified in the way a person relates to the world in different situations. In other types of study such as discourse analysis, patterns are identified in the way language is used to achieve certain effects (Kelly 2006a: 363).

Themes may exist across time and situations. These themes may not be identified by virtue of repetition but can be inferred from links in time where one event may seem to be linked sequentially with another (e.g. We may infer that a person's suicide attempt was associated with his failure at school.) The conditions surrounding the link are explored (Kelly 2006a: 363).

- **Integration**

Kelly (2006a: 363) states that the growth of qualitative research has been accompanied by suspicion of all-encompassing theories of social life and human experience. One needs to reflect on what type of general account is acceptable.

Themes are tied together to yield a general, overarching account. The final account relates to general theoretical concerns. Themes are tied together to yield a general account at a higher level of abstraction.

The researcher writes a situated account, which is the researchers' re telling of what the research participants disclosed (Kelly 2006a: 364). Individual accounts are integrated into the general account without recourse to specific contexts. This level of analysis is particularly appropriate for providing a report across cases.

6 COHERENCE BETWEEN HERMENEUTICS AND THE PERSON-CENTRED APPROACH

Rennie (2007:1) states that Carl Rogers and Abraham Maslow serve as examples of the tacit use of hermeneutics in the theory development. Both were humanistic psychologists. Humanistic psychology focused on restoring to psychology the nature of what is involved in being a person. In this regard, the founders took into account cognition, emotion, feeling, will, ethics, aesthetics as well as intra personal, inter personal and transpersonal relationships. Rennie (2007:1) believes that the scope of these concerns made humanistic psychology into a world-view. He also believes that there is unity between the theories of Rogers, Maslow and hermeneutics as a method.

Rennie (2007:5) alludes to how Rogers integrated the American values of liberalism and individualism, his Christian parentage, his observations of growing plants on his parents' farm, his studies, interviews with parents and his attention to tape-recorded client-interviews, to develop his person-centred approach to therapy. He argues that his theory was derived from a purposeful and systematic interpretation of memories, experiences and beliefs integrated with his interpretation of the meaning of experiences and observations made by himself and others. He believes that although Rogers did not call his approach hermeneutics, that it is what it was. Despite Rennie's (2007: 5) claim that the person-centred approach and hermeneutics belong to the same genre, he does

not spell out the common principles. The researcher reflected on these claims and suggests some reasons why the person-centred approach and hermeneutics are coherent.

The values of respect and individualization are foundational in the person-centred approach. In hermeneutics, the research participants are approached from a respectful stance. Themes are sought in a hermeneutic approach; the individual and particular are acknowledged and respected (Kelly 2006a: 363).

The person-centred approach views the individual within a phenomenal field:

Proposition 1. “Every individual exists in a continually changing world of experience of which he is the centre.” (Rogers 1951:483).
Proposition 2. “The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, “reality.”” (Rogers 1951:484).
Proposition 3. “The organism reacts as an organized whole to this phenomenal field” (Rogers 1951:486).

According to the person-centred approach, the meaning of concepts such as self emerge from this field. In a hermeneutic analysis, both the individual perspective and context are examined. The way in which meaning emerges from the context is disclosed.

Although the person-centred approach was developed for work with individuals, others have extended the principles and propositions for work with groups and communities (Grobler et al 2003; Louw 2000). Through hermeneutics, contexts such as culture and common practices that have meaning for people can be included in the analysis.

Empathy is a central feature of the person-centred approach. Empathy incorporates both basic and advanced empathy (Grobler et al 2003:179-199).

The use of empathy as a tool in hermeneutic enquiry has been discussed. Hermeneutic enquiry also uses advanced empathy. Kelly (1997:413). states that people are motivated by unconscious processes and may not always understand their actions. He states that such actions need to be interpreted. This fits proposition 13 of the person-centred approach.

Proposition 13. states: “Behaviour may, in some instances, be brought about by organic experiences and needs which have not been symbolised. Such behaviour may be inconsistent with the structure of the self, but in such instances the behaviour is not “owned” by the individual.” (Rogers 1951: 509).

Connecting islands is an aspect of advanced empathy. Grobler et al (2003:186) describe connecting islands as a skill whereby links are made within the client’s story. These links may be developed into themes. This skill is similar to that used in a hermeneutic analysis. When the researcher writes an account, links are made between situations and cases. This leads to the development of themes. In both the person-centred approach and the hermeneutic analysis, discrepancies may be illuminated. In the person-centred approach, the symbolisation of unconscious experience can lead to change. Rogers (1951:513) proposition 15 states: “Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self.” Addison (1999:150) cautions that the research process using hermeneutics can accelerate change. Researchers need to be conscious of the way their research practices impact the participants.

Based on the contention that the person-centred approach and hermeneutics are closely linked in terms of values and practice, a hermeneutic approach to data analysis has been adopted in this study.

7 THE USE OF BOTH QUANTITATIVE AND QUALITATIVE DATA IN A SINGLE STUDY

Rogers (1985:13) cautions against rigidity in the choice of methods used in research. He stresses that the method chosen should be appropriate to the research question. Just as an interpretive approach is one way of knowing, it is not the best or only way. In qualitative research, use of multiple data resources, multiple data collection methods, multiple methods of analysis and multiple investigations serves to insure the “trustworthiness of findings” (Moon et al 1990:361).

Rossman & Wilson (1985:629) state that using quantitative and qualitative methods in a single research project has been the subject of much controversy. There appear to be three perspectives, namely the purist, the situationalist and the pragmatist positions.

Purists believe that quantitative and qualitative paradigms are incompatible because they are based on different notions about reality and differ with respect to what constitutes valid research (Firestone 1987:16; Smith & Heshusius 1986:4-12). Purists usually focus on paradigms and view the ontological and epistemological assumptions of quantitative and qualitative research as mutually exclusive and contradictory. This perspective views social science research as a dichotomous endeavour. Qualitative research is seen as a means of understanding the participant while quantitative research is seen as the opposite extreme were events are defined and structure imposed by outsiders (Rossman & Wilson 1985: 630).

Situationalists on the other hand, believe that both approaches have value. This view tends to promote a side-by-side use of qualitative and quantitative research. Situationalists feel that the certain methods are most appropriate for specific situations, but do not promote and integrated approach (Rossman & Wilson 1985:631).

Pragmatists suggest that there is a false dichotomy between quantitative and qualitative methods. They suggest that each method has inherent weaknesses and strengths and advocate tapping the relative strengths of both (Rossman & Wilson 1985:631). Pragmatists believe that the method used should be the one best suited to answering the research questions (Moon et al 1990:358; Rogers 1985:7). They argue that many studies contradict the purist's assumptions that method-types are linked to a specific paradigm. Rogers (1955:275-277) discusses the subjectivity inherent in all research. For instance, quantitative researchers often immerse themselves in a situation during the planning and pre-testing phases of research and may use the opinions of others to generate items for questionnaires, etc. (Firestone 1987:17). Some qualitative studies involve counting and other typically quantitative features. Firestone (1987:20) suggests that there are a number of reasons for selecting a methodological approach, including one's values about the world, how it may be understood. He states that the method of presentation is chosen so that it advances certain arguments for the credibility of one's conclusions. He argues that the research report is written in a style that supports and reinforces the researcher's assumptions. The author suggests that these non-logical methodological tendencies fit with the philosophical understandings of both positivist and phenomenological paradigms. Firestone (1987) points out that the researcher's way of collecting data and processing information has an impact on the conclusions that are drawn. "These steps shape the final text, which reinforces these assumptions stylistically" (Firestone 1987:19).

Firestone (1987:20) emphasises that quantitative and qualitative studies are complementary and provide different kinds of information. Several others support this view (Kelly 2006b: 287; Atkinson & Heath 1987:10; Rossman & Wilson 1985:361; Moon et al 1990:358). Where studies using different methods provide similar results, one can be more certain that the results were not influenced by the method. Where results diverge, more research is needed and a comparison of the studies can suggest useful lines of enquiry. The classic strengths of

qualitative methods according to Firestone (1987:20) are concrete depictions of detail, access to process and attention to the participant's perspective, which help to overcome the abstraction inherent in quantitative research. The advantages of quantitative research are generalisability and abstraction. Choosing methods is not just a matter of arriving at a single truth from different directions. Firestone (1987:16) states that the two methods are complementary. In qualitative studies use of multiple methods of data collection and analysis, both quantitative and qualitative are used to enhance validity. This process is known as "triangulation." When triangulation is used, data are gathered from multiple perspectives so that distortion that could arise from a single source is minimised (Krefting 1991: 218). Various strategies for triangulation exist. The most common is triangulation of data methods, in which data gathered by various means such as interviews and questionnaires are compared (Krefting 1991: 218). Triangulation of data sources involves gathering data from different groups, in different contexts or at different times (Krefting 1991: 218). Theoretical triangulation means that ideas from diverse or competing theories can be tested (Krefting 1991: 218) Triangulation of investigators occurs when more than one person is involved in the research (Krefting 1991: 218). Triangulation can be used to gain greater confidence in the researcher's conclusions (Kelly 2006a: 287). Both methods can work interactively (Rossman & Wilson 1985:639). Discrepancies may suggest areas for further enquiry. This is particularly valuable in exploratory research (Rossman & Wilson 1985:633).

Relevance to this research

In this study, the emphasis was on a qualitative paradigm. However, some quantitative data was gathered to assess the incidence of trauma in the research group. In qualitative research, use of multiple data resources, multiple data collection methods, multiple methods of analysis and multiple investigations serves to insure the "trustworthiness of findings" (Moon et al 1990:361). Reliability is also increased by prolonged engagement in the field and persistent observation (Moon et al 1990:369).

Qualitative research emphasises social context, multiple perspectives, complexity, individual differences, circular causality, recursion and holism. (Moon et al 1990:364). It is assumed that the meaning of human creations, words, actions and experiences can only be ascertained in relation to the context in which they occur (Terre Blanche et al 2006b: 275). In a hermeneutic analysis the context in which the study was conducted is described as well as the researcher's theoretical orientation to allow the reader to re-contextualize the study. The cultural and historical context, as well as research in the field of trauma are discussed in the literature review, which follows this chapter.

8 RELIABILITY AND VALIDITY

Reliability and validity are assessed by different criteria in quantitative and qualitative research. "Reliability refers to the extent to which the results are repeatable. This applies to both the subjects' scores on measures (measurement reliability) and outcome of the study as a whole" (Van der Riet & Durrheim 2006:92). This concept is highly valued by positivistically orientated researchers because positivism holds that reality is stable and unchanging. Researchers using an interpretive approach do not assume that they are investigating a stable, unchanging reality and therefore do not expect to obtain the same results repeatedly. In place of reliability, they propose that findings should be **dependable and trustworthy**. These concerns establish how confident the researcher is with the truth of findings based on research design, informants and context.

Four aspects of trustworthiness in qualitative research have been identified, namely truth-value, applicability, consistency and neutrality (Krefting 1991: 215). Truth-value is obtained as human experiences, as they are lived and perceived by informants, is discovered. Multiple realities, as revealed by participants, are represented. Findings are tested against the data (Krefting 1991: 215).

According to Stiles (1993: 601-602), reliability in qualitative studies concerns the procedural trustworthiness of the research. The report should convey what a person who was observing the process would have seen. With this in mind, the context of the research is described. Verbatim evidence is included in the report to allow the reader to assess the interpretation. Stiles (1993: 602) suggests that the researcher's orientation should be disclosed so that the reader may assess the degree to which observations permeated and altered the researcher 's pre conceptions. Dependability is achieved through a thorough description of the research context and process to show how actions evolved out of the context of the investigation and detailed statement of the methods used in the research (Van der Riet & Durrheim 2006:92; Stiles 1993:603).

Validity refers to the extent to which research conclusions are sound. Positivistically orientated researchers design studies in which threats to validity are identified in advance and measures are taken to rule out these variables as alternative explanations for the research findings. Qualitative researchers do not believe that research findings can be accurate reflections of a stable reality (Van der Riet & Durrheim 2006:90). They suggest that research can be evaluated according to its **credibility**, that is, the extent to which research produces findings that are convincing and believable. "Nuisance variables" are not viewed as threats to validity, but are viewed as part of the context, which, as part of the "real world," should be included and understood. The researcher constantly seeks discrepant evidence as a means of producing a rich, credible account. One way of doing this is to use triangulation (Stiles 1993:604). Asking peers to check the emerging account, to ensure findings are grounded in the data, enhances credibility (Krefting 1991: 219).

Generalisability is the term used in positivistic research to refer to "external validity". It refers to the extent to which one may infer claims from the research to broader populations (Van der Riet & Durrheim 2006:91). These concerns are significant when researchers wish to make universal claims, describe

populations, or uncover universal laws and mechanisms. Case study research and interpretive researchers do not make such claims or seek generalisable findings. Instead, they argue that findings should be **transferable** (Van der Riet & Durrheim 2006:91-92; O'Leary 2005:70). Other researchers refer to this as applicability (Krefting 1991:215). Stiles (1993: 598) states in qualitative research the focus shifts from generalisability to facilitating an understanding, which readers can adapt to their own contexts. Stiles (1993: 596) points out: "Human experience is no less real than objects or observable behaviour. Because experience is fleeting, unsubstantial and variable across cultures and circumstances, however, any account of experience will be particularly bound by context." Applicability refers to the extent to which findings can be applied to other settings (Krefting 1991: 216). Transferability is facilitated by giving the reader a detailed description of the context and process of the research. These understandings may be transferred to new context or studies to provide a basis for reflection on meaning and actions that occur in these contexts (Van der Riet & Durrheim 2006:92).

In qualitative research, generalisation is not the aim, but applicability may be gauged by the extent to which findings are transferable. Findings are transferable to the degree of similarity between different contexts. Krefting (1991: 216) states that as long as the original researcher presents sufficient data to allow comparison, he or she had addressed the need for applicability. This is because the responsibility of assessing the appropriateness of transferring the findings to another context rests with the person wanting to transfer the findings.

Consistency refers to whether the findings would be similar if the enquiry was repeated with the same participants in a similar context (Krefting 1991: 216). According to Krefting, (1991: 216) consistency is defined in terms of dependability. Dependability is enhanced by tracing and explaining sources of variability such as increasing insight on the part of the researcher, fatigue in informants or important life changes.

Neutrality refers to freedom from bias in the research procedures and results. Findings emerge from informants themselves and the context of the research (Krefting 1991: 216). Prolonged contact with informants and lengthy periods of observation enhance this process (Krefting 1991: 216).

9 CHAPTER SUMMARY

Research is based on assumptions regarding ontology, epistemology and methodology, which give rise to different paradigms. Qualitative research often includes quantitative data as a way of presenting another perspective. This is known as triangulation. A mixed paradigm was chosen for this study, although the emphasis is on the qualitative aspect of the research. Justification for this use of multiple methods was presented. Quantitative methods, with descriptive statistical analyses were used to provide a profile of the participants and to explore the incidence of trauma. The meaning and effect of trauma was explored using qualitative methods. An interpretive approach, with its emphasis on the research participants' frame of reference and subjective experience was deemed to be coherent with the person-centred theory underlying the research. Reasons for this choice were elucidated. A hermeneutic approach was selected as a means of data analysis. Rennie (2007:1-14) explains that Rogers made tacit use of this method in developing his person-centred theory. A hermeneutic method examines subjective experience, using empathy as a means of enquiry. Texts are analysed and re contextualised so that meaning-in-context can be derived. The researcher then engages in distanciation to produce a more general, over arching account at a higher level of abstraction. The researcher's ideas about the fit between the person-centred approach and hermeneutics were presented. Hermeneutics requires the researcher to disclose his or her pre-conceptions and theoretical orientation as well as the context and process of the research. This enables the reader to contextualise the report (see chapter 8). The cultural, social, political and historical context, as well as the learning environment surrounding this study is the subject of the literature review that follows this chapter.

CHAPTER 4

ETHNO CULTURAL CONSIDERATIONS IN THE STUDY OF TRAUMA

1 INTRODUCTION

In a multicultural society such as South Africa, the challenge facing many researchers is how to work with people from diverse cultural backgrounds. Louw (2007:44) points out that a person-centred perspective accepts that culture and cultural variables affect any relationship, including the research relationship. Almost all the theory, research and measurement of trauma and its manifestations have been generated by European, American, Israeli and Australian researchers and professionals (Marsella et al 1996c: 116). These groups share Western cultural traditions so issues of reliability, validity and applicability are not of concern *within* these groups. However, when the same concepts are applied cross culturally to people who identify with non-Western cultural traditions, there are risks of ethnocentric bias. Ethnocentricity can be defined as the tendency to view one's own way of thinking as right, correct or moral and to reject others as incorrect or of limited accuracy or value (Marsella et al 1996c: 116). Dinicola (1996:407) suggests that cultural misperceptions often act like a dirty window, obscuring our ability to perceive clearly. Ethnocentrically biased concepts do not include experiences of others with regard to notions of health, illness, personhood, normality, expressions of distress and phenomenological experiences of difficulties such as trauma (Marsella et al 1996c: 116). Rogers (1951:484) suggests that people are unique so not all members of a culture will perceive trauma the same way.

The aim of this chapter is to create awareness of diversity and to foster openness for different meanings and constructions around trauma. The researcher conducted a literature study on other perspectives in an effort create openness to a variety of views of trauma. Descriptions of *trauma* were not always found in the sources consulted, but perspectives on *illness* were described. These are presented in this chapter to assist in opening a space for a variety of constructions of illness, health and distress, to fit with the person-centred stance adopted in this research.

As a non-black African, the researcher believed it was important to consider the African worldview to enhance her empathy with the social work students, who may identify with this perspective. In keeping with the person-centred approach, the researcher has attempted to understand and be open to alternative worldviews and perceptions of trauma, healing and resilience. A brief and by no means complete picture of African culture presented. This does not imply any disrespect to cultures that are not covered, nor does it imply that such cultures are less relevant or less significant. Much still needs to be learnt about the African worldview, which has frequently been neglected in research (Mokgatlhe 2001:30). In this discussion the assumption has been made that communities share a culture, so the terms “community” and “cultural group” have been used interchangeably. There is not one African worldview that is universally applicable to all African groups, but there are the pattern of thinking is different from the tendencies in the Western worldview.

In multicultural societies, people vary in the extent to which they endorse and practice the values, beliefs and behaviours that are associated with a particular cultural tradition (Marsella et al 1996c: 117). Culture, ethnicity and race do not necessarily co-inside. Singh and Tudor (1997:34) point out that race refers to a category of persons who are related by ancestry and heredity, that are perceived in terms of external features or traits. Ethnicity relates to nationality. Culture on the other hand is a broader term that may be thought of as a worldview. Therefore a person may identify with a race without sharing a cultural or ethnic identity associated with that race. This is frequently true in the process of acculturation (Singh & Tudor 1997:34). Similarly, ethnicity is only one aspect of culture. These authors state that culture, ethnicity and race may serve as filters through which cross-cultural relationships are mediated and they emphasise the importance of making cultural assumptions and stereotypes explicit rather than leaving them unsymbolised (Singh & Tudor 1997:32-46). in this chapter an attempt is made to create an awareness of diversity and not to determine how members of any culture see trauma. The objective is to create some discussion and openness for different meanings and constructions as suggested in propositions 2 and proposition 7.

2 CULTURAL MEANING SYSTEMS

According to the PCA, individuals, groups and communities develop their own unique perceptions, which constitute their reality.

Proposition 1 states: “Every individual exists in a continually changing world of experience of which he is the center “(Rogers 1951: 483).

Proposition 2 states: “The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, ‘reality’ ” (Rogers 1951: 484).

Cultural groups develop a sense of self. The ideas, values, traditions, and taboos of each community are shaped through experience, in interactions with others and become integrated into the self of the community (Grobler et al 2003:15). This is in keeping with Roger’s proposition 9 which states: “As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed – an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with values attached to these concepts” (Rogers 1951: 498).

These perceptions are contained in cultural meaning systems. Cultural meaning systems are “the organisation of cultural knowledge in a semantic system. Analogous to scientific paradigms, but much larger, a cultural meaning system generally structures cognitive reality for an entire society” (Castillo 1997:285). In its broadest sense, culture refers to a “worldview.” A worldview is the way in which individuals perceive their relationship to the world and interpret and make sense of reality (Mokgatlhe 2001:39). In this sense, culture is the sum total of knowledge passed on from generation to generation within any given society (Castillo 1997:20). This body of knowledge is organised in a systematic fashion so that it can be easily passed on. These systematic bodies of knowledge are referred to as “*cultural meaning systems*” (Castillo 1997:20). Cultural meaning systems are sometimes referred to as paradigms or worldviews. Cultural meaning systems

encompass the norms, values, traditions, taboos, spirituality and customs of a community. They contain ideas about what is acceptable and unacceptable, normal and abnormal, disease and illness, curing and healing, death, life events, symbols and rituals. They may be conceptualised as the self of the cultural group. Through cultural meaning systems, the self of the community is passed on from one generation to another.

Culture may be defined as shared learned behaviour which is transmitted from one generation to another to promote group adjustment and adaptation. Kamwangamalu (1999:24) defines culture as follows: “Culture is the socially learned, shared assemblage of practices, perceptions, attitudes, world view, value system and beliefs that determine the texture of our lives as members of a given community.” He suggests that culture embraces norms, values, beliefs and expressive symbols, including language. Norms are the way people behave in a given society. Values are what they hold precious or dear. Beliefs reflect what they think about how the universe /world works and their explanations of phenomena. Expressive symbols, such as words, art and dance are representations of values, norms and beliefs. Culture is represented externally as artefacts, roles and institutions. It is represented internally as values, beliefs, attitudes, cognitive styles, epistemologies and conscious patterns. Language is an intrinsic part on one’s culture. The way a cultural group sees the world is reflected in language (Marsella et al 1996c: 117).

Cultural meaning systems serve several functions. These are a representational function, a constructive function, a directive function and an evocative function.

- Cultural meaning systems serve a representational function. They enable members of a community to represent the world symbolically, using signs and symbols. These representations vary in their level of abstraction. For example a symbolic representation like a photograph looks like the object it represents. These representations are known as icons. Signs are more abstract. For example, a cross is a Christian sign. A symbol is even more abstract than a sign and has no connection to what it represents. Writing

on a page is an example of a symbol. Unless one knows the meaning of the letters and the rules for putting them together, writing is no more than marks on the page. However, when the rules and symbols are understood and a shared meaning is constructed between the reader and writer. The symbols become intelligible and richly meaningful.

- Cultural meaning systems construct things. Rituals exemplify the constructive function of cultural meaning systems. A wedding ceremony for example constructs a change in a person's status and relationship in society. Another example of the constructive function of cultural meaning systems is a tribal god. These constructions would not exist without the meaning system that created them (Castillo 1997:21-22).
- Cultural meaning systems serve a directive function (Castillo 1997:23). They direct how people are treated or how to respond to phenomena. Communities have different experiences and attach meanings to their experiences (Grobler et al 2003:29). These meanings are likely to have a high degree of commonality, but members of communities also form unique perceptions. The directive function of cultural meaning systems relates to proposition 12 which states: "most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of self "(Rogers 1951: 507*).* If we consider cultural meaning systems as intrinsic to the self of the community, these meaning systems in turn direct behaviour and guide perceptions of members of the cultural group. Proposition 2 states that people respond to reality as perceived. These perceptions and meanings guide the behaviour of people. An example of the directive function of cultural meaning systems is the caste system in India that determines how people in different social strata behave and are treated. Similarly, a diagnosis of illness may direct the behaviour of the patient and those around him or her. Cultural meaning systems direct the behaviour of the sick person, doctor and society.
- Cultural meaning systems serve an evocative function. They evoke emotions. Many powerful feelings are evoked by cultural entities constructed by cultural meaning systems. For example, graduating from

University may evoke joy, a death may evoke grief. This is the evocative function of cultural meaning systems (Castillo 1997:24).

2.1 Culture and the meaning of trauma

The word “trauma” means “to wound” (Matsakis 1996:17). Cultural schemas mediate what situations are regarded as traumatic. For example, Castillo (1997: 141) explains that sexual encounters between children and adults are usually defined as abuse and as such are regarded as traumatic. However, sexual relations between children and adults are not considered traumatic in all cultures. In societies where sexual contact between children and adults is taboo, but the child is simultaneously expected to have sexual contact with an adult, who is also in a position to demand compliance, the child receives contradictory messages; Sexual activity in children is punished by adults, yet an adult is the child’s sexual partner and children are expected to obey adults. The child may not be able to accommodate these contradictions and may cope by dissociating, that is entering a trance state. These memories may emerge later in life in the form of anxiety, sexual dysfunction or mood disturbances. Castillo (1997:141) states: “The trauma resulting from abuse frequently results more from the *meaning* of what is happening than from the physical events themselves.” He describes a traditional society namely Mangaia, where sexual behaviour by children was accepted and sexual contact between children and adults did occur, there was no evidence of trauma as a result of these encounters. The prevailing cultural schemas did not include “trauma” as a meaning for these events. Cultural meaning systems serve a constructive function. As people communicate within a society, they create cultural entities by a process of social agreement. Therefore, culture can mediate perceptions of what constitutes trauma, illness, disease, normality and abnormality.

2.1.1 The distinction between illness and disease

With respect to illness a distinction is made between “disease” and “illness.” The term “illness” refers to the subjective experience of being sick, the experience of symptoms, suffering, help seeking, the effects of treatment, social stigma, explanations of causes of the illness as well as the impact on

family and occupational functioning. In contrast, the term “disease” refers to the diagnosis of the doctor or folk healer, taken from the paradigm in which the healer was trained (Castillo 1997:6-7). Matsakis (1996:17) states “trauma refers to the wounding of your emotions, your spirit, your will to live, your beliefs about yourself and the world, your dignity, and your sense of security.” This description highlights the subjective nature of the suffering induced by trauma. It can be deduced from this description that the experience of being traumatised can be seen as an ***illness***. Simultaneously, the experience of being ill, with its inherent suffering can be traumatic. In this discussion the term, “illness” and “trauma” have been used interchangeably.

Both the client and clinician develop perceptions of the problem. Culture affects the way the distress is perceived (Castillo 1997:27). Definitions of what constitutes trauma may differ in different cultures. This view coincides with the PCA which, according to proposition 7 holds that: “The best vantage point for understanding behavior is from the internal frame of reference of the individual himself” (Rogers 1951: 494).

2.2 Culture and the self

The self is a central concept in the PCA. Markus and Kitayama (1991:226) point out that the self is primarily a product of social factors. This is consistent with Roger’s proposition 9 where the self emerges in interaction with significant others. Thus culture plays a crucial role in shaping the self-concept. A concept that has proved useful in studying the impact of culture on the self is collectivism verses individualism (Castillo 1997:39). Other researchers use the terms sociocentric or ensembled self, corresponding to the interdependent self and egocentric, autonomous individualist self to denote the independent self (Markus & Kitayama 1991: 226).

A collectivistic view of self is a self-identity that is centred on the groups or society of which one is part (Castillo 1997:40). A collectivistic society views the self as interdependent. Individuals are perceived as not having a fully formed identity apart from the group. Group membership confers identity. Life outside the group is construed as a loss of identity or a kind of exile (Castillo

1997:40). Individuals who construct the self in this way see themselves in relation to others. The emphasis is on connectedness with others, wholeness, and seeing oneself as part of an encompassing relationship and recognising that one's behaviour is determined by, contingent upon and organised by what one perceives to be the thoughts, feelings and actions of *others* in the relationship. The interdependent self cannot be conceptualised as a bounded whole, made up of traits or unique attributes, because it changes structure with the nature of the social context and one's role and status in various relationships. The core aspects of the self-schema are predicated on significant interpersonal relationships (Markus &. Kitayama 1991:227). The notion of autonomy is secondary to and constrained by connectedness to others. The concerns for a person with this type of self-structure tend to be belonging, reliance, dependency, empathy, occupying one's proper place and reciprocity. The nightmare of a person with an interdependent self is exclusion (Markus & Kitayama 1991: 228).

In contrast to this concept, an independent view of the self refers to the idea that an individual is an independent, self-contained entity, possessing a unique configuration of attributes or traits, abilities, motives and values. Behaviour is generally assumed to be an expression of these attributes. Getting ahead, expressing oneself and independence tend to be valued (Markus & Kitayama 1991:224). Individualistic societies have a personal identity that is centred *in* the self. People with individualistic constructions of self see themselves as autonomous individuals with personal choices, desires and rights. Dependence is seen as weak and undesirable. Personal freedom and personal power are valued. Social relationships are construed as voluntary associations that the individual may choose to maintain or terminate (Castillo 1997:40).

Markus and Kitayama (1991:225) state that an independent construal of self is exemplified in American and Western European cultures whereas Japanese, Asian, African and Latin-American cultures exemplify the interdependent view of the self. This implies that both these construals of self are found in South Africa, where the African and Indian people are likely to display an

interdependent construal of self and white people are more likely to hold a more independent view of self. The notion of an independent or interdependent construal of self is by no means universal. For example, within a Western culture, the independent view of self may be somewhat less descriptive of women in general or of members of certain religious groups, including Christians. The distinctions may be regarded as general tendencies (Markus & Kitayama 1991:235; 228).

2.3 Culture and emotions

Proposition 5 states that: “Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived” (Rogers 1951: 491).

Proposition 6 states that: “Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism” (Rogers 1951: 492).

Markus and Kitayama (1991:235) point out that both culture and the self play a crucial, mediating role in shaping emotional experience. The emotional meaning of events including trauma, is an emergent product of social life (Markus & Kitayama 1991:235). It is suggested that trauma, such as rape or a physical attack, may evoke emotions of fear, guilt, anger, grief and loss. The specific emotions expressed are mediated by culture. Markus and Kitayama (1991:235) suggest that people with an independent construal of self become adept at managing and expressing ego-found emotions such as anger, frustration and pride, whereas people with a more interdependent self-concept become experts at managing sympathy, shame and guilt. The self mediates the nature of the emotions attended to and guides actions based on emotions. Thus emotional experience in response to traumatic events may vary across cultures and individual, specifically in relation to the self-structure. Emotion accompanies and facilitates goal directed behaviour (Grobler et al 2003:63). Going beyond this, culture is an important factor that may guide the display of

emotion, how emotion is perceived and indeed which emotions are experienced.

Castillo (1997:56) suggests that emotions depend on culture because cultural schemas mediate between sensory experience and emotional reactions. Cultural schemas guide the way sensory stimuli are appraised, how meaning is assigned to events and the norms of behaviour. As a result, emotions are not uniform across all cultures (Castillo 1997:56). When confronted with an event, including traumatic events, a person will assess the situation cognitively, and arrive at an initial interpretation of the situation. This interpretation leads to an emotional feeling. For example, the physical sensation of excitement and anxiety may be similar, but the label assigned to the feeling will depend on one's initial appraisal of the event. The next step is a culturally based behavioural response (Castillo 1997:57-58).

Castillo (1997:58) points out that not all cultures experience the same emotions, nor do people from various cultures express emotion the same way. Culture imposes restraints on emotional expression. Social structures also define social status and different emotions and behaviours are considered proper or improper according to social rank, gender, ethnicity and so on (Castillo 1997:59). Proposition 11 states: "as experiences occur in the life of the individual, they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self" (Rogers 1951: 503).

Emotions that do not fit with the self of the cultural group may be inhibited, denied or distorted (Grobler et al 2003: 35). In addition, emotion tends to be expressed in ways that enhance and maintain the organism (Rogers 1951: 492). Open expression of some emotions may be socially unacceptable, especially for people in subservient positions. Culture determines how unexpressed emotions are handled. A means of expression needs to be found that allows the person to avoid being sanctioned or stigmatised. Castillo

(1997:60) suggests that one way in which such expressions may be achieved is somatisation, that is the expression of distress in bodily symptoms. Another means is dissociation, in which the person may take on an alternate identity to the cultural repertoire, for example, through spirit possession. The person expresses the unacceptable emotions in this state. The person avoids stigmatisation because he or she is considered to be possessed by a demon or spirit. These considerations are significant in the study of trauma, as will be discussed (see chapter 5). Some researchers have suggested that intrusive thoughts and memories of traumatic events seem to transcend cultural differences, but avoidance of reminders of trauma, numbing of emotions and hyper arousal seem more closely linked to cultural affiliation (Marsella et al 1996c: 121). In particular, people from non-Western cultures may express their response to trauma in the form of somatic symptoms which are almost entirely overlooked in measuring instruments derived in a Western context (Marsella et al 1996c: 121).

2.4 Culture, illness and behaviour

Every society has its own concepts of health and illness, normality and abnormality, what is appropriate and what is inappropriate. Cultures differ in the problems they identify and the way that difficulties are diagnosed and handled (Mokgatlhe 2001:36).

In particular, illness and mental disorders encompass a highly complex construction of experience and biology involving many factors with no clear boundaries between mental illness and mental health (Castillo 1997:3). Certain categories of behaviour or emotion may be considered abnormal, threatening or alarming within a community. Communities will protect themselves against whatever appears to threaten their self-concept, values continued existence, safety and so on. Communities also develop ways of dealing with individuals within the group who appear deviant and such persons may be viewed as mentally ill. Proposition 16 states: “Any experience which is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself” (Rogers 1951:515).

The community may defend itself against clinicians who offer interventions that do not fit the culture.

Communities also develop explanations for trauma, calamity and illness. When a member of a community experiences calamity, distress, trauma or illness, culture influences idioms of distress. These idioms are the ways people behave to express that they are ill. This can include physical actions, mannerisms, help-seeking, figures of speech and cognitive emphasis on certain symptoms and de-emphasis on others (Castillo 1997:29).

Culture influences the perceptions, meanings and diagnoses. Problems are diagnosed in a way that fits with culture and certain diagnoses and syndromes are culture-specific. Cultural meaning systems construct diseases that are experienced by the patient/client and are confirmed by the healer (Castillo 1997:29). Culture can also prescribe what is assumed to be appropriate treatment. Thus treatment is culture based. Culture also defines appropriate treatment outcomes (Castillo 1997:30). However, if the help seeker and helper are from different cultural backgrounds, the “illness” experienced by the client may not coincide with the “disease” diagnosed by the helper (Castillo 1997:31). As a result there is a difference between *healing* and *curing*. Treatment of illness, i.e. a person’s subjective experience is described as healing, while disease and curing go together (Castillo 1997:32).

2.4.1 Ways in which symptoms have meaning

Illness has meaning when an experience, whether a sensation, thought, emotion or behaviour is recognised and constructed as an indicator of illness. This means that the experience is interpreted within a cultural meaning system as an indicator of illness (Castillo 1997:33). People react as a whole to their experiences, with emotions, cognitions, physical sensations and so forth (proposition 3). The ill person is also affected by responses of significant others and the values and interpretations of his or her society. Illness assumes cultural significance that includes what society thinks about the ill person and whether the person is stigmatised or not. The person may have to live with the meaning imposed by culture (Castillo 1997:34). Illness acquires

personal and social meaning. Cultural groups have their own ideas that explain the onset of the problem, the effects, what course the illness will take and what treatments are appropriate (Castillo 1997:35). These meanings shape the suffering associated with the illness (Castillo 1997:34).

2.4.2 Healing

Healing means treating the person's subjective experience of distress, including distress induced by trauma or illness including mental illness or what is perceived as abnormal behaviour. Treating a person's subjective experience, that is healing, is important because illness is a subjective experience that may not coincide with disease as perceived by the clinician (Castillo 1997:77).

Proposition 11 states: "As experiences occur in the life of the individual, they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self" (Rogers 1951: 503).

This implies that treatment and diagnosis of the person must fit the self of the person and fit the norms, meanings and values of the culture. Communities make decisions that are consistent with the self and explanatory systems of the culture. This presents particular challenges in cross-cultural practice (Castillo 1997:77).

The healer should keep the distinction between disease and illness in mind because much of what constitutes distressing experiences or abnormality is made up of the cognitions, perceptions and emotions, especially those related to anxiety, hopelessness and helplessness (Castillo 1997:77). The meaning that is attached to the experience can create, perpetuate, exacerbate or alleviate the person's subjective experience of distress i.e. illness. Because the self of the patient emerges an interaction with significant others namely the clinician (proposition 9) the patient may take over the values of the

clinician (Castillo 1997:78). This is reflected in proposition 10 which states: “The values attached to experiences, and the values which are a part of the self structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as if they had been experienced directly” (Rogers 1951: 498). Clinicians develop their own perceptions and constructions of the client’s difficulties. These constructions may add to the client’s trauma. If, for example, the clinician views the person’s problem as a “genetically based incurable brain disease,” the clinician constructs a view that the problem is internal to the client (a disease) stable (chronic) and general (affecting may areas of life). This construction can create perceptions of hopelessness and helplessness for the person and exacerbate the emotional distress associated with the person’s difficulty (Castillo 1997:78). Such perceptions are contrary to the person-centred approach, which takes an optimistic growth orientated stance. Castillo (1997:78-81) suggests that healing should foster hope and be coherent with the distressed person’s cultural meaning systems. Interventions or explanations that do not fit the client’s cultural meaning system are likely to be rejected. Proposition 16 states: “Any experience which is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself” (Rogers 1951: 515). This implies that members of a cultural group will protect themselves from whatever appears to be a threat to their self-concept as a community, their values, their traditions or explanatory systems, that is perceptions. It is essential to understand the community’s own belief system and explanatory models to work with people within the community. Castillo (1997: 82) points out that folk healers are effective in treating the client’s illness as opposed to the disease and advocates the combined use of folk and western healing practices.

2.4.3 Healing that is coherent with culture

Castillo (1997:78) suggests that there are three components to healing that is coherent with culture, namely comprehensibility, manageability and meaningfulness.

- Fear of the unknown can worsen the illness. The unknown can be perceived as catastrophic by the client and exacerbate distress. Comprehensibility refers to enabling the ill person to understand the source of illness, the mechanism of illness and how it affects the body and his or her life. Folk healers are unlikely to tell a patient that the source of the illness is unknown. Their explanations vary from soul loss, soul theft, spirit attack, spirit possession, breaking taboos, neglect of ancestors, sorcery, witchcraft and biological disease. All these explanations are able to provide comprehensibility to the client and, as such, can be of value (Castillo 1997:79).
- The second component of healing is manageability (Castillo 1997:80). This relates to the perception that one is competent in meeting the demands of the illness, that the clinician is able to treat the illness and that the situation is not hopeless. The clinician should be perceived as a powerful and competent ally in handling the illness. Treatment methods may include ritual healing, cleansing ceremonies, or medication, depending on the cultural entity of the client (Castillo 1997:80).
- The third component in healing is meaningfulness. Meaningfulness refers to the provision of the sense of purpose in the illness experience. From a person-centred perspective, the traumatic experience or illness can be integrated into the person's life story and organised in a non-stressful relationship to the self. The illness ceases to be perceived as a threat. The creation of new meaning is consistent with proposition 15, namely: "psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self" (Rogers 1951: 513). On the one hand the ill or traumatised person may symbolise most of their experiences in a way that is consistent with the self of a community, confirming their self-perception. On the other hand the experience may be integrated or accommodated, that is restructured, acquire new meaning and be integrated into the self of the person or community (Grobler et al 2003:78). Religion, for example may provide a moral reason for the illness or create a perception that there is

value in the experience. For example, illness may be viewed as stemming from a breach of cultural taboos or from sin. These explanations suggest an avenue for symbolic healing in which atonement can be made. Similarly, if the suffering associated with the illness is given beneficial religious value, the experience and perception of suffering can be altered and the distressing emotions associated with the illness can be changed. Folk healers use rituals to provide symbolic healing. This process is precluded in a disease-centred approach, because, in a medical approach, disease does not possess meaning in a moral sense, whereas a spiritual-orientation allows this interpretation. Folk healers frequently make use of symbolic healing. Symbolic healing refers to the use of transformational symbols in healing rituals for the purpose of altering the meaningfulness of events, emotional experiences and illness. Transformational symbols can be objects, ideas or actions of the healer that transform the client's subjective experience. Examples include medicines, herbs, prayer, rituals, penance, holy objects, sacred words, incantations, proverbs, Scriptures and so forth (Castillo 1997:82-83). It appears that transformational symbols help to make unsymbolised experiences conscious and facilitates their integration into the self. Castillo (1997:82) attests to the value and effectiveness of folk-healing practices. He advocates the combined use of biomedical interventions and folk healing in a client-centred combination.

2.4.4 Healing and change

Proposition 17 states the conditions under which change and healing can occur: "Under certain conditions involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences" (Rogers 1951: 517). It seems that rituals and the use of symbols can create such a context for the ill person.

It is interesting to note that culture shapes the response of the community to the client's reaction to trauma, that is, the person's symptoms. For example, it is known that trauma can evoke a state of trance or dissociation. Trance is a narrowed focus of attention such that what is outside attention is lost to

consciousness (Castillo 1997:219). “Dissociation is characterised by a loss of integration of faculties of or functions that are normally integrated in consciousness” (Castillo 1997:219). This lack of integration may affect memory, sensation, motor function, cognition and personal identity or sense of self. Dissociation is based in spontaneous trance reactions to extreme stress such as combat, accidents, physical or sexual abuse or severe loss such as loss of a parent or sibling in childhood. These trance reactions seem to be universal phenomena with much cultural variation in how they are displayed, depending on prevailing cultural schemas (Castillo 1997:226-227). If trance responses are prolonged or repeated, they can lead to a development of separate streams of consciousness, which, in turn can evolve into separate conscious entities each with their own sense of identity, behaviour, memories and desires (Castillo 1997:227). In some cultures, for instance in India, these entities will be experienced as *spirit possession*. Castillo (1997:238) states that charismatic Christians may also attribute dissociative state to Satanic or demon possession. More commonly, in Western cultures, trance states may manifest as *separate personalities*, a condition that is labelled dissociative identity disorder. “Dissociative identity disorder (DID) is characterised by the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behaviour” (Castillo 1997:225). This is accompanied by dissociative amnesia. According to Castillo (1997:225) dissociative identity disorder is caused by spontaneous trance reactions to traumatic stress, usually occurring in childhood.

It is important to note that the self as shaped by culture influences dissociative experiences. In cultures with an independent construal of self, dissociative experiences tend to be experienced as separate, independent personalities. In cultures with an interdependent view of self, dissociative experiences tend to be perceived as a state of connectedness with wider spiritual forces. Persons in modern societies will seldom be possessed by ghosts, demons or deities but may dissociate into separate human personalities, while the converse is true of persons-in-pre modern societies (Castillo 1997:239). This demonstrates the central role of the self in shaping perceptions.

Trance states can be adaptive. They allow a person to escape from the constraints of reality. For example, dissociation may allow a child to escape awareness of sexual abuse. However, in Western cultures, individuals who dissociate, hear voices or report contact with spirits tend to be labelled as mentally ill and are usually stigmatised. In other cultures, this capacity may be valued and the person may well be integrated into the community as a shaman, mystic or folk healer. Trance states are used in many communities during religious rituals, allowing perceptions of direct experience with supernatural beings and providing opportunities for healing and maintaining group cohesion (Castillo 1997:220). Many individuals are skilled at entering trance states, particularly shamans, mystics and folk healers. Generally speaking, these people are not considered mentally ill within the culture, even though they hear voices and view themselves as possessing supernatural powers (Castillo 1997:219). This is an example of how a community may restructure a reaction to trauma in a way that promotes healing by creating new meaning for a phenomenon and integrating the individual's experience into the self of the community.

2.4.5 Culture specific syndromes

Some syndromes are culture-based entities that exist in particular cultural context and are responses to certain precipitants within the cultural meaning system. These entities have been labelled cultural bound syndromes, or, keeping in mind that all classifications are culture bound, culture-*specific* syndromes (Castillo 1997:37). Folk healers are frequently more effective in treating these syndromes than Western clinicians because the healer treats the "illness" rather than the "disease" diagnosed by the clinician (Castillo 1997:38).

2.5 Culture, healing and the body

Grobler et al (2003:211) state: "We can describe culture as being person-centred, existing in the minds of people, in their feelings, meanings, values, and behaviour." Although culture is shared to some extent by members of cultural groups, no two people share exactly the same cultural world (Grobler et al 2003:211). There are indications that cultural meaning systems become

ingrained in the nervous system of members of the community. Studies have shown that neural structures in the brain can be altered in response to trauma, medications, psychotherapy, personal experience and cultural learning (Castillo 1997:6). Each person's experience is constructed and the subjective construction of experience can differ widely in the same situation among different individuals. These constructions are sometimes called cognitive schemas. Cognitive schemas are largely dependent on cultural learning (Castillo 1997:6). Castillo (1997:39) states "Every human experience, including every thought, has its biological basis in the neural networks of the brain. The gross structure of the neural networks is defined by genetic inheritances, but dendritic structure, receptor properties and connections between individual neurones and the patterns of connection between neurons are developed over time through experience of the physical and social environment. Thus neural networks of the brain that control cognition, emotion and behaviour structured through the brains interaction with the environment, including the internalisation of cultural schemas" (emphasis mine). This implies that cultural schemas are internalised in the neural networks of the brain of members of a cultural group in a combination of shared learned perceptions and unique, individual perceptions thereof (Castillo 1997:20). As a result of enculturation, every individual learns a language, religion or cultural meaning system that is structured in the neural networks of the mind brain. For example, if you speak Zulu you must have neural connections for Zulu language encoded in the brain (Castillo 1997:268).

Patterns of connection between nerve cells and the strength of these connections are determined by use (Castillo 1997:268). By thinking in a language or habitually accessing certain beliefs, particular nerve pathways are created and strengthened. Castillo (1997:268) states: "In a very real sense, the socio cultural environment becomes physically structured in the brains of individuals." The gross anatomical structure of the brain may be the same in all humans, but the micro-anatomy varies with culture as culture-specific patterns of thought and meaning organise the way nerve cells connect together and create cultural schemas" (Castillo, 1997:268). However, the connections of synapses between neurones can be altered. This is known as

"plasticity." Synaptic modifications include synapse turnover, changes in synaptic transmission and long-term potentiation. Synapse turnover is a normal process in which synapses are modified in response to learning, experience, disease or injury. Synaptic transmission involves to the use of chemical substances (neurotransmitters), which carry the message from one nerve cell to the next. The transmission strengthens or weakens depending on use (Castillo 1997:269). Long-term potentiation refers to an enduring increase in functional synaptic strength. In this process a number of adjacent nerve fibres are activated together, which results in the formation of associations. This process is important for learning and memory.

These considerations indicate that, even though the basic structure of the brain is determined by genetic factors, personal experience mediated by culture places its own unique imprint on the micro structure of the brain. Specific neural pathways are reinforced and strengthened while others fall into disuse. This implies that cultural meaning systems are "wired" into the neural networks of the brain (Castillo 1997:270). Individual variations within a culture are mediated by the use-dependent plasticity of the nervous system (Castillo 1997:270). Relatively stable patterns are established through repeated experience, thought or behaviour (Castillo 1997:271).

2.6 Paradigms

Cultural meaning systems shape cultural entities, including mental illness and culture-specific syndromes (Castillo 1997:33). In one sense all syndromes are culture bound. Western medicine classifies and groups signs of distress and defines mental disorders accordingly. Other cultures have their own system of classification and nomenclature. These categories become reified. Reification means that human-made constructions are treated as if they possess their own independent reality. These constructions do not exist apart from the cultural meaning system that create them (Castillo 1997:19).

It is important to note that distress, and illness, including mental illness are structured by an indigenous set of cultural schemas (Castillo 1997:37).

Sometimes a set of cultural schemas is referred to as a “worldview” or a “paradigm.”

From within a paradigm, deviance tends to be regarded as ignorance, moral depravity or mental illness (Castillo 1997:13). Paradigms can give rise to ethnocentrism.

Disease-centred psychiatry, which is the approach of some practitioners in a Western culture, is an example of a paradigm. Within this paradigm behaviour that deviates from the norm is viewed as psychopathology or mental illness. Mental illnesses are assumed to be caused by specific biological anomalies or brain diseases. Disease centred psychiatry seeks to identify the biological factors that cause “mental illness.”

Within the biological/medical /disease-centred paradigm, it is assumed that people are more similar than different because all human beings are assumed to be the same on a biological level. Thus mental illness is assumed to show itself in the same way in all societies, regardless of culture. Attributing the signs of distress we observe in others to mental illness caused by brain disease is too simplistic to accommodate research findings, especially those of cross-cultural studies (Castillo 1997:6).

3 ETIC AND EMIC APPROACHES TO RESEARCH

There are a variety of approaches to cross-cultural research. One approach, the universalist approach, assumes that universal truths or principles can be uncovered. This approach is known as an “etic” approach. The underlying philosophy is that people are more similar than different and seeks underlying physical and mental qualities that lend themselves to the development of diagnostic categories and syndromes. This is the approach of the medical and psychiatric model of mental health/illness. It is assumed that mental illness will manifest similarly across cultures and that it is governed by universal causes and mechanisms (Mokgatlhe 2001:34). This approach facilitates comparisons across cultures. Other researchers argue that we can only understand behaviour, distress, health and illness if we take the cultural context into

account. These researchers adopt a more relativistic stance. This approach is known as an “emic approach”. It assumes culturally varied definitions of abnormality. An emic approach embraces findings that differ across cultures, so truth is conceptualised as culture-specific. The traditional African worldview, healing practices and view of illness, trauma and calamity can only be explained by an emic approach. Mokgatlhe (2001:35) suggests that Africans cannot be adequately understood using psychological and conceptual frameworks that have been developed from the experience of Euro-Americans. She did not specify which paradigms would be inappropriate.

Two independent systems of thought or worldviews co-exist in South Africa, namely the African worldview and the Western worldview. Both offer systems for explaining and treating distress that are based on entirely different assumptions. South African Black communities are often faced with a dilemma when in need of assistance as to whether to consult a Western or African practitioner or some combination of the two. Urbanization, industrialization and religious conversion have brought changes into many Black communities, undermining the group-orientated lifestyle that characterises Black society (Mokgatlhe 2001:38). As stated, most research and theory on trauma has emerged from Western countries, using the assumptions that underlie Western culture. A brief overview of these assumptions is present here followed by an overview of the African worldview.

4 THE WESTERN WORLDVIEW

4.1 The Western worldview is individualistic

There is a strong focus on individuality in the Western worldview. A person’s privacy, unique traits and self-reliance are valued. There is a belief that, since resources are scarce people must compete for them. Resources are acquired for personal use. People are expected to own and protect their possessions.

4.2 The Western worldview values material possessions

Material objects are valued. Owning possessions is a means of acquiring status.

4.3 The Western worldview is dualistic

In this perspective, distinctions are made between mind and matter, mind and body, feelings and beliefs, the spiritual and worldly realms.

4.4 The Western worldview is competitive

Competition is promoted and practiced. Emphasis is placed on winning, expressing oneself and getting ahead.

4.5 The Western worldview emphasises the nuclear family

The emphasis is usually on the nuclear family rather than extended family or clan.

4.6 The Western worldview's concept of time

Time is seen as moving from past to present with a strong focus on the future. Time is seen as scarce. It is believed that time should be used wisely to prepare and plan for the future.

4.7 The Western worldview values objectivity

There is an emphasis on being objective. Being able to distance oneself from a phenomenon and be critical and analytic is usually valued. Scientists are assumed to be able to separate their feelings from their thoughts and analysis (Mokgatlhe 2001:39-41).

This description is broad and there are variations in the Western worldview. It serves to highlight the contrasts between the Western worldview and the more intuitive, holistic, spiritual and collectivistic system of thought that characterises the African worldview.

5 THE AFRICAN WORLDVIEW

Viljoen (1997:616) emphasises that just as there are different views and theories within the Western perspective there are a variety of views within the African perspective. Therefore, what is written here is limited, because there is no single "African worldview." Nevertheless, despite the diverse African population groups, an overarching African perspective that is distinct form a

Western view can be discerned and there are similarities and themes in various African cultures (Louw 2007:46).

5.1 The African worldview is holistic

The African worldview is holistic and group-orientated. Humans and the cosmos are seen as an indivisible whole. Humans, nature and the spiritual or supernatural realm are regarded as an integrated unity (Viljoen 1997:617; Mokgatlhe 2001:39-40). Within this unity, three levels or orders can be distinguished, namely the macro –, meso – and micro – cosmos. These orders blend together in everyday life (Viljoen 1997:617). Strong emphasis is placed on spirituality (Mokgatlhe 2001:39). The macro-cosmos is the domain in which God and spirits are encountered. The belief is that God once lived with man, but withdrew, leaving the ancestral spirits as all-important intermediaries between men and God. God is believed to no-longer concern Himself with the affairs of men, but ancestors are prominent in this regard (Viljoen 1997:617). The meso-cosmos is understood as the realm where sprits, sorcerers and shamans such as rain makers, healers and priests are influential. Conflict and events such as sickness and death are explained with reference to these forces (Viljoen 1997:618-619). Such phenomena are attributed to external agents. Thus people are perceived as being at the mercy of supernatural beings or powers (Viljoen 1997:619). Lastly, the micro-cosmos is the domain of the person in his or her every day life.

5.2 The African worldview is collectivistic

The African worldview places strong emphasis on the survival of the group rather than survival of the individual, collective responsibility and unity with nature. It is assumed that a person becomes conscious of his or her being in the context of relationships. Consistent with the emphasis on connectedness is a strong sense of community and a tendency to be aware of support from community and duties and responsibilities toward the community. In-group solidarity is expected and there is a strong distinction between in- and out-group members (Mokgatlhe 2001:40). Teffo (1995:103) stresses that individuality is not negated in the African Worldview. What is discouraged is that the individual should take precedence over the community.

5.3 The African worldview values the extended family

People are valued for their role in society (Mokgatlhe 2001:42). When a man marries, his wife does not belong to him alone, nor do the children, but all are regarded as part of a corporate body of kinsmen (Viljoen 1997:621). Closely related to this sense of unity is a strong sense of being part of an extended family. The relationships within the family are defined by rituals (Mokgatlhe 2001:40).

5.4 The African worldview holds values of *ubuntu*

"*Ubuntu*" is a Nguni term which means "humanism" or the art of being human (Kamwangamalu 1999:37). The concept of *ubuntu* is found in other African languages, though the word itself may differ in different tongues. It is a multidimensional concept that represents certain core African values, namely respect for any human being, respect for human dignity and human life, collective sharing, obedience, humility, caring, solidarity, hospitality and interdependence. The common theme in *ubuntu* is that it is a value system against which members of a community measure their humanness. Teffo (1995:103) states that the ideal person, according to an African worldview is one who has virtues of sharing, compassion and social commitment to support others living in harmony, hard work, discipline, honour and respect are valued. These values are not innate but are transmitted within a society through proverbs, myths, stories and riddles (Kamwangamalu 1999:27).

The concept of *ubuntu* is portrayed in the following proverbs:

- *Motho ke motho ka bangwe* (A Pedi proverb meaning, Man is a man through others).
- *Bubedi lwa disu mbubedi lwa diulu* (The sickness of the eye is the sickness of the nose meaning "your neighbour's problem is your own problem.")
- *Mwena mutumba menwanenu* (A neighbour is a sibling meaning "care for your neighbour as you do for your siblings.") (Kamwangamalu 1999:27).

These proverbs reflect one of the core values of culture, namely communalism, according to which the interest of the individual is subordinate to that of the group (Kamwangamalu 1999:27). Interdependence is highly valued in Africa, whereas, in the West independence is valued. This can lead to clashes when differing cultures are brought into contact (Kamwangamalu 1999:30). Kamwangamalu (1999:27) suggests that no-one in an African culture lives for him or herself. Life is organised around the family, village and clan. Children, for example, belong not only to their parents, but are also under the authority and control of any adult in the community (Kamwangamalu 1999:28).

Ubuntu emphasises that each person owes his or her existence to others. A person comes from a social cluster and exists in a social group. This is expressed in the saying “a man can only be a man through others.” (Kamwangamalu 1999:29). The experience of self in relation to others seems to have been negative for Black South Africans where the society was fragmented by apartheid and *ubuntu* did not extend across racial divisions. Teffo (1995:102) believes that, in South Africa, others are not valued as “Other,” but different schemas exist for black people and white people. He states, “Being black in the world is to experience oneself as a problem, a non-being in the eyes of non-black. Blackness is a mode of being[existence]… ruptured by alienation, hate, indifference and confusion.”

Kamwangamalu (1999:35-38) questions whether *ubuntu* is unique to African cultures. He points out that *ubuntu* is a concept that can be encoded in English as “humanism”. He suggests that several ingredients of *ubuntu* are integral to Western psychological therapies, namely warmth, respect, compassion, empathy, support, mutual understanding of a shared worldview (Kamwangamalu 1999:33). Hanks (2008:116) has suggested that the values and philosophy of *ubuntu* are so closely related to the humanistic school of psychology, of which the person-centred approach is a part, that she views *ubuntu* as a paradigm within this school. Thus the person-centred approach appears to be well-suited to research with people who come from African cultures where *ubuntu* is part of the worldview.

Kamwangamalu (1999:35-38) suggests that the values evoked by *ubuntu* are shared by societies all over the world but, it is a sad fact that these values of *ubuntu* have not been lived out in either Western or non-Western cultures. How does one explain apartheid where the humanness of people was shattered? How does one account for the Nazi holocaust, or slavery where Westerners did not display respect for the dignity of others? He points out that human values have not only been disregarded by Westerners. In Africa, how does one account for political dictators whom Kamwangamalu (1999:37) describes as "political human monsters"? He suggests that practices in Africa such as "muti", where a person is killed for the purpose of using his body parts to advance one's own cause or status and the practice of witchcraft are a violation of the values of *ubuntu*.

It seems that *ubuntu* is an ideal, but communities, both African and non-African, often fail to implement it. When such violations occur, society as a whole is traumatised.

5.5 The African worldview and sense of time

The African view of time extends from the present to the past. The elderly are respected. Ancestors are believed to have significant influence. There is little focus on the future. Africans believe that the future has no meaning because it has not yet been lived (Mokgatlhe 2001:40).

5.6 The African worldview incorporates spirituality

According to the African worldview, all people, as well as animals and the plant world are filled with spirit. There is believed to be a relationship between them. The spirits of deceased ancestors are believed to be active in the world of the living. Relationships with ancestors are regulated by rituals, which often incorporate the slaughtering of animals to appease the ancestral spirits. Both supernatural and natural causes are believed to bring illness or calamities. Thus trauma may be explained by indigenous South Africans with reference to spiritual forces. Bodibe (1992:151) states that, according to the African worldview, all afflictions are explained in terms of failure to propitiate the gods, or as a consequence of going against the will of the ancestors. Essentially, in

African thought, danger is always lurking and one is protected from calamity by the ancestors. Other sources of mental and physical distress are sorcery and witchcraft. Marginalised and vulnerable people in the society are frequently the targets of these activities. Sorcery is the use of medicine or magical substances to cause harm and witchcraft is the manipulation of psychic powers. Trauma can be sent by these agents. These beliefs themselves can exacerbate trauma. Kirmayer (1996:132) states “seemingly trivial events may be terrifying if they are interpreted as evidence of black magic or the action of malign spirits. Where such beliefs are prevalent they may not, in themselves indicate individual pathology but may reflect widespread social concerns, manifested in individuals who are vulnerable not only because of their personal characteristics but also because of their social positions.”

6 THE INFLUENCE OF THE AFRICAN WORLDVIEW ON MATTERS OF ILLNESS AND TRAUMA

The African Worldview influences beliefs about the causes of trauma, calamity and illness and how such matters should be remedied. The emphasis on wholeness in the African Worldview means that the interrelatedness of all life forms is taken for granted. Little distinction is made between the mental and physical, the physical and spiritual or the individual and group. According to Poland and Hammond-Tooke (2004:26) ancestors are believed to watch over the living with a benevolent eye. If, however, one fails to build up the household, the anger of the ancestors may be provoked. This anger is typically believed to be triggered by failure to provide hospitality to the wider community or by any display of disrespect to older members of the family by junior members. Behaviour that threatens the well being and equilibrium of the social system such as selfishness, aggression, arrogance or envy are believed to precipitate mental problems (Beuster 1997:6; Mokgatlhe 2001:43). Illness or calamity may be sent as a warning or punishment. Thus the origin of illness, calamities and traumas are believed to be punishment from the gods, a curse, witchcraft, natural causes, a disruption in social relationships, angry ancestors, possession by evil spirits or the breaking of customs or taboos (Mokgatlhe 2001:43).

6.1 Perceived causes of illness and traumatic events

Beuster (1997:9) states that, traditionally, Africans do not believe in chance(random causes). They believe that the causes of all problems can be uncovered. Little distinction is made between the mental or physical realm. The Zulu and Xhosa people group disorders into two broad categories, based on the perceived cause of the difficulty. Some disorders are ascribed to natural causes and are categorised as "*umkhuhlane*". The other category, "*ukafaa Kwabantu*" refers to disorders that are ascribed to supernatural factors such as God, ancestors, magic or pollution. Disorders that are ascribed to natural causes include colds, flu, venereal disease and malaria. Traditional Black people are generally willing to consult Western practitioners about such problems.

Traditional healers are called upon to deal with all problems relating to ancestors, witchcraft, sorcery, possession or other spiritual forces. The task of the healer is to use divination to uncover the cause of the problem and prescribe a remedy.

6.1.1 God as a causative agent

In rare cases, disease or misfortune is ascribed to God, but only if no other cause can be identified by the traditional healer. Although God is acknowledged as the Creator, the role played by God in the individual's life is perceived as distant and abstract. Christianity has influenced these ideas, particularly in the Zionist churches, where a fusion of traditional African and Christian beliefs are found. In this church, possession states are attributed to the Holy Spirit (Beuster 1997:9).

6.1.2 Ancestors as a causative agent

Although explanations for misfortune or illness seldom refer to God, the ancestors are believed to be deeply involved in such situations. The living spirits of the dead are known as "*Badimo*" (Sotho) or "*Amadlozi*" (Zulu). The ancestors are one's forbears.

Generally the ancestors are believed to preserve the honour, traditions and good reputation of the tribe. They are believed to maintain intimate relationships. They are believed to provide protection against evil and destructive forces (Mokgatlhe 2001:44; Beuster 1997:10). However, transgressions can be punished by sending misfortune, calamity, trauma or illness as a warning to amend one's ways and follow the culturally prescribed code of conduct. To avoid punishment, many birth, initiation, marriage and death rites must be performed. If ignored punishment in the form of ill-health, misfortune, lack of material resources or even death of a family member may ensue (Mokgatlhe 2001:44).

The ancestors also require offerings in the form of animal sacrifices and sorghum beer. They need to be informed of developments in the family, such as marriages or births. They may call individuals to serve them as a diviner or *sangoma* (Zulu) (Beuster 1997:10). If these demands are ignored, calamity may follow. Favour can be regained by performing certain rituals (Beuster 1997:10).

6.1.3 Witchcraft and sorcery as causative agents

The traditional healer may divine that witchcraft or sorcery are at work. The traditional African people believe that witches and sorcerers have the power to intervene in the affairs of humans. Witches are believed to have the power to change shape or become invisible, so they can cast spells without being detected. They are also believed to manipulate supernatural creatures, called familiars to inflict trauma on their victims. Familiars can be mythical animals, snakes, rodents, owls or supernatural creatures such as the "*Thikoloshe*". The *Thikaloshe* is a small man with one buttock and a giant penis that is carried over the shoulder (Beuster 1997:11). A *Zombie* or "*Izitunzela*" is a familiar that is a living corpse with no tongue. Witches use these creatures to inflict trauma or mental illness in the lives of their victims (Beuster 1997:11). Another agent who can affect the affairs of others is the sorcerer. Sorcerers do not have supernatural powers, according the African beliefs, but use magic potions, medicines or poison to inflict harm or suffering on others. Sorcerers may

poison their victims or may cast spells by blowing powder while using the victim's name (Beuster 1997:11).

6.1.4 Pollution as a causative agent

Indigenous South Africans believe that certain situations or circumstances can cause contamination or pollution. These conditions are associated with the reproductive system, sexual intercourse, and a woman's menstrual cycle. Situations relating to death, miscarriage and abortion are also believed to be the cause of contamination. Even going on a long journey is believed to place one at risk for possession by spirits in a strange area. Thus illness, trauma or adversity may be the result of exposure to a polluted environment associated with major life events such as birth, death, miscarriage, abortion and menstruation. States of pollution demand cleansing rituals involving washing, vomiting and purging (Beuster 1997:12). Contamination may be avoided by being strengthened or immunised, using culturally prescribed rituals.

The African belief in the connectedness between the individual and the environment is evident in these beliefs.

7 THE TRADITIONAL HEALER

The traditional healer plays a prominent role in traditional African society in dealing with trauma, calamity, personal relationships and illness. There are various healers. The *inyanga* is a man or woman, who, after being selected by the ancestors through illness or dreams, undergoes training under the mentorship of a healer. It is believed that the power of healing spirits enters this person, who, in turn, practises as a healer. A *sangoma* is a healer who can see into the future and distant past. Once they are in a trance, they are believed to communicate with the ancestors to tell the person seeking help what is wrong. The *herbalist* is the traditional pharmacist who is well-versed in the medicinal properties of plants and herbs which are used to effect a cure for various ailments (Bodibe 1992:152). According to Bodibe (1992:152) there are two common factors in the manner in which traditional healers receive their calling. Firstly, the ancestors are involved and secondly, therapeutic skills are acquired via the route of illness. Among the Nguni people of South

African, an illness known as "*Ukuthwasa*" is believed to be a positive calling by ancestors to become a traditional healer. Symptoms of "*thwasa*" differ from person to person. Somatic symptoms could be stomach-ache, nervousness, back pain, wrist pain, prolonged hiccups, flatulence, numbness or conversion reactions. Behaviourally, the person may withdraw socially, neglect grooming and hygiene, wander around aimlessly and complain of excessive dreaming. People may report that an ancestor appeared to them in an altered state of consciousness (Bodibe 1992:13-14; Mokgatlhe 2001:48). The person enters a period of treatment/training under the mentorship of a practising traditional healer. The candidate learns to use bone throwing for divination as well as the use of herbs. Attention is paid to singing, dancing and drumming and the person learns to hear and interpret messages from ancestors as conveyed in dreams, visions, illnesses and calamities (Bodibe 1992:153). Divination is a state of altered consciousness in which the ancestors make their messages known as the healer acts as a medium (Mokgatlhe 2001:48). *Twasa* is a culture-specific experience that is often confused with schizophrenia because the person manifests with hallucinations, delusions and wild behaviour when seen from a Western perspective. Mokgathle (2001:48) believes that *twasa* cannot be treated by Western methods of intervention. Treatment involves animal sacrifices within the family or training as a traditional healer.

7.1 Healing practices

Illness or distress is not seen as located in an individual, but its significance is grasped in terms of interpersonal relationships. Healing, in turn, involves the entire group. Spirituality and rituals are important aspects of healing, set in motion by a traditional healer (Mokgatlhe 2001:44). Diagnosis is intuitive, experiential and symbolic. Africans do not distinguish between consciousness, dreams or hallucinations nor between religious beliefs and empirical reality (Beuster 1997:7). In the African tradition, it is the duty of the *sangoma* or healer to diagnose by means of divination (Beuster 1997:8). The afflicted person usually enjoys social support and is made the object of social concern. The prescribed rituals relate the person to the wider cosmological and social sphere (Beuster 1997:8).

Bodibe (1992:153) describes the healing practices of healers in a traditional Xhosa culture. Ritual dancing, singing, relating of dreams and divination are core practices. The rituals take place in a closed, circular hut. The wall of the hut is lined by a ring of chanters and drummers. Within this circle, other traditional healers and trainees arrange themselves around the hearth at the centre. A rhythmic circular dance is performed to give expression to pent–up feelings. Certain songs are regarded as communication with the ancestors. Treatment involves not only the psyche of the client, but also the body. During the dance, energy is generated and the person enters an altered state of consciousness. The client relates troublesome dreams. It should be kept in mind that the dreams are seen as messages from the ancestors. The traditional healer interprets the dream's meaning and prescribes treatment.

8 A BRIEF COMPARISON BETWEEN AFRICAN AND WESTERN COUNSELLING PRACTICES

There are similarities between the healing practices described above and Western counselling. Both emphasise the importance of building a relationship based on trust. Both aim at wholeness and positive growth. Both emphasise the expression of feelings (Bodibe 1992:155).

However, there are differences. Western thinking and culture influence counselling in several ways. Central to the Western worldview is a focus on individuality. Thus counselling is confidential and is often offered on a one to one basis, whereas in African culture, help is offered in a communal context. Western counselling tends to focus on the individual whereas the African approach emphasises the integration of the person and the community. Western thinking is influenced by ideas of reductionism, meaning that if you study something in more and more detail, you will understand the whole. The scientist is assumed to be analytical and objective (Bodibe 1992:150). In contrast, in African thought, the part is understood with reference to the whole. The African approach is symbolic and intuitive, linked to African beliefs, cosmology and spirituality. Western therapies are based on logical principles which have no direct link to religious or spiritual beliefs.

In African culture, the diviner is directive in his approach as the mouthpiece of the ancestors, endowed with special powers and wisdom. Western counselling, especially from a person-centred approach, is based on the principle that the client is responsible for his or her own decisions and actions.

The African tradition stresses unity of body and mind whereas Western culture often holds a dualistic view. Dualism suggests that there is a distinction between mind and matter, thinking and feeling, subjectivity and objectivity.

Traditional healing utilises vibrant dancing, singing and trance whereas Western counselling tends to be more, cerebral, sedate and abstract (Bodibe 1992:155-156).

9 CHAPTER SUMMARY

It is essential that social workers should be sensitive to the cultural context in which they operate. Ignoring a person's cultural background can only result in misunderstanding and ineffective interventions. Striving to understand and empathise with another person's frame of reference or worldview is an integral part of the person-centred approach.

A person-centred perspective recognises that no person can be understood independently of his or her beliefs, values, traditions, myths, symbols, religion, language, thought patterns or customs. Individuals are carriers of culture, are influenced by culture and, in turn, influence culture. All individuals exist within a culture and tend to see life with reference to that background or worldview. Therefore culture influences what is perceived and how perceptions are interpreted. It shapes the manner in which distress is treated and handled. Mokgalthe (2001:31) states "we can therefore argue that although people from all cultures are more similar than different and in this way identify many psychological constructs and skills applicable in all cultures, it would be simplistic to over generalise and accept that Western psychology is applicable to Africa in all it's aspects". Most research on trauma has been carried out by researchers operating from within a Western worldview while the African worldview has been largely unstudied (Marsella et al 1996c: 116; Mokgatlhe

2001:30). This chapter presents an overview of the African worldview that differs significantly from a Western perspective. There is a dearth of literature relating the African worldview and trauma. Although cross-cultural studies abound in America, but these studies refer to ethnic minorities in America and provide little insight into cultural differences in South Africa. Cross cultural research carries an inherent risk of ethnocentric bias. The current study, conducted by a white South African, could fall prey to this trap. The researcher has reviewed the literature in an effort to gain insight into the role of cultural meaning systems, the African worldview, as well as distinctions between this orientation and the Western culture in which she was raised have been noted.

Broadly speaking, a Western worldview promotes individuality, competition and materialism. The emphasis in families tends to be on the nuclear family. Time is conceptualised as being made up of a past, present and future with an emphasis on forward planning. Reductionism, dualism and analytical thought characterise this perspective. In contrast, the African worldview promotes collectivism and a group orientation. The emphasis in families is on the extended family. Time is conceptualised as being made up of an immediate present and a long past. Holism is central to the African worldview. Ubuntu is a value system which emphasises respect in one's relationship with others. A person is defined by his or her social relationships. Spirituality features powerfully in the African worldview. Calamities, material lack and illness are explained and handled with reference to this realm.

Healing practices in both African and Western cultures share the features of a trusting relationship in which growth and expression of feeling is promoted. However, diagnostic and treatment practices differ. Western counsellors adopt a confidential, individual approach, while African healers promote group participation and strive to re-integrate the help-seeker into the group and wider cosmos. Western practitioners use principles of reason and critical analysis in making a diagnosis while African healers are intuitive in their approach and use divination in their rituals. Western practitioners working from a person-centred perspective are non-directive whereas African healers

are authoritative and directive. Western healers rely on rational thought and the scientific method to guide their practices whereas African healers rely on spiritual explanations and divination. Western counsellors are licensed following University education whereas African healers are “called” in a culture-specific syndrome and are trained through a mentor.

It is recognised that culture is not static and Black African people vary in the extent to which they identify with their beliefs. In South Africa, the influence of industrialization, urbanisation, politics, religion and capitalism have been instrumental in modifying African value systems and practices (Mokgathle 2001:40).

There is controversy in the literature as to whether an etic or emic approach should be followed in cross cultural research. A person-centred view suggests that people cannot be understood apart from the cultural context through which their perceptions and understandings are filtered and mediated. This chapter represents an effort to understand the African perspective, and other cultural views which differ fundamentally from the researcher’s own Western background.

CHAPTER 5

A WESTERN WORLDVIEW OF TRAUMA

1 INTRODUCTION

Sometimes a set of cultural schemas is referred to as a “worldview” or a “paradigm.” The perceptions, values, traditions, explanations, norms and beliefs of cultural groups are contained in cultural meaning systems, which systems express the self, as described in the previous chapter. All communities develop cultural meaning systems (Castillo 1997:20). This applies to the scientific community as well. Meaning systems within the scientific community are called “paradigms.” Paradigms are less comprehensive than cultural meaning systems (Castillo 1997:285). “A paradigm is a generally accepted view of the nature of the scientific discipline; the paradigm defines the discipline in question and sets limits on enquiry” (Castillo 1997:12). This means that paradigms guide and influence a field of study, including the study of trauma. Researchers and practitioners working from a particular paradigm generally assume that the paradigm is an accurate description of their field. The assumptions and premises on which the paradigm is based tend to go unquestioned (Castillo 1998:12). The paradigm provides a foundation of knowledge, the limits of knowledge and defines what problems are relevant, what methods can be used and what solutions are fitting and acceptable (Castillo 1997:12). These considerations relate to proposition 11 in which Rogers suggests that when an experience is symbolised and fits with the self, it is integrated into the self. When an experience is perceived as irrelevant to the self, it is ignored (Rogers 1951: 503). The self evolves in interaction with the environment and in turn acts as a lens through which the world is viewed according to propositions 9 and 10 (Rogers 1951: 498). In the same vein, a person is prepared for admittance to a community such as the scientific community by formal study of a paradigm. During this process, the person learns how to apply the rules of a paradigm and operate within its boundaries as well as what constitutes deviance.
The self, or paradigm guides or directs behaviour according to proposition 12 (Rogers 1951: 507).

The medical/biological model, which is the approach of some practitioners in a Western culture, is an example of a paradigm. Within this paradigm behaviour that deviates from the norm is viewed as psychopathology or mental illness. Mental illnesses are assumed to be caused by specific biological anomalies, brain diseases or chemical imbalances. Psychiatry, a branch of medicine, and neuroscience, seek to identify the biological factors that cause "mental illness." Most research on trauma has been carried out in countries that share a Western Worldview, particularly under the umbrella of medicine and as a result a substantial proportion of the literature is based on the concept that responses to trauma are biological in nature and, if prolonged, constitute a culturally defined disorder (Marsella et al 1996c: 116). The medical model seeks to diagnose and label such disorders. The person-centred approach does not engage in diagnosis and labelling, as does the medical model, but the constructs put forward by the medical model, namely post traumatic stress disorder is so widespread in the literature that any discussion of trauma would be incomplete without it. This concept is presented here as a cultural product of Western society that is a particular frame of reference from which trauma may be explained and managed. It is presented as one perspective, not the truth about trauma. It is currently the dominant paradigm.

The practical component of this study focused on the perspectives of participants themselves. The aim of this chapter is to acknowledge the perspective of the positivist, medical model. The biological/medical paradigm has generated much valuable research in the field of trauma. Although it is based on different assumptions to the person-centred approach, this paradigm has provided insight into the biological responses to frightening events and suggests possible mechanisms through which experiences such as flashbacks, nightmares, somatic complaints and dissociation, which may be part of the traumatised person's experience, can be explained. It offers explanations as to why certain threatening experiences may remain unsymbolised and suggests possible mechanisms that underlie this phenomenon. In other words, it is relevant to social workers and others who adopt the person centred approach, because it offers an explanation for certain of Rogers' (1951) propositions, although this connection is not

specifically stated in the literature reviewed. The researcher has made these connections in this chapter. The researcher was formerly a physiotherapist, trained in the biomedical model so she found the link between the propositions of the person-centred and research from a medical perspective fascinating and meaningful. The medical model will be evaluated from a person-centred perspective at the end of this chapter.

2 THE DSM IV-TR

Castillo (1997:275) states, “[t] here are culturally specific ways of being normal.” Conceptions of health and illness including mental illness are based on cultural schemas (Castillo 1997: 277).

Paradigms are influenced by prevailing views in society at large, just as the self emerges in interaction with others according to proposition 9 and 10 (Rogers 1951: 498). The terms “psychopathology” and “mental illness” suggest that one way that Western Societies explain behaviour or emotions that deviate from the social norm is that they are linked with “illness” or biological factors. This has not always been so. Western cultural schemas have changed and evolved over time. For example, Greek philosophy influenced Western civilization and thought. In ancient Greece, a distinction was made between the body and the mind (also referred to as the soul or psyche). The cause of abnormal behaviour was sought in one entity or the other. In addition, throughout history, people have supposed that agents outside our bodies such as spirits, divinities, demons, the moon or stars could influence behaviour. There have been times, particularly during the middle ages when deviant behaviour was explained predominantly in terms of witchcraft and demon possession in the Western World. Other explanations centred on the moon and stars, hence the term “lunatic” that may be used to describe a person exhibiting culturally strange behaviour (Barlow & Durand 1995:8-16).

About 100 years ago the nature and cause of syphilis was discovered and with it an explanation for the hallucinations and delusions that are associated with the condition emerged (Barlow & Durand 1995:17-18). Syphilis was

shown to be caused by a germ. When a cure for syphilis was found that altered the behavioural and cognitive symptoms associated with the disease, attention shifted to possible biological explanations for what was seen as abnormal behaviour and emotions. As drugs were discovered that influenced these conditions, theories and explanations for culturally defined abnormal behaviour shifted towards biological factors (Barlow & Durand 1995:18-19). Attention was also paid to environmental influences, giving rise to psychological therapy (Barlow & Durand 1995:19). The point is that much research and treatment of what the Western world saw as abnormal behaviour took place under the umbrella of medicine, giving rise to the medical model of psychopathology. A model is an analogy that is used to describe a process that cannot be observed directly (Sue, Sue & Sue 2000:33). The medical model dominated the study of abnormal behaviour from the 1960's to the 1980's when many researchers believed that so called mental disorders were caused primarily by chemical imbalances or genetic abnormalities, giving rise to disease centred psychiatry (Castillo 1997:3). However treatment with medication led to somewhat limited success and it became apparent that so-called abnormal behaviour could not be attributed purely to biological factors. It also became apparent medication treated symptoms not diseases (Castillo 1997:3). Castillo (1997:5) points out that it was assumed that the brain and its physiological processes are the same in all people, that is although people may not think the same thoughts, they think in the same basic way from a physiological point of view. It was assumed that the biological responses to traumatic events are likely to be the same across cultures. However cross-cultural studies revealed wide variations in the course of mental disorders and responses to pharmacological interventions were not consistent, especially in studies on schizophrenia (Castillo 1997:4). It gradually became clear that a purely biological explanation for so-called abnormal behaviour was simplistic as the brain proved to be more plastic (modifiable), than expected. It has been found that psychotherapy can alter the brain's structure and biochemical processes. Therapy can also alter neural networks and connections in the brain (Castillo 1997:82; Barlow & Durand 1995:59-64). The role of learning and culture were shown to affect the nature, course and outcome of so-called mental problems. It emerged that

cultural meaning systems are encoded in the micro anatomy of the brain, influencing the nature of neural connections and the strength of these connections as well as the pre-disposition for particular pathways to be activated (Castillo 1997:82; Barlow & Durand 1995:59-64). This implies that each person's experience and perception of trauma is unique but members of cultural groups may be similar to each other in terms of the meaning they attach to these events and the way they display and manage the distress generated by these experiences (Castillo 1997:5). Thus the role and importance of the social and cultural environment became apparent (Castillo 1997:3-4).

Currently, the medical model has been broadened to take the effects of culture, biology and the environment into account. The medical model assumes that certain behaviours and emotions, regardless of the cause, constitute symptoms and that clusters of symptoms denote specific definable disorders (Castillo 1997:3). Symptoms have been classified and specific categories of disorders have been constructed on this basis, such as anxiety disorders, somatoform disorders (disorders relating to bodily symptoms), mood disorders, personality disorders, dissociative disorders (disorders of consciousness and memory) and a host of others. The classification system devised by the American Psychiatric Association (APA) is known as the Diagnostic and Statistical Manual. Currently the fourth edition of the manual is in use and is known as the DSM IV-TR (APA 2000). The DSM IV-TR is a cultural entity. A group of experts communicated with each other and collectively decided on what constituted a particular disorder (Castillo 1997:22). The DSM IV-TR operates as a set of constitutive rules that have the power to create cultural entities and once created, these entities can be reified (Castillo 1997:23). Reification means that human-made constructions are treated as if they possess their own independent reality. These constructions do not exist apart from the cultural meaning systems that created them (Castillo 1997:19).

The manual lays down the basis for the diagnosis and labelling of disorders. The DSM IV-TR includes criteria for Posttraumatic Stress Disorder (PTSD)

and Acute stress disorder in an effort to define how a traumatised person may be recognised. Castillo (1997:277) points out that any professional diagnosis is a culture-based reality. It should be emphasised that the DSM IV-TR is based on a Western Worldview in which the principles of cause and effect relationships, reductionism and dualism are enshrined.

The person-centred approach does not engage in diagnosis and labelling, based as it is on a phenomenological approach to people's experiences. Although the biological/medical model is based on different assumptions to the person-centred approach, this model has provided insight into the biological responses of animals and humans to frightening events. Research has demonstrated changes in the central nervous system, in neurotransmitters and physiological responses that suggest explanations for the hyper reactivity, loss of responsiveness, dissociation, memory disturbance and somatic complaints that may be part of a traumatised person's experience (Van der Kolk & Saporta 1991). Explanations have been offered as to why certain threatening experiences may remain unsymbolised and possible mechanisms that underlie this phenomenon have been explored. A review of the literature pertaining to these findings is presented here.

3 POSTTRAUMATIC STRESS DISORDER (PTSD)

The American Psychiatric Association introduced trauma as a construct in the third diagnostic and statistical manual (DSM III) as a "catastrophic stressor that would evoke significant symptoms of stress in most people." Initially trauma was defined in terms of the event itself. Furthermore trauma was thought to be "a rare and overwhelming event, generally outside the range of usual human experiences." Events that fitted this definition of trauma included rape, assault, incarceration, in a death camp, military combat, natural disasters such as earthquakes, accidents, war and domestic violence. These experiences were assumed to differ from "common experiences" such as bereavement, chronic illness, business losses or marital conflict (Friedman 2006:2). However, it become apparent that exposure to events classed as trauma in the DSM III are far from rare and almost 50% of all Americans will be exposed to at least one traumatic event such as assault, military combat,

accident, rape or domestic violence. It also became evident that many people can and do absorb the impact of such events (Friedman 2006:3). Therefore the definition was changed to focus not on the event itself, but on the person's *response* to the event. The DSM IV-TR constructed criteria for the condition "posttraumatic stress disorder" to describe the condition and experience of a person when the effects of a distressing event persist for at least a month after the event. These criteria are divided into six sections labelled A-F and are as follows:

3.1 Diagnostic criteria for 309.81 posttraumatic stress disorder

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

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

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

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed
2. Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognisable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific re-enactment may occur
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

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

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

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

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper vigilance
5. Exaggerated startle response

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

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

Specify if:

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

Specify:

With Delayed Onset: If onset of symptoms is at least 6 months after the stressor. (APA: 2000:467-468).

As discussed previously, the concept of diagnosis is not compatible with a person-centred approach. Nevertheless, the concept of PTSD is discussed here as a frame of reference adopted by many medical practitioners and writers in the field of trauma. To be diagnosed with PSTD a person must have been exposed to a catastrophic event (the A1 criterion) and must display emotional distress because of the exposure (A2 criterion).

3.2 EXPLANATION OF THE CRITERIA FOR POST TRAUMATIC STRESS DISORDER

3.2.1 The A1 criterion

People who meet the DSM IV–TR A1 criterion have been exposed to an event that involves actual or threatened death or injury, people who have witnessed

such events or people who witness the aftermath of the catastrophe (such as dismembered bodies) but were never personally in danger also meet the criterion. Finally the person may also be “confronted with” a life threatening event, such as hearing about the violent rape of a loved one, but has not seen or gone through the experience personally (Friedman 2006:11).

3.2.2 The A2 criterion

Some people exposed to events that meet the A1 criterion do not experience distress. To meet the diagnostic criteria, the person must experience distress. The DSM IV–TR characterises the nature of the distress as fear, helplessness or horror. If the person does not experience one or more of these responses, he or she does not meet the criteria for PTSD. This often applies to medical staff, social workers and emergency personnel who are exposed to traumatic stressors continually as a result of their personal responsibilities (Friedman 2006:11). Trauma, in this definition refers to situations in which one is rendered powerless and danger is involved.

3.2.3 Criteria B, C and D symptom clusters

PTSD consists of three symptom clusters that relate to re-experiencing the trauma (criterion B), avoiding it (criterion C) and hyper arousal (criterion D).

3.2.3.1 Intrusive symptoms (criterion B)

Flashbacks are intrusive symptoms of trauma. A flashback is a sudden vivid recollection of the traumatic event, accompanied by strong emotion (Matsakis 1996:22). The traumatic event may be re-played in the form of vivid recollections of the incident in which the person is thrust back into the episode as if it were happening again and he or she loses contact with the present. The person does not lose consciousness but may or may not lose contact with the present. This is also referred to as a brief psychotic episode or acute dissociative state (Friedman 2006:5). Flashbacks may involve one or more senses. He or she may “see” the event, hear the sounds or smell the odours associated with it. The person may act as if he or she were in the original traumatic situation. Auditory flashbacks differ from the voices associated with the psychotic episodes and schizophrenia in that they are very close to the

sounds heard in the original trauma. Somatic flashbacks can take the form of pain, panic attacks, difficulty breathing or medical conditions when the feelings and bodily sensations experienced in the trauma emerge as bodily sensations, pain, breathing difficulties or other somatic symptoms for no apparent reason (Matsakis 1996:22-23).

People with PTSD have chronically disturbed sleep which appears to be linked to hyper arousal. They are extremely sensitive to sounds during sleep which precipitate nightmares (Van der Kolk & Saporta 1991). Nightmares may disrupt sleep. Nightmares associated with PTSD have an eidetic (picture–like) quality rather than on oneiric (dream-like) quality (Van der Kolk & Saporta 1991).

Re-experiencing may take the form of thinking or feeling as if one were back in the traumatic situation. The trauma may be re-experienced on an emotional level as anger, sadness or panic that arises without any conscious thought of the traumatic event.

Re living the trauma may be sporadic or cyclical. It may be triggered by anniversaries, life cycle transitions or stimuli in the environment that act as triggers, sparking the memories. These are all symptoms of intrusion or re-experiencing the trauma (Matsakis 1996:21; Friedman 2006:5).

3.2.3.2 Numbing and avoidance (criterion C)

Numbing and avoidance are cognitive, emotional or behavioural strategies that are used to ward off the distress of the trauma itself or the intrusive symptoms associated with it. Avoidance involves making efforts to avoid feelings, activities, places, conversations and people associated with the trauma. Some people display psychogenic amnesia, that is, inability to recall aspects of the trauma, or inability to recall the incident at all. The person may suppress feelings in order to block out the emotions associated with the trauma. This is known as psychic numbing (Friedman 2006:6; Matsakis 1996:26). These responses may leave the person feeling alienated from

others, unable to enjoy previously enjoyable activities and a loss of joy or hope for the future.

3.2.3.3 Hyperarousal (criterion D)

The possibility of death or injury can give rise to fear and anxiety. Seeing or knowing about the death, injury or harm of others may give rise to feeling of grief and horror. Strong feelings of anger may be generated. All these emotions have a strong physiological component (Mastakis 1996:27). In a dangerous situation, adrenaline (a stress hormone that produces alertness) may be released, placing the body in a state of heightened alertness. The person who was traumatised may continue to exist in a hyper-reactive psychophysiological state that includes an exaggerated startle response, difficulty falling asleep, difficulty staying asleep, and difficulty focusing on a task or concentrating. This inner tension may manifest in irritability or outbursts of anger. People who have been exposed to dangerous or horrifying situations may display hyper vigilance, becoming very concerned with the safety of themselves or loved ones (Matsakis 1996:28-29).

This cluster of symptoms closely resembles the DSM IV–TR criteria for panic disorder and generalised anxiety disorder (Friedman 2006:6).

3.2.3.4 Duration (criterion E)

Most of these responses are expected after an upsetting event. The DSM IV-TR specifies that PTSD can only be diagnosed if the person has experienced these responses for at least one month.

In summary, to receive a diagnosis of PTSD according to the DSM IV-TR, one must:

1. Be exposed to an event in which one experienced, witnessed or was confronted with an event that elicited feelings of fear, helplessness, or horror.
2. Display one or more intrusive symptoms
3. Display three or more avoidant symptoms
4. Display two or more hyper-arousal symptoms

5. The disturbance must cause a disturbance in the person's social, occupational or other important areas of functioning
6. These symptoms must be present for at least one month. If they are present for more than one month but less than three, a diagnosis of acute PTSD is made. If symptoms last more than three months, a diagnosis of chronic PTSD is given. If symptoms only manifest six months or more after the event, a diagnosis of delayed PTSD is made.

PTSD cannot be diagnosed until a month has passed since the trauma. Prior to this, another condition, acute stress disorder is diagnosed, which manifests within four weeks of the event. The predominant features are dissociation accompanied by some re-experiencing, avoidance, anxiety or arousal, lasting for a minimum of two days. The cut-off point of a month is seen as somewhat arbitrary (Mastakis 1996:30). In addition, strong reactions to extreme stress may be considered normal and appropriate, but result in the diagnosis of a "disorder" according to the DSM IV-TR (Gerrity & Solomon 1996:88). This highlights the constructed and somewhat arbitrary nature of the classification system. There is substantial overlap between acute stress disorder and PTSD as can be seen in the following criteria laid down by the APA and distinction on the basis of 30 days seems arbitrary.

3.3 DSM–IV–TR diagnostic criteria for 308.3 acute stress disorder

A. The person has been exposed to a traumatic event in which both the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
   (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
   (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
   (3) derealisation
   (4) depersonalisation
   (5) dissociative amnesia (i.e., inability to recall an important aspect of trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurring images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma. (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilising personal resources by telling family members about traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event (Adapted from APA, 2000).

The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, or medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a pre-existing Axis 1 or Axis 11 disorder.
(APA: 2000: 471)

It is important to note that traumatic events have the potential to catalyse PTSD, but most people who are exposed to them do not experience persistent PTSD (Naparstek 2006:31). Factors that buffer of exacerbate the trauma have been researched.

3.4 Risk factors for post traumatic stress

- **Risk factors related to the event**

People's reactions to the trauma depend in part on the nature of the event itself (Naparstek 2006:49-54).

- **Proximity**

PTSD is more likely to develop in people who are close to the trauma. It is important to note that it is the perception of danger, not the event itself that generates the potential for PTSD (Naparstek 2006:49).

- **Duration**

The longer the duration of the trauma, or the greater the number of incidents, the more likely it is that the person will develop PTSD. Duration also impacts those working with people who are exposed to trauma (Naparstek 2006:49-50).

- **Extent of brutality**

It has been noted that atrocities and interpersonal violence have greater potential to create long-term effects than natural disasters, even though both may be frightening. It was noted that 65% of men and 45% of women who had been raped rated this as their most upsetting experience and developed PTSD. Other experiences with a high probability of PTSD were combat exposure (38,8%) probability of PTSD), childhood neglect (probability of PTSD 23,9%) and childhood abuse (23,3% probability of PTSD) among men (Kessler et al 1995: 1033; Naparstek 2006:50).

- **Betrayal**

Betrayal undermines truth and generates deep concerns about safety, self worth and the trustworthiness of others, creating greater potential for PTSD than victimization by a stranger (Naparstek 2006:5).

- **Perceived degree of danger**

People respond to their perceptions and the greater perceived the degree of the threat, the greater its ability to trigger PTSD (Naparstek 2006:50).

- **Perpetrating violence**

Perpetrators of violence may experience more severe guilt, intrusive memories and feelings of alienation than non perpetrators (Naparstek 2006:50).

- **Social context**

The meaning ascribed to the event by the wider culture will affect perceptions of the event and the subsequent inpact of the event. For instance, war veterans whose society viewed the war as just and honourable exhibited low rates of PTSD compared with veterans who participated in a war that was devalued by their society (Naparstek 2006:51).

- **Unpredictability**

The greater the uncertainty during the event, the greater its potential to destroy a sense of control and the more likely it is to generate signs of PTSD (Naparstek 2006:52)

- **Being trapped**

Being trapped can generate powerful feelings of powerlessness which are, by definition, associated with PTSD (Naparstek 2006:53-54).

- **Survivor traits**

Survivor traits may buffer or predispose one to PTSD (Naparstek 2006:54-60). Women are more vulnerable to PTSD than men, although men are more likely to be exposed to trauma, around the world, including South Africa (Naparstek 2006:55). Children are more likely to develop PTSD than adults. They are more likely to freeze and dissociate in response to threat at the time of the event, which is associated with a higher risk for PTSD (Naparstek 2006:57; 60).

- **Psychological history**

A history of trauma or psychological problems make a person more vulnerable to signs of PTSD (Naparstek 2006:58).

- **Education**

For reasons that are not clear, people with higher levels of education are less vulnerable to PTSD than the less well-educated (Naparstek 2006:58).

- **Social support**

People who have social support are less at risk than those without (Naparstek 2006:59).

- **Reactions at the time of the trauma**

Certain reactions at the time of the trauma are predictive of subsequent PTSD (Naparstek 2006:60-67).

Panic at the time of the occurrence is linked to subsequent PTSD. People who dissociate at the time of the trauma are particularly vulnerable. However, people who dissociate are particularly amenable to image-based techniques of healing.

There seem to be inborn differences in people's tendency to secrete the stress hormone, cortisol. Survivors of trauma who develop PTSD seem to have chronically low levels of cortisol which rise sharply when exposed to stress, settling back to even lower levels. In other words, their cortisol levels seem hyper reactive. This profile seems unique to PTSD (Naparstek 2006:61-63).

- **Intoxication**

Intoxication at the time of trauma seems to have a protective value. However, long term alcohol use creates stressful feelings of withdrawal, which, in turn exacerbates symptoms of PTSD (Naparstek 2006:64).

- **Sense of control**

Survivors of traumatic events who were able to for example, rescue co-workers, manipulate attackers or out manoeuvre the danger in some way are less prone to PTSD than those who experienced powerlessness. People who are proactive seem less likely to dissociate so the cause-and-effect relationships are not clear (Naparstek 2006:64).

- **Self blame and negative beliefs**

People who blame themselves are more likely to experience PTSD symptoms (Naparstek 2006:65).

- **Subsequent health problems**

The rate of PTSD among people with chronic conditions such as fibromyalgia, chronic fatigue syndrome and irritable bowel syndrome, is extraordinarily high. These conditions may be linked to dysregulated chemical homeostasis of the body. (Naparstek 2006:67).

4 EVALUATION OF DSM IV-TR CRITERIA FOR PTSD

Post traumatic stress disorder has become one of the most popular areas of research and interest among mental health professionals and academics, although reference to the experience it describes is centuries old (Marsella et al 1996a :xv). Exposure to trauma has always been part of human existence and reaction to extreme stress have been noted by authors dating back 4000 years to Homer's Ulysses and Shakespeare's Henry IV where post traumatic stress reactions to war are recorded.

Despite its popularity, the value of the DSM IV-TR criteria for PTSD as a basis for the identification and assistance of people who have experienced trauma have been questioned (Friedman & Marsella 1996:12; Retief 2004:17; Beaulieu 2003:26; Gerrity & Solomon 1996:88). The controversy revolves around discrepancies within the diagnostic categories of the DSM IV-TR itself, cross-cultural issues and deciding what traumatic events qualify as "traumatic."

4.1 The nature of the event

An usual feature of PTSD is that presence of a specific stressor is intrinsic to the diagnosis. To receive a diagnosis of PTSD an etiological factor, namely a traumatic event is included as a necessary element. Norris (1992:409) states "exactly what constitutes a traumatic event is subject to debate". In terms or the PTSD criteria the event is described as follows:

“The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

The person’s response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganised or agitated behaviour” (APA 2000:467).

This implies that events such as the destruction of one’s home or a threat to life would qualify as traumatic, but divorce or illness would not (Norris 1992:409). Some researchers argue that an event may not induce feelings of intense horror or powerlessness to be traumatic. Events such as divorce, failure, life transitions, rejection, illness or the birth of a handicapped child may be appraised differently by individuals who may regard these events as traumatic (Friedman & Marsella 1996:15; Beaulieu 2003:26-27; Retief 2004:17).

Proposition 7 states:
“The best vantage point for understanding behavior is from the internal frame of reference of the individual himself” (Rogers 1951:494).

This stance is echoed by researchers Friedman and Marsella (1996:15), who point out that the subjective appraisal of an event may determine whether a person perceives a stressful episode as traumatic or not. Similarly, Beaulieu (2003:26-27) points out that an event need not be “catastrophic” to result in psychological trauma. She cites verbal abuse of a child as an example. Although separate incidents may not be catastrophic in themselves, they may be linked to the person’s low self-esteem, fearful avoidance of people and reluctance to take on challenges and any other evidence of psychological pain in the individual. The abuse may be viewed by one person as a sad aspect of an otherwise happy childhood. But another may be traumatised. The effect of the abuse may be viewed as causing psychological trauma in someone who appraised it as pervasive and painful. Thus trauma cannot be defined strictly in terms of the magnitude of the event because it is a subjective experience.

Faced with the vast spectrum of people each of whose experiences are particular and personal, it is impossible to arrive at a universally agreed upon definition of trauma (Beaulieu 2003:26-28). Beaulieu (2003:29) concludes “an event was traumatic if the individual who went through it feels that it was traumatic. It is the ongoing deleterious effects of an occurrence that identify it as trauma, rather than the event itself.” Her own definition of trauma is that trauma is “any experience that leaves an imprint that continues to give rise to negative effects and recurrences in one or more of the sensory, emotional or cognitive systems” (Beaulieu 2003:28). This description fits with the person-centred approach which holds that individuals are best understood from within their own frame of reference (proposition 7).

4.2 Controversy within the DSM IV-TR

Part of the controversy centres on the overlap between the diagnostic criteria formulated by the DSM IV-TR for PTSD and other diagnoses defined by the manual. It is beyond the scope of this discussion to provide details of other disorders such as somatoform disorders (symptoms related to bodily states), dissociative disorders (symptoms related to memory and consciousness) mood disorders and so forth. Further details are found in the DSM IV-TR (APA:2000). People who have experienced trauma show a range of symptoms that are part of other disorders as defined by the manual. Therefore, it should be noted that PTSD is not necessarily a final common pathway in which specific neural pathway are activated or damaged, giving rise to specific manifestations, but PTSD shares many features with other ways of showing distress (Kirmayer 1996:148). A comparison between acute stress disorder and PTSD shows a substantial overlap between them. People who have been exposed to trauma usually do not manifest distress in a manner that fits neatly into the PTSD criteria. Other signs of distress including anxiety, depression, dissociative features and somatic complaints may predominate (Kirmayer 1996:147). Some people manifest only some features of PTSD and receive a diagnosis of partial PTSD (Beaulieu 2003:30). Relying on lists of symptoms defined by someone other than the client him or herself may ignore much of the person’s experience. This is at odds with the

phenomenological stance of the person-centred approach that views people and their experiences as unique:

Proposition 1

"Every individual exists in a continually changing world of experience of which he is the center" (Rogers 1951: 483).

Proposition 2

"The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, 'reality' "(Rogers 1951: 484).

Once diagnostic categories are created they tend to be reified. Relying on lists of symptoms and diagnostic criteria may cause the clinician to ignore signs of distress that do not fit these criteria. It seems that the phenomenological approach, working with the client's own experiences, as advocated by the person-centred approach is a useful way of noticing, accepting and dealing with a whole variety of manifestations of distress.

4.3 Dissociation

Kirmayer (1996: 144) points out that manifestations of distress are shaped by culture. He suggests that symptoms generated are culturally determined (Kirmayer 1996:150). The notion of a simple cause and effect relationship between trauma and specific symptoms ignores the socially constructed idioms and expressions of distress (Kirmayer 1996:150). For example, in the DSM IV-TR a diagnosis of brief reactive psychosis has been applied to conditions that involve the phenomenon of dissociation . Dissociation is a process where elements of experience are not integrated into a whole. In other words, experience is compartmentalised (Van der Kolk & Fisler 1995:510). Dissociation involves functional alterations of consciousness, memory and identity (Kirmayer 1996:141). Common dissociative phenomena include de realization, de personalization, alterations in time perception and difficulties in concentration (Kirmayer 1996:142). During depersonalisation, one temporarily loses a sense of one's reality. During derealization one loses a sense of realness in the external world. Things may seem to change shape

or size. People may seem robot-like (Barlow & Durand 1995:223). When trauma is experienced, time may be stretched or compressed. Events may seem to occur in slow motion (Naparstek 2006:84). In many non-Western cultures, dissociation is a common feature of religious rites and rituals and is not regarded as indicative of pathology (Kirmayer 1996:141). Cultural factors may influence the susceptibility to dissociate as entering a trance state may be expected during religious ceremonies and may not be seen as pathological (Kirmayer 1996:142). Dissociative phenomena seem to be shaped and controlled by cultural expectations (Kirmayer 1996:144). Dissociative identity disorder, a condition constructed in the DSM IV-TR has been related to childhood trauma and abuse (Kirmayer 1996:142). This (dissociative identity disorder) appears to be primarily a Western phenomenon. In non-Western cultures, when individuals experience autonomous voices within themselves, these are generally understood to be Spirits, ancestors or culturally determined agents, rather than strands of a personal history (Kirmayer 1996:144). Viewing alternative voices as different parts of one's personal history fits the individualism of Western culture, while more collectivistic cultures would be likely to view such voices as coming from outside (Kirmayer 1996:145). However, Western culture tends to define these experiences as pathological. It is important to note that distress and illness, including mental illness are structured by an indigenous set of cultural schemas (Castillo 1997:37).

Currently PTSD is classified by the DSM IV-TR as an anxiety disorder since the core symptoms resemble those of generalised anxiety disorder, it can be understood as a response to frightening events in which fear becomes generalised to external cues and internal thoughts and feelings. However, dissociative phenomena are also prominent in PTSD. It seems that the classification of PTSD as an anxiety disorder may not fit the descriptions of distress given by many people who have experienced trauma and this classification has been questioned by clinicians. Indeed, dissociation is such a common feature of acute and post traumatic stress disorder that some writers suggest that PTSD and Acute Stress Disorder should be viewed as dissociative disorders rather than anxiety disorders (Kirmayer 1996:131). This

implies that the distinction between posttraumatic disorder, generalised anxiety disorder and disorders in which dissociation are prominent are not clear. The person-centred approach may be a useful approach to dealing with trauma because it places much emphasis on the symbolisation of unsymbolised experiences as stated in proposition 15 and 17:

Proposition 15

"Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self" (Rogers 1951: 513).

Proposition 17

"Under certain conditions involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences" (Rogers 1951: 517).

4.4 Somatisation

To complicate the picture further, somatic symptoms are also prominent features of PTSD in the form of autonomic hyper arousal, leading to substantial overlap with the DSM IV-TR category for somatoform disorders (Kirmayer 1996:131). Somatization refers to the process of experiencing emotional distress in the form of somatic complaints. The DSM IV-TR refers to somatoform or conversion disorders, where medically unexplained functional symptoms are present, hypochondriasis, which refers to bodily pre occupation and concern about illness and somatic presentations of difficulties that are conventionally viewed as cognitive or emotional in nature. These categories of disorders reflect a presumed distinction between physical and emotional distress that typify Western thinking. Such distinctions may not be made the same way in other cultures. In some cultures, somatic symptoms are used to communicate distress and a wide range of social and personal concerns (Kirmayer 1996:132-133). Such expressions of distress may go unnoticed by Western practitioners. In fact, somatic symptoms accompany most experiences of emotional distress (Kirmayer 1996:132). In many cultures,

somatic distress is recognised as an indication of personal or social difficulties (Kirmayer 1996:133; Jenkins 1996:169; 172).

Somatic manifestations of distress are not absent in people from Western cultures, but these signs are explained in a way that is coherent with the culture. In Western culture, it is understood that somatic symptoms of distress are worsened by “stress” in conditions such as irritable bowel, fibromyalgia and chronic fatigue. Anxiety may be expressed as heart palpitations, hyperventilation, “tightness in the chest”, muscle tension or headaches in Westernised cultures. While some may accept the connection between these physical states and emotions, a significant number deny any link (Kirmayer 1996:140). These experiences seem to be legitimised by attributing the cause to viruses and environmental toxins, rendering symptoms such as fatigue, weakness, headache, dizziness and muscle pain, more acceptable to the Western mind (Kirmayer 1996:136-137). Therefore, somatic symptoms are not seen or interpreted as a way of communication distress but are seen as the outcome of factors outside the person. The notion of stress as a sufficient cause for a person’s distress may make the person’s difficulties coherent, acceptable and explicable to themselves and others. Stress is seen as being outside the person, inevitable and is experienced universally. It serves to displace the stigma of diagnostic labels from the person. This may alter the person’s experience of PTSD by protecting him or her from expectations that imply personal blame or weakness (Kirmayer 1996:154). This may be helpful in a Western culture where distress is commonly attributed to personal traits and implied character flaws (Kirmayer 1996:155). In many non-Western cultures, somatic symptoms are used to communicate distress and a wide range of social and personal concerns (Kirmayer 1996:132-133). Such expressions of distress may go unnoticed by Western practitioners and may be misdiagnosed as somatoform disorders, rather than expressions of distress following trauma.

4.5 Comorbidity

The distinction between the diagnostic categories of the DSM IV-TR are by no means clear and there is a substantial overlap in symptoms in different

categories as defined by the manual itself. The DSM IV-TR classification system is based on the notion that each disorder is a separate category. As a result very little attention has been paid to how these disorders may be connected emotionally or culturally. This is at odds with the person-centred approach, with its emphasis on the subjective experience of people. Furthermore, the person-centred approach views people as a whole and does not compartmentalise their experiences into separate entities. In terms of the DSM IV-TR, if an individual meets the diagnostic criteria for PTSD it is likely that he or she would meet the DSM IV-TR criteria for one or more additional diagnoses, usually an affective disorder or personality disorder (Friedman & Marsella 1996:20). This is known as co- morbidity. “Co- morbidity refers to the simultaneous existence of two or more disorders” (Castillo 1997:171). Other co-morbid conditions include panic disorder, general anxiety disorder, obsessive-compulsive disorder and substance abuse. This raises the question as to whether these conditions are in fact additional pathologies or whether the diagnostic criteria for PTSD are not comprehensive enough. It has been shown experimentally that the depression that accompanies PTSD is biologically different to primary major depression. This suggests that the depression is part of PTSD rather than a co-morbid condition, as currently classified by the DSM IV-TR (Friedman & Marsella 1996:20). Castillo (1997:172) suggests that anxiety mood and somatoform disorders should be seen as connected because they all relate to disordered emotions. Somatoform disorders are based on the experience of emotional distress through somatic (bodily) symptoms (Castillo 1997:172). Cross-cultural studies indicate that somatic symptoms are the most common manifestations of anxiety worldwide (Castillo 1997:189). This widespread manifestation of anxiety worldwide calls the classification system of the DSM IV-TR that sees somatoform disorders as separate from anxiety disorders into question when viewed from a client-centred perspective (Castillo 1997:189).

These considerations indicate that the broad distinction between affective, anxiety somatoform and dissociative disorders enshrined in the DSM IV-TR are not natural divisions demarcating clear boundaries in the phenomenology of disease, disorder or illness. Instead they are socially constructed. Once

established, nosological categories tend to become reified. This process of reification tends to obscure variations within categories or overlap between` them. If the person's experience does not fit the listed criteria, clinicians using the model may seek to diagnose "co-morbid conditions," create additional residual categories such as "not otherwise specified" (NOS) or ignore much of the person's own experience (Kirmayer 1996:154).

It has been suggested that the diagnosis of PTSD and co-morbidity does not capture the complexity of adaptations to traumatic experiences (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman 1996a: 84). They note that prolonged trauma, particularly if it occurs early in life, can lead to disturbed regulation of affective arousal, dissociation and misinterpretation of somatic sensations. These authors suggest that dissociation, somatisation and affective disturbances contribute a spectrum of trauma-related disorders and should not be conceptualised as separate diagnoses. They maintain that the diagnostic system of classification is not conducive to thoughtful exploration of the relationships between these syndromes (Van der Kolk et al 1996a: 90). The link between these experiences and expressions of trauma been sought in the biological field in studies that have examined both animal and human responses to overwhelming threat. Research has demonstrated changes in the central nervous system, in neurotransmitters and physiological responses that suggest explanations for the hyperactivity, loss of responsiveness, dissociation, memory disturbance and somatic complaints that may be linked with traumatic experiences (Van der Kolk & Saporta 1991).

Understanding biological explanations for the effects of trauma requires some knowledge of the structure and function of the brain, nervous system and chemical reactions in the body (Sue et al 2000:35). An overview is provided here.

5 OVERVIEW OF THE NERVOUS SYSTEM

The nervous system is made up of nerve cells, also known as neurones that are responsible for the transmission of information throughout the body. A typical nerve cell has a cell body, with two kinds of branches, namely axons

and dendrites. Nerve cells are not actually connected in the sense that they do not touch each other. The space between them is known as the synaptic cleft. Dendrites receive messages in the form of chemicals, known as neurotransmitters from the axon of adjoining neurones. These chemicals trigger the release of electrical impulses within the neurone that transmits the message from one nerve cell to the next, or to the muscles and organs of the body.

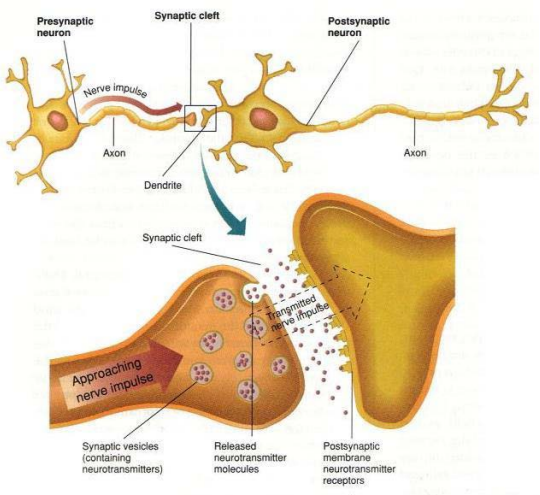

Figure 1 – The synaptic cleft

(From Barlow & Durand 1995:48)

Van der Kolk (1996b: 216) emphasises that “brain, body and mind are inextricably linked, and it is only for heuristic reasons that we speak of them as if they constitute separate entities.” Mental processes are a product of the brain and body, which interact through nerve impulses and chemicals in the nervous system and bloodstream. This is in line with Rogers proposition 3 which states:

“The organism reacts as an organized whole to this phenomenal field” (Rogers 1951: 486).

These complex interactions are revealed when a person experiences trauma.

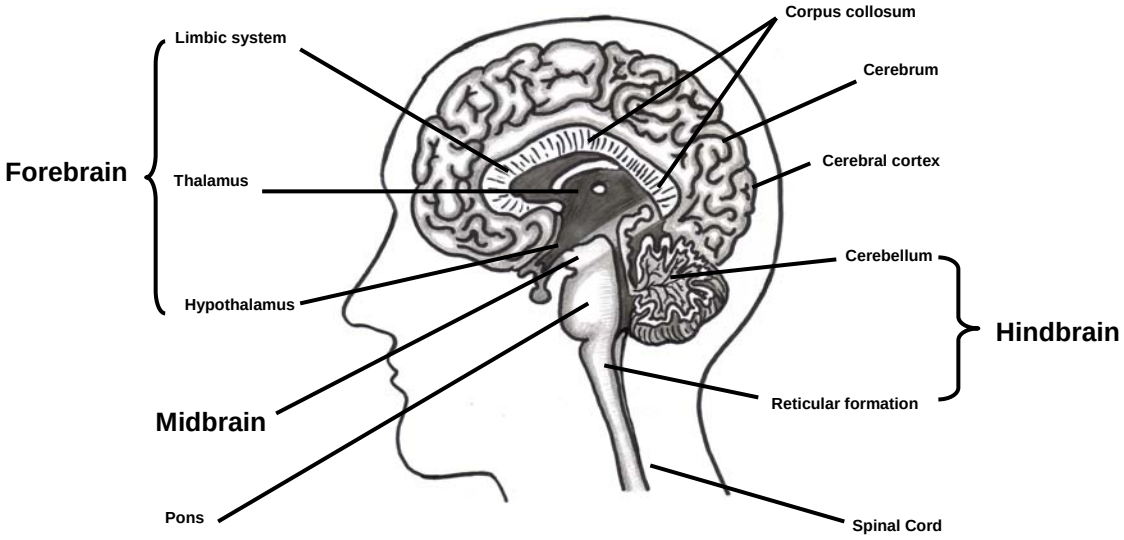

Figure 2 – The human brain

(Adapted from Barlow and Durand 1995:49)

From a *functional* point of view, the human brain has developed three systems for maintaining an individual his or her internal and external environment. These are:

- The brainstem and hypothalamus, which are responsible for the maintaining internal homeostasis (balance)
- The limbic system which maintains a balance between the external world and internal reality
- The neo cortex which is responsible for analysing and interacting with the external world (Van der Kolk 1996b:214).

One model of the brain suggests that the brain is made up of three intimately connected brains within each other. The deepest part, the reptilian brain is made up of the medulla, pons and spinal cord. It governs survival instincts such as mating, defence, finding food and so on. The next layer is the old mammilian brain or limbic system, which is the centre of emotion. The outer layer is the neo cortex which controls abstract reasoning (Maclean cited in Capacchione 1991:38). Different kinds of processing emanate from each. The reptilian brain produces instinctual action tendencies, the limbic system

accounts for emotional awareness and the neocortex for declarative knowledge.

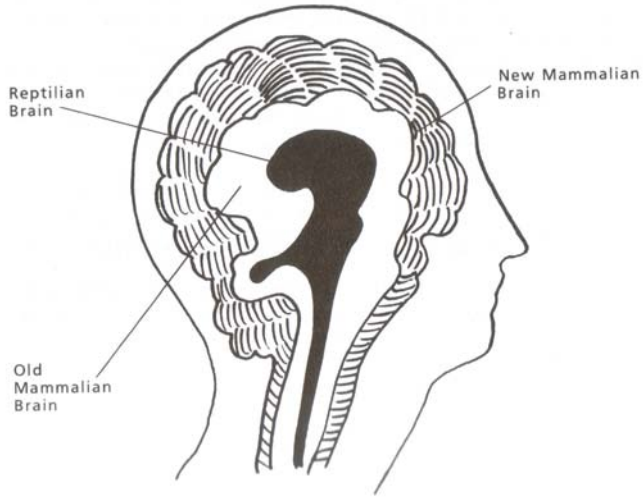

Figure 3 – The triune brain

(Adapted from Lucia Capacchione 1991:38)

From a *structural* point of view, one way of viewing the brain is to see it in two parts: The forebrain or telencephalon and the brainstem. The brainstem is made up of the hindbrain, the midbrain and the diencephalon.

The hindbrain contains structures called medulla, pons and cerebellum. These structures regulate automatic bodily functions such as breathing, digestion and heartbeat. The cerebellum controls motor co-ordination (Barlow & Durand 1995:48).

The midbrain coordinates movement with sensory input. It also contains parts of a system that controls arousal, tension, sleep or wakefulness called the reticular activating system (Barlow & Durand 1995:48).

An area that controls behaviour and emotion is located at the very top of the brainstem. It is called the diencephalon and contains two major structures called the thalamus and hypothalamus (Barlow & Durand 1995:48). The hypothalamus is linked to the endocrine system, a system of ductless glands that release a variety of hormones into the bloodstream (Barlow & Durand 1995:51). The hypothalamus activates the pituitary gland. The pituitary gland

releases a chemical (adrenocorticotropin or ACTH) that stimulates the adrenal glands. The adrenal glands release a variety of stress hormones, the best known of which is probably adrenalin. Adrenalin produces the alert, energised state that is typical of high levels of arousal. The hypothalamus, pituitary gland and adrenal glands are interrelated and together or known as the hypothalamic-pituitary-adrenal axis (HPA axis) (Van der Kolk 1994).

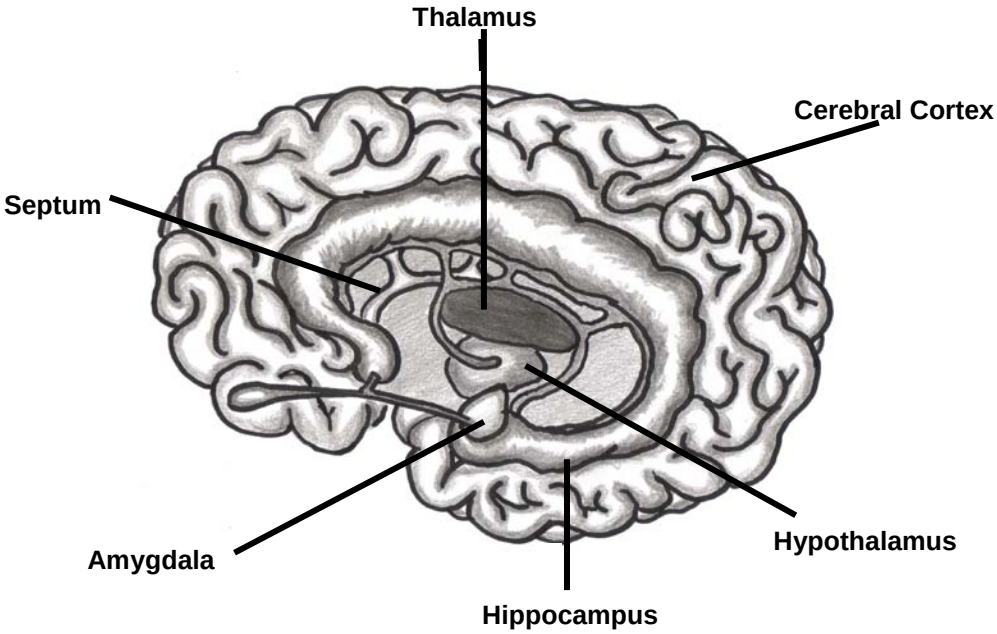

Figure 4 – Section of the brain

(Adapted from Barlow & Durand 1995:49)

The second part of the brain is called the telencephalon (forebrain). The limbic system is located at the base of the telencephalon. This system is intimately involved in responding to frightening stimuli. The limbic system is made up of the hippocampus (sea horse), cingulate gyrus (girdle), septum (partition) and amygdala (almond). These areas regulate our emotional experiences, emotional expression and to some extent our ability to learn and control impulses. It also regulates sexual and aggressive drives, hunger and thirst (Barlow & Durand 1995:50). The amygdala are intimately involved in responses to fear. Laboratory rats with surgically removed amygdala do not show fear (Naparstek 2006:71). The limbic system is the region where memory is processed (Van der Kolk & Saporta 1991). It plays a crucial role in guiding emotions that motivate survival-related behaviour, such as feeding, mating, fight and flight. Destruction of parts of the limbic system eliminates

social behaviour such as play, co-operation, mating and caring for the young (Van der Kolk & Saporta 1991). Disruption of early attachment directly affects maturation of the limbic system (Kling & Stekliss 1996 cited in Van der Kolk & Saporta 1991).

The hippocampus records the spatial and temporal dimensions of memory. It is involved in short-term memory and enables the organism to learn form experience (Van der Kolk & Saporta 1991).

The largest part of the forebrain is the cerebral cortex. It is divided into two halves or hemispheres, which look alike, but have different functions. The two hemispheres communicate via a structure known as the corpus callosum (Ogden, Minton & Pain 2006:5). Broadly speaking, the left hemisphere is largely responsible for verbal and cognitive processes and the right hemisphere creates images and perceptions. The neocortex is involved in problem solving, learning and stimulus-discrimination. It also transcribes subjective experience into a communicable form (Van der Kolk 1996b: 216-217). In other words it symbolises experience. This function is impaired when trauma is encountered. The cortex also mediates reasoning strategies, goal setting, predicting outcomes and deciding on the relevance of stimuli. These functions can also be impaired by trauma (Van der Kolk 1996b: 216-217).

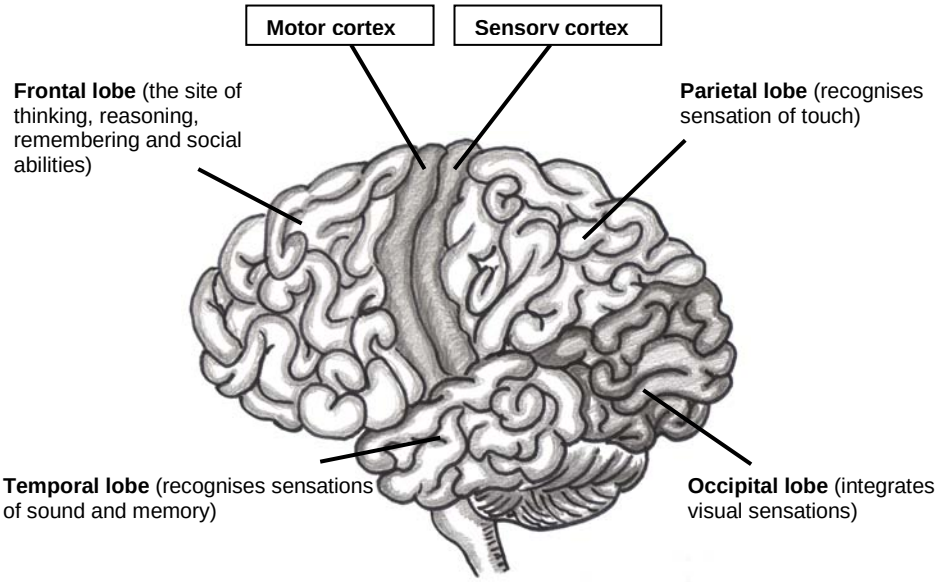

Figure 5 – Lobes of the brain

Both the left and right hemispheres are conventionally divided into four regions or lobes, namely temporal, parietal, occipital and frontal. Very broadly speaking, the temporal lobe is associated with recognising sights and sounds and long- term memory. The parietal lobe recognises sensations of touch. The occipital lobe deals with visual input. In fact all four regions work in an integrated way to process sensory input and motor output (Barlow & Durand 1995:50). The frontal lobe is concerned with thinking, reasoning and memory. It enables us to relate to the world and people (Barlow & Durand 1995:50).

5.1 The central and peripheral nervous systems

The nervous system comprises the central and peripheral nervous systems. The brain and spinal cord make up the central nervous system. The peripheral nervous system supplies the body and organs with nerves that connect them to the central nervous system. The peripheral nervous system comprises the somatic nervous system that supplies the muscles under voluntary control and the autonomic nervous system that regulates involuntary functions such as heart rate. The autonomic nervous system is made up of two divisions, the sympathetic nervous system (SNS) and parasympathetic nervous system (PNS). These two divisions act in a complimentary way. The sympathetic nervous system mobilises the body during times of danger or stress. When the sympathetic nervous system is triggered, the heart beats faster to increase the blood supply to the muscles, breathing rate increases to supply extra oxygen and the adrenal glands release hormones, adrenaline, cortisol and norepinephrine, to mobilise the body.

One of the functions of the parasympathetic nervous system is to balance the sympathetic nervous system. The parasympathetic nervous system normalises arousal and facilitates energy storage (Barlow & Durand 1995:51).

5.2 Neurotransmitters and hormones

The body is also under the influence of a variety of chemicals. Different biochemical substances known as neurotransmitters carry messages between nerve cells. The endocrine glands secrete hormones that affect bodily functions. With regard to fear and stress, epinephrine and norepenephrine are

important neurotransmitters in the peripheral nervous system. They are known as “catecholamines” (Barlow & Durand 1995:55). These catecholamines are also secreted by the adrenal glands. But norepinephrine (also known as nor adrenalin) is also an important neurotransmitter in the brain itself. Norepinephrine receptors are located in the pons, which controls respiration. Norepinephrine (also known as noradrenaline) is the neurotransmitter that is responsible for delivering messages about the need to prepare for emergencies to the rest of the central nervous system. It is produced primarily in a region in the brain known as the locus coeruleus. This region plays a crucial role in arousal (Van der Kolk & Saporta 1991). It prepares the body for defensive reactions. Endogenous opiates are morphine-like chemicals that are produced by the body to lessen pain when needed. They inhibit the locus coeruleus and this inhibits the release of norepinephrine (Van der Kolk & Saporta 1991). (This induces passive coping or freezing when confronted with danger.) The norepinephrine circuit extends to the limbic system, cerebral cortex and brain stem. This circuit is particularly active in controlling emergency reactions (Barlow & Durand 1995:55). These reactions may take the form of fight, flight or freeze.

5.3 The flight/fight response

When one is faced with an emergency, the cardiovascular system is activated. Blood vessels constrict in the periphery, raising blood pressure. Blood is redirected to the muscles. The skin becomes pale as blood is redirected from the surface to vital organs, so one may turn “white with fear”. Shivering, trembling and piloerection serve to conserve heat. Breathing becomes deep and rapid to provide more oxygen. Cognitive processes and perception are heightened to increase alertness. Glucose is released from the liver to energise muscles and organs. Pupils dilate to allow better vision and hearing becomes more acute. Digestion is suspended, reducing the flow of saliva and causing a “dry mouth.” There is a tendency to eliminate waste products, resulting in defecation, urination and/or vomiting. All these responses are geared towards fight or flight (Barlow & Durand 1995:67). On a neurological level, a series of complex processes is occurring. Trauma sets in

motion a chain of neural and biochemical events designed to help the victim to escape or, if that is impossible, to minimise pain.

5.4 Memory

An understanding of memory functions is crucial to understanding the effects of trauma (Van der Kolk & Saporta 1991). One of the distinguishing features of PTSD is the intrusive re-experiencing of the trauma in the form of nightmares, flashbacks or somatic reactions (Van der Kolk & Saporta 1991). Traumatic memories seem to be fixed in the mind. They resist integration and are unaltered by the passage of time. It seems that the imprint of traumatic memories is qualitatively different to other memories. Perceptual elements seem more prominent than narrative, declarative, symbolised components (Van der Kolk & Fisler 1995:508). Memories of frightening events may be recalled in vivid detail but the loss or absence of recollections of trauma is also a prominent feature of traumatic memories (Van der Kolk & Fisler 1995:509). The length of time over which the amnesia persists is variable. Recall is typically triggered by exposure to sensory or affective stimuli that are associated with the trauma (Van der Kolk & Fisler 1995:509). Affect is a powerful cue. The affective cue need not necessarily be fear, but any affect related to the trauma experience can trigger retrieval of trauma-related sensations, including longing, intimacy and sexual arousal (Van der Kolk & Fisler 1995:501).

The nature and reliability of traumatic memories has been the subject of controversy (Van der Kolk & Fisler 1995:505). This is partly because it is not possible to study traumatic memories in the laboratory, so some researchers have been reluctant to acknowledge the veracity of observations from clinicians working with traumatised people. Complete amnesia for the trauma may be present and recall may suddenly be precipitated in the form of vivid flashbacks and emotional re-living of the traumatic experience (Van der Kolk & Fisler 1995:509). These clinical observations are not reproducible in the laboratory because it is not possible to replicate the type of situations that trigger traumatic memories in the laboratory for *ethical* reasons. One simply cannot expose research subjects to situations that evoke extreme fear,

helplessness or horror. For this reason, much research has been carried out on animals and results from these studies have been compared with the responses of people who have experienced traumatic stimuli such as rape, armed attacks, domestic violence and child abuse (LeDoux 1994: Seligman 1975; Van der Kolk et al 1996a; Van der Kolk & Fisler 1995).

5.4.1 The processing of memory in non-threatening circumstances

Experience is encoded, stored and retrieved by biological mechanisms in a complex array of interacting systems in the brain. LeDoux (1992: 270-271) states that affective experiences are memories in the sense that they represent information storage in the nervous system and have powerful influence on subsequent information processing. Such memories are however frequently unsymbolised, but can influence future behaviour.

According to Beaulieu (2003:36) and LeDoux (1992:271) the first step in the encoding of everyday memories is taken when information from the sensory organs is relayed to the thalamus. From the thalamus neural signals are relayed to the cortex where the information is elaborated into perceptions and thoughts (LeDoux 1992:171). Once a perception is formed, the information is conveyed to the limbic system, the amygdala in particular where the emotional significance is assigned. The amygdala transform sensory stimuli into emotional signals and they control and initiate emotional responses (LeDoux 1992:275). When any memory is formed, once the emotional significance of the input has been assigned by the amygdala, other areas of the brain evaluate the meaning of the information. The hippocampus is involved in this process. The hippocampus is a sea horse shaped structure that records the spatial and temporal dimensions of experience (Van der Kolk & Saporta 1991). It co-ordinates the short-term recall of events and facts by synchronising the activation of related neural networks that encode the sensory and cognitive information that compose a given memory. The emotional meaning is relayed to the cortex. The stimulus is given meaning by being integrated with information from previous memories. It is important to note that emotional processing precedes any conscious emotional experience (since conscious experience is mediated by the cortex), so emotional

processing is unconscious. The end product can be represented consciously, but the process by which emotional memory is generated is unconscious (LeDoux 1992:273). The cortex discerns the relevance of stimuli, predicts outcomes and is involved in problem solving. An important function is that it transcribes experience into a communicable, symbolised form (Van der Kolk 1996b: 216).

It was thought that emotions such as joy, pleasure, pain, fear and so forth were assigned only after the nature of the situation was appraised by the cortex. However LeDoux (1994:56) has shown that an alternative neural pathway comes into play when fear is induced. His research shows that memories for frightening events are processed differently to everyday memories. This finding is crucial to understanding the nature and effect of traumatic memories (Beaulieu 2003: 37).

5.4.2 Changes in memory processing in traumatic situations

A feature of the nervous system that is particularly relevant to trauma is that *fear leads to the activation of an alternative pathway*. While most of the neural outflow from the thalamus leads to the cortex as described above, an alternative parallel circuit dominates in emergencies (Beaulieu 2003:37; LeDoux 1994:52-53). In addition to the polysynaptic pathway described above, the thalamus sends an additional signal directly to the amygdala in emergencies. This circuit bypasses the multiple synapses described above (from the thalamus to the cortex and then to the amygdala). Saving time is a priority in emergencies. A short cut is used in which a signal passes from the thalamus directly to the amygdala, which facilitates a quick response to the emergency. It allows the amygdala to respond directly to information from the sense organs *before the information is filtered and interpreted by the cortex* (Beaulieu 2003:37). The amygdala are able to send response signals that initiate the fight/flight or freeze responses that are typical of threatening situations. When the situation is perceived as potentially threatening, the amygdala activate the hypothalamus, which triggers the pituitary gland to activate the release of stress hormones from the adrenal glands (Naparstek 2006:72).

In the case of non-threatening stimuli, the amygdala receive input from the cortex. Emotional processing begins relatively late in the sensory-processing sequence, and the amygdala respond to information about fully perceived objects and events. In an emergency, the thalamus activates the amygdala and prepares them to respond at the same time that it activates the cortex. In the case of thalamo-amygdala impulses, emotional processing begins earlier and is based on relatively crude representations. Thus *emotional* evaluation *precedes* conscious awareness or evaluation of the threat (LeDoux 1994:56). People are autonomically and hormonally activated before appraising what they are relating to. A high degree of activation of the amygdala can generate emotional responses and sensory impressions that are based on incomplete information rather than fully integrated perceptions. However, failing to respond to a genuine threat is more costly than reacting unnecessarily to a benign stimulus, so that seems to be why both pathways are activated when the organism is threatened. Later the cortex may confirm the reality of the threat or disconfirm it and dampen down the emergency response (LeDoux 1994:56).

An example given by LeDoux (1994:56) may clarify this process. Say one was walking through a forest and heard a rustle in the leaves. One may then catch a glimpse of a brown, elongated object in one's path. The amygdala would trigger a fight or fight response as if the object were a harmful snake, signalling the hypothalamus to activate an adrenalin rush to activate the body, before the cortex has appraised the stimulus. Only after the body has been prepared for action, does the hippocampus compare this stimulus with previous information. The cortex also decides whether this is a genuine threat, in which case the fear-induced response would be sustained, or, with its ability to distinguish between stimuli, it may recognise that the object is not a snake but a stick, for instance, and dampen down the emergency reaction.

5.4.3 Biases in traumatic memories

Traumatic memory traces are biased toward early activation. The memory trace laid down by the amygdala take precedence during subsequent emergencies or potentially threatening situations (Beaulieu 2002:37). Long

term potentiation (LTP) involves a change in the efficiency of synaptic transmission along a neural pathway. Signals travel more readily along the pathway once long term potentiation has taken place (LeDoux 1994:54). Emotional memories seem to involve long-term potentiation of the amygdala (LeDoux 1994:55). Therefore, it is difficult to eliminate intense emotional memories (LeDoux 1994:55). The memory traces laid down by the amygdala in response to threat seem to be especially durable. In rats a single exposure to a bell tone prior to a painful shock was enough to establish a fear response to the bell with no further shock over many trials (LeDoux 1994:50). The amygdala allow one to act without knowing why (Naparstek 2006:72). The durable, easily activated memory traces laid down by the amygdala are postulated as the mechanism for the unconscious, automatic and behavioural responses that follow fearful situations, even when the person has no conscious, cortical memory of the threat. During threatening events the amygdalic pathway may be privileged to such an extent that normal incorporation of cognitive information into the perception of events is delayed or bypassed (Beaulieu 2003:40). This is known as dissociation. Dissociation refers to the absence of the normal integration of thoughts, emotions and experiences into the stream of consciousness and memory (Panzer & Viljoen 2004:11). Dissociation may occur at the time of the trauma. This is commonly described as a sensation or perception of being removed and distant from events, feeling that one is observing the trauma as if it were a movie, detachment or feeling that one was observing the trauma happening to another self. Such reactions seem to be associated with the lack of integration of the memories (Naparstek 2006:88-91).

5.4.4 The process by which traumatic memories may remain unsymbolised

Proposition 6 states:

“Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism” (Rogers 1951: 492).

This proposition suggests that significant events tend to be emotionally laden. It has been shown that memories of emotionally charged events tend to be clearer than memories for less significant events (Beaulieu 2003:38; Van der Kolk, Hopper & Osterman 2001; Eyseneck & Keane 1995:188-190). LeDoux (1994:50) suggests that emotions themselves are memories.

Memories of non-traumatic significant events (such as a wedding or graduation) and traumatic experiences (such as a waking up from general anaesthesia during surgery) were compared and the processes by which these memories were encoded and recalled were elucidated (Van der Kolk et al 2001).

When any memory is formed, once the emotional significance of the input has been assigned by the amygdala, other areas of the brain evaluate the meaning of the information. The hippocampus is involved in this process. There is a feedback loop between the amygdala and hippocampus and the more intense the input from the amygdala, the stronger the activation of the hippocampus. The more significance is attributed to the event by the amygdala, the better the stimulus will be attended to and the better the memory will be retained (Beaulieu 2003:36; Van der Kolk et al 2001:27-28). Thus memories for personally significant events such as for instance a wedding, graduation or other personally meaningful occasion tend to be vivid. The strong activation of the amygdala induces a neuro-endocrine response that strengthens the communication between the hippocampus and amygdala. This explains why memories for emotionally laden events are often clearest. However, when there is a high stress response, high levels of nor epinephrine and gluco-corticoids are released. These in turn *inhibit* the hippocampus. This means that very high levels of emotional arousal disrupt the person's ability to evaluate and categorise experience by interfering with hippocampal functions (Van der Kolk et al 2001:28).

Using brain imaging techniques, the areas of the brain that are active during the recall of traumatic memories and non-traumatic memories were

compared. During the recall of traumatic memories, Broca's area, which controls speech, showed decreased activity, while the right medio-temporal region, that controls images, was more active (Van der Kolk et al 2001:18). This led to the conclusion that, under extreme stress, memory is not encoded in a coherent, narrative form, leaving the sensory elements of the memory un-integrated and unattached. These elements tend to return as flashbacks in which the trauma is re-lived as sounds, smells, bodily sensations and visual images (Van der Kolk et al 2001:23). Such flashbacks are described as "speechless terror." The researchers state "traumatic memories persist as implicit, behavioural and somatic memories and only secondarily vague, over general, fragmented, incomplete and disorganised narratives" (Van der Kolk et al 2001:25-26).

In this study (comparing traumatic memories with memories of other significant events), the same questions were posed to each group. No subject who had experienced trauma reported having narrative recall of the trauma initially. They could not tell a story about the incident, but the experience was first recalled either as a somatosensory or emotional flashback. As more sensory modalities become involved and the flashbacks reached a peak, a narrative account started to emerge (Van der Kolk & Fisler 1995:517). On the other hand, subjects who had not experienced trauma seemed to regard some of the researcher's questions as nonsensical. None had the olfactory, visual auditory or kinaesthetic re-living of significant events (such as a wedding or graduation). They had never had vivid flashbacks or nightmares related to these experiences. They did not have periods in their lives where they had complete amnesia for the occasion and environmental triggers did not elicit vivid detailed memories of the events. No subject reported making special efforts to avoid memories of these significant occasions (Van der Kolk et al 2001:17). These findings indicate that traumatic memories are qualitatively different to other memories for significant events.

Declarative memory (also known as explicit memory) refers to conscious awareness of facts or events that have happened to a person. This form of memory requires an intact frontal lobe (of the cortex) and an intact

hippocampus (Van der Kolk & Fisler 1995:507). This implies that if the cortex is by-passed the memory will not be translated into a symbolised, narrative form. LeDoux (1992:270) points out that emotions can be memories in the sense that they represent information storage in the central nervous system. However, affective memories may not be consciously recollected. Emotional memories may be encoded via two pathways. Under non-threatening circumstances, the cortico-amygdala-hippocampal pathway dominates (Beaulieu 2003:36). Such memories are explicit and can be symbolised. However, when a threat is encountered, the amygdala can lay down memory traces independent of the cortex, where conscious processes occur (LeDoux 1992:277). Such memories are implicit and unsymbolised. This is because when fear dominates, the amygdala lay down memories of emotional experiences, independent of the integration mediated by hippocampal-cortical memory systems. One effect of strong activation of the amygdala is that memories tend to be fragmentary, unlike the narrative form that typifies every day memory. When the brain and body are geared to survive, memories are stored at sensory and perceptual levels, in partial, incoherent sequences. “Memories of this nature are retrieved later as isolated images, bodily sensations, sounds and smells that feel alien and separate from other life experiences.” (Van der Kolk et al 2001:28). The hippocampus locates and anchors events in time and space. Because this function is impaired when severe threat is present, these fragmented memories lead an isolated existence. Reminders of the trauma may trigger intense reactions. The trigger for their reaction seems to be unsymbolised. Reactions may also be triggered in traumatised people in response to intense but neutral stimuli, such as loud noises, demonstrating a loss of the ability to discriminate between stimuli (Van der Kolk 1996b: 219). The cortex is involved in stimulus-discrimination. When it is by passed, as traumatic memories are laid down, the ability to distinguish between threatening and neutral stimuli is lost (Van der Kolk 1996b: 216). Re-experiencing of trauma seems related to long-term potentiation (i.e. facilitation) of the locus coeruleus pathways, that release nor epinephrine, the neurotransmitter that prepares the body to respond to emergencies (Van der Kolk & Saporta 1991). Traumatised people go from stimulus to response without being able to work out what made them upset.

Trigger reactions make traumatised people prone to go into fight, flight or freeze, or alternatively they may overreact and intimidate others as a response to minor provocations. These responses seem to be reflected in Proposition 13 which states:

"Behavior may, in some instances, be brought about by organic experiences and needs which have not been symbolized…"(Rogers 1951: 509).

Research on traumatic experiences suggest mechanisms which may underlie this observation (Van der Kolk et al 2001:28).

Declarative memory (also known as explicit memory) refers to conscious awareness of facts or events that have happened to a person. Declarative knowledge is "knowing that" (Eyseneck & Keane 1995:146:167). In other words, it refers to symbolised experiences. The cortex transcribes subjective experience into a communicable form (Van der Kolk 1996b: 216). This form of memory requires an intact frontal lobe (of the cortex) and an intact hippocampus. In other words the cortex and hippocampus are responsible for translating experiences into a symbolised form. Implicit or procedural memory also known as non-declarative memory) refers to knowing how to perform motor skills, emotional responses, reflex actions and classically conditioned responses (Van der Kolk & Fisler 1995:507). Many components of memory systems operate outside conscious awareness (Van der Kolk & Fisler 1995:506). This type of memory relates to unsymbolised experiences. It has been suggested that fear responses are conditioned at the time of the trauma and are stored as implicit memories (LeDoux 1994:50).

Declarative or explicit memory is an active constructive process (Van der Kolk & Fisler 1995:507). The nature and content of declarative memories depends on existing cognitive schemas and perceptions. Events that are integrated into existing schemas are no longer available as separate entities. Once integrated, memories are modified by associations and mood state at the time of storage and recall (Van der Kolk & Fisler 1995:507; Eysenck & Keane 1995:146-150). This means memories are subject to some distortion.

When people are significantly threatened, attention narrows. Under these conditions, explicit memory may be blocked, but implicit memory is not. The person may know the emotional valence of the experience but be unable to verbalise reasons for their behaviour Inhibition of the hippocampus as described above seems to be the mechanism whereby explicit memory formation is blocked (Van der Kolk & Fisler 1995: 511). This inability to construct a narrative account, linked with vague tension and apprehension because of lack of integration of the traumatic memory by the cortex may be the mechanism underlying Roger's observation in proposition 14, which states:

> "Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension" (Rogers 1951: 510).

Some traumatised individuals perceive awareness of their own emotions as danger. They may see emotions as a reminder of their inability to affect outcomes in their life (powerlessness). Emotions such as anger and fear may serve as reminders of the trauma (Van der Kolk 1996b: 219). The inability to organise and integrate the memory into a narrative leaves the person with a "phobia of memory" and seems to pre-dispose the person to the intrusion of elements of the trauma as somatic experiences, anxiety, obsessional preoccupations and terrifying perceptions (Van der Kolk& Fisler 1995:512). When memories are not integrated and associated with existing schemas, and are unattached to other memories they seem to be stored and organised on somatosensory or iconic levels (Van der Kolk & Fisler 1995:521). It seems that the imprint of traumatic memories is qualitatively different to other memories (Van der Kolk & Fisler 1995:508).

Van der Kolk and Fisler (1995:520) state "when people receive ordinary, non traumatic sensory input, they synthesise this incoming information into symbolic form, without conscious awareness of the processes that translate

sensory impressions into a personal story. In contrast traumatic memories seem to be fixed in the mind. They resist integration and are unaltered by the passage of time. Perceptual elements seem more prominent than narrative, declarative components."

Van der Kolk et al (2001:27) suggest that, when a traumatic memory is activated, as in flashbacks, the person is literally *having* an experience. They seem out of touch with feelings. Their bodies respond as if they are being traumatised again, with the secretion of neurotransmitters and stress hormones that are part of that response, but, they state, "the retrieval of the memory is dissociated and the victim does not seem able to "own" what is happening." This links with Rogers proposition 11 and suggests a mechanism whereby his clinical observations can be explained.

Proposition 11
"As experiences occur in the life of the individual, they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self" (Rogers 1951: 503).

Numbing of responsiveness may be experienced as depression, anhedonia, loss of motivation, psychosomatic complaints or dissociation. According to Van der Kolk and Saporta (1991) it interferes with therapy, making it harder for the person to be creative, explore, remember and symbolise, all of which are crucial to finding meaning in the trauma. Van der Kolk and Fisler (1995:520) conclude that "the failure to process information on a symbolic level following trauma is at the very core of the pathology of PTSD."

In trauma, the person is not subject to a single noxious stimulus such as a shock, but a whole cascade of frightening sensory information is poured into the senses in an ongoing flood. Each one of those stimuli, consciously perceived or not, may become permanently associated with the physiological responses induced by overwhelming fear. This creates fearful associations

that are divorced from the context, space and time (Beaulieu 2003:40). Traumatic memories are readily evoked but lack the detail, nuance and integration of other memories. Each time the traumatic memory is triggered a cascade of biochemical responses, reminiscent of the original trauma, is triggered. These biochemical changes will now be described.

5.5 Biochemical responses to trauma

The inclination to fight flee or freeze is mediated by different biochemical processes that have long term effects on the brain and subsequent responses to stress.

5.5.1 Biochemical changes during the fight or flight response

When the meaning of the situation is construed as dangerous, mediated by the hippocampus, which compares new information with past experience, the fight or flight response is triggered. Any function that is superfluous to survival such as digestion, immunity, hunger and sleepiness are suppressed. Blood pressure rises, the heart beats faster, vessels in the stomach constrict, breathing quickens and perspiration increases to regulate escalating body temperature. The liver releases glucose so the body is infused with a surge of energy (Naparstek 2006:73).

Both the nervous and endocrine systems are activated by the amygdala. The amygdala stimulate the hypothalamus, which activates the pituitary gland (Naparstek 2006:72). The pituitary gland controls the production of hormones in the thyroid and adrenal glands (Van der Kolk 1996b: 216). The hypothalamic-pituitary-adrenal (HPA) axis controls the release of hormones, namely cortisol, glucocorticoids, vasopressin and oxytoxin, and endogenous opiods (Van der Kolk 1996b: 222). All these hormones prepare the body to respond rapidly to an emergency. In particular, endogenous opiates reduce the body's sensitivity to pain. They are morphine-like substances. The amygdala stimulate the hypothalamus to produce corticotrophin releasing factor (CRF), which stimulates the pituitary and adrenal glands to release epinephrine, nor epinephrine and cortisol. These hormones produce an alert, energetic feeling. Nor epinephrine increases alertness and short-term

memory. It causes the pupils to dilate, increases ocular divergence (peripheral vision) and increases muscle tone in the limbs. Along with nor epinephrine, a flood of endorphins or endogenous opiates are released. These are pain-killing neurotransmitters that account for elevated pain thresholds in extreme situations so that self-protective responses to pain won't hamper life-saving manoeuvres. In this fight or flight phase, a huge amount of energy is released. Whether or not the person actually takes action, this energy is released. Thereafter the parasympathetic nervous system takes over, settling the charged systems down by releasing acetylcholine to slow heart rate, lower blood pressure, return blood to the organs and re activate digestion. The body is always cycling in and out of varying states of excitation and relaxation maintaining a balance (Naparstek 2006:73).

5.5.2 Biochemical changes during the freeze response

A second biologically driven response to danger is the freeze response, where the organism becomes immobilised. Clients who have experienced trauma describe two types of freeze response. In the first, people report feeling very aware of the environment, threat cues, escape routes or protective impulses. They are motionless, panic stricken and watchful, but full of pent up energy. The organism is ready to explode into action if the opportunity presents itself. It is described as a sense of frozen watchfulness, in which the muscles are still and tense, but the person still feels able to move. This type of freezing seems to involve a highly energised sympathetic nervous system (Ogden et al 2006:93). The second type of freezing is experienced as paralysis, with a terrifying feeling of being unable to move or breathe. This response is elicited by a sense of utter entrapment with no possibility of action being able to avert the threat (Ogden et al 2006:94). This response can be seen by animals overtaken by predators where flight is pointless. The immobilising defence of death-feigning, fainting or total passivity takes over when all other defences have failed. The sympathetic nervous system shuts down (Ogden et al 2006: 95). Tense muscles become still, blood pressure drops, heart rate slows and additional doses of pain-killing endorphins are released. In the animal world, freezing may abort an attack, because some predators cannot see prey that is not moving. When the freeze

response occurs the organism undergoes biochemical extremes in a very short space of time, collecting and holding biochemical residue from each phase. In the wild, this is not problematic because the animal usually gets eaten. If it survives, it performs a number of manoeuvres to discharge these residues. Most animals display trembling or shuddering. Sometimes their motor movements are similar to running or whatever its muscular movements were just before freezing. It is as if the activity needs to be completed. The animal then perspires, breathes deeply and moves off, apparently no worse off. Humans who undergo the freeze response do not seem to discharge the overload of autonomic energy the way animals do. It seems that humans do not discharge the physiological tension after the danger has passed (Naparstek 2006:75). It seems that this truncated freeze response may lay the groundwork for the imprinting of the trauma in the arousal patterns of the central nervous system (Naparstek 2006:76).

When people freeze they also dissociate. People who cannot flee physically flee emotionally by becoming distant and emotionally detached from the scene. Memory access and storage is impaired and amnesia for at least some of the event is common.

Freezing is evaluated negatively by many people. Freezing may be judged as cowardly, ineffective and weak-willed. It seems that helplessness is viewed as devastating evidence of a character flaw (Naparstek 2006:76).

5.5.3 Kindling

A traumatic life event can sensitise the neural pathways to stress. This lowers the person's threshold for stress. As a result less stressful events can trigger a stress response and an increasing number of events are perceived as stressful. As a result, the threshold of the stress response is lowered repeatedly until the stress response is triggered without any external stimulus. This process is known as kindling. The notion of kindling is based on experiments with animals in which electric shocks were applied to the animal's brain to induce seizures. With repeated trials, less and less electric current was needed to induce a seizure until the animal started to have

spontaneous seizures, with no shock preceding them. These seizures occurred more and more frequently and affected increasingly large areas of the brain. The initial shocks were the “kindling” that set the process in motion. Kindling affects the neural pathways by strengthening connections between them and altering the efficacy of the neurotransmitter systems. Neurons become sensitised and become more prone to firing in response to diminishing stimuli. A personal history of trauma can set this process in motion (Castillo 1997:267).

One of the dilemmas for a traumatised person is that the cycling between the parasympathetic and sympathetic activation does not stop but becomes a self-sustaining feedback circuit. A possible explanation is given by Naparstek (2006:71). It seems that the undischarged freeze response results in a sustained alarm state that produces heightened sensitivity in the neural networks of the amygdala. This is known as long-term potentiation. The amygdala are programmed to recall danger-related information. This circuit is privileged to such an extent that the incorporation of cognitive information into the perception of events is bypassed (Beaulieu 2003:40). It is also evident that internal cues can activate the cycle. After a traumatic incident, when spontaneous memories, flashbacks or nightmares occur, the amygdala activated again. The amygdala may also be re-activated by external cues such as smell, loud noises, sounds or sights. The aroused amygdala trigger the alarm state again, releasing nor epinephrine and cortisol followed by the same parasympathetic rebound. The amygdala’s hyper activation results in impaired narrative memory and reduces the ability of the hippocampus to integrate the memory with cognitive information (Naparstek 2006:77). As a result, traumatic memories become increasingly intrusive and exaggerated at the expense of conscious memory, language, analytic thinking and narrative processing of the event. The cycle becomes self-perpetuating and the person may oscillate between arousal and emotional flatness. There is a tendency to become increasingly numb and disconnected over time. Memories, flashbacks and nightmares can activate patterned neuro- muscular responses. When these muscles are used for normal activities, such as exercise, the familiar cascade of nor epinephrine followed by opiods can be

released. Stimulating muscle trigger points can have the same effect (Naparstek 2006:78). The constant activation of the autonomic system may account for the acute autoimmune and myofascial pain symptoms commonly found in survivors of trauma (Naparstek 2006:79).

6 LONG TERM EFFECTS OF TRAUMA

6.1 Physical effects

The person certainly reacts as a whole to trauma. Following a traumatic experience, somatic complaints such as restlessness, sleep difficulties, inability to relax, fatigue and shallow breathing, are commonplace. The immune system is the body's defence system and as such is profoundly affected by trauma. In general, stress disrupts the balance in the body's neuro hormones. The more the stress is prolonged, as for example by repeated flashbacks, the longer the imbalance of normal immune responses. In the long term, this can lead to overall suppression of the immune system (Beaulieu 2003:53).

A number of people experience headaches, backache, skin rashes and itching (Naparstek 2006:69). Other somatic complaints include feeling flushed and hot as well as bodily pain (Jenkins 2002:171). Many survivors display conditions linked to the auto immune system including fibromyalgia, irritable bowel syndrome, multiple chemical sensitivity, reflex sympathetic dystrophy and pelvic pain. These symptoms are often referred to as functional syndromes, meaning conditions for which no obvious physical explanation can be found. Many of these conditions are directly linked to the autoimmune system. This link to the body, especially the auto immune system makes sense when one considers the survival response triggered by trauma (Naparstek 2006:69).

Emotional responses affect the heart, changing heart rate, rhythm, cardiac output and blood pressure. The most profound effect on the heart is induced by anger. This is particularly relevant to men, who are more likely than women to experience anger after traumatic experiences. Any recollection of the

trauma can trigger the anger, with the effect on the heart that this entails. Dysregulation of catecholaimines seems related to these elevated cardiovascular responses. The elevation in heart rate and blood pressure seen in survivors of war seem to place these people at greater risk for heart attacks and cardio-vascular disease. Fear also impacts the cardiovascular system (Beaulieu 2005:55).

Heightened arousal is costly in terms of energy. Adrenaline stimulates energy consumption, exhausting energy stores. This leads to exhaustion and depleted energy (Beaulieu 2003:55-56).

Van der Kolk and Fisler (1995:520) believe that dissociation is at the very core of the pathology of PTSD. Dissociation can become a physiologically kindled response. In a well functioning organism, stress stimulates a rapid and pronounced hormonal response. However, persistent stress blunts this response and produces desensitisation (Van der Kolk & Saporta 1991). When a threat is encountered, the immediate response is alarm with activation of the sympathetic nervous system. If the threat continues and the person is helpless, the person may “flee physically” and dissociate, entering a trance like state. This switch from a sympathetic hyper aroused state to the parasympathetically mediated hypo-arousal phase follows from the perception that the threat cannot be evaded or modified (Panzer & Viljoen 2004:12). Van der Kolk, Van der Hart and Marmar (1996b; 307-308) suggest that dissociation occurs on three levels. Primary dissociation refers to the inability to integrate a traumatic experience into a personal memory and identity, leaving the experience split into isolated somatosensory elements, divorced from a personal narrative. It may be experienced as un-integrated affective states. This may be manifested as intrusive symptoms, nightmares or flashbacks. Secondary dissociation refers to dissociation at the time of the trauma. It is described as a feeling of being out of the body, or viewing what is happening to them as a spectator. This helps to protect the person from the full impact of his or her pain or distress. This puts the person out of touch with his or her feelings. It is also known as peritraumatic dissociation. Tertiary dissociation refers to the development of distinct ego-states to contain the

trauma, which vary with culture (Van der Kolk & Fisler 1995:51; Castillo 1997:226-227).

It has been argued that we are unable to remember traumatic events that take place early in life because the hippocampus has not matured to the point of forming consciously accessible memories. However, the emotional memory system, which develops earlier, forms and stores unconscious memories of these events (LeDoux 1994:57). The hippocampus only matures in the third or fourth year of life. The amygdala that records the quality of experience matures earlier (Van der Kolk & Saporta 1991). Therefore trauma may affect mental and behavioural functions later in life, although the process may be inaccessible to consciousness. The effects of trauma in young infants have been described by Panzer and Viljoen (2004:11-15). The first two years of life are a critical period for the maturation of the right hemisphere and limbic system and this system is extremely sensitive to the environment (Panzer & Viljoen 2004:11). Disruption of early attachment directly affects maturation of the limbic system (Kling & Stekliss 1996 cited in Van der Kolk & Saporta 1991). When an infant is exposed to abuse and there is no one to soothe the infant, the child experiences a “fright without solution.” Attempts to elicit the care givers help, for instance by crying, may lead to further abuse, forcing the infant to inhibit these responses in order to survive. The infant may cope by dissociation, separating explicit and implicit processing of the memory (Panzer & Viljoen 2004:11). Permanent changes in the structure of the brain can be produced by repeated trauma early in life, where sympathetic arousal is followed by parasympathetically mediated dissociation. This process is linked with high levels of cortisol (a stress hormone) in the infant brain. These chaotic fluctuations in the biochemistry of the brain causes thinning of the connections between the brain and both branches of the autonomic nervous system and a loss of reciprocal co-ordination between the excitatory component of the autonomic nervous system, namely the sympathetic nervous system and its inhibitory component, the parasympathetic system. The amygdala have inputs to the parasympathetic nervous system. This system is responsible for passive coping, death feigning, immobile behaviour and parasympathetic activity (Panzer & Viljoen 2004:14-15). The tendency to

dissociate in response to less and less stress, becomes established. This in turn inhibits emotional learning and impairs memory for the trauma. Early trauma without support leads to impaired communication between the left and right hemispheres of the brain. This results in alexithymia, meaning “having no words for feelings.”

6.2 Cognitive effects of trauma

Trauma creates difficulties with focus. People who have been through trauma may be distracted by their efforts to avoid reminders of the trauma. There is a sense of being “scattered”. It may be difficult to sort out relevant and irrelevant information. The ability to distinguish between stimuli may be impaired and over time the person may react to a variety of cues with equal emphasis. Perceptions become more biased towards noticing what is anxiety provoking or alarming at the expense of noticing what is nurturing and pleasant (Naparstek 2006:81). Survivors of trauma may be distracted by these concerns and have difficulties with short term memory (Naparstek 2006:84).

6.2.1 Flashbacks, amnesia and nightmares

Memories for the trauma remain fixed and intense. They resist the integration and distortion that characterises every day memories. Fluctuations in the level of detachment during trauma may explain the fragmentary quality of traumatic memories (Panzer & Viljoen 2004:14). Traumatic nightmares have been known to remain fixed for a period of fifteen years. Although traumatic memories may present themselves as vivid flashbacks, amnesia for the event is also common. In the case of childhood abuse, the entire childhood may be unavailable to conscious recall (Naparstek 2006:82-83).

6.2.2 Time distortion

Traumatised people often report experiencing the trauma in a detached way. Some report that it seemed as if the event occurred in slow motion. If dissociation is kindled, this may become a habitual experience. People report “losing time” as they slip in and out of trance states (Naparstek 2006:84).

6.2.3 Changes in information processing

Children who are subject to chronic abuse are forced to train focus away from language and verbal content toward non-verbal, danger related cues such as body language, tone of voice, facial expression and so forth. This type of processing facilitates a quick response to danger, but occurs at the expense of abstract reasoning and the use of language and ideas. Such children are hyper vigilant and are often misdiagnosed as having attention deficit disorder (Naparstek 2006:85).

6.2.4 Obsessive thinking

Some survivors of trauma cope with their anxiety by focusing it on other tasks, routines or schedules. By focusing anxiety elsewhere, they are able to distract themselves from thinking about the trauma. This state of affairs is usually temporary but may persist over many years (Naparstek 2006:82).

6.2.5 Unexpected gains

The changes in information processing and loss of focus seem to be linked with dissociation. When people dissociate, their ability to think clearly, see escape routes, solve problems or stay grounded is lost. Constriction of attention, withdrawal and detachment are the essence of dissociation, which enables one to cope with the fear and pain associated with the trauma.

One of the benefits of this manner of coping may be the emergence of heightened intuition. Some survivors develop their intuitive abilities to help others. Some seem exquisitely sensitive to what other people are feeling or experiencing. Some express themselves in a variety of creative ways such as art, music drama or psychic phenomena (Naparstek 2006:90-94).

6.3 Emotional effects of trauma

People who have been through trauma may suffer from feeling too much and feeling too little (Ogden et al 2006:16). They alternate between avoidance of cues reminiscent of the trauma and intrusive re-living thereof (Ogden et al 2006:4).

People who have been through trauma may lose the ability to use emotions as signals from which to construct meaning, because they may interpret benign stimuli as dangerous. The intensity of emotions and sensory stimuli impair reality testing and resultant behaviour is often impulsive and reactive rather than reflective and adaptive (Ogden et al 2006:34). Feelings associated with post traumatic stress tend to be overwhelming and powerful. They seem to defy description (Naparstek 2006:96). People seem overwhelmed by sorrow. They may grieve the loss of their innocence, their dreams or the disappearance of a predictable, reasonable world. They may feel upset that they can no longer take anything for granted, whether that means safety, health, loved ones or possessions. Losses may include family members, friends, homes or possessions. Many experience intense rage (Naparstek 2006:96).

Flashbacks bring with them the feelings that were part of the original experience – possibly fear, horror, helplessness and fear of death (Naparstek 2006:99). Some survivors experience rage that makes them feel like a threat to themselves and others (Naparstek 2006:103-105). Some turn the rage against themselves and engage in self-destructive actions like cutting or injuring themselves (Naparstek 2006:105).

Survivors frequently oscillate between intense feelings and emotional numbness. This is the emotional counterpart to the hormonal shifts that occur after trauma or flashbacks. Over time, numbness seems to predominate. The endogenous opiods flooding the survivors system seem to be responsible (Naparstek 2006:106).

6.3.1 Shame and guilt

A distinction has been made between shame and guilt. Guilt is described as the self's negative evaluation of particular behaviours while shame involves the negative evaluation of the entire self (Leskela, Dieperink & Thuras 2002:223).

Survivors may feel guilty for being unable to ward off the disaster, what they did or failed to do. The person may feel guilty for freezing in terror. Some try to blame others to ward off the tyranny of their own guilt (Naparstek 2006:115-118).

Many survivors of trauma experience intense self-loathing and shame. This may be described as a sense of being contaminated, defiled, damaged, dirty or different (Naparstek 2006:107; Retief 2000:104). Shame tends to involve feelings of worthlessness and powerlessness. It may include doubting one's right to exist. Shame is positively correlated with PTSD. Veterans with PTSD had higher shame-proneness than those without (Leskela et al 2002:224).

Many survivors struggle with the image of themselves as an accomplice or perpetrator, especially if they have been forced to betray others or co-operate with the victimiser in some way (Naparstek 2006:108). Shame has been attributed to breaking interpersonal ties with others in trauma related contexts. For some people, for example survivors of war, this may be the aftermath of breaking the bridge to what is familiar in life, depersonalisation of others or failure to act in accordance with internalised values. It may mean that interpersonal ties are severed by death. Shame may be related to betrayal. Interpersonal ties may also be destroyed by broken trust and the resultant feelings of isolation and paranoia (Wong & Cook 1992:561).

6.3.2 Alienation

Survivors of trauma often feel alienated from others as if the "interpersonal bridge" has been broken. The survivors must bear the burden of what he or she knows and may doubt him or her self and others. Trauma survivors may feel separate from others and have feelings of deep loneliness (Naparstek 2006:110-112).

One of the effects of trauma is that it can break trust and destroy one's confidence that the world is safe and predictable. *"The traumatic event, by its very nature has revealed, with its cruel disregard for the survivor, that his point of view counts for nothing"* (Naparstek 2006:38). One's sense of control

and efficacy are undermined. One no longer believes in a just world. Belief in a just world suggests that, by our actions, we can make good things happen and ward off the bad (Naparstek 2006:38). This belief can result in “blaming the victim”. For example, with respect to rape, people may comment “she must have led him on” or, “look how she dressed!” Males are more likely to make such attributions than females. The tendency to blame the victim enables one to protect oneself vicariously (Baron & Byrne 2000:67). Observers tend to blame the victim because, by perceiving themselves as different to the victim in terms of character or behaviour, perceptions of one’s own personal vulnerability are minimised (Janoff-Bulman, Timko & Carli 1985:166). It seems that hindsight contributes to the tendency to blame the victim. Once people receive information about the outcome of an event, they are unable to ignore the information and presume that the event was predictable. People who suffer as a result of the event are judged as culpable, because we tend to assume that the person should have foreseen the sequence of events (Janoff-Bulman et al 1985:162-163). It is not only observers who blame the victim but survivors may blame themselves. Self-blame may seem preferable to accepting that the trauma was random. Survivors seem to believe that, if the event was their fault, they can avoid future calamity.

In order to understand the circumstances surrounding the person’s victimization, it is necessary to reconstruct the victim’s perceptions before the traumatic event (Janoff-Bulman et al 1985:173).

With the loss of faith that the world is meaningful, the loss of one’s sense of self and the loss of a continuous personal narrative, life itself may seem meaningless. Those who can find meaning in their suffering are likely to recover and grow (Naparstek 2006:43-45).

6.3.3 Emotional numbing

Dissociated experience tends to remain unnamed by thoughts and language. This results in alexithymia, meaning “having no words for feelings.” Such dream-like experiences are numbed and are not fully integrated into the life of

the person. These experiences are frequently accessed during stress, particularly in attachment-related contexts (Panzer & Viljoen 2004:14). Dissociation can help one cope with overwhelming threat, but, when employed as a routine strategy, a pattern evolves in which neural networks become sensitised so that less and less stress is necessary to evoke subsequent dissociative states. Once dissociated, a person is inaccessible to the external environment and resistant to bonding with others. As a result of the disturbance in a traumatised person's ability to regulate autonomic reactions to both internal and external stimuli, the person is unable to use emotions as signals to take adaptive action. Emotional arousal and goal directed responsive actions become disconnected (Van der Kolk 1996b: 217-219).

Numbness is a form of "emotional anaesthesia" that may follow trauma. The principle feature of emotional numbing is the absence of feelings of intimacy, love and affection coupled with a lack of care or concern about oneself or others (Glover 1992:644). Survivors of trauma have used the following terms to describe this state: shut down, numb, hollow, dead, empty and bored. The person may feel like a robot, recording data but having no feelings. This provokes questions such as "who am I?" and "does life have any meaning?" (Glover 1992:645).

Some traumatised people may act in flippant or socially unacceptable ways because of a lack of concern about the feelings of others. People experiencing numbness feel alienated from others and lose interest in the outside world. Emotional numbness may be associated with and preceded by somatic analgesia or parasthesias (pins and needles) (Glover 1992:645).

Numbing is associated with impaired memory, problem-solving, concentration and slowed thought processes. People experiencing numbness tend to avoid reminders of the trauma and are loath to participate in intimate relationships (Glover 1992:646). Some however, participate in risky behaviour, such as skydiving, racing, gambling, drug use and self-inflicted pain in an effort to feel

alive. It seems that emotional numbness is an endorphin-mediated phenomenon (Glover 1992:647).

6.3.4 Openness

Naparstek (2006:118) states that a number of survivors emerge from their traumatic experiences with greater openness, the ability to feel deeply and an ability to savour the preciousness of life and appreciate beauty more than before. For many the capacity to empathise and relate to others deepens. Many find paths of creative expression or spirituality.

6.4 The behavioural effects of trauma

6.4.1 Avoidance and isolation

Survivors of trauma may go to great lengths to avoid reminders of trauma. However, they may become sensitive to neutral stimuli that are in some way linked to the trauma (e.g. time of day, weather patterns, etc.). They may go to great lengths to avoid apparently normal activities.

Survivors may feel embarrassed about their anxiety. This may make them careful to conceal their avoidant behaviour from others (Naparstek 2006:125). Survivors may become reluctant to leave the perceived safety of their own home, a condition known as agoraphobia. Some survivors who were victimised by authority figures may avoid dealing with superiors whenever possible (Naparstek 200:125-128).

6.4.2 Avoidance of intimacy

Survivors of trauma may fear emotions that could serve as reminders of the trauma. They may overreact and scare people with their intensity or shut down and tune people out. They may avoid close relationships. They may avoid sexual intimacy, or alternatively they may use sex, flaunting it as a way of keeping anxiety at bay (Naparstek 2006:130).

6.4.3 Overprotection of others

Survivors of trauma may become extremely concerned about those they love, becoming overprotective and controlling. They may hover over their children, lay down rigid rules and prevent them from participating in normal activities (Naparstek 2006:132).

Naparstek (2006:132) points out that the majority of survivors of abuse go out of their way NOT to become abusers themselves. However, it seems that about a third of the victims go on to become perpetrators of abuse themselves.

6.4.4 Substance abuse and addictive behaviours

Survivors of trauma may indulge in food, alcohol or drugs in an attempt to regulate overwhelming feelings (Naparstek 2006:137). Eating disorders may develop. Other survivors engage in compulsive sexual activity. Others turn to self-mutilation (Naparstek 2006:138-140).

6.4.5 Impaired motivation

When a sense of safety exists, people readily engage with the environment, but when one mis-perceives environmental cues as danger, defensive strategies are triggered (Ogden et al 2006:33).

People tend to dissociate in traumatic situations when resistance is futile. This leads to a sense of self that is helpless or powerless. As the dissociation becomes more and more kindled and pervasive, the person becomes increasingly apathetic. This person may be perceived as “easy to push around” and may be subject to further abuse (Naparstek 2006:141 - 145).

6.4.6 Compulsive busyness

Survivors of trauma may engage in compulsive activity, keeping busy in an effort to ward off anxiety or flashbacks. They strive to avoid thinking, so fill time with work, cleaning, planning or errands, many of which are unnecessary from a practical point of view. Proposition 13 and 16 apply, namely:

Proposition 13

"Behavior may, in some instances, be brought about by organic experiences and needs which have not been symbolized" (Rogers 1951: 509).

Proposition 16

"Any experience which is inconsistent with the organization or structure of self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself" (Rogers 1951: 515).

Naparstek (2006:145-146) points out that it is not unusual for the compulsive over work to exacerbate the trauma symptoms by precipitating exhaustion.

6.4.7 Stress induced analgesia and self-mutilation

Lowered sensitivity to pain can be induced in animals by exposing them to inescapable stress such as electric shock, fighting, starvation or a cold-water swim. This is known as stress-induced analgesia (Van der Kolk 1994). The secretion of natural morphine-like substances, known as endogenous opiods reduces the body's sensitivity to pain. These chemicals are produced by the human body as well as in animals when threatening situations are encountered. This process protects an organism against feeling pain whilst taking defensive action. It reduces panic. It also inhibits memory. This enables the organism to avoid consciously experiencing or remembering extreme stress. Impaired memory also therefore keeps them from learning from experience (Van der Kolk 1994).

Opiate withdrawal symptoms can be induced in animals exposed to stress such as electric shock or swimming in cold water by relieving the stress. People with PTSD also develop opiate-mediated stress-induced analgesia (Van der Kolk 1994). Survivors of severe trauma describe a triad of physical analgesia (diminished physical sensation), psychic numbing and depersonalisation. It seems that repeated trauma leads to prolonged stress induces analgesia. This numbing may be reversed by naloxone or by an act of

self-mutilation (Van der Kolk & Saporta 1991). Naloxone is a drug that reverses the effect of opiods (Favazza & Conterio 1988:28).

6.4.7.1 Self-mutilation as a response to dissociation

Research on non-human primates indicates that self-mutilation is a common response to social isolation and fear (Van der Kolk, Perry & Herman 1991: 1670). Immature animals are particularly prone to developing biological emergency responses, including flight, fright and freeze reactions to repeated stress or previously neutral cues associated with noxious stimuli (Van der Kolk et al 1991: 1670). These stress responses tend **not** to diminish with time.

Non-brain damaged adults who mutilate or injure themselves usually have a history of severe childhood trauma. This behaviour is associated with abnormalities in neurotransmitters that reduce sensitivity to pain, namely the endogenous opiod and catecholamine systems (Van der Kolk & Saporta 1991). Van der Kolk and Fisler (1995:519) have found that childhood trauma triggers more destructive self soothing manoeuvres such as self-mutilation and binging than trauma that begins in adulthood. This supports the idea that childhood trauma results in more widespread biological dysregulation and is more difficult in regulating internal states than trauma that begins in adulthood. Nevertheless, the onset of self destructive behaviour has been associated with rape and war trauma in adults, strengthening the link between self mutilation and trauma (Van der Kolk et al 1991: 1665).

Deliberate self-harm includes cutting, burning, slashing, banging, hitting and bone breaking. These behaviours seem distinct from suicide attempts, in terms of age of onset, sex ratio and meaning (Van der Kolk et al 1991:1665). Dissociation, self-destructiveness and impulsive behaviour are hypothesised to be hormonally mediated responses that are triggered by cues reminiscent of trauma (Van der Kolk et al 1991: 1670). It seems that the pain induced by self-mutilation may cause the release of endogenous opiods, the body's natural pain killers, which trigger a pleasant opiate-induced feeling that alleviates negative emotions (Favazza & Conterio 1988:28). It was found that ongoing dissociation is directly associated with cutting (Van der Kolk et al

1991:1667). Subjects reported that cutting relieved the deadness and dysphoria of dissociation. Cutting may also be a way of quietening hallucinations, altering personal relationships or stimulating biological homeostasis. Favazza and Conterio (1988:27) state that self-mutilation can provide relief from episodes of negative emotions such as anger or anxiety or depression, loneliness and emotional emptiness or depersonalisation, racing thoughts and boredom. They also note that sacrifice of a body part such as an eye, may avert suicide.

These findings suggest that self mutilation is an attempt to regulate stress induced analgesia or numbness, or is used as a way of communicating trauma related distress. This links with Rogers proposition 5 which states;

“Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived” (Rogers 1951: 491).

Van der Kolk et al (1991:1667) found that both self-mutilation and suicide attempts were associated with histories of childhood physical and sexual abuse as well as parental separation and neglect. Subjects with a history of sexual abuse and those with a history of separation and neglect proved to be the most persistent self-mutilators, despite therapeutic intervention. They concluded that childhood trauma contributes to the initiation of self-destructive behaviour, but lack of secure attachments maintains it. Those who felt unloved as children were least able to use interpersonal resources in the course of the study to overcome their self-destructive behaviour (Van der Kolk et al 1991: 1667). The researchers concluded that trauma-related interpersonal communications played a role in suicide attempts, but cutting serves primarily to regulate internal affective states (Van der Kolk et al 1991:1670). These actions may be experienced as a way of punishing oneself, a way of punishing others or a cry for help after feeling abandoned (Van der Kolk et al 1991:1670).

This suggests that self harm may be an expression of the trauma induced belief that one is bad and needs to be punished as suggested in proposition 12:

"Most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of self" (Rogers 1951: 507).

6.4.7.2 Re-enactments and flirting with danger

A phenomenon is that survivors of trauma sometimes display a tendency to replay the trauma in subsequent scenarios. For example, someone who was beaten as a child may choose an abusive partner. It seems that the self, formed in the interaction with the abuser, is unconsciously drawn to a partner who represents danger and punishment, (Proposition 10 &12) (Retief 2000:27). Naparstek (2006:133) emphasises that these enactments are motivated by unsymbolised experiences and may be driven by an unsymbolised need. Naparstek (2006:135) explains "People are unknowingly addicted to their own biochemicals and are thus *provoking doses of their own stress neurohormones."* She suggests that people become addicted to their own adrenaline and endogenous opiods. These findings are similar to those from animal studies. When exposed to stress, the body releases endogenous opiods to deaden pain, which is known as stress induced analgesia. Animals who have developed stress-induced analgesia tend to return to the source of their pain when exposed repeatedly to high stress. In one study, animals were exposed to high stress for a period. Thereafter the degree of arousal was varied. In a state of low arousal, the animals were calm and sought novelty. When highly aroused, they sought what was familiar, even to the extent that they returned to a box in which they were shocked previously. They went back to the stressful environment when subsequently stressed. It seems that this perseveration was dissociated (uncoupled) from the usual reward systems (Mitchell, Osbourne & Boyle 1985, cited in Van der Kolk 1994).

It seems that this unconsciously driven drive to satisfy an unsymbolised need explains this phenomenon as articulated in proposition 13, which states:

"Behavior may, in some instances, be brought about by organic experiences and needs which have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not "owned" by the individual" (Rogers 1951:509).

It is important to note that, in relation to the "abuser", the self evolves as a victim (proposition 12). A survivor of such trauma may unknowingly portray him or herself as "prey" by words, actions and body language (Naparstek 2006:136). This behaviour may unwittingly draw abusive partners to the person acting in this way.

6.5 The effect of repeated trauma on the self

Traumatised people tend to interpret reactivated sensorimotor responses to trauma as information about the self and may conclude" I am never safe' or "I am a marked woman" or "I am worthless" (Ogden et al 2006:3). Dissociation leads to a disrupted sense of self. This loss of self is described as feeling empty, lost, dead or futile. Motivation is impaired by the survival strategies of passive disengagement, escape and energy conservation (Panzer & Viljoen 2004:14).

The self emerges in interaction with others, according to propositions 9 and 10. It is becoming apparent that these interactions influence the brain structure, producing enduring effects on the self. Infants are born with a limited capacity for self-protection and self-regulation. Becoming attached to others influences our ability to regulate stimulation. Early disruption of attachment has long-term detrimental effects on interpersonal relationships and the capacity to cope with stress (Ogden et al 2006:41).

The infant begins to interact with his or her primary caregiver (usually the mother) in a series of face-to-face and body-to-body contacts, which regulates the infant's autonomic and emotional arousal. These interactions impact the infant on a physical level because they facilitate or impair the development of the part of the brain responsible for self-regulation of arousal, namely the orbital pre frontal cortex (Ogden et al 2006:42). This is the area of the brain's

cortex that lies just above the eyes. It is involved in the regulation of the body and reflection on changes in that state. It also mediates attachment (Ogden et al 2006: 153).

When an infant is distressed, he or she turns to the caregiver for comfort. Throughout life, when people are threatened, they tend to call on others for help (Ogden et al 2006:90). Early trauma leads to failure of this defence. If the source of fear is also the primary caregiver, infant's ability to recover, reorganise and feel safe is undermined. The child is strongly aroused with no attachment-mediated comfort and repair. An infant predictably turns to the caregiver when stressed, but if the caregiver further stresses the infant, an irresolvable paradox is created. Both the need for attachment and the need to fight, flee or freeze is triggered (Ogden et al 2006:53). The child cannot develop a sense of unity and continuity of self. This shows up as emotional instability, social dysfunction, cognitive distortions and poor response to stress (Ogden et al 2006:43). It is noted that neurones in the orbitoprefrontal cortex are pruned according to the way in which the infant is stimulated. This is the area that mediates emotional and autonomic arousal. It also influences socio, emotional processing and the capacity to cope with stress. Early interactions determine whether a person can allow him or her self to go to others for support (Ogden et al 2006:55).

When the infant experiences frightening circumstances without solutions, he or she tends to enter a state of hypoarousal or passive coping. In this state energy is conserved, affect is reduced and the infant disengages from the social system. These patterns become part of the self (Ogden et al 2006:57-58).

6.5.1 Complex PTSD

Some writers believe that PTSD, as constructed in the DSM IV-TR, is inadequate to describe the effects of prolonged and repeated trauma (Herman 1992:377-391). They contend that PTSD relates to relatively isolated incidents of trauma. However, when a person is subjected to coercive control such as domestic violence, child abuse, prison, certain religious cults, brothels or a

concentration camp, survivors frequently display signs of distress with many common features, despite their disparate circumstances. The common thread seems to be that survivors are unable to flee from coercive control, whether due to economic circumstances, psychological means (as in the case of battered women, abused children or religious cults), or physical force (as in prisons or concentration camps). Clinical observations suggest that survivors display signs of distress that are more complex diffuse and tenacious than PTSD, have more difficulties with relationships and identity and are more vulnerable to repeated harm, either self-inflicted or at the hands of others (Herman 1992:378-379). It seems that constant interactions with the perpetrator of abuse or coercive control has profound effects on the self of these trauma survivors.

Propositions 9 and 10 relate to the development of the self:

Proposition 9
“As a result of interaction with the environment, and particularly as a result of evaluational interaction with others, the structure of self is formed – an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with values attached to these concepts” (Rogers 1951: 498).

Proposition 10
“The values attached to experiences, and the values which are a part of the self structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as if they had been experienced directly” (Rogers 1951: 498).

In contrast to the person-centred approach in which diagnosis, and labelling are avoided, the medical model seeks to define syndromes and explain them in terms of cause and effect. As a result, much of the person’s experience may be ignored, if it does not fit the category as defined by the diagnostician. Alternatively, new categories may be constructed. It is proposed that a new

diagnosis, “Complex PTSD” or DESNOS (disorder of extreme stress not otherwise specified) be included in the DSM IV-TR to capture the wider range of symptoms displayed.

The proposed diagnostic criteria for DESNOS (or complex PTSD) are as follows.

1. A history of subjection to totalitarian control over a prolonged period (month’s to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems of sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

2. Alterations in affect regulation, including
   - Persistent dysphoria
   - Chronic suicidal preoccupation
   - Self-injury
   - Explosive or extremely inhibited anger (may alternate)
   - Compulsive or extremely inhibited sexuality (may alternate)

3. Alterations in consciousness, including
   - Amnesia or hypermnesia for traumatic events
   - Transient dissociative episodes
   - Depersonalisation / derealization
   - Reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

4. Alterations in self-perception, including
   - Sense of helplessness or paralysis of initiative
   - Shame, guilt, and self-blame
   - Sense of defilement or stigma
   - Sense of complete difference from others (may include a sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alterations in perception of perpetrator, including
   - Preoccupation with relationship with perpetrator (includes preoccupation with revenge)
   - Unrealistic attribution of total power to perpetrator (caution: victim’s assessment of power realities may be more realistic than clinician’s)
   - Idealization of paradoxical relationship
   - Sense of special or supernatural relationship
   - Acceptance of belief system or rationalizations of perpetrator

6. Alterations in relations with others, including
   - Isolation and withdrawal
   - Disruptions in intimate relationships
   - Repeated search for rescuer (may alternate with isolation and withdrawal)
   - Persistent distrust
   - Repeated failures of self-protection

7. Alterations in systems of meaning
   - Loss of sustaining faith
   - Sense of hopelessness and despair

   (Herman 1997:121)

Herman (1992:380) refers to three categories that do not readily fall within the classic diagnostic criteria as described by DSM IV-TR. These are somatic, dissociative and affective experiences. Her ideas are summarised here

6.5.1.1 Somatisation in complex traumatic stress

Repetitive trauma is linked with hyper vigilance, anxiety and agitation without any baseline of calmness. Survivors of the Nazi Holocaust, as well as South East Asian refugees, seem to develop tremors, choking sensations, pelvic pain, headaches, gastro intestinal disturbances and nausea. Survivors of childhood sexual abuse also frequently display somatic signs of distress (Herman 1992:380).

6.5.1.2 Dissociation in complex traumatic stress

Herman (1992:381) states “People in captivity become adept practitioners in the arts of altered consciousness”. She adds that prisoners frequently instruct each other about how to induce trance states. These methods are used consciously to withstand pain, hunger and cold. Abused children may apply these mechanisms to preserve the myth of “good parents” and to wall off the contradictory images of the self and the parents (Herman 1992:381).

6.5.1.3 Affective changes in complex traumatic stress

Some people emerge from prolonged abuse with their faith in tact, but most seem to feel forsaken by God and man and experience tenacious depression. Various features of trauma seem to combine to aggravate the experienced of

depression. The chronic hyper arousal of trauma aggravates the insomnia, nightmares and somatic complaints of depression. The dissociative aspect of trauma aggravates concentration difficulties. The numbing and loss of initiative of trauma adds to the apathy and helplessness of depression. The onslaught against the self-image heightens guilt feeling and loss of faith adds to hopelessness (Herman 1992:382).

These concerns emphasise that, in keeping with the person-centred approach, diagnostic labels and symptoms do not capture the reality of a person's own experience. What may be "depression" to one person may be an expression of "trauma" to another. These labels are merely constructs that are arbitrary, but may facilitate communication between those using them.

People in captivity or coercive relationships may be humiliated and experience anger. However, the person may not be able to express anger at the time because his or her survival is at stake. Survivors are frequently angry towards others who remained indifferent to their plight, or failed to help. Many survivors may fear retribution if anger toward the perpetrator is expressed even after the person is freed. Subsequent outbursts of rage may alienate others and exacerbate the survivor's social withdrawal. Many experience self-hate and chronic suicidal tendencies (Herman 1992:382). Treating depression without adequate attention to the trauma is not useful.

6.5.1.4 Changes in interpersonal relationships

In situations of captivity or coercive relationships, the self of the victim evolves in relation to the perceived power of the perpetrator. Political prisoners, abused women and abused children are frequently subject to similar methods of control or "brain washing" (Herman 1992:383). These methods are aimed at creating a perception of fear and helplessness, to destroy the person's sense of self in relation to others and to foster a perception of attachment to the perpetrator. Violence, the treat of death or serious harm, inconsistent enforcement of petty rules and unpredictable outbursts of violence are used to induce terror in the victim. The perpetrator may also destroy the victim's sense of autonomy using deprivation of food, shelter, exercise, personal

hygiene or privacy. Once a degree of control is established, the perpetrator may become a source of solace. The capricious granting of small indulgences may undermine the psychological resilience of the victim more effectively than deprivation and fear. As long as the victim maintains strong relationships with others, the perpetrator's power is limited. However, the perpetrator usually isolates the victim, prohibiting communication, or material support and seeking to break the victim's emotional ties with others. The victim may be forced to witness or participate in abuses against others (Herman 1992:383-384). The victim becomes emotionally and physically dependent on the perpetrator and a traumatic bond develops between them. This may be seen between hostages and their captors or battered spouses and the abuser.

Increased dependence on the abuser creates conditions in which initiative and planning are restricted. For example, a prisoner or battered woman may no longer focus on escape, but on how to survive or make the captivity more bearable. Chronically traumatised people are frequently viewed by others as passive or helpless. The person, however, may view any act of independence as insubordination and fear punishment (Herman 1992:384).

The abused person may continue to fear his or her captor, even long after being freed. This may take the form of a preoccupation with evil in the world, brooding over specific instances or the fear that the perpetrator will hunt him or her down. The person may also feel empty and confused without the perpetrator (Herman 1992:384-385). Survivors seem to approach new relationships as if life-and-death were at stake, oscillating between intense attachment and terrified withdrawal. Survivors of childhood abuse may be handed the diagnosis of borderline personality disorder or multiple personality disorder. Survivors of childhood abuse may be inclined to form intense attachments to idealised caretakers, ridden with boundary violations, conflict and the potential for exploitation (Herman 1992:385).

6.5.1.5 Changes in identity in complex traumatic stress

Where a person is subjected to coercive control the structure of the self, including body image, images of others, values and ideals are undermined.

“While the victim of a single acute trauma may say she is “not herself” since the event, the victim of chronic trauma may loose the sense that she has a self.” (Herman 1992:385). Survivors of child abuse report a contaminated sense of self in that they may feel guilty. Fragmentation of the self is common, reaching its extreme in multiple personality disorder in which aspects of the self are dissociated and experienced as separate identities or “others.” (Herman 1992:386).

6.5.1.6 Repetition of harm in complex traumatic stress

In PTSD, the traumatised person may have repetitive experiences in the form of flashbacks, dreams and intrusive memories. In the case of chronic trauma, survivors may inflict harm on themselves or be at risk for harm from others. Survivors may engage in self-mutilation, cutting or other forms of self-harm, which are distinct from suicide.

It is interesting to note that the risk of rape, sexual assault and battering is doubled for female survivors of childhood abuse compared with other women (Herman 1992:387). Survivors of childhood abuse may become involved in the abuse of others either as passive by-standers or as perpetrators (Herman 1992:387). A history of childhood abuse is a risk factor for becoming an abuser, especially in men (Herman 1992:387). Women who have witnessed domestic violence or sexual abuse are at risk for marrying abusive partners (Herman 1992:387).

6.5.1.7 Many do not abuse but display caring in complex traumatic stress

Herman (1992:387) concludes that complex PTSD may co exist with PTSD, but extends beyond it. There is widespread misunderstanding of survivors of long-term trauma, with a tendency to blame the victim and find fault with his or her character (Herman 1992:388). The survivor’s problems are further complicated by the tendency to keep domestic violence or child abuse a secret. Observers who have never experienced prolonged terror tend to assume that they would cope better than the victim and apply concepts to the victim that are gleaned from non-coercive relationships without full

appreciation of the effects of long-term coercive control. Victims are frequently stigmatised and labelled with a “personality disorder.” Herman (1992:387) strongly advocates expanding the DSM IV -TR category of PTSD to include the complex disorder of extreme stress (DESNOS) to remove the stigma of the personality flaw from survivors of long-term trauma.

7 IMPLICATIONS FOR THE FACILITATION OF RECOVERY

The literature reviewed this far implies that dissociation is at the heart of the long term deleterious effects of trauma. This implies that therapy should focus on integration. Van der Kolk et al (2001:28) advocate that clients should be assisted to verbalise their experiences. They suggest that trauma may leave an indelible imprint on the brain, but that, once people start talking about these sensations and try to make meaning of them, they are transcribed into every day memories and are transformed. They suggest that people seem unable to accept experiences that have no meaning, but once they can make sense of the experience, they can fill in the blanks, complete the picture and integrate the memory into the life story. This involves bringing fragmented memories to conscious awareness for integration to be possible. It seems obvious that people who have been subject to distressing and frightening experiences need a safe context in which to explore and integrate these experiences. The emotional relationship in therapy is used to cover the deficiencies in the emotional relationship in the trauma-related context. The clinician facilitates the regulation of emotions, including those that have been previously walled off by dissociation (Panzer & Viljoen 2004:14). These observations are linked with Roger’s perceptions of change. He suggests that change occurs in the context of a safe relationship in proposition 17:

> “Under certain conditions involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived, and examined, and the structure of self revised to assimilate and include such experiences” (Rogers 1951: 517).

He also suggests that change involves integrating previously unsymbolised experiences into the self in proposition 15:

“Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self” (Rogers 1951: 513).

8 EVALUATION OF THE BIOLOGICAL/MEDICAL MODEL

The biological model is basically a universalist or etic approach that assumes biological responses to trauma are the same across cultures. The assumption is that, biologically, people are the same and require the same treatment regardless of race and culture. The diagnostic criteria and classification system developed in the DSM IV –TR system is based on this approach (Mokgalthe 2001:34). The value of this approach is that it enables us to make comparisons across a range of contexts. Commonalities and differences between cultures can be discerned. However, this model has implications that are not consistent with the person-centred approach. It obscures the uniqueness of people in responding to their experiences, whether external or physiological. Individual, group and in-group variability may be ignored. Specifically labelling and diagnosis may have detrimental implications for people (Mokgatlhe 2001:34). According to Kleber, Figley & Gersons (1995:4) “[t] he concept PTSD has become so fashionable that it is dominating the debate worldwide about human responses to catastrophic events. Western conceptual frameworks dominate the field. Nevertheless, the concept has inherent limitations in capturing the complex ways in which individuals, communities, and indeed whole societies register tragedy.”

The diagnostic system developed in the West is not necessarily the most useful way of understanding trauma. An emic approach fits the philosophy of the person-centred approach, with its phenomenological view of people. Whether to adopt an etic or emic approach is the source of ongoing controversy in the field of cross-cultural research. Cultures differ in their beliefs about what constitutes normal and abnormal behaviour. In contrast to an etic approach, an emic approach assumes that cultures differ with respect to these perceptions. An emic approach seeks to understand phenomena in context. One drawback of this approach is that society is assumed to be static

and that cultural groups maintain meaning in a stable uncontaminated way. Studies in this tradition tend to be small and this does not allow broad, cross-national comparisons. A disadvantage of an emic approach is that it can lead to knowledge that is fragmented and difficult to organise (Mokgatlhe 2001:34). Much valuable knowledge has been generated by researchers in the medical and biological field that may explain responses to trauma. It is interesting to note that a study of the biology of trauma seems to lend support to the person-centred approach and provide an explanation for many of Roger's clinical observations encoded in his propositions. In particular:

- Rogers proposition 11 states that experiences that are threatening to the self may be denied. The biological explanations of dissociation explain why this may occur.
- Rogers proposition 3 suggests that people respond as a whole to their experiences and that these responses are integrated. The biological model offers insight into the biological aspects of trauma and suggests mechanisms by which emotions, physical sensations, cognitions and memories are linked. However, the biological model does not account for signs of distress for which no biological cause can be found.
- Rogers states that people respond to the phenomenal field as perceived (proposition 2). The biological explanations for hyper arousal may explain why people remain alert, vigilant and "jumpy" when perceptions of safety and predictability are shattered by frightening experiences.
- The medical/biological model has revealed the central role of dissociation in creating and maintaining unsymbolised experiences, which play a central role in Roger's propositions (11, 12, 13, 14 and 15).
- The medical/biological model suggests the process by which dissociated or unsymbolised experiences are generated, by discovering that memory processes follow a different course under threatening conditions, when compared with memories for other significant events (Van der Kolk & Fisler 1995:505-525).

- Rogers suggests that behaviour may be motivated by unconscious experiences (proposition 13). An understanding of the biological mechanisms that bypass the formation of narrative memories and leave a person vulnerable to trigger reactions, flashbacks and nightmares validates this proposition.
- The medical/biological model suggests reasons why traumatised people may struggle to verbalise feelings.
- The medical/biological model also offers understanding as to why survivors of trauma may engage in self mutilation to satisfy a need for auto-regulation of stress induced analgesia. This is consistent with proposition 5.
- Similarly, the medical model offers an explanation for re enactments of trauma, linking this phenomenon to an unsymbolised need for auto regulation.
- Studies on survivors of childhood trauma offer suggestions about the role of dissociation in creating a perception of the self as powerless, leading to decreased motivation. (proposition 12)
- Experiences that are threatening to the self may be denied or distorted (proposition 11). After trauma, the person may seem emotionally numb and unable to connect with others or to trust. The biology of dissociation explains that this could be a biologically mediated parasympathetic response.
- Rogers also suggests that the self evolves in interaction with others and that most ways of behaving fit the symbolised self. The concept of complex traumatic stress suggests how the self is impacted by prolonged contact with abuse.
- The medical/biological model has revealed that the self of cultural groups is encoded in the brain. It has been shown that learning alters the structure of the brain. It is also noted that these connections are plastic and can be modified (Barlow & Durand 58-65). These findings link with the person-centred view that the self guides and motivates behaviour (proposition 12) and that perceptions can change (proposition 2, 15).

- It is noted that the environment may induce the release of chemicals, for example, in response to fear. This shows that the body itself responds to the phenomenal field as perceived (Proposition 2). This implies that chemical imbalances may not be pre-existing conditions that cause responses in people but may be provoked by the environment and by people's experiences. In this way, the model emphasises the holistic nature of people, which is in keeping with the person-centred approach (proposition 3).

Certain aspects of the biological/medical model are at odds with the person-centred view:

- The biological model implicitly assumes a correspondence between organic dysfunction and mental dysfunction but such an assumption is over simplified, ignoring the influence of the environment, culture or the person's own perceptions and decisions. Such assumptions are contradictory to the person-centred approach, which holds that individual's experiences are unique and personal (proposition 1&2) and that individuals are motivated to actualise the self (proposition 4). People are growth orientated according to the person-centred approach and may overcome biological limitations.
- Survivors react to trauma in accordance to what it means to them. Generating meaning is an active process that takes place within an individual, social, cultural and political frame of reference (Summerfield 1995:20). It is simplistic to regard the experience of PTSD as a state. One should not assume that PTSD is something that is present or absent. PTSD is not a thing a person has. It is an experience with which he or she lives. According to the person-centred approach a checklist of symptoms cannot capture the complexity of subjective distress. There is no one to one correspondence between the experience itself and an objective disorder (Summerfield 1995:18).
- A wholesale adoption of the biological model may foster a person's helplessness by creating the perception that the person is at the mercy

of immutable biological laws and mechanisms. This is contrary to the person-centred approach, which holds that people create their perceptions (proposition 2) and choose how to respond to their experiences (proposition 4), whether external or internal physiological responses.

8.1 Problems of labelling

The aim of the DSM IV-TR is to diagnose and label what it defines as disorders. Diagnostic categories are a convenient way of organising complex observations, but once created they tend to be reified (Barlow &Durand 1995:112). The person-centred view does not engage in diagnosis and labelling. The person-centred approach assumes that each person's experience is unique and personal. It also assumes that behaviour is a goal directed attempt to satisfy perceived needs, (proposition 5), a form of self-expression (Proposition 12), or motivated by unsymbolised experiences (proposition 13).

- One of the difficulties with labelling and diagnosis is that once a person is labelled there is a tendency to categorise (and limit) the whole person in terms of that label (Barlow & Durand 1995:112). Nevertheless the medical model that is the foundation of this classification system has stimulated extensive research in the field of trauma that can enhance the person-centred practitioner's understanding of the traumatised person's experiences.
- If the label is associated with some impairment in functioning, the person may be stigmatised because of the label's negative connotation. This is against the person-centred approach's values of respect and unconditional positive regard (proposition 17).
- Once labelled, a person may integrate the label into his or her self-concept, because the self evolves in interaction with significant others, so the label may be harmful to the person (proposition 10).
- The person may begin to take on the role of a sick or crazy person and play the role into which he or she has been cast, as this behaviour becomes an expression of self (Proposition 12).

- The way in which distress is expressed is not the same in every culture. Alternative modes of expression may be completely overlooked by researchers and practitioners using diagnostic categories, if the person's mode of expressing distress does not fit the diagnostic criteria. (Barlow & Durand 1995:112; Sue, Sue & Sue 2000:39-40).
- The label may influence those interacting with the person in ways that are not helpful to the client. Once created, labels tend to guide what we notice and attend to and much of the client's experience may be ignored. Once nosological categories are created, they tend to be reified. This may have far reaching legal and political implications. Simpson (1995:187-212) highlights the abuses of the PTSD diagnosis by perpetrators of torture and abuse of human rights under apartheid in South Africa. Under this system, political detainees were held without trial and without access to an independent lawyer, doctor or family, usually in solitary confinement. Detainees were subjected to lengthy periods of interrogation and they have often alleged that they were tortured. Simpson (1995:204-206) provides examples to illustrate how psychiatrists collaborated with perpetrators when acting as expert witnesses in court to affirm that the detainees did not meet the criteria for PTSD. For example, a Pretoria psychiatrist testified that keeping a detainee standing for 10-14 hours without rest whilst under interrogation would not be highly stressful. Furthermore he concluded that PTSD cannot be diagnosed "unless there is absolute, external independent, irrefutable and objective proof of the nature of the trauma" (Simpson 1995:206). Such evidence undermines the victims claims of torture. Rigid application of PTSD criteria stripped of an awareness of the context of the sufferer can cause further victimisation in oppressive political contexts. For example it is impossible to assess "markedly diminished interest in significant activities" in a person in prison. When prisoners are subject to torture, avoidance of situations that precipitate the trauma is likely to be impossible to achieve (Simpson 1995:193). The criteria are meaningless when stripped of the wider context in which the person finds him or herself. The person-centred approach views people as central to their own phenomenal fields

(Proposition 2). The rights of these prisoners were undermined by rigid application of the diagnostic criteria laid down by the DSM IV manual, stripped of their wider context, which made it impossible for them to prove their allegations of torture. The criteria were misused to protect the perpetrators of abuse. Focusing on symptoms not a person can dehumanise the client (Castillo 1997:3).

- Trauma means to wound. While the effects of trauma undoubtedly induce suffering, the idea that this suffering is a disorder or represents some sort of damage is a social construction that may be an insult to those survivors who reassemble their lives and grow from experience. The medical model tends to focus on “pathology” and “psychological damage.” The person-centred approach, in contrast, is ideally placed to understand the suffering induced by trauma with empathy and to explore how people grow and actualise themselves despite adversity. It is the task of humanistic approaches to psychology to retain its focus on people, their potential and strengths rather than symptoms and the illnesses they can produce.

9 CHAPTER SUMMARY

Scientific communities develop paradigms that guide their perception of reality (ontology), what questions are asked and what constitutes valid answers. Models, theories and hypotheses are constructed that are consistent with the paradigm. Paradigms are influenced by the wider cultural meaning systems in which they are embedded, just as the self emerges in interaction with others (Propositions 9-10).

Most research on trauma has been constructed by people who share a Western worldview. The medical model in particular has generated extensive research. Within this framework criteria for what the model defines as posttraumatic stress disorder have been constructed by a group of people working within the framework. Although the person-centred approach does not engage in diagnosis or labelling, this construct is used repeatedly in the literature concerning trauma and any discussion of trauma would be incomplete without it. The DSM-IV TR (2000) is the manual of the American Psychiatric Association in which the criteria for PTSD and acute stress

disorder are listed. These criteria focus on intensive symptoms, hyper arousal and dissociation as a basis for the diagnosis of PTSD.

Certain factors either exacerbate or buffer the effects of a traumatic incident. Women and children are more at risk of PTSD than men and adults. Close proximity, longer duration, the degree of brutality and high perceived level of threat as well as betrayal, great uncertainty, injury, extensive loss and a high degree of entrapment and powerlessness are related to the increase of risk for PTSD. Perpetrators are more at risk than victims. The meaning assigned to the event and level of social support can be a buffer or exacerbate the experience. A person's history, level of education, and degree of panic are associated with the risk. Dissociation at the time of the trauma is likely to increase the tendency to PTSD as is drinking and intoxication after the event. A sense of control during the incident serves as a buffer.

The criteria for PTSD have been the subject of controversy. Cross-cultural studies show that response to trauma may be expressed in ways that do not fit the PTSD criteria, particularly with respect to somatisation and dissociation. Currently PTSD is classified as an anxiety disorder, but recent research suggests that dissociation rather than anxiety is the core feature of PTSD.

Animal studies and research with traumatised human beings suggests mechanisms by which the memories and emotions associated with frightening experiences may remain dissociated, implicit and unsymbolised. The memories related to threatening events are encoded using a different pathway to everyday, non-traumatic memories. This short-cut leaves memories for trauma un-integrated with cognitive and perceptual elements. Such memories by-pass the cortex and hippocampus. As a result they are not transcribed into a narrative, explicit, symbolised form. They are encoded as fragmentary somatosensory and affective images. These incoherent sequences may return as vivid flashbacks, nightmares or affective re-living of the trauma. Amnesia for all or part of the incident is also a common feature of traumatic memories.

The nervous system becomes increasingly sensitised to cues that provoke dissociation. This leaves the person vulnerable to acute immune conditions, structural changes in the brain, cardio vascular complaints and low energy. Besides the physical effects of trauma, cognitive effects may include changes in emotional processing, obsessive thinking, flashbacks, nightmares and heightened intuition. Survivors of trauma may experience emotional effects such as shame, guilt, alienation from others, alexithymia, emotional numbness or increased openness and creativity. From a behavioural point of view, survivors may go to great lengths to avoid reminders of trauma. Intimacy may suffer. Survivors may overprotect others. Some engage in substance abuse or self-destructive actions. Stress induced analgesia may account for self-mutilation and re enactments that are linked with trauma. Some survivors display impaired motivation or compulsive busyness.

There has been sufficient concern about differences between acute and ongoing trauma that a new diagnosis, has been proposed, namely complex PTSD. This construct focuses less on subjective experiences than on interpersonal relationships, dissociation, somatic symptoms and alterations in one's worldview, in terms of hope, trust and meaning (Marsella et al 1996b: 532; Herman 1992:387). Herman (1992:387) suggests that complex PTSD may co-exist with PTSD but goes beyond it.

The medical model is based on assumptions that differ from the person-centred approach. Nevertheless, research findings from this perspective lend support to several of the propositions put forward by Rogers. The model offers explanations for the process by which unsymbolised experiences, that play a central role in the person-centred approach may be generated. The medical model may be useful in enhancing the person-centred practitioners understanding of the biological, emotional and cognitive experiences generated by trauma as well as the impact of trauma on the survivor's experience of the self.

CHAPTER 6

TRAUMA IN SOCIETY

1 INTRODUCTION

A hermeneutic analysis requires the social and historical context are taken into account (Terre Blanche et al 2006b: 275). The aim of this chapter is to consider the role of violence in society as a factor that increases the incidence of trauma. There are many examples of violence within the history of South Africa, such as the Boer war and wars between the indigenous inhabitants and settlers. South Africa has a history of oppression and the struggle against apartheid as well as a war on her borders in the recent past. These conflicts are discussed in this chapter as examples of trauma, because they are two more recent things that have happened in South African society. South African youth were at the forefront of both a war on the border and violent political protest against apartheid, particularly between 1976 and 1989. Members of the South African defence force, with an average age of nineteen years were actively involved in the black townships suppressing these protests. The average age of social work students in the Lintvelt's (2008:29) study is 30, so many may students in the current study may have been directly involved in the violence themselves, or they may have grown up in homes and families that were. This is significant, because it is also known that trauma of parents affects children (Lykes 2002:95; Kleber 1995:304; Riggs, Byrne, Weathers & Litz 1998:87). Trauma creates a situation in which family, friends, co-workers, helpers and those who read or hear about the event are impacted as well. The key to understanding this widespread response to trauma is empathy. Whilst empathy is used as a means of helping by those in caring occupations, it can also be exploited by those in power as a way of terrorising the population and gaining coercive control. Terms that have been applied to the empathetic response to another's trauma are trauma infection, secondary victimisation, vicarious trauma and the ripple effect of trauma. Many South Africans are surrounded by violence, as will be discussed in the next chapter.

Trauma does not occur in a vacuum. The society in which we live even influences the occurrence of the events themselves (Kleber, Figley & Gersons 1995:1). Swartz & Levett (1989:747) point out that when considering the effects of repression, one should consider not only specific events such as detention, disappearances and public executions, but also broader social factors that make repression possible, such as poverty, unequal education and family breakdown.

Trauma extends beyond the individual, reaching into families and society as a whole. Simpson (1995:188) believes that the effect of apartheid reverberates not only within the survivors, but also within surviving communities and subsequent generations (Simpson 1995:188). For this reason the concept secondary traumatic stress is likely to be very relevant to the participants in the study.

2. VICARIOUS TRAUMA, SECONDARY TRAUMATIC STRESS AND COMPASSION FATIGUE

Various terms have been used to describe the distress of people who are exposed to the trauma of others. These terms are secondary traumatic stress (STS), vicarious trauma, traumatic counter transference and burnout. Some authors use these terms interchangeably (MacLiam 2003:31) while others distinguish between them (Adams, Boscarino & Figley 2006: 104; Jenkins & Baird 2002: 424). These terms are used to refer to the reactions elicited in members of social networks by exposure to trauma survivors' terrifying, horrific and shocking images (Jenkins & Baird 2002). Mere knowledge of exposure of a loved one to trauma can be as traumatising as well (Figley & Kleber 1995: 75 – 77). Those close to the traumatised person hear about the event and construct in their imaginations. Thus, friends and neighbours of a traumatised person are confronted with the event and its attendant suffering. Co-workers similarly visualise themselves in the victim's shoes. In particular, those who work in similar occupations to the traumatised person may fear that they too will be victimised (Figley & Kleber 1995:79).

2.1 Secondary traumatic stress

Jenkins & Baird (2002: 424 – 426) suggest that secondary traumatic stress, vicarious trauma and burnout are related but not synonymous. In their view, secondary traumatic stress is the emotional distress experienced by persons having close contact with the trauma survivor, especially concerned family members and helpers. The symptoms of STS are nearly identical to PTSD. The main difference is that the one who is directly traumatised may develop PTSD, but those who hear about the trauma may develop STS (Jenkins & Baird 2002: 424).

The term secondary traumatic stress is frequently used to refer to two different concepts. This discussion would not be complete without clarifying the two ways in which the term is used. *Secondary traumatic stress* refers to the PTSD like responses of people who are exposed to the trauma of others. *Secondary traumatisation* occurs when people, institutions, caregivers and others to whom the trauma survivor turns for assistance respond in inappropriate ways. Such responses include blaming the victim, ridicule, denial of assistance, minimising the person's pain or denying the person's distress, disbelieving the person, punishing the victim or denying him or her justice. Such responses constitute trauma in their own right (Matsakis 1996: 90 – 91).

2.2 Vicarious trauma

Changes in beliefs, expectations and assumptions about the world are central to the effects of being traumatised (McCann & Pearlman 1990: 137). Vicarious traumatisation has been described as the permanent transformation of these inner experiences on the part of a person who engages empathetically with another person's trauma. The main features of vicarious traumatisation are disturbances in one's cognitive frame of reference with regard to identity, world view, spirituality, deeply held views about others, relationships and one's presence in the world (Jenkins & Baird 2002: 424).

People who are exposed to the cruel ways in which humans may behave may experience disruptions in their ability to trust (McCann & Pearlman 1990: 138).

A person may experience disruptions in his or her sense of safety when exposed to an awareness of harm done to innocent people. Notions of one's power and efficacy in the world may be altered. This may lead to recurring domineering behaviour (McCann & Pearlman 1990: 139). The person's sense of autonomy and self esteem may be violated. Someone who held an idealistic view of human nature may become cynical and pessimistic. People who are exposed to trauma survivors may experience a sense of alienation that results from exposure to horrific images and cruel realities (McCann & Pearlman 1990: 141). They may reflect on why these events happen and engage in victim-blaming.

It has been noted that working with survivors of trauma can provoke helper's own unresolved emotions, fears and retaliatory wishes. This phenomenon is known as "counter transference" (McCann & Pearlman 2002: 134). Work with victims of trauma can evoke ambivalent, negative and judgemental feelings as well as existential anxiety about death and non-being. One may feel deeply vulnerable as a result of identification with the victim or rage at the perpetrator. Over-identification may be a problem fro a helper when a client comes from a background that is similar in terms of culture, social values and experiences (Cerney 1995: 137).

Memories of the other person's victimisation may be internalised and lead to temporary or permanent changes in the memory system. These alterations in the memory may return as intrusive images or flashbacks (McCann & Pearlman 1990: 141).

Such are the effects of vicarious traumatisation. They may be profound and long lasting (Jenkins & Baird 2002: 424).

In the workplace, vicarious trauma is unique to trauma work. It goes beyond the sadness of dealing with clients struggling with depression and despair. Pearlman & Saakvinte (1995: 151 – 152) identify factors that are specific to trauma work that place unique demands on the helper. They suggest firstly that traumatic events such as childhood sexual abuse are painfully real. They

are part of our society. Denial of such phenomena is eroded by exposure to clients who have been through such experiences.

Secondly, helpers in the field of trauma are inevitably confronted with their own vulnerability. As workers are exposed to client's stories, they know that they could also be victimised.

Thirdly, clients frequently serve as a reminder of one's own personal trauma. Exposure to clients whose trauma is similar to one's own may evoke old memories and associated emotions.

Fourth, clients who have been hurt and betrayed may bring powerful emotional needs to the helping relationship, coupled with mistrust. Some clients are unable to be soothed. They may unconsciously re-enact painful, abusive and denigrating responses in the helping relationship. The helper may be cast in malevolent, dangerous or exploitative roles that may assault the facilitator's identity. This may trigger defensiveness in the helper. The facilitator is, in effect, thrust into the position of a witness to damaging and often cruel events. This may trigger feelings of helplessness in the helper.

Finally, working with survivors of trauma may result in permanent changes in one's frame of reference. Trauma may bring a variety of losses, whether innocence, loved ones, bodily integrity hope, trust or safety. Trauma survivors invite us as helpers to acknowledge this painful reality and so open us up to our own grief.

2.3 Compassion fatigue and burnout

Compassion fatigue refers to the formal caregiver's reduced capacity or interest in being empathetic or bearing the suffering of clients (Adams et al 2006: 103). "Burnout is conceptualised as a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support" (Jenkins & Baird 2002: 424). Burnout is also known as compassion fatigue. Secondary trauma, vicarious trauma and burnout are similar in that they arise from emotionally

engaging with traumatised people in an empathetic way. However, burnout is related to tedium in the workplace rather than exposure to specific client problems, whereas vicarious trauma and secondary traumatic stress have not been linked to workplace conditions (Jenkins & Baird 2002: 425; Adams et al 2006: 107).

Symptoms of burnout have been identified as depression, cynicism, boredom, loss of compassion and discouragement. Factors which contribute to burnout are professional isolation, the emotional drain of being consistently empathetic, ambiguous successes, lack of therapeutic success, non-reciprocated giving and failure to live up to one's own expectations (McCann & Pearlman 2002: 133).

Compassion fatigue arises because when human beings are subjected to trauma they seek solace from others. Those who care about the victim may be traumatised by engaging with the person in an empathetic way. Helping professionals who bear the emotional burden of working with traumatised people are at risk for developing stress reactions because of their exposure to horrifying events (Figley & Kleber 1995:79). Burnout is described as a state where helpers suffer from:

- Emotional exhaustion (I feel emotionally drained by my work)
- Depersonalisation (I worry that my work is hardening me emotionally).
- Reduced personal accomplishment (I feel I am not influencing people's lives positively anymore in my work).

Of the three elements, emotional exhaustion seems to be the key contributor to burnout (Figley & Kleber 1995:94).

When helpers experience burnout, work is adversely affected through poor performance and absenteeism. Interpersonal symptoms include withdrawal from clients and co-workers (Figley & Kleber 1995:94).

2.4 Preventing burnout

Four factors seem to contribute to compassion fatigue. Poor self-care, previous unresolved trauma, inability or refusal to control work stressors and lack of satisfaction from work (Radey & Figley 2007: 207) Radey & Figley (2007: 207) suggest that compassion fatigue can be countered by focusing on compassion satisfaction, or feeling fulfilled by working with clients.

Focusing on positive fulfilment from work can generate positive energy. To flourish, social workers need to focus on the joy of helping others. According to Radey & Figley (2007: 209) this can be achieved by:

- Viewing one's work as a calling rather than a job
- Self-care, including exercise, correct eating
- Taking time off,
- Allowing time for self-reflection, visits with friends or family and personal therapy
- Organisations can care for staff by limiting and diversifying case loads, providing adequate supervision, adequate benefits and opportunities for development.
- Organisations can provide a warm, supportive welcoming environment where staff feel they can depend on their colleagues
- Clinicians need to find ways of integrating clients' expertise into their worldview and balance positive and negative views of human behaviour
- Become more creative
- Recognise clients' successes
- Create opportunities in supervision where helpers' successes can be shared
- Maintain focus on clients' potential for growth
- Learn to find meaning even in adversity
- Set boundaries between one's personal and professional life (Radey & Figley 2007: 209 – 214; Friedman 2006: 31).

There seems to be no classroom or internship requirements for students to learn self care. It seems that there is an assumption that these practices will emerge. However, there is no evidence that this happens. Self-care seems largely overlooked. Radey & Figley (2007: 212) suggest that such activities are essential to avoid burnout and that they should form part of the educational curriculum.

2.5 Resilience

Allan, la Grange, Niehaus, Scheurkogel & Stein (1998: 138) found an unexpectedly low incidence of traumatic stress in emergency workers who were exposed to repeated stressors. Some people are resilient in the face of adversity Factors that account for this were explored. Twin studies indicate that some people are genetically more resistant to stress than others. Personality variables also play a role. People who are by nature anxious, dependent, non-assertive, and who find it difficult to adapt to new situations, are less resilient. Those with an internal locus of control, who do not feel at the mercy of fate, are more resilient. A person who believes, “although the situation looks bad, I am going to manage it,” is likely to be more resilient than one who believes “everything is over, I can’t go on” (Allan 1998: 138).

People who do not have a history of psychiatric illness or treatment tend to be more resilient than those that do. It is interesting to note that people who have, in the past, survived trauma *and* have developed management strategies are likely to be resilient when facing subsequent traumas. This implies that the number of traumatic incidents per say may not be the crucial factor, but resilience relates to the manner in which the person managed them.

It is comforting to know that trauma does not inevitably lead to deleterious effects. However, most people who are exposed to trauma show some stress response. Sadly, this is often exploited. The role of vicarious trauma in perpetuating and exacerbating trauma in society will now be discussed.

3 THE HIDDEN STRUCTURES OF VIOLENCE IN SOCIETY

Vicarious trauma is frequently associated with violence. South Africa is infamous for its high levels of violence, so it is appropriate to consider how violence may become entrenched in a society.

Violence has been defined as “avoidable insults to basic human needs, and more generally to life, lowering the real level of needs satisfaction below what is potentially possible” (Galtung cited in Pilisuk & Tennant 1997). Poverty, inequality and social domination are all sources of suffering that are products of social arrangements created and maintained by people. Culture and the norms and practices of a society can be a source of violence by allowing dehumanisation of certain groups. These norms and practices are known as cultural violence. Such cultural violence leads to *structural* violence when it is incorporated into formal laws or the economic environment and structural violence is part of the social order. Violence becomes institutionalised by these processes (Pilisuk & Tennant 1997). In other words, violence in the form of poverty and oppression become part of the fabric of society as it is written into the statute books, laws and economic policies of the country. Such violence is supported by the practices of society itself and is maintained by those with political and economic power. Structural violence frequently exacerbates and stimulates individual acts of direct violence (Pilisuk & Tennant 1997). Direct violence is an event such as assault or rape. Structural violence is harder to identify than direct violence. It is most often left unchallenged and the cycle of violence continues (Pilisuk & Tennant 1997). Structural violence is a process that rises and falls. Cultural violence tends to remain more constant, given the slow pace of change in cultural systems. It has been observed that, in most cases, there is a progressive build up from cultural violence to institutionalised structural violence and then to direct, individual acts of violence (Pilisuk & Tennant 1997). Poor and oppressed people are at risk for the deleterious effects of violence. It is noted that individuals who are marginalised, who are not linked to a supportive network of care, are all at risk for disease, AIDS, depression, substance abuse, child abuse, homicide or infant mortality. Poverty, social marginality and loss of control are all factors that are linked to the Global economy, where the poor

are at risk for exploitation (Pilisuk & Tennant 1997). Whether trauma is human-induced or a natural disaster, most of those affected are impoverished people who are oppressed in other ways by their life circumstances. In addition, 90% of casualties in contemporary armed conflicts are civilians, typically the poorer members of society (Eagle 2002:75).

Direct violence is used by both those with and without status and control. Those who feel they are underdogs may use violence to overcome their powerlessness and poverty or to get revenge at the society that has marginalised them. Those at the top may use violence to entrench power (Pilisuk & Tennant 1997).

4 POVERTY

Pilisuk & Tennant (1997) point out that poverty, inequality and social marginality as well as the domination of resources by favoured groups are forms of societal violence. These phenomena produce suffering and death. They are, in their view products of social arrangements created by people, not acts of nature. They suggest that the normative beliefs and practices of a society can be a source of violence by allowing the dehumanisation of certain persons or groups. They point out that this form of violence may be incorporated into formal legal and economic policies. This was true of South Africa during the apartheid era. Patel (2005: 71) notes that the welfare system in South Africa was based on such discriminatory practices during apartheid. Despite the ending of apartheid, Patel (2005:51) states that poverty remains one of the greatest challenges facing Southern Africa.

There are many ways to view and describe poverty, ranging from a quantitative, monetary perspective and a people-centred qualitative and descriptive orientation (Schenck and Louw 2009: 352). One approach, the social exclusion perspective, suggests that poverty may be defined in terms of the exclusion of people from benefiting from the general prosperity of society. The concept of social exclusion focuses on the processes, mechanisms and institutions that exclude people. Exploitation, domination alienation and oppression are regarded as major contributors to exclusion. Such poverty may

arise in connection with cultural and political norms that make people unwilling to participate in society, such as institutionalised racism, sexism or geographical location (Schenck & Louw 2009:356).

Schenck and Louw (2009:357) explain that one theory of poverty describes the poor as trapped in a cluster of disadvantage. Aspects of this cluster are material poverty, physical weakness, isolation, vulnerability and powerlessness. In his view long term poverty is a form of entrapment or captivity. Poverty has also been linked to oppression, lack of knowledge, lack of awareness and a culture of silence. A culture of silence refers to apathetic silence that may characterise the poor (Schenck and Louw 2009:358).

Although poverty and societal violence seem to be linked, no literature was found in which poverty was seen as a form of trauma. However, the link between marginalisation, oppression and exploitation alluded to thus far suggests poverty may indeed be a form of trauma, not just a phenomenon that is associated with other forms of trauma. This may be a fruitful area for investigation.

5 TRAUMA AS A MEANS OF SOCIAL CONTROL

Sadly, the human capacity for empathy may be exploited by those in a position of political power. One way of entrenching control is by inflicting trauma on others as a means of intimidation and coercive control (Figley & Kleber 1995:95). Terror can be used to generate an attitude of fear and submission. Terrorisation of whole populations is often used as a means of social control where little distinction is made between combatants and bystanders (Summerfield 1995:27). Political terror affects at least three groups: the perpetrator, the victim and the target or bystander. The victim is usually destroyed, but the bystander reacts to the spectacle and spreads the news, resulting in submission and accommodation by others in the population (Mehlwana 1996:29). Mehlwana (1996:29) states “the act of violence or the threat of violence, especially when it is politically motivated, brings about catastrophic emotional reactions and social effects.” If a person identifies with the victim or perceives the victim as similar to the self he or she tends to

imagine him or herself in the same predicament. The more closely the bystander identifies with the target, the greater the distress (Straker 1992:103).

Victimisation is reflective of more general power imbalance in society (Eagle 2002:78). One of the essential features of secondary victimisation is a sense of powerlessness (Figley & Kleber 1995:78). Lykes (2002:97) points out that fear and terror may be used to control the population and maintain benefits for the ruling party for example to ensure the continuation of a source of cheap labour. Such direct violence is used to maintain structural violence in the society.

A central feature of secondary victimisation is that one's assumptions about a safe predictable world have been shattered (Figley & Kleber 1995:78). The aim of atrocity is the intentional destruction of social, economic and cultural networks (Summerfield 1995). Becker (1995:107) uses the term "extreme traumatisation" to describe the process of trauma in the context of political repression. He describes extreme traumatisation as an individual and collective process that occurs in a given societal context. Its aim is to destroy individuals and their sense of belonging to a society and also to destroy their social activities. It is characterised by the attempt of some members of a society to destroy other members of the same society. It is not limited in time, but generates cumulative effects as acts of violence are repeated and news thereof spreads through the community. The idea that symptoms of posttraumatic stress disorder emerge after (post) a traumatic event simply does not apply in such contexts. Extreme traumatisation is both an individual and socio political process.

War and organised violence are used intentionally to damage social and cultural institutions (Summerfield 1995:21). In repressive societies, governments may suspend constitutional rights. Opponents of government may be executed, sent into exile, the press may be censored, authors and publishers may be jailed and property may be confiscated (Kornfield 1995:117). When atrocities are perpetrated, the whole social fabric of society

may be ruptured with dramatic changes to population demographics, mass displacements of people and disruptions of basic conditions of life. Attempts to understand the impact of forced removals and political conflict affecting whole communities are thwarted when trauma is seen as an individual matter (Eagle 2002:80).

Violations of human rights generate a general atmosphere of political threat and an environment characterised by chronic fear (Kornfield 1995:117). Fear becomes a permanent component of everyday life. Feelings of helplessness, defencelessness and impotence are generated, not only in those directly affected, but also in those who are uncertain about the victim's fate. This is in itself a form of torture (Kornfield 1995:117). Many people, for example political activists and their families are subject to continuous and cumulative trauma as a result of politically motivated disappearances, imprisonment, and killings (Becker 1995:101). These events may affect individuals, families or communities, as atrocities are committed to serve as a warning to others (Becker 1995:101-102). Such experiences are part of continuous trauma that cannot be grasped by the term "post" as in posttraumatic stress. The trauma seems not to end (Becker 1995:102).

In conflict-ridden societies, atrocities such as public execution, disappearances, torture and sexual violations are frequent occurrences. People who share values such as community leaders, priests, health workers and teachers are often targeted. These dynamics are often played out against a background of poverty and subsistence economics (Summerfield 1995:18). In totalitarian states or during war, torture may be used as a means of intimidation. Most torture worldwide does not take place to subjugate individuals but rather to terrorise whole communities (Summerfield 1995:20). Kornfield (1995:116) describes torture as follows: "Torture consists of the deliberate and systematic application of excruciating pain to a person in an attempt to undermine the will, the affective links, and the loyalties, beliefs, and physical and psychic integrity of the individual. Life threats and physical pain are the essence of torture. At a broader level, the reason for torture is to

intimidate third parties, thereby ensuring responses of fear, inhibition, paralysis, impotence, and conformity within society."

The overall result is "psychosocial trauma", where whole populations, not just individuals are affected. Aberrant and dehumanising social relations are crystallised. The social chain tends to break at the weakest link, namely the most unprotected members of society (Kornfield 1995:118).

6 APARTHEID AS A SYSTEM OF INSTITUTIONALISED VIOLENCE

Simpson (1995:188) describes South Africa as a society that has suffered the chronic effects of the trauma of apartheid. He believes that the effect of apartheid reverberates not only within the survivors, but also within surviving communities and subsequent generations (Simpson 1995:188). This implies that the trauma of apartheid is likely to affect some Unisa social work students who are of the generation when the system was in force or those students who are the offspring of that generation.

According to Simpson (1995:188) apartheid was a system of repression and discrimination that made extensive use of expertise drawn from behavioural science to maintain control by a minority over the majority. The evils of apartheid included murder, chronic discrimination, poverty, landlessness, lack of freedom and denial of political power, which were imposed on those outside the ruling caste. South Africa has a reputation as the only country which in the recent past has legalised and institutionalised racial violence. When apartheid shaped the laws in South Africa (from 1948-1994) racial segregation was enforced. This policy had the effect of de humanising and suppressing non-white people. The policy was, of course, unpopular with non-white South Africans, who opposed it, initially through passive resistance and mass action, which escalated into armed struggles between agents of the government and the people.

7 THE STRUGGLE

Soweto, South Africa, erupted in 1976 when thousands of school children took to the streets to protest against inferior education and by the end of the year

176 had died and more than 1000 were injured (Straker 1992:1). A generation of youth known as “Comrades,” “Young Lions,” and the “Lost Generation” emerged as a consequence of apartheid who adopted a radical and confrontational stance. In 1976 these youth moved to the forefront of the struggle when they protested against Afrikaans as a medium of instruction in school (Mehlwana 1996:33-34). School-going children in South Africa proved to be an active force in society rather than passive recipients of society’s influence on them (Swartz & Levett 1989:742). The youth of South Africa were socialised in an environment where violence was justified in political terms (Mehlwana 1996:34). Many of these activists were surprisingly young. Straker (1992; 1988:385) studied a group of 60 township youth involved in political unrest. Of these:

- 14 were 12–15 years
- 34 were 16–18 years
- 12 were over 18 years

The group comprised 19 girls and 41 boys. They identified themselves as freedom fighters involved in the Struggle. The Struggle refers to politically motivated protest, violence and unrest aimed at ending apartheid (Straker 1988:385).

Although the protests subsided in the late 1970’s they ignited again in 1980, reaching a peak between 1984 and 1986. Straker (1992:1) states that South Africa was in a state of civil war at that time. Young black activists were involved in politicising the community, enforcing consumer boycotts and organising work stay aways. The State retaliated and the activists responded with petrol bombings, attacking symbols of the State and violence toward other black people who were regarded as sell-outs or traitors.

In 1984 black people in urban areas were allowed to participate in elections to an advisory municipal body, urban black councils, to which increasing powers were delegated. These councils became known as community councils.

However, many black people did not view these councils as an adequate means of providing them with meaningful participation in the policies of the country (Haysom 1986:2-7). A group of right-wing supporters emerged around 1985, who opposed leaders of groups that resisted apartheid or homeland rule. They were known as vigilantes. The vigilantes emerged as supporters of these community councils and homeland rule. The term “vigilante” or *Mabangalala* has a particular meaning in South Africa. It refers to groups who were intent on killing anti-apartheid activists (Haysom 1986:2). A considerable amount of attention was focused on what was described as “black-on black” conflict. This term served to obscure a pattern of violence that was occurring outside the law. These vigilantes believed they had police support (Haysom 1986:1). Police, when asked to curb or respond to vigilante activity, frequently turned a blind eye (Haysom 1986:8). Intense conflict arose between the activists and vigilantes.

Apart from politically motivated violence, non-political violence has long been a feature of township life. Straker (1992:48–49) explains that disciplinary committees and peoples’ courts were established in black townships to combat crime and deal with conflicts including marital conflicts. These committees meted out punishment by beating. It seems that at times punishment was excessive. It is not clear from her discussion whether these committees were involved in deaths and necklacing, but these practices were carried out within the community against those perceived as traitors, informants or sell-outs (Straker 1992:1). These informal courts are known as kangaroo courts. Mehlwana (1996:31) notes that in most informal settlements, informal people’s courts, (also referred to as Kangaroo courts) exist where popular justice is meted out in opposition to formal, state-recognised justice. These conditions often result in the escalation and legitimisation of violence where the instigators are often not punished.

The notorious practise of necklacing became widespread. A rubber tyre, filled with petrol, was placed around the person’s neck and set alight. Straker (1992:114) states that 600 incidents of necklacing occurred in South Africa up to 1988.These executions were usually performed in public.

In addition to conflict between the activists, vigilantes and representatives of the State, a large part of the black population was subject to harassment by the South African Police and South African Defence Force. People were detained and allegedly tortured (Straker 1992:1).

Many young people witnessed or participated in these forms of violence (Straker 1992:1). Straker (1992:19) suggests that it is a misperception among white South Africans that the uprisings in the black townships between 1984-1986 reflected agitation and intimidation of the masses by a few troublemakers. She relates that in fact the **majority** of young black people took part and that those who remained uninvolved were exception rather than the rule. This implies that many social work students may have been privy to the violence of the time. If they were not involved, it is likely that their parents or family members were.

Protests during the 1980's gave rise to a number of civic associations, youth movements and women's organisations. These organisations later formed the membership base of the United Democratic Front (UDF), which was launched in 1983 to campaign against the ruling party's move to establish a tri-cameral parliament and retain the homeland system. This proposed parliament allowed for participation by whites, coloureds and Indians in a tri-cameral parliamentary system. Whites would retain the majority. Blacks were expected to exercise their political rights in the homelands and local government. This dispensation was widely rejected by the UDF and Congress of South African Trade Unions (COSATU). The UDF became organised as an alliance of about 700 grassroots organisations. This culminated in urban uprisings and led to the declaration of a state of emergency (Patel 2005:81-82).

The structure of violence in South Africa was marked by explanations that it was orchestrated by a small group of agitators, motivated and controlled from outside. This view fostered the hope that the violence could be contained without real social change (Straker 1992:21). Straker (1992:21) points out that the ranks of resistance movements are seldom filled by criminals or dropouts.

Rather, it is the more intelligent, socially sophisticated members of society who fill leadership positions. Such people have fewer feelings of powerlessness than non-militants. They are often better educated and better integrated into the community than non-militants. They are the people who refuse to accept discrimination as inevitable and do not adapt passively to it. The youth in Straker's (1992:92) study had defined themselves as freedom fighters. They believed they should be brave, independent and assertive. Expressions of vulnerability were seen as threatening to the group. The group's identity was bound up with themselves as people in conflict, opposing vigilantes and the State. They participated in boycotts, stay aways, and protests to express this identity.

Much research on violence in South Africa focused on children and youth. Black youth were at the forefront of the protests and unrest in South Africa. Straker (1992:2) suggests that human rights organisations, in an effort to quell the violence, highlighted the plight of young people, but this unintentionally created a negative image of black youths. She suggests this image was exploited by those in power. The State promoted an image of the youth as conspirators and revolutionaries or as victims of outside forces to justify its use of repression (Straker 1992:2).

The government declared a State of Emergency in 1985 and 1986, giving official acknowledgement of the extent of the problem (Straker 1992:19).

For South African youth, this period has been described as a period of both euphoria and terror. They had a newfound sense of power and vision and saw themselves as leading the older generation to freedom. Parents however often resented having these views forced on them and feared for the safety of their children (Straker 1992:19). They had reason to be anxious. Swartz and Levett (1989:741) state that, from 1984–1986 the following statistics applied to children in South Africa (the age of the children was not stated in he article):

- 300 children were killed by police.
- 1000 children were wounded.

- 11,000 children were detained without trial.
- 18,000 children were arrested on charges related to political protest.
- 173,000 children were held in police cells awaiting trial.

These figures do not reflect the plight of children who had experienced deaths in the family, exile or detention of family members and other forms of intimidation. The education of many young people was disrupted because schools were regarded as symbols of apartheid and as such many were burned (Straker 1992:19).

One of the apartheid policies that provoked violent protests was the homeland policy. The South African government strove to create “independent states” for black people along ethnic lines and would forcibly remove and relocate whole groups to these locations (Straker 1992:8). The Homeland System dispossessed Africans and made them foreigners in the land of their birth. Under this system millions of black South Africans were moved away from their places of residence to designated areas in the countryside, the Homelands, which made up 13% of the country. Legislation was introduced to impede the influx of Africans to the towns (Mehlwana 1996:32-33). Black people were required to carry a pass (dompas) permitting them to enter white areas for a limited time (Straker 119:24). Straker (1992:33) states that the apartheid government encouraged birth control amongst black people, but not white people. As a result, many young black people became parents producing children for the revolution “as an act of protest.”

Simpson (1995:189) points out that large numbers of South Africans suffered chronic, sequential trauma arising from “forced removals,” migrant labour, internal deportations, external exile, torture, political harassment, killings and social unrest. There were a number of secondary effects, including a high divorce rate, rape, intra and extra familial abuse, suicide, crime and murder. Rates for these social pathologies were higher in South Africa than elsewhere in the world. Political violence in South Africa attracted the attention of researchers in South Africa, while more habitual forms of violence tended to

be neglected. The term “political violence” refers primarily to the violence of politically motivated acts such as insurrection and repression of opposition. Political violence is also termed “unrest” in South Africa (Turton, Straker & Moosa 1991: 77).
Simpson (1995:188) states “It has become abundantly clear that both acute and chronic trauma were deliberately planned, designed, and administered in order to achieve this aim (i.e. political control) rather than that they were simply by-products or side effects of the process. The apartheid system has been recognised as a series of crimes against humanity, and the suffering it caused was integral and was in no way regretted by it’s perpetrators and profiteers.”

The extent of segregation in South Africa is reflected in the response of those who offered therapy to the youth. The counselling team in Straker’s study (1992:94) was made up of mainly middle classed health professionals “living in peaceful suburbia, the idea of a civil war taking place fifteen kilometres from where we lived had not penetrated our consciousness. The knowledge was too powerful and we also had a clear psychic investment in not fully acknowledging the horror of the situation around us.”

8 THE BUSH WAR

Meanwhile a related but different war was waged by white South African youth. Troops from South Africa were drawn into an armed conflict along the borders of South West Africa/Namibia and Angola. International politics contributed to the involvement of South African troops in another country.

South West Africa/Namibia has a history of bloodshed as a result of cultural clashes. (Steenkamp1983:2). The area was colonised by the Germans in 1883. In 1915 South African forces invaded and conquered the area for Britain and in 1919, in terms of the treaty of Versailles, Germany renounced claim to the colony. In 1920, the territory was entrusted to South Africa as a mandate. In 1945, the Union of South Africa, being of the opinion that the mandate had lapsed with the demise of the League of Nations, began negotiations to incorporate the territory into South Africa, a proposal that was

rejected by the United Nations. The opposition between the UN and South Africa was fuelled by the former's recognition of the liberation movement, Swapo (South West African People's Organisation) as the official voice of the South West African (Namibian) people. This body was made up of almost entirely of Wambo people (Steenkamp 1983:2–3).

The South African "Bush War" began when the first armed conflict between South African security forces and Swapo took place in 1966 in South West Africa/Namibia and escalated until the 1970's when the responsibility for maintaining security was passed to the South African Defence Force (SADF).

Meanwhile in the neighbouring Portuguese territory of Angola, three liberation movements had emerged, namely, the Popular Movement for the Liberation of Angola (MPLA) the National Front for the Liberation of Angola (FNLA) and the National Union for the Total Independence of Angola (UNITA).

This precipitated a civil war (Steenkamp 1983:3). In 1975 Angola entered the struggle for liberation and South Africa entered Angola.

Swapo and their Angolan counterparts, the MPLA and FAPLA had Soviet backing, training and advisors. The FAPLA and MPLA were aided by Cuban troops with a frightening reputation. The weaponry with which the enemy were supplied seemed to shock and frighten the SA troops as they faced MIG fighters, AK47's and Russian armoured vehicles (Batley 2007:19). A South African veteran described his reaction as follows:

"Arriving at the combat zone 300km inside Angola, I underwent a rude awakening. The enemy possessed jet fighters which cruised the skies and on the ground had tanks, minefields and artillery".

Batley (2007:19) states that the Russian MIGS seemed to be the greatest contributor to PTSD among South African troops in the Bush War. The government created an ideological discourse around the border, designed to instil compliance through fear and patriotism for the State (Drewett 2003:93).

The concept of a “Communist threat” and “total onslaught” was promoted as the reason for the war. The presence of Russian aid was exploited to promote this ideology. Government propaganda created an image of the South African Defence Force (SADF) defending Christian values against Communism along the geographical border. Thus the geographical and ideological border became linked (Drewett 2003:85).

By 1980 South African troops were permanently active in Angola. Resistance to the South African Defence Force (SADF) was widespread in South Africa, especially in the 1980’s. The SADF was generally hated by black people for its role in supporting apartheid. Resistance was less common amongst whites, but was significant all the same (Drewett 2003:79). Joining the army was frequently regarded as a rite of passage from boyhood to manhood, through military training. Unlike youth in the townships where both boys and girls were active participants, the SADF drafted only white males to serve in the ranks (Drewett 2003:80; 88). Between 1972 and 1989 about 600 000 conscripts and short service members went through the South African Defence force (Batley 2007:2). The average age of these troops was nineteen (Batley 2007:8). The options were limited: join the military, police, go into exile or prison or dodge conscription for as long as possible (Drewett 2008:80). English and Afrikaans speaking troops tended to have different attitudes to conscription, with English youth being less enthusiastic and patriotic than their Afrikaans counterparts, as reflected in the following poem written in that era (Batley 2007:101).

Join the army

Join the army
Fight for a cause you don’t care about
Join the army
Fight for your country in another one
Join the army
And lose what you fought over
Join the army
And get what they say is ours

(Batley 2007:101)

Initially “the border” referred to the geographical border between South West Africa (Namibia) and Angola, but later it included Lesotho, Botswana, Swaziland and Zimbabwe where “cross-border raids” took place (Drewett 2003:79). As the civil war intensified, troops in the SADF were moved into the black townships, raising questions about the very location of the border. The news reports, security at home, bomb drills at school and military service have been part of the white youth’s context and history. White youth too have to grapple with prejudice and dehumanisation of the out group (Straker, 1992:141). Resistance to conscription manifested in the End Conscription Campaign’s “troops out of the townships campaign” (Drewett 2003:86). “With the civil war the border crept closer to home, dividing people everywhere, spreading suspicion and fear” (Drewett 2003:87). The prevailing ideology of the war was questioned (Batley 2007:8):

I am supposed to be grateful
for being allowed
to ‘Fight for my Vaderland’.
Am I?
I am a Mech-soldier
Blessing…..or curse*?*

(Batley 2007:8).

South Africa aided UNITA against the MPLA. In the end the MPLA took over the government, leaving South African troops in a similar position to soldiers returning from Vietnam–a defeated group returning from an unpopular war (Batley 2007:1).

Naparstek (2006:51) explains that the meaning attached to traumatic events by society as a whole influences the impact. For example, Finnish, World War II veterans had extremely low rates of PTSD and showed high rates of subjective well-being. They were greeted as heroes and the war in which they fought was generally viewed by their society as honourable and good. Veterans experienced their participation in the war as indicative of strengths such as integrity, courage and honour and spoke enthusiastically about “fighting spirit” and bonds of loyalty to each other.

In contrast, American veterans of the Vietnam War tended to be devalued and showed rates of PTSD as high as 30%. The war was regarded by society as a whole as unpopular. Indeed, it was the epidemic of symptomatology within the group that catalysed the creation of PTSD diagnostic category in the DSM IV-TR (Naparstek 2006:52). South African troops returning from the bush war found themselves in a similar position, except that there is very little research or literature concerning this group (Batley 2007:116–117). The seeming senselessness and powerlessness of the war is reflected in the following poem by a South African trooper (Batley 2007:116 –117).

Go Home

This foreign land
where a white boy
on white sand listens
to the clicking tongue
of a foreign people
saying
Bwana, go home.

(Batley 2007:132)

One soldier noted that the most distressing aspect of his experience in the army was the reception he got when he returned (Batley 2007:103):

"The worst thing that happened to me wasn't up there; it was the day I came back. Suddenly the Border seemed real and it stayed real for quite a time and everything around me, the whole city, was unreal. I phoned a friend who had been there and we went out to a disco. At about 11 o'clock we left and there were these school outjies [boys] outside. They started a fight for no reason, just to beat up someone who looked as if he was in the army. We got beaten up so badly we had to go to 1Mil [First Military Hospital]. My lip was torn, my eyes were popping out, my nose was skew. I couldn't close my jaw, I was cut all over. I was beaten with a pipe and I can remember thinking, 'Wow, we're being beaten,' and we tried to say, 'Hey, come on, don't do this.' We felt an unbelievable disappointment in the people of our own country who could do this to us after we'd been up there for so long fighting and suffering."

The conflict in Angola ended in 1989 when South Africa withdrew from Angola (Batley 2007:1) and Namibia was granted independence. Up to then Namibia had been occupied by South African troops (Batley 2007:2). South African troops who fought in the Bushwar were faced with an ironical situation: The very government that had conscripted them to fight gave Swapo, their erstwhile enemy, R5 million to celebrate Namibia's independence from South Africa. The troops found themselves facing radical political and social changes in which they cannot, as defeated warriors, be regarded as heroes. Changes have occurred in South Africa with a shift in government which has made this war politically unpopular. Many troops were viewed as "apartheid stooges" (Batley 2007:2). They face a marginalised position in South Africa that adds to the confusing trauma that they carry as a legacy of the war. Batley (2007) refers to it as "a secret burden." Batley (2007:3) states: "These soldiers were conveniently swept under a carpet of animosity and disdain, ultimately to be forgotten."

9 THE TRANSITION FROM WAR TO PEACE

One of the difficult transitions to be made by participants in war and civil conflict is that morality appropriate to civil life differs from that of war. In war, the exercise of violence is condoned, but in civil life it is not. Soldiers involved in war tend to develop distinct value systems, one pertaining to peace and one pertaining to war. This point is illustrated by the observations of a boy in a Nazi concentration camp. (Shantall 2002:230) The boy witnessed a German guard beating up a nine year-old Jewish boy from his group with a truncheon. He describes the incident as follows:

"He didn't kill him but he hurt him. I afterwards watched that guard walk out of the camp, walk through the camp gate along the path to the SS quarters, walk through the gate in front of his house, and his own children came running to meet him. And he picked up one child, threw him up in the air and caught him. He behaved like any normal father would with his children.

I was left with a question: What is this? What does all this add up to? This man was obviously able to demonstrate affection to children. What are we?

At the time I was fourteen years old. I came to the conclusion that for this man to act in such an ambiguous way, is that he has been taught that we, being Jewish were not human. And that even though we may have looked like children, we were not children. We were a sub-species, some kind of animal, so he did not have to exercise the normal behaviour an adult was supposed to show towards children."

A South African veteran described the experience of two distinct context-bound value systems like this (Batley 2007:107):

"Disillusionment is one of the big things. On the Border itself, nothing that you've been taught for 18 years counts. Politeness couldn't get you anywhere. When you come back, you have to revert to being decent. It's very confusing. You don't know what's right or wrong, real or unreal, because it's two worlds. You've got two souls, an army soul and this one."

A peculiar feature of violence in South Africa was that black youth found themselves in combat in the midst of civilian life. They were not soldiers fighting on a front. It was therefore, extremely difficult to define a set of values pertaining to war and those pertaining to civilian life (Straker 1992:111). The identity of the enemy, especially in the townships, was ill defined. It was also easy to over generalise situations in which violence was appropriate (Straker 1992:111).

Exposure to combat seemed to uncover an inner enemy in which some troops questioned their own humanity. One soldier describes an incident in which scorpions were thrown into a steel helmet (Batley 2007:22):

"The idea was to heat the steel helmet to such a point that the scorpions became incensed and would fight one another or sting themselves to death. Now obviously there is a quantum leap between the cruelty involved in torturing scorpions and that required to mistreat people. Yet I am disturbed, for I sensed a kind of original or primeval evil in the impulse that caused this game, and could see what it could lead to if it was allowed to blossom

unchecked. And I saw also in those scorpions enraged by the heat into attacking each other an organism which displayed in a naked an hideous form the same aggression evidenced by their captors, for whom the discomfort caused by a sweltering and indifferent heat led almost instinctively to aggression" (Batley 2007:22).

These examples raise important questions. What induces seemingly ordinary people to engage in violence and, in particular, perpetrate atrocities?

Kelman (1973:33) suggests that the most widely accepted justification for violence is that it serves a defensive purpose. Violence is seen as a legitimate way of warding off threats to one's physical well being as well as a society's basic values or vital national interests. Such justification reduces inhibitions in the perpetrators. Secondly, violence is often carried out in response to orders from superiors. It seems that people are inclined to distinguish between norms in authority situations and interpersonal situations in everyday life. In authority situations, the authority figure is seen as taking responsibility and being accountable while the subordinate's focus tends to shift towards how well he is completing the given task (Kelman 1973: 41). This tends to decrease the subordinate's tendency to question (Kelman 1973:42). Authority figures commonly invoke a transcendent mission to reduce the moral scruples of those carrying out orders. Terms such as "national security" or "reducing the Communist threat" are invoked to reduce moral restraints and legitimising violence (Kelman 1973:45).

Mass destruction can be facilitated by making the process routine. Army drill and training serves this end by making the process routine, mechanical and programmed, the likelihood of questions and moral restraint is reduced. Orders pass through a chain of command to reduce the perception of individual responsibility and accountability. The more responsibility is spread, the more individual decision-making is reduced and the more the sense of responsibility becomes diffused (Kelman 1973:47).

A key element in the commission of atrocities is dehumanisation of the victim. Victims of human-made disasters are labelled as disordered in order to justify the actions of perpetrators (Becker 1995:103). Those who act as victimisers commonly try to block out all human characteristics of the victim to disguise their own criminality (Becker 1995:103). Dehumanisation is a feature of any war situation (Kelman 1973:49). To the extent that victims are dehumanised, principles of morality pertaining to people no longer apply to them (Kelman 1973:48).

Empathy is a key element in regarding another as human. Kelman (1973:48) states "I would propose that to perceive another as human we must accord him identity and community. To accord a person identity is to perceive him as an individual, independent and distinguishable from others, capable of making choices and entitled to live his own life on the basis of his own goals and values. To accord a person community is to perceive him – along with oneself – as part of an interconnected network of individuals who care for each other, who recognise each other's individuality, and who respect each other's rights."

One way of dehumanising the victim is to place him or her in a category and to react to him or her on the basis of this category (Kelman 1973:49). Racism one of the scourges of South Africa epitomises this process of social categorisation. Once categories are created, killing is based on the category, not the threat imposed by the individual (Kelman 1973:50). Once categorised, people are killed because their deaths serve the policy purposes of their executioners (Kelman 1973:50). These thoughts raise the question of what the effect of these experiences is in peacetime? How do erstwhile enemies forge a society in which they can co exist? Does participation in violence create a brutalised individual? Kelman (1973:51) believes that it does. Continuing participation in atrocities does not only increase the tendency to dehumanise the victim but also increases the dehumanisation of the "victimiser." He or she loses his personal identity and sense of community (Kelman 1973:51). In dehumanising his or her victim he loses his ability to care for them, to have compassion or treat them as human beings. He or she becomes numb and detached. In so far as a person excludes a whole group

from his or her network, his or her community becomes constricted and the person's involvement in humankind declines. As the victimiser discards personal responsibility and empathy, he or she loses his or her capacity to act as a moral human being. This raises another issue. What are the long-term implications of participation in violent acts?

10 LONG TERM EFFECTS OF SOCIAL TRAUMA

Straker (1992:82) points out that in wars, the dead and physically injured may be numbered and counted, but those who suffer emotionally and psychologically remain hidden. Concern with the impact of war on children and youth has only gained momentum over the last thirty years or so. It has been found that the most important mediating variable in the impact of disasters on children is the response of adults in the environment (Straker 1992:85). It is increasingly recognised that most people survive multiple hardships. and some are strengthened thereby, but that does not mean these hardships have no ill effects (Straker 1992:83). Straker (1992:83) found that 50% of the group studied who had participated in the struggle showed signs of psychological disturbance at the time of follow-up. Although her sample is small and results cannot be generalised, she offers insight into the responses of activists after the struggle had ended.

Empathy inhibits violence. The capacity to experience empathy and guilt is crucial to the survival of humaneness and society. Straker (1992:104) concluded that the events of 1984–1988 tended to define for the group who should and who should not be recipients of these qualities. While empathy for insiders was enhanced, empathy towards the out-group was diminished.

While most studies focus on victims of violence, less attention has been paid to the perpetrators. In Straker’s (1992:103–104) study about 80% of the group had witnessed or participated in attacks on people. About 30% of the subgroup had been very negatively affected by the experience, even if they were not directly responsible for its perpetration, but for failing to prevent it. Straker (1992:104) notes that the greater degree of empathy a perpetrator has with the victim, the more distressed they become.

Perpetrators are more distressed if they perceive the act to be committed in a state of frenzy. Distress is also relative to the degree of brutality. Conversely, if violence is viewed as necessary, and the context is construed as just, the person tends to feel less guilty and less distressed (Straker 1992:104).

Straker (1992:65) describes “psychological casualties” as “individuals who have been so overwhelmed by their circumstances that they can no longer function in everyday life within the parameters and constraints laid down by their own communities.” After the struggle some youth acted out and became anti-social while others attempted to anaesthetise themselves through substance abuse. Others developed psychosomatic complaints, anxiety and depression. Cultural explanations for these symptoms were invoked. Many of the youth believed their symptoms arose because vigilantes had a stronger witchdoctor than they did (Straker 1988:391).

11 ATTITUDES OF SURVIVORS OF THE STRUGGLE TO VIOLENCE

Mehlwana (1996:38) states that: “Some children have become so immune to violent actions that they see violence as both an acceptable way of expression and as a way of channelling their emotions. Children have seen too much. Violence is everywhere – the forces of both domination and liberation have expressed themselves violently.”

No research on veterans of the bush war with respect to their attitudes towards violence could be found. Straker (1992:98) assessed the attitude of black South African youths who had been part of the struggle towards violence. This investigation took place in 1989, after the struggle had ended. Most survivors were in favour of violent change. They believed real change could not be achieved without violence. They also expressed personal desires for revenge. They wished to hit back at their oppressors and avenge the injustice and trauma to which they had been subjected. Some wished to target the State specifically. Others wished to target Whites in general. Their fantasies about revenge were all violent at the time of the follow-up (1989).

Straker (1992:132) notes that violence in the townships served a group function in that it fostered cohesion. However, it did not have a transforming, healing impact on individuals. The tension and euphoria experienced after participating in violent acts was short-lived. Some participants in her study used violence as a way of acting out, reducing tension, anxiety or depression. When used in this way violence acquired and addictive quality. The intensity of emotion generated was sought in its own right (Straker 1992:132). These sentiments are echoed in the following extract from Batley's (2007:104) study of SADF veterans:

Back there

"When you first get back you have a sort of death wish. You don't care about anybody's life because you've seen so many spillages. If you were to kill someone down here, you wouldn't give a damn. That feeling still comes back, but it's fading, luckily. But the concept that the human life is worth so little is still there. I go down the road at 170 kms [kilometres] an hour and I wish I could cause an accident and see blood, just to see something happen, to feel the adrenaline pumping again. When you get back home, you don't want to stay here, you want to go back there. Time and again I've thought, 'I just want to join the army, I want to go back.' You're looking again for that adrenaline, that feeling of hungriness, but connected to it is the ultimate enjoyment."

In 1986 violence was romanticised and formed part of the war ethic. The youth also saw violence as a legitimate mode of self-defence (Straker 1992:100). By 1987 the participants in Straker's (1992) study had developed more diverse attitudes to violence. Some had renounced violence, because it was seen as counter-productive. Some expressed regret about their behaviour whilst carried away in the crowd. However, 90% of the group was still in favour of violence. Some believed violence has strategic value as a way of achieving political ends.

It is significant to note that most participants in Straker's study (1992:102) felt empowered and elated by participating in violence as part of the crowd during the unrest. This positive effect frequently evaporated as the crowd dispersed.

They were left with a feeling of fear and emptiness thereafter. They sensed some internal moral code had been breached. This feeling of remorse seemed to be followed by fear of reprisal. The anonymity of being in a crowd seemed to offer some protection. At the time of follow up, about 10% of the group were *tsotis* [gangsters] whose capacity for empathy had been dampened and whose aggression was entrenched. The rest viewed aggression as linked to political ends.

12 CHILDREN IN WARTIME

Children are often affected by witnessing atrocities in war. Reynolds (1990:4) recounts the following description from a child in Zimbabwe:

"I left home after I had seen the terrible killing of the people by the regime. People were shot dead in public places, in front of their children and wives. A certain man who lived near us was shot dead at a beer gathering. His dead body was then carried uncovered on the back of a pick-up. The dead man's mother and wife were shown the corpse, and it was taken to the police station. It was then put on a table outside the police yard for some days. This touched me so much that I left straightaway to cross the Botswana border" [Partson Ndou of Beit Bridge].

War has an enormous impact on children. Children are killed in war. Some lose parents or kin. Others lose their security as homes are burned or they become refugees. Children's health is affected as clinics may close, immunisation programmes may collapse and medicine becomes scarce. For example, in Zimbabwe, half the clinics in Mashonaland closed by 1979 and antenatal care fell away. Schooling is disrupted and young people may be recruited or abducted to serve as soldiers (Reynolds 1990:2–3).

Children may become involved in war as soldiers or messengers. Such children may acquire power in their communities because of their important and dangerous roles. Children could use or abuse this power and be left with an aftermath of guilt. Reynolds (1990:7) writing about the war in Zimbabwe states, "A number of people told me they had been threatened, frightened,

even beaten as a consequence of evidence given by children either to the comrades of the soldiers."

Reynolds (1990:8) points out that girls were used in Zimbabwe to serve the guerrillas by cooking for them, sleeping with them and gathering information by having sex with enemy soldiers.

After the Zimbabwe war, children, who may have caused an adult's death, had to live with their consciences and resume positions in the community, which once again placed them in a subordinate position to adults. Some struggled with the transition.

These situations are not unique to Africa. Kornfield (1995:115-116) reports that more than 4000 people were assassinated in Chile from 1973-1990 under the dictatorship of Augusto Pinochet. More than half were killed by state agents. Some were sentenced in court martials, others were shot while supposedly trying to escape imprisonment, many people were arrested at home, in front of their families by large contingents of police who ransacked their homes. Arrests sometimes took place in the streets, with or without witnesses. Often the whereabouts of prisoners was not known for 5-20 days. Family members were left to worry about the person's safety. They knew that the person was in danger of death or torture. Detention without trial was common. People could be transferred anywhere in the country (Kornfield 1995:116). Kornfield (1995:119) states that, in Chile, silence was the predominant reaction to fear and political repression because human rights were associated with death and extreme danger. In this way a culture of silence develops among the poor and oppressed.

13 THE EFFECT OF WAR ON CHILDREN

War has been a feature of South African society within the last thirty to thirty-five years that has clearly affected children and youth who are alive at the present time, either as combatants or their children. Reynolds (1990:1) points out that during war many aspects of childhood are denied or foreshortened. After war, children attempt to return to childhood. Some are relieved, some

are reluctant and some are unable to make the transition. Attitudes towards discipline may be shaped by the experience of conflict or war. Straker (1992:52) cites Setiloane saying that in a recent study the attitude of ordinary black children to discipline showed that they favoured harsh discipline for what seemed to be minor transgressions, even within the family. In her own study, Straker (1992:52) found strict discipline might be interpreted as concern. Harsh discipline was seen as enforcing respect and strengthening family bonds. Most youth endorsed rule setting by parents and enforcing rules with harsh measures.

In Straker's (1992) research, during the struggle, the youth appealed to adults as role models, for guidance and reassurance. Those with strong family ties were the most resilient. Those who experienced conflict between the family and demands of the struggle fared worst. Leaders tended to be socialised into the struggle by family members (Straker 1992:85). The youth drew comfort from the awareness that adults and community leaders had been involved too. This seemed to lend legitimacy to their actions and fits with Rogers (1951:498) proposition 10.

14 THE EFFECT OF WAR TRAUMA ON VETERANS' CHILDREN

Children who are traumatised are members of a community and bear the legacies of earlier generations (Kleber 1995:304). Lykes (2002:95) suggests that war trauma lives on in those who experienced the trauma and their offspring. He states that the past is brought into the present through the intergenerational dynamics of families. Ironically, silence serves to transmit the unspeakable. It protects the survivor, but gives voice to the imagination of the children and survivors. Women in particular are targets of violence and both women and children are marginalised in most societies (Lykes 2002:97). Lykes cites cases where girls and women were repeatedly raped in Guatemala. Foetuses torn from pregnant women were beaten against trees to kill them and women were tortured in front of their children or vice versa. Women are more likely than men to survive these ordeals and are left with the emotional and material burdens of these atrocities. The effect of trauma may

be linked to throwing a stone into a pond, which creates a series of concentric circular ripples.

It is also important to note that civilians constitute the majority of those affected by contemporary warfare. Children are exposed to violence as part of the civilian population either as victims or witnesses and even as fighters themselves (Lykes 2002:96). In South African townships a considerable amount of conflict took place in the context of civilian life and in the Bush war civilians were frequently targeted. Terror may create a situation of “normal – abnormality” or “terror as usual” which is witnessed and experienced by children in which the population is silenced. Fear is exploited in this way to maintain control (Lykes 2002:97). Terror threatens the future through its destructive effects on the next generation’s capacity to affirm itself (Lykes 2002:98).

Conflict may result in the displacement of individuals or their families, either as refugees or exiles. Van der Veer (1995:152) points out that, for refugees, traumatisation is not linked to an isolated incident but tends to be an enduring, cumulative process that continues in exile. It is a chain of events. It seems that more recent, stressful experiences such as failure to get a job, a racist remark or bad news from the home country bring back memories of earlier trauma (van der Veer 1995:153). Refugees or exiles and their families have to face being uprooted from home. This experience brings with it the loss of familiar relationships with family and friends. In exile, most refugees have to start at the bottom of the social ladder. They lose status. Former qualifications may not be recognised, which has implications for the social and economic status of both adults and children. Language barriers may make further education difficult. The refugee may experience a loss of meaning in life as the familiar social environment is stripped away (Van der Veer 1995:154). Van der Veer (1995:155) describes three phases of the refugee experience

- The phase of political repression,

- The phase of traumatic experience such as detention, terror, combat, disappearance of relatives and friends and hardships in refugee camps. Emotions may include guilt, fear, self-blame, disgust, bereavement, betrayal and anger.
- The phase of exile where one may receive bad news from home, difficulties with adjustment, language problems, social isolation and uncertainty about political asylum and difficulties finding accommodation or employment.

15 THE IMPACT OF WAR ON FAMILY RELATIONSHIPS

It is evident that the impact of trauma extends to people who are intimately involved with the victim (Riggs et al 1998:87). Children may be traumatised merely by knowing that a parent has been through trauma, but few studies on children have been published (Figley & Kleber 1995:84). Children, exposed to the parents' reaction, may display hyper arousal, intrusion and enactments similar to those of the parents. Parents' reactions play a crucial role in shaping those of the children. Child development may be impaired. For example, a study showed that survivors of the holocaust had difficulty allowing children to separate from their parents to become independent (Figley & Kleber 1995:85). Parents tend to rely on children for support.

Although no studies pertaining to South African veterans were found, research with veterans from the Vietnam war indicates that these survivors with PTSD are less satisfied with their intimate relationships, and that these relationships are less cohesive, less expressive, fraught with more conflict and are more violent than those of veterans without PTSD. Veterans experiencing PTSD were twice as likely to be divorced and three times as likely to have experienced multiple divorces than veterans without PTSD. Partners of veterans with PTSD had taken more steps towards separation and expressed greater fear of intimacy (Riggs et al 1998:96). Veterans with PTSD were more likely to abuse alcohol and drugs, be depressed, face legal problems, have difficulty retaining jobs and experience health problems, all of which have a

negative impact on the family as a whole. The extent to which South African veterans have similar difficulties appears to be an unexplored field.

The foregoing discussion has shown that detention was a feature of the war in South Africa. War captivity is known as one of the most traumatic experiences and affects the quality of life for many years. Ex-prisoners of war were found to be emotionally detached from their families, preferring solitude and being prone to outbursts of anger towards family members (Solomon & Dekel 2008:261). Loneliness is an important aspect of captivity. Many veterans are lonely in captivity, and, once released, feel estranged because of a sense that those close to them do not understand their experiences (Solomon & Dekel 2008:262). Close relationships can buffer the impact of stress but loneliness can have a deleterious impact on intimate relationships (Solomon & Dekel 2008:262). Ex-prisoners showed lower levels of marital adjustment than non-prisoners (Solomon & Dekel 2008:262; 270). This must impact the children. Solomon & Dekel (2008:270) suggest that feelings of humiliation and shame may prevent traumatised veterans from asking for help or sharing experiences. This has the overall effect of decreasing communication in the family. Loneliness was shown to have a greater impact on marital adjustment than PTSD (Solomon & Dekel 2008:270).

A study of ex-prisoners of war from World War II showed that emotional numbing is particularly detrimental to intimate relationships (Cook, Riggs, Thompson, Coyne & Sheikh 2004:40). It is interesting to note that veterans in this study, with an average age of 80 enjoyed higher levels of marital satisfaction than younger generations (Cook et al 2004:41). However, those with PTSD showed significantly more difficulties on every measure of intimate functioning examined (Cook et al 2004:41).

Byrne & Riggs (1996:221) found that aggression is a significant problem for male veterans and their intimate partners. In this study 42% of veterans had engaged in physical aggression towards their partners (Byrne & Riggs 1996:218). Fully 100% acknowledged using psychological aggression and 88% verbal aggression. The spouse, partner and children of the traumatised

person are affected. Difficulties with cohesion and intimacy may arise. Spouses may feel helpless and lonely while children may display problems in social relationship (Figley & Kleber 1995:79). These findings suggest that the notion that having a family for social support automatically buffers one from the effects of trauma is mistaken (Figley & Kleber 1995:81).

16 ONGOING VIOLENCE AS PART OF THE FABRIC OF SOUTH AFRICAN SOCIETY

Harris (2002:180) states: "In the South African context the normal society is *not*, divorced from violence." South Africa is seen as a culture of violence. "A culture of violence can be described as a situation in which social relations and interactions are governed through violent rather than non-violent means" (Harris 2002:180). Harris (2002:180) suggests that the culture of violence is a legacy of apartheid era where violence was used to gain political power. In South Africa violence is accepted as a normal legitimate solution to problems, particularly because it was legitimised by political role players in the past (Harris 2002:180).

One of the unintended effects of the struggle is the rise of xenophobia in South Africa. "The word "xenophobia" describes violent actions towards foreigners as well as negative and social representations of immigrant refugees and migrants (Harris 2002:177). Following the democratic elections in 1994, South Africa became the "Rainbow Nation" or "New South Africa." With the end of apartheid it seems that a new set of discriminatory practices and victims has emerged. High levels of violence have been directed against foreigners, particularly African foreigners living in South Africa. Xenophobia refers to a dislike or hatred of foreigners, but cannot be separated from community violence. It is hypothesised to have a variety of sources.

One explanation of xenophobia locates it within a context of social change. In the post-apartheid era, expectations have been raised but discontent at the realisation that expectations cannot be met immediately are at a peak. It is suggested that discontented people seek a scapegoat to blame for ongoing deprivation and poverty. Foreigners are presented as a threat to jobs,

housing, education and health. In this way foreigners may become the target of community violence (Harris 2002:171). It has been suggested that the isolation of the South African community accounts for the foreigner's selection as a target. South Africa's rigid internal boundaries and exclusion from the international community has created a society where the inclusion of foreigners is not part of the culture. Foreigners may be seen as part of the "unknown." South African society has developed a culture where it is difficult to tolerate difference (Harris 2002:171).

African foreigners seem to be particularly at risk. It seems that visible differences such as bearing, hair, clothing and accent serve as biological markers because they point out whom to target (Harris 2002:174). Foreigners are presented in the media as masses flocking illegally into the country. These words carry a connotation of uncontrollability and criminality. Xenophobia encourages foreigners to leave South Africa. Those who stay are likely to feel unsettled living in South Africa.

Harris (2002:177) points out that post apartheid South Africa incorporates two discourses or ways of speaking, namely the African Renaissance and the New South Africa. Both foster a drive towards economic, political and social development. However, the African renaissance downplays national borders and emphasises pan-African cohesion. In contrast, the "New South Africa" conveys notions of building the nation and nationalism. Such sentiments can feed xenophobia. Xenophobia may be seen as one side of the nationalism coin and can be a negative consequence of nationalism and nation-building (Harris 2002:179). It is noted that hostility towards foreigners has become one of the most significant features of post-apartheid South Africa (Harris 2002:181).

Harris (2002:180) suggests that while the level of political violence has dropped, there has been a dramatic increase in violent crime. "So while the form of violence has changed, violence itself persists as a dominant means to solve problems in South Africa" (Harris 2002:180). It has been pointed out that the focus on political violence in South Africa has obscured the role of

violence that is not politically motivated (Turton, Straker & Moosa 1991:77). However, such violence is rife and has been rife for some time. Straker (1992:106) points out that slum conditions and general adversity facilitate anti-social and violent behaviour.

17 POLITICAL VIOLENCE AS A PHENOMENON THAT WAS SUPERIMPOSED ON NON-POLITICAL VIOLENCE

A study of students in Alexandra Township (South Africa) indicated that life was marked as a matter of course by material hardship, crime and violence even in the absence of political unrest (Turton, Straker & Moosa 1991:82).

In the ordinary course of events, over a one year period 80% of the youth reported witnessing at least one incident of rape, murder or assault that was *not* politically motivated (Turton, Straker & Moosa 1992:72). The most commonly reported types of violence, both during and apart from political unrest are assault, assault with sharp weapons and killings (Turton, Straker & Moosa 1991:82).

It is interesting to note that members of the South African defence force report high levels of exposure to violence in the course of civilian life. Results of a study of defence force members after the apartheid era showed that 89% had been exposed to trauma and, consistent with findings in the community, most had been exposed to multiple incidents. Eighty-nine percent of army personnel reported exposure to at least one traumatic event in their lifetime. These included sudden unexpected death of someone close (55%), physical assault (47%), transport accidents (43%), and combat exposure (39%). The mean traumatic exposure was 4.3 incidents (Seedat 2003:71-72).

More than half the respondents had inflicted at least one trauma on someone including assault (33%), fire/explosion (16%), attack with a weapon (15%) and serious injury of another (14%). It was estimated that 25.8% of the sample met the criteria for PTSD which is higher than in other military samples. This was attributed to high levels of **pre** military stress exposure. The occurrence of PTSD was related to both greater exposure to trauma and being a

perpetrator. It was noted that exposure to non-combat related trauma played a significant role in the development of PTSD in this group.

Gangs have always been a part of township life as have unemployment and poverty. Straker (1992:107) states there is a general culture of violence that is unrelated to political conflict. The political conflict seems to have been super imposed on *already* violent conditions. According to Straker (1992:107) “the most destructive element of this exposure to violence is the degree to which violence is perceived to be part of everyday life. This in itself, if children are not simultaneously exposed to loving, caring relationships in situations of stable child-care could be sufficient to promote pervasive and indiscriminate anti-social behaviour. This kind of anti-social behaviour is far more difficult to contain than that stimulated by individual experience in civil conflict” (Straker 1992:107).

18 TOWARDS THE FUTURE

Societal factors facilitate or hinder recovery from distressing events. Trauma has a meaning that extends beyond the individual. It destroys the social system of protection and meaning that surrounds the individual. The traumatised person has been set apart from other human beings, resulting in impaired social relationships. Trust is broken and connectedness is severed. Recovery is inseparable from the social and cultural context (Kleber 1995:299).

Many survivors of war have been disappointed to find that post-war society is not what they expected. Many are confronted with unexpected losses (Kleber, Figley & Gersons 1995:3). Simpson (1995:210) suggests that survivors of the struggle in South Africa have been left disillusioned by the lack of attention to their needs and wishes. A further source of distress has been that perpetrators of human rights abuses have, to a large extent, escaped punishment. He concludes “Those who dreamed of freedom and recognition for their contribution to attaining it have been trampled, and express no hope for the future: a situation far worse than their state under apartheid, for no one will liberate them from the Liberation that failed to set them free. This is a

basis for severe, continuing, and evolving post traumatic problems. The new Political Correctness forbids victims to speak of their experiences. In the name of reconciliation, they must be silent about their anguish – The Silence of the Lame – as those who are responsible for the new suffering are admired international icons. The future for survivors of apartheid has never been bleaker." Similarly veterans of the Bush war have found themselves without a sympathetic audience to hear their pain. It has been difficult for them to find meaning in these experiences.

Victims react to trauma in accordance to what it means to them. Generating meaning is an active process that takes place within an individual, social, cultural and political frame of reference (Summerfield 1995:20). Summerfield (1995:21) suggests "the grief of a mother for a 10-year-old-son shot dead on the streets of Soweto by the South African Police may be eased since the cause for which he died has had a positive outcome in a more egalitarian society."

Terror forces a re-thinking of the past (Lykes 2002:104). It is essential that survivors are assisted to reconstruct social and economic networks as well as their cultural identity. Societal reparation and social justice are crucial to recovery (Lykes 2002:104). Pilisuk & Tennant (1997) point out that, for violence to be reduced, the structures that underlie violence must be changed. Such structures are not immediately obvious. Writing in 1992, Straker (1992:107) states: "Hope for the future is clearly contingent upon providing the majority of black youth the opportunities for which they have been fighting." However it seems that this goal has not yet been achieved. Large numbers of South Africans have remained in the grip of poverty, HIV/AIDS and social difficulty. The high levels of crime, violence HIV/AIDS and poverty that continue to plague South African society, which provides the context for this study, will be reviewed in the next chapter.

19 CHAPTER SUMMARY

The effects of trauma extend to family members, to friends, co-workers, helpers and others in society. The key to understanding the ripple effect of

trauma is empathy. Those who are close to the victim or hear about the incident imagine themselves in the traumatised person's shoes and emotions that reflect those of the victim are triggered. The capacity for empathy is frequently exploited by those in positions of power who may commit atrocities to serve as an example to others. In this way submission is induced in the population. Terror is used as a way of entrenching control.

South Africa has a history in which such practices were used during the apartheid era. During the reign of apartheid South Africa became involved in a war on the border known as the bush war, as well as wide spread civil conflict within her borders. As young black people in particular became involved in civil unrest and protest against apartheid, a civil war ensued that has become known as "the Struggle". Since the average age of social work students is thirty, these experiences are likely to be salient to this group. Offspring of veterans are known to be affected by the trauma of the parents so research and the impact of war experiences on the families of veterans were reviewed. Long-term effects of trauma on South African youth were discussed as well as the attitudes of the survivors towards violence. It is noted that political violence in South Africa was superimposed on structural and non-political, direct acts of violence. Hope for the future of South Africa is dependent on meeting the needs for which the young people fought. However, many have been left disappointed and disillusioned. The social difficulties which form the context of this study will be reviewed in the next chapter.

CHAPTER 7

THE CONTEXT OF THE RESEARCH

1 INTRODUCTION

This chapter provides an overview of the context in which social work is practiced in South Africa. The aim is to paint a picture of the environment in which most students were raised, in which social work is practiced and in which social work education is offered. A hermeneutic analysis requires that the empathic account of the participants' experience is seen against the wider context of which the participant is part, so this chapter has been written with that in mind (Kelly 2006a: 345; Addison 1999:150; Kelly 1997:417).

Although social work students in South Africa make use of the same international theory and textbooks as colleagues elsewhere in the world, practice needs to be relevant to the society that legitimises and supports the profession (Earle 2008:125). Therefore much of the education of social work students is contextual, through practical placements in which theoretical knowledge is applied. Therefore the social context in South Africa is very pertinent to student social workers who are the focus of this research. During training and in practice as professional social workers, theory needs to be applied to the specific context in which social work is practiced. At the same time, the social worker him or her self is influenced by the context in which he or she was raised. This means that the practice and training of social workers cannot be divorced from the reality of changes that South Africa is facing. According to the person-centred approach, change that is threatening to the self tends to be resisted. Behaviour tends to be consistent with the symbolised self. Discrepancies in values or threats to the self create stress (Rogers 1951: 510-515). This implies that widespread changes in South Africa may be a source of stress to the social work students in this study.

Widespread political and policy changes as well as changing needs in society have impacted the profession. With this in mind, the image of social work is discussed. Despite the largely negative perceptions of the profession,

individuals still choose to study social work. According to Earle (2008:63) the number of registrations in first year at Unisa grew from 610 students in 2000 to 1 590 in 2002 and 2 442 in 2004.

The profession of social work is supported and legitimised by society in order to meet its needs. It goes beyond the scope of this chapter to give a detailed description of all the areas that are the scope of South African social work practice, but an overview of some concerns is presented.

The literature indicates that being a competent social worker takes more than knowledge and technical skill, but entails the integration of values that inspire excellence and fuel compassionate care (Clark 2006:82-84). This implies it involves development as a person who adopts the profession as a calling that is consistent with personal values (Clark 2006:82).

The Unisa Department of Social Work, where the research was conducted, aims to facilitate personal growth in students as professionals as well as enabling students to acquire theoretical knowledge and practical skills. The person-centred approach to learning, adopted by this department, will be reviewed.

2 SOUTH AFRICA

South Africa has been known for its apartheid policies in which racial discrimination was institutionalised over a period of forty-six years (1948-1994). Different state departments were created for every population group (Van Dyk 2000 b: 22). This included the institution of racially segregated departments within the welfare sector. During the apartheid era, differences in education, coupled with a variety of laws had the effect that whites obtained better jobs at the upper level of the economy, while blacks occupied unskilled and semi-skilled positions (Van Dyk 2000 b: 22). A democratic government came under power in 1994 and apartheid laws were dismantled. A policy of black economic empowerment came into being to redistribute wealth. A unified education system was established as well as a unified health system (Van Dyk 2000 b: 22). At the time these changes took place, the professions

reflected race and gender hierarchies and to varying degrees, these distinctions have persisted (Earle 2008: vii). With the advent of a change in government, the focus of welfare changed from being nationally fragmented and predominantly focused on the needs of the white population to being unified nationally and focused predominantly on the needs of the majority previously disadvantaged black population (Earle 2008:23). Social work has a particularly complex role in this scenario with its key role in implementing the state's welfare policy. This policy now focuses on the development and empowerment of previously disadvantaged groups. There is a growing shortage of social workers. For example, an escalating HIV/AIDS epidemic has created the need for a variety of social work interventions. Social workers are expected to deal with statutory work generated by rising numbers of orphans due to AIDS as well as delivering services to meet other social, family and individual needs (Earle 2008:2). There is a need for community development to address poverty. High levels of crime create additional demands on professional social workers for trauma interventions. Clearly, social problems do not disappear as an outcome of legal and political change. South African society presents many needs that provide the focus of social work practice including poverty, unemployment, HIV/AIDS, malnutrition and infant mortality, teenage pregnancy, low levels of literacy and education, high levels of violence abuse and neglect, crime and racism (Earle 2008:18). An overview of three areas of concern will be presented as examples that illustrate the context in which social workers and social work students operate.

Currently the SA population is estimated at 49 million (CIA fact book 2009). Of the inhabitants, about 79% are Black, 9.6% are White, 8.9% are Coloured and about 2.5% are Indian (CIA fact book 2009).

2.1 Poverty, family life and education in South Africa

Patel (2005:51) states that poverty remains one of the greatest challenges facing Southern Africa. About 50% of the population in the region live below the international poverty line (CIA fact book 2009). About 14 million people are said to be vulnerable to food insecurity and 43% of households suffer from food poverty (Machethe 2008).

Poverty in the midst of plenty is a striking feature of South African society. The abundance of some emphasises the neediness of others. South Africa's poverty and wealth profile tends to be skewed in favour of the White population (Advameg 2008) It is noteworthy that 40% of the households with the lowest income earn less than 6% of the total income, while 10% with the highest income earn more than half the total income (Advameg 2008) Among Black households, 50-60% are poor compared with 2% of White households. Of the more than 40 million inhabitants in South Africa, Blacks and Coloureds are the poorest (Bak 2004:88). Poverty is more pervasive in rural areas, particularly the former homelands, where 65% of the poor are located. 78% of those likely to be chronically poor live in rural areas (Machethe 2008).

Louw (2007:259) explains that poverty is defined in a number of ways and there is no agreed upon standard for poverty. All views of poverty refer to lack, deprivation or deficiency. Some views focus on quantitative, monetary indicators while others view poverty in person-centred, qualitative terms. Schenck and Louw (2009:354-355) point out that various definitions of poverty overlap. According to Schenck and Louw (2009:357) from a person-centred perspective, poverty is all that holds people back from a full and healthy life. It refers to the extent that needs are unmet.

In terms of the income perspective, poverty may be viewed in terms of a lack of income. The basic needs perspective regards poverty as absence of access to basic services or means to meet basic needs. According to the social exclusion perspective, poverty may be viewed as the exclusion of people from benefiting from the general prosperity of the country. This approach views poverty as more than an economic issue. It takes societal forces such as domination, exploitation, oppression, alienation and vulnerability into account. In the previous chapter, such forces were described as a form of violence, based on the notions of Pilisuk and Tenant (1997).

Many segments of the South African population have been identified as vulnerable to poverty, especially women and children. Only 40% of Black

children are reported to live with both parents, 46% live with their mothers only and 13 % live without parents (Bak 2004:88). Female-headed households are generally poorer than male-headed households (Louw 2007:294).

In South Africa, 17% of households are regarded as very poor (spend less than R600 per month) and 25% are poor (spend between R600 and R1000 per month). This means that poverty affects at least 32% of the population (Statistics South Africa cited by Louw 2007:288). Those most likely to be affected by poverty live in rural areas, are African, are larger families, and are unemployed (Louw 2007:288).

South Africa's unemployment rate is estimated at 22.9% (CIA fact book 2009). The unemployment rate increased by 28% between 1994 and 2006 (Dimant, Lebone & MacFarlane 2007:141). Currently poverty is becoming more class than race based as Blacks are moving into the middle class and claiming a greater share of the country's wealth (Louw 2007:267).

Poverty hinders the progress of people (Louw 2007:267). This includes absence or limitations of choice and opportunities such as access to education, upholding human rights and the security of political and social freedom (Louw 2007:267). Poverty is associated with low status and may make a person more vulnerable to powerlessness and exploitation (Louw 2007:267-269). Poor people may become trapped in a cluster of disadvantage as lack of financial resources exacerbates related difficulties. For example, without money it is difficult to get around to seek work. Inadequate finance contributes to malnutrition, lowered resistance, vulnerability to disease and inability to access health services. Poverty is, therefore a multidimensional painful experience that demands urgent attention in South Africa.

Poverty affects family life. Poverty, unemployment and malnutrition are factors that contribute to the neglect and ill treatment of children (Van Dyk 2000b: 71). Sixty eight out of every thousand children in South Africa will die before the age of five (WHO:2007). The infant mortality rate is 44,42 deaths per 1000

live births (CIA fact book 2009). Poor education may perpetuate the cycle of poverty. Many South African women do not complete their education due to teenage pregnancy. South Africa has a teenage pregnancy of 15% among women aged 15-19 (Earle 2008: 19).

A survey conducted in 120 Kwa –Zulu Natal schools in 2006 found that 887 schoolgirls fell pregnant that year. Sixty of the pregnant girls reported that they were pregnant as a result of sexual abuse. Schoolgirls who fell pregnant were allowed to attend school until their seventh month of pregnancy, when they were asked to leave. After giving birth they were often not re-admitted to the same school, so had to enrol elsewhere or drop out (Botsis, Cronje & MacFarlane 2007:310). The tendency to drop out of school has implications for the young mother's future job prospects. The relationship between poverty and teenage pregnancy is circular. A study on teenage pregnancy in South Africa suggested that teenagers living in poverty might sell sex to older men and in turn risk falling pregnant (Macleod 1999b: 12). In poor families, parents who need to work but are unable to afford childcare may leave children in the care of siblings. It has been suggested that this contributes to teenage pregnancy in the sense that teenagers who take on a baby-sitting role may be prepared for early motherhood (Macleod 1999b: 12). Additional factors that increase the rate of teenage pregnancy were cited. Lack of communication between parents and children with regard to sexual matters seems to be a contributing factor (Macleod 1999b: 9). It seems that the breakdown in cultural traditions exacerbates the situation (Macleod 1999b: 13). However, the cultural values placed on motherhood may contribute to the incidence of teenage pregnancy. In some cultures, young women are keen to fall pregnant to avoid the stigma of being infertile (Macleod 1999b: 13). Boys in a Zulu or Xhosa culture felt pressured to demonstrate they are sexually capable, but are not expected to carry responsibility for the child, apart from payment of damages, so further financial responsibility falls to the girl (Macleod 1999b: 12).

Most teens in the Macleod's (1999b: 11) study felt intimidated or coerced into having sex initially and the sexual relationship continued to have violent

features (Macleod 1999b: 11). Teenagers seemed suspicious of efforts to promote the use of contraceptives, which was seen as an effort by Whites to limit the Black population (Macleod 1999a: 5).

Teenage mothers may become trapped in a cycle of poverty because teenage pregnancy may affect schooling, and in turn, contribute to poorer job opportunities and low income (Macleod 1999a: 1). Pregnancy was also associated with dropping out of University in a study of social work students (Earle 2008: 123). Some students had had abortions and continued with their studies. Students in this study considered termination of pregnancy as creating more distress than the initial pregnancy and were concerned about the long-term effects in their careers (Earle 2008:124). Since 1997 abortion has been legal in South Africa and 440 000 abortions were performed up to 2005 (The Citizen, 3 October 2005: 3).

Poverty and low educational levels are linked. One of the factors that adds to poor educational levels is the impact of HIV/AIDS. The AIDS prevalence rate among adults is 18.1% (CIA fact book 2009). The premature death of large portions of the adult population has widespread implications. Up to a quarter of public servants are expected to die by 2012, including many teachers who make up almost 40% of public servants (The Sunday Independent, 28 March 2004:5). In a survey conducted in 2005, 12% of teachers that were tested were HIV positive (Botsis et al 2007 :307). Between 1990 and 1995, school enrolments increased by 4,21%, but between 1995 and 2000, it declined to 0,05%. The drop was attributed to declining fertility rates and rising infant mortality due to HIV/AIDS (The Sunday Independent, 28 March 2004:5). Other factors may contribute. As family members fall ill, less money is available for fees and increasing numbers of children are dropping out of school. Household income drops as family members fall ill. Public health services are over-taxed by the epidemic. HIV-related illnesses among health care workers constitutes another cost of the disease. Productivity in both agriculture and business is lowered as workers fall prey to the disease (Van Dyk & Van Dyk 2002: xiv). The number of orphaned children due to AIDS is climbing steadily. There were 719 000 child/youth -headed households South

Africa in 2006, when the first phase of this research was implemented (MacFarlane 2007:332).

Poor levels of education are of concern in South Africa. When the number of matriculants who passed their examinations in 2006 is calculated as a proportion of the 2003 grade 10 class, only 32% of the learners actually passed and 587 851 learners dropped out of school (Botsis et al 2007:311). Some students reportedly stayed home because they could not afford fees. Crime also has an adverse impact on education and school attendance. It is reported that many coloured learners failed to attend school, particularly in the Western Cape, because of intense gang activity (Botsis et al 2007:311).

As far as early childhood development (ECD) is concerned, only 12% of teachers working in ECD facilities in South Africa are trained. One million (17%) of children of the naught to six age group attend such centres, while 83% of the population do not have access to an ECD centre and the educational benefits thereof. More than 90% of ECD facilities are community driven efforts. (Botsis et al 2007:305).

Clearly, poverty, unemployment and a variety of associated social needs will persist for some time and the need for social work services cannot be denied.

2.2 HIV/AIDS in South Africa

Approximately 5.7 million South Africans are infected by HIV (CIA fact book 2009). It is estimated that 800 people die per day per day in South Africa of Aids (Noble 2008). South Africa has the largest number of people in the world who are living with HIV/AIDS and, although South Africa makes up only 0,68% of the world's population, it is estimated that 10% of all HIV infected individuals are in South Africa (Van Dyk & Van Dyk 2002:xiv). AIDS is linked to 47% of deaths in the country (Noble 2008:5). It is noteworthy that the annual number of registered deaths rose by 87% between 1997 and 2005. Among the 25-49 age group, the rise was 169% in the same period (Noble 2008:4). Such an increase among younger people can only be attributed to disease (MacFarlane 2007:321). The AIDS prevalence rate among adults is

18.1% (CIA fact book 2009). South Africa had prevalence rates of 29,1% amongst pregnant women in 2006 (Noble 2008:1). A third of infants born to infected mothers will succumb to the disease. A study of a representative sample of South Africans, the National HIV Survey, revealed that 10,8% of all South Africans over the age of two were living with HIV in 2005 (Noble 2008). There are 1 700 new cases of HIV infection daily in South Africa (POWA 2008a).

HIV has a profound effect on children in infected families. Patel (2005:166) notes that poverty amongst children is exacerbated by the effects of HIV/AIDS. Children are particularly prone to being poor. Poverty levels of children aged 0-14 years and in child-headed households are worse than that of the general population. She notes that:

- The HIV prevalence rate amongst children 2-18 years of age is 5.4% and the maternal orphan rate is 3.3%.
- A tenth of children are estimated to have lost a parent by 9 years of age and 15% have lost a parent or caregiver by age 14.
- Children of African descent, children in poor households and children living in informal settlements are most affected.
- Three percent of children between 12 and 18 years of age indicated that they head households.

Factors associated with the high prevalence of AIDS in South Africa are inadequate knowledge about how to avoid AIDS; high levels of poverty and inequality; the low status of women in many communities; the high incidence of rape; social and family disruption due to apartheid and labour migration; the widespread practice of having multiple sex partners in some communities and resistance to condom use (Mynhardt 2002: 70). A high rate of baby rape is associated with the myth that having sex with a virgin – the younger the better – is a cure for HIV/AIDS. This may partially explain South Africa's notoriety for this particular crime (POWA 2008b).

South Africa has instituted extensive anti HIV/AIDS campaigns, which include improved nutrition. This has had the beneficial effect of reducing malnutrition among children. The number of malnourished children has dropped from 25 per 100 in 2002 to 9.8 per 100 by 2004 (MacFarlane 2007: 313). Infant mortality has dropped from 58 per 1000 in 2002 to 48 per 1000 in 2006. This is accounted for by improvements in the infrastructure, increased use of ante-natal clinics and a focus on prevention of mother to child transmission of HIV. However, the infant mortality rate of 48 per 1000 births is still unfavourable when compared with developed countries where deaths are below 10 per 1000 (MacFarlane 2007: 317). Cholera and malaria have also been successfully reduced in South Africa.

At the end of 2006 people with HIV qualified for a temporary disability grant provided they passed a means test, attended a state institution, could submit a medical report confirming disability and had a CD4 count of less than 200. Long-term social assistance is being considered. (MacFarlane 2007: 359).

Many people with HIV/AIDS may not attend local clinics and may not be included in these statistics. Traditional healers are often the first port of call for treatment. Their popularity may be seen in that in 2006, 300 000 traditional healers were operating in South Africa and claimed R250 million (MacFarlane 2007: 359).

2.2.1 The impact of HIV/AIDS on the social work profession in South Africa

According to Earle (2008:19) the prevalence of HIV/AIDS amongst women aged 15-19 years is 15% and in women aged 25-29 it is 33.3%. It is still 19.3% in the 35-39 year age group. The high prevalence of HIV/AIDS in women aged 15-39 has implications for social work. It is significant to note that most registered social workers in 2005 were female (89.3%) and 67,4% were aged between 20 and 39. With the high HIV/AIDS prevalence in women in this age group, the stage is set for a huge decline in the availability of social workers in the future (Earle 2008: 19). Secondly, HIV/AIDS is increasing the welfare needs of South Africans, particularly among previously disadvantaged

people. Ill health, consequential loss of income due to inability to work, large numbers of orphans, and sexual and commercial exploitation of children are secondary effects of the disease that are the focus of the social work practice. Related activities include the provision of disability grants, foster care grants, bereavement counselling, physical and emotional support and therapy, placement of children in foster care, monitoring the safety and well being of children in these placements, assisting with orphans and child headed households, protection of children's property rights, as well as promoting the education, rights and well being of such families.

Implementation of the programme to provide anti-retro virals has been delayed by the current shortage of social workers. It seems that the relevance of social work and the future demands that will be placed on the profession have been seriously underestimated (Earle 2008:20-21). Referring to *The Department Of Health's Operational Plan For Comprehensive HIV And AIDS Care, Management And Treatment For South Africa* Earle (2008:21) states that planning has been woefully inadequate as indicated by the following quote:

- While the need for social work is evident in the tables in the plan, the document contains no discussion relevant to this group of professionals.
- Considering the fact that social workers have statutory obligations to deal with the management and placement of orphaned children (among which group the largest portion is due to HIV/AIDS), that is a long-term and time-consuming responsibility and cannot be undertaken by any other group of professionals, and that it must be considered an integral part of any comprehensive care programme, it is clear from the patient time allocation that this social work function has not been included, and that the plan underestimates the real demand for social work support.
- A further concern regarding the calculations of staff requirements is that the plan is based on the premise that *the great majority of South Africans that are currently not infected remain uninfected*. This is a very risky

premise considering the example set by certain prominent national leaders.

- The plan relies heavily on the input of NGOs and community based organisations (CBOs) in providing community and care support; however, it makes no mention of the present severe challenges that this sector faces in accessing funding.
- Stating as its long term strategy for increasing the number of relevant health-care workers the increased production of such workers and the creation of additional posts, the plan makes no mention of either factors that constrain the production of professionals or of the fact that the large numbers of posts within the public health care sector are vacant at present and that increasing the number of posts is only likely to lead to increased vacancy rates.

In conclusion, social work is a scarce skill and the need for social workers is poised to increase exponentially in future.

2.3 Crime in South Africa

- A woman is raped every 26 seconds in South Africa.
- One in two women have a chance of being raped in their lifetime.
- One in four women are in an abusive relationship.
- A woman is killed every six days by her intimate partner in South Africa.
- A child is abused every eight minutes in South Africa.
- A child is raped every 24 minutes in South Africa.
- A child is assaulted every 14 minutes in South Africa.
- One in four girls and one in five boys under 16 have been sexually abused.
- A Johannesburg survey revealed that one in four men had raped a woman.
- 85% of rapists were armed, usually with a knife and most rapes were gang rapes.
- Every year there are 18 438 armed attacks within peoples' homes.

- Every day in South Africa 50 people are murdered (18 148 murders per annum).
- Every day there are 558 assaults with intent to do grievous bodily harm (203 777 per year).

(POWA 2008a; SAPS 2009a).

The magnitude of crime in South Africa has been described as a "violation of human rights." This statement was made in a report by the United States of America's Department of State Human Rights (The Citizen, 9 March 2007: 1-2). Certain crimes were singled out as human rights violations especially crimes against children. Specifically, during 2006:

- 23 453 children were raped.
- 1075 children were murdered.
- 20 879 children were assaulted.

(The Citizen, 9 March 2007: 1-2).

South Africa has one of the highest rates of child and baby rape in the world. It was noted that, from 2000-2001, a total of 131 973 cases of crime against children were reported. This translates into eight cases being reported each hour. Of 22 000 cases of child rape, only a 10% conviction rate was secured. There were also 1 400 vacancies for social workers with the child protection unit at that time (The Citizen, 29 May 2003a: 24).

South Africa is becoming a global centre for the child sex-trade. One of the reasons given for this trend is poverty. Black children were found to be particularly vulnerable because many are forced onto the streets as a result of poverty or abuse at home. Many are orphaned due to HIV/AIDS. There are as many as 719 000 youth/child-headed households in South Africa (MacFarlane 2007:332). The Internet has reportedly led to an increase in sexual exploitation of children. Images are exchanged and arrangements are made between adults on-line for access to children. Children aged between eleven and twelve were reportedly most at risk. South Africa was described as a haven for paedophiles (The Citizen, 29 May 2003b: 1-2).

During 2008-2009, a total of almost 2.1 million serious crimes were registered in South Africa. During 2000 South Africa had the highest murder rate in the world as well as the highest rate of rape (Lebone 2007:431). During 2008/2009 there were 18 148 murders, 246 616 burglaries at residential properties and 18 439 armed robberies against families in their own homes as well as 13 920 armed robberies at people's places of work. During the six-month period between 1 October 2008 and 31 March 2009, there were 24 836 rapes reported in South Africa. A total of 38 148 sex-related crimes were recorded (SAPS 2009b). In 2006 there were 636 farm attacks and 88 farm murders (Lebone 2007:437). The level of violence associated with crime in South Africa is worrying (Lebone 2007:490).

Statistics released in 2006 showed that the rate for all except four of the most serious crimes fell during the 2004/05 and 2005/06 financial years. The exceptions were theft of motor vehicles, commercial crime, drug related crimes and driving under the influence of alcohol (Lebone 2007:489).

In January 2004 the South African Government decided that serious crime should be reduced by 7-10% per year for 10 years. A report is issued each year to assess progress towards this goal. This report will be reviewed briefly (S A Police Services 2007:1-37). Crime is categorised in the report as contact crime, contact related crime, property related crime, crimes heavily dependent on police action for detection (such as illegal possession of drugs) and other serious crime.

2.3.1 Contact crimes

Contact crimes involve physical contact between the victim and perpetrators. Such contact is usually violent in nature. Specifically, murder, attempted murder, rape, assault with intent to do grievous bodily harm (assault GBH), common assault, indecent assault, aggravated robbery and other robbery fall into this category. According to police statistics, these crimes account for 32,5% of South Africa's reported serious crimes. Such crimes have serious consequences, such as death, injury, psychological trauma and loss and/or

damage to property. When reported crimes were analysed, it emerged that 89% of common assault and assault (GBH) were social or domestic in nature. This means those involved knew each other. Similarly, 82% of murders, 59% of attempted murders and 76% rapes in the sample involved people who were known to each other. Most social contact crimes (80%) were driven by alcohol abuse. These crimes are seen as crimes that are related to the fabric of society.

Most robberies (80%), carjacking, truck-jackings, business robberies and cash-in-transit heists are perpetrated by assailants armed with firearms. Attempted murder and murder are associated with these incidents (S A Police Services 2007:3).

Crime figures for the country as a whole, as presented by the government from April to September 2006-2009 are tabulated below.

Table 1- Crime incidents

REPORTED CRIME FIGURES APRIL TO MARCH	2006/2007	2007/2008	2008/2009	INCREASE /DECREASE 2008/2009
Murder	19,202	18,487	18,148	-1.8%
Attempted murder	20,142	18,795	18,298	+12.09%
Assault /grievious bodily harm	218,030	210,104	203,777	-3.09%
Common assault	210,057	198,049	192,838	-2.6%
Common robbery	71,156	64,985	59,232	-8.9%
Robbery / agg circumstances	126,558	118,312	121,392	+2.6%
Car hijacking	13,599	14,201	14,915	+5.0%
Truck hijacking	892	1,245	1,437	+15.4%
Common robbery	71,156	64,985	59,232	-8.9%
Robbery at residential premises	12,761	14,481	18,438	+27.3%
Robbery at business	6,689	9,862	13,920	+41.1%
Robbery of cash in transit	467	395	386	-2.3%
Street robbery	92,021	77,984	72,194	Not reported
Burglary at residential premises	249,665	237,853	246,616	+3.7%
Burglary at business premises	58,438	62,995	70,009	+11.1%
Drug-related crime	104,689	109,134	117,172	+7.4%
Neglect and ill-treatment /children	4,258	4,106	4,034	Not reported
Culpable homicide	12,871	13,184	12,571	Not reported
Kidnapping	2,345	2,323	2,535	Not reposted
Public violence	1,023	895	1,500	Not reported
Total Sexual Offences	65,201	63,818	71,500	Not reported
Theft of motor vehicle and motorcycle	86,298	80,226	75,968	-5.3%
Theft out of or from motor vehicle	124,029	111,661	109,548	-1.9%

REPORTED CRIME FIGURES APRIL TO MARCH	2006/2007	2007/2008	2008/2009	INCREASE /DECREASE 2008/2009
All other theft	415,163	395,296	394,124	-0.3%
Commercial crime	61,690	65,286	77,474	18.7%
Crimen injuria	36,747	33,064	30,355	Not reported
Illegal possession of firearms	14,354	13,476	14,045	+4.2%

The Centre for Justice and Crime Prevention (Cited in Sunday Times, 22 April 2007:15) found that there is a North-South divide in the nature of crime. While Gauteng is plagued by house robbery and hijacking, people in the Northern, Western and Eastern Cape are at highest risk for murder and sexual abuse. High levels of inequality, where the poor and rich live in proximity are linked to car hijacking and house robberies. This situation is characteristic of Gauteng. Wealthy Sandton (in Gauteng) for example has triple the number of house robberies than that of poverty-stricken Alexandra (in Gauteng) next-door. High levels of equality and social contact are linked to murder, rape, assault (GBH) and sexual violence against children. These crimes are intimate crimes in which the victim and perpetrator are in close social contact. In areas of Gauteng, where people live in isolation behind the high walls, the incidence of these crimes is lower than in the Cape. Alcohol abuse plays a role in 80% of social contact crimes and the wine-producing areas of the Cape have a particularly high incidence. The report took the ratio of the population into account and suggests that the country's most dangerous areas to live in were not the cities, but rural areas or areas along the country's borders (Sunday Times, 22 April 2007:15).

During the first semester of the 2007/2008 financial year, police reported the following trends in their effort to reduce crime (S A Police Services 2007:1-37).

Table 2- Crime reduction/increase

Crime description	% increase or decrease 2007/2008:
Common robbery	- 12,2%
Robbery with aggravated circumstances	- 9,7%
Attempted murder	-7,6%
Murder	-6,5%
Indecent assault	+ 3,5%
Assault (GBH)	-2,8%

Rape	-3,6%
Common Assault	-5,1%

These figures, as well as those in table 1 indicate that the aim of reducing serious crime by 7-10% has, in most cases, not been achieved. Armed robberies at residences in 2008/2009 increased by 27.35% compared with the previous year. Car hijackings increased by 5% during this period. An armed attack in or outside a person's home strikes at the heart of one's privacy and security. Vehicles are commonly hijacked either on residential properties or on the street outside. Car hijackings affect the middle to higher socio-economic groups and 70% of these crimes are perpetuated outside people's homes (SAPS 2007). The increase with respect to business robberies in 2008/2009 was 41.1 % (SAPS 2009b). Attempted murders increased by 12.05%. The murder rate dropped by 1.8%. This means that, instead of an average of 50.6 murders per day in 2007/2008, South Africa experienced 49.7 murders per day in 2008/2009. This is a negligible decrease.

Aggravated robberies frequently involve firearms (80%) and include hijacking, house and business robberies, cash in transit heists and street robberies and muggings. These crimes frequently intrude into people's private space. General aggravated robberies are associated with townships and central business districts. Most victims are not well-known or high profile people (S A Police Services 2007:15). Almost three quarters of aggravated robberies were street or public robberies between April 2006 and March 2007 where people were robbed of their belongings at gun or knife point (The Citizen, 4 July 2007:2). The main targets are cash, cellular telephones, laptop computers and other valuables such as jewellery.

All crime-reduction relies on a competent and motivated police force and justice system. Some crimes are classified as those heavily dependent on police action for detection. These offences include illegal possession of firearms, use, possession or dealing in drugs and driving under the influence of alcohol. An increase in these crimes may indicate an increase in the incidence of crime itself or an increase in police activity. From the above discussion, it is apparent that these crimes may be linked to other serious

crimes. For example, there is a link between alcohol and drug use violence, rape, assault, murder and attempted murder. Suicide is also associated with alcohol and drug use. Substance abuse is expensive and is frequently linked to theft. During the first semester of 2007/2008 there was an increase of 32,9% of cases of driving under the influence of alcohol or drugs, possibly as an artefact of more stringent legislation in this area.

The crime situation in South Africa is cause for serious concern. According to Patel (2005: 182) young people are commonly either victims or perpetrators of crime. The majority of perpetrators and victims of lethal crime are young men, particularly black men. Most offenders in lethal crimes are black men aged between 18 and 30 years of age and most victims of such crimes are black men between 16 and 35 years of age. Young men between the ages of 18 and 25 years on age made up 39.05% of the prison population at the end of January 2004 (Patel 2005:182).

In 2006, 240 prisons with a capacity of 114 000 inmates had a population of 158 501. In that year, the Independent Complaints Directorate received 1 643 allegations of criminal offences committed by police officers and 2 855 allegations of misconduct. There is one police officer per 389 members of the population (Lebone 2007:438). With only 125 521 police officers to combat crime and achieve the desired reductions in serious crime, the SA Police resources have been stretched to the limit, so much so that, according to the Citizen (13 October 2004:1) private security companies have been hired country wide to protect the South African Police Services. The responsibility of guarding police premises was outsourced to private security companies.

Crime does not only affect the victim him or herself, but has a ripple effect on the family and community. The effects on family, friends, work colleagues and society as a whole cannot be measured.

It is against this backdrop of social problems that social work is practiced in South Africa.

3 THE SOCIAL WORK PROFESSION

Social work is a profession that focuses on enabling people to reach their full potential, enrich their lives and prevent dysfunction. Social work grew out of humanitarian and democratic ideals and is based on values of respect for the equality, dignity and worth of people. Empowering people, addressing needs, promoting human rights and establishing social justice are the motivation for social work, (Hare 2004:418-419). Empowerment is a broad concept that includes the process of increasing personal, interpersonal and political choices and power so that individuals, families and communities can take action to improve their lives and meet their needs (Hare 2004:413). This is accomplished by a variety of methods. There are many variations in social work practice, ranging from individual, clinical social work, community work, statutory work, group work and social policy planning. The core concept is that social work focuses on the person-in-the-environment. Some interventions place more emphasis on the environment while others address the person him or herself. The emphasis is always on human well-being. The International Federation of Social Workers agreed on the following definition of social work in Montreal in July 2000:

"The Social Work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, Social Work intervenes at points where people interact with their environments. Principles of human rights and social justice are fundamental to social work" (Rautenbach & Chiba 2009:3)).

3.1 The history of social work in South Africa

Patel (2005:66) notes that colonialism and apartheid shaped the evolution of the nature form and content of social welfare in South Africa. During the 1920's growing concern about poverty amongst white South Africans culminated in an investigation organised by the Dutch Reformed Church in South Africa and funded by the Carnegie Corporation of New York. A report was issued in 1932, recommending that a social welfare department should be established and that social workers should be trained to address the needs

of the destitute. Therefore the development of social work in South Africa was driven by a need to deal with poverty (Drower 2002:8). Under the rule of the Nationalist Party, a period of racial segregation of society as well as government departments began in 1948. Racial discrimination was reflected in the welfare policy, service delivery and the training of social workers (Drower 2002:8). In the early 1950's the Department of Social Welfare had its responsibilities for Black and Coloured people transferred to the Departments of Bantu Administration and Coloured Affairs respectively. A separate Department of Indian Affairs was formed in 1961 to cater for the needs of Indian people. The segregation of services along racial lines perpetuated discrimination and meant that blacks, who had the greatest need, received the smallest portion of the welfare budget. Patel (2005: 71) notes that, in 1990 whites, who made up 13% of the population received 23% of the welfare budget. Blacks, who made up 76% of the population received 52% of the budget.The decentralisation of services resulted in duplication, inefficiency and conflicting standards for service delivery (Brown & Neku 2005:303).

Although South African social workers adopt the same professional values and ethics as social workers abroad and although social work in South Africa has its roots in religiously inspired voluntary work, the fact that social work was initiated, supported and legitimised to address the needs of "poor whites," the profession has gained an image as an "apartheid tool" that was used to promote racial segregation and marginalisation of previously disadvantaged groups (Earle 2008:22). The principle approach to social work during the apartheid era was the residual approach, with an emphasis on working with individuals and small groups (Earle 2008:22). During the apartheid era a number of grassroots organisations were formed and flourished. These organisations were youth movements, civic associations and women's organisations.Such groups banded together to form the membership base of the United Democratic Front that was launched in 1983 and spearheaded protests against the apartheid system. Social workers who opposed the current policies began to consider the social development efforts of grassroots organisations as an alternative approach to welfare (Patel 2005:82). Progressive social welfare and development organisations were funded by

sympathetic foreign donors, most of whom were sympathetic to the mass democratic movement. The approach to service delivery was people-centred and participatory. The aims of these organisations ranged from meeting basic needs, promoting empowerment, promoting social justice, focusing on human rights and alternative models of service delivery which could be applied in post-apartheid society. A developmental approach to social welfare emerged (Patel 2005:83).

3.2 The changes in welfare policy

With the advent of democracy in 1994, segregated services were abolished. The ANC government embarked on a programme of "transformation". This included reversing past imbalances through a deliberate process of affirmative action, introducing legislation to support developmental welfare, integration of welfare services, addressing poverty as a priority and developing professional standards for training, education and employment of personnel (Brown & Neku 2005:304).

During the apartheid era, the emphasis in social work had been on improving individual functioning, with minimal consideration of the structural environment (Rautenbach & Chiba 2009: 8). With the abolition of apartheid, the policy behind social welfare shifted to a developmental approach This model was considered necessary to address widespread poverty and underdevelopment in South Africa (Rautenbach & Chiba 2009:8). The philosophy behind social development is to link the promotion of human welfare to economic development (Bak 2004:82). Patel (2005:156) explains that a developmental approach to social welfare aims to promote social change through a dual focus on the person and the environment as well as the interaction between them. The purpose is to promote problem solving in human relations. It includes individuals, families, communities and wider society. It focuses on strengths and assets. Much emphasis is placed on human rights. Self-help and grassroots empowerment of local communities are fundamental ideals (Bak 2004:85). The profession of social work is confronted with a substantial increase in its client population with the move to a developmental approach to

welfare focusing on previously disadvantaged segments of the population (Earle 2008:44).

A report issued by the Human Science Research Council (Earle 2008:23) suggests that the relationship between the social work profession in South Africa and the State is fraught with tension. The implementation of changes has not always been consistent, the practical implementation of the policy has not been clear, there has been a lack of resources for implementing the policy and there has been a lack of forethought regarding the intended and unintended consequences of implementation (Earle 2008:24).

Funding has been drastically affected by changes in South African welfare policy. As casework has been associated with what the government defines as the unpopular residual approach, subsidisation for remedial and statutory casework has virtually disappeared (Earle 2008:26). A developmental welfare approach has been instituted and community work has come to be mistakenly associated with community development. The ANC government changed the subsidisation model from supporting social work posts directly to supporting programmes with outcomes that are in line with the social development policy, incorporating methods of group and community work in preference to case work (Earle 2008:26). Practitioners have complained that the government now controls the whole welfare sector, and agencies are disempowered due to their dependence on government funding. Social workers feel they have to follow the government's dictates, despite their better creative and professional judgement. They argue that those falling within "disadvantaged groups" are not only African, but span all race groups (Earle 2008:27). Despite arguments that a particular approach to social work does not imply a particular method, this policy has not been translated into practice with funding favouring group and community work to the detriment of equally important statutory and casework (Mc Kendrick 2001:109; Earle 2008:28).

Relations between the government and non-government welfare organisations (NGO's) have become increasingly strained. Funding is related to community development programmes, but NGO's have been mandated to

carry out statutory work with no additional funding for this added workload (Earle 2008:24). The whole restructuring process has been implemented without raising funds for social welfare. Of the welfare budget, 90% is allocated to social security, such as pensions and grants and only 10% is used to support welfare institutions (Bak 2004:86). Non-government organizations carrying out statutory work never receive more than 60% of their finance from the government (Bak 2004:86). Previously, responsibility for welfare was seen as a joint responsibility of the government and civil society (through non-government welfare organisations) but government funding to NGO's has been reduced. These reductions in funding have placed constraints on the activities of NGO's which are, none the less, indispensable. Their role has been described as follows, "they are the little legs of the millipede, each one small on its own and theoretically dispensable, but without the collection of little legs, the fat body of the millipede would go nowhere. So with the government and the NGO's." (Earle 2008:28). The HIV/AIDS epidemic has added greatly to the load of statutory work and is placing added strain on these organisations (Earle 2008:45). Salaries have been increased in the government sector with a resultant exodus of social workers from the NGO's to take up more lucrative posts in the Department (Earle 2008:29). The solution does not seem to be to increase the number of social workers employed in government posts however. A situation in which social services becomes state-determined is seen as undesirable and a threat to democracy. There needs to be a healthy tension between the "people helping" and the "society changing" advocacy aspects of social work (Earle 2008:30).

3.3 The image and status of social work in South Africa

Currently the image of social work has come under attack. It seems that the marginalization of social work stems from its history. Mc Kendrick (2001:106) suggests that:

- Social work is associated with apartheid.
- Social work is associated with helping white people.
- Social work is associated with casework and "Social control".

- Social work did not prioritise black poverty.
- Social work was excessively pre occupied with professional status.
- Social workers kept others out of their field.

The extent to which these criticisms are valid is a source of heated debate. Despite a submission to the Truth and Reconciliation Commission, it seems that social work does not enjoy high status in South Africa. The result is a chronic shortage of social workers. With a ratio of 1 social worker for 40 000 people, high workloads, poor working conditions and poor salaries have had the effect of demoralizing social workers (Mc Kendrick 2001:106-107). A study conducted by Schenck (2004:184-195) among rural social workers revealed that they are expected to practice in settings where working conditions are often inadequate. Many organisations lack resources such as transport, stationery, furniture or office space that affords clients' privacy during interviews. There is a lack of adequate supervision and support (Brown & Neku 309; Schenck 2004:184-195). There is also a lack of awareness about what social workers do and what their capabilities are (Schenck 2004:195). Bad working conditions make it difficult to make a difference in people's lives and change the image of social work (Schenck 2004:195).

The exposure of corruption within the Department of Social Development has done further damage to the image of social work. The media have levelled accusations of inefficiency against the Department and against social workers, but the public seem unaware of the limited resources available to social work staff (Earle 2008:32-33). The poor image of the profession is seen as a factor that contributes to unethical behaviour (Lombard 2000:313).

Social work is practiced mainly by women and occupations dominated by females tend to have lower status than those dominated by men (Earle 2008:30; Baron & Byrne 2000:193-195). The low level of pay seems to be linked to the idea that social work is an expression of female community responsibility and that, as women, social workers' salaries are there to supplement those of male breadwinners (Earle 2008:30).

Social work has been declared a scarce skill. In this respect, social workers have been supported by the government (Earle 2008:45). However, several authors suggest that social workers are experiencing a crisis in professional identity (Lombard 2000:313; Mc Kendrick 2001:106; Drower 2002:7; Gray 2000:100-101). It seems that widespread changes in the welfare policy underpinning the profession have led to a questioning of the nature and value of social work (Drower 2002:7; Gray 2000:100). The relevance of social work has been questioned (Gray 2000:101). Social workers may feel ill-equipped to meet all the demands of social development and indeed it is acknowledged that social work alone cannot accomplish the task of development. Part of the policy of social development is that social work will not be carried out by one profession and additional professions have been introduced (Bak 2004:84). Recently several new "professions" have been placed under the umbrella of the South African Council for Social Service professions (SACSSP) along with social work. These include child and youth care, social auxillary workers, community development work, and probation work (the latter are still in process). Some writers argue that these functions are aspects of social work not separate professions (Gray 2000:102-105). Gray (2000:100) states that with the change to community development and the introduction of these newcomers "[T] here followed a powerful political force which preached that what South African welfare needed was not social work but social development." This led to the marginalisation of the profession. Gray (2000: 99-105) hints that social work has been deliberately denigrated. He believes that introducing additional social service professions has had the effect of undermining the profession of social work, rather than supporting it. Lack of clarity about the roles of these newcomers seems to have added to the "crisis of identity" within social work. The role of social work itself and each of the social work methods was not clearly spelt out in this process of transformation (Bak 2004:84). It has been pointed out that social development has never been alien to social work with the profession's emphasis on social justice, poverty alleviation and upliftment of people. These principles are not markedly different from the ecosystemic paradigm that has largely guided and dominated social work practice since the 1970's (Gray 2000:105; Hare 2004: 413-415). Social workers feel unsupported as they strive to meet the growing

demands of the communities they serve. In one study, social workers saw themselves “like earthworms - doing the good job, but unnoticed, unrecognised and undervalued” (Earle 2008:34). Despite the need for social work services and despite the fact that social work has been declared a scarce skill, the profession does not enjoy high status in South Africa and is often affected adversely by the welfare policy and “quarrels at the top” (Earle 2008:34).

The image of social work is damaged by the media (Gibelman 2004: 331). Television conveys an anti-professional, disrespected image of social workers. It implies “anyone can do it.” Once public perceptions are formed, they are resistant to change. Gibelman (2004:332) observes that generally professionals in the legal profession, paramedics, judges and fire fighters are portrayed by the media in a positive light. “But the social worker continues to be portrayed as uneducated and bumbling, if not outright laughable. The perpetuation of this view reinforces prevailing attitudes about social work and its labour force.” She also comments that odd interviews or broadcasts where social workers are interviewed about an issue have far less impact than popular television shows and television shows or films. Popular television shows and movies are not kind to social workers (Gibelman 2004: 333).

The advocacy role of social work may make the profession unpopular. The image of social work may be affected by the so-called “courtesy stigma.” If a person works with a stigmatised group it is as if membership of that group is extended to the helper. That person becomes a “courtesy group member” and becomes the target of whatever negative stereotypes may be associated with the group (Baron & Byrne 1994:411). One social worker explained: “We work with poor, abused, mentally ill people. Isn’t that important? Our society doesn’t value these people, so it doesn’t value those who work with them. Society wants us to keep them quiet, keep them out of the newspapers, keep them out of our homes. Then everything will be fine” (LeCroy 2002:37).

South Africa presents a variety of opportunities for the practice of social work and presents a broad spectrum of needs as the potential focus for the

profession. It is immediately apparent that the practice of social work in South Africa is extremely challenging and demanding and the recruitment and retention of social workers requires urgent attention. One is left wondering why students enter University to enter the profession at all.

3.4 Motivations for studying and practicing social work

Social workers may enter the profession in response to pragmatic concerns. Unlike the majority of professional degrees, social work does not have mathematics or science as admission requirements, making it an option for students who do not have these subjects. Employment is virtually guaranteed. With 37.9% of posts vacant within the government sector, work is readily available. With the salary difference between government posts and NGO's it is likely that the vacancy rate in the organisations is even higher (Earle 2008:49). Additional draw cards are flexible and independent work, personal offices and sometimes vehicle subsidies. Some students choose social work when they discover that they have been unable to gain admission to first-choice courses (Earle 2008: 88). Social work may be seen as a stepping-stone to new horizons. For example, social work skills acquired in South Africa are readily transferable overseas making this field of study an option for those wishing to emigrate (Earle 2008:43). The degree also provides access to other fields of study such as law or psychology (Earle 2008:3). There is also a big drive on the part of the government to give subsidies and bursaries to students.

Some students choose the profession after career guidance or in response to suggestions from family (Earle 2008:88). Students may be motivated to pursue social work because of personal involvement in community projects or having personally received social work services (Earle 2008:88). Students may enter the profession because of awareness of the social needs in their own community and seeing addressing these needs as a key reason for studying social work (Earle 2008:89). It has been noted that in many rural African communities social workers command respect and enjoy a higher level of status than other employees in these areas and this may be an additional motivator to study social work (Earle 2008:91).

It seems that social workers who are respected and happy in their work are motivated by intrinsic rather than extrinsic job rewards (Earle 2008:91-920). It seems that many social workers are motivated by the desire to meet existential needs. Social work presents many opportunities for individuals to actualise altruistic values. These seem to be key factors in fuelling compassionate care and enabling social workers to persist in the work they do despite the difficulties (LeCroy 2002:142-143). The belief that they are making a difference seems to motivate social workers to keep working despite lack of monetary compensation (Earle 2008:27). In fact, many social workers enter the profession despite the poor pay. Social workers who enjoy their work seem motivated and inspired by a sense of meaning and purpose. A core theme running through the reasons for working as a social worker is the belief that it is “a calling”. The meaning of this concept was explored in a series of interviews by LeCroy (2002). The voices of social workers recorded in his report speak for themselves:

Some enter the profession because some experience disturbed or upset them in their own backgrounds and stirred a desire to do things differently. “Growing up in my family... I felt that people weren’t emotionally or psychologically invested in what was going on with me... I wanted to provide people with the opportunity to express their emotions and feelings in a place where they were going to be heard. That is what got me into social work.” (LeCroy 2002:21).

Some social workers seem motivated by a desire to give something back after experiencing personal pain, particularly if help had been offered by a social worker. One practitioner expressed it like this:

“I was a foster child and realised everything before had been really, really bad. It was the reverse of what most children in foster care experience. They say they get in the system and it ruins their life. I never looked at it that way. I looked at the system and the people in the system as giving me life. One lady I knew in particular was what you’d call the ideal social worker. She could talk

to you and there'd be forty other people trying to get her attention, but you were the centre of her world... That is how I became a social worker" (LeCroy 2002:31).

Being a victim of social discrimination or being aware of discrimination seems to inspire a social conscience within some social workers. Some are motivated by their desire to engage in work that has significance to the nation. This sentiment is expressed in the following quotations:

"I am an advocate for social change. I want to change the world and make it a safer place" (LeCroy 2002:28).

"Social work is a calling, a call to do something. There is a restlessness inside of you and you have the opportunity to deal with that restlessness. That restlessness has to do with injustice in the world, specifically the world of our community, of our state, of our nation" (LeCroy 2002:62).

Some social workers see social work as a way of fulfilling personal spiritual goals. "I know I am in the centre of God's will for my life. He is my boss and although I honour and abide by my daily supervisor the real joy I have in doing social work comes from Him. He gives the power, strength and joy. There is a great reward in the work I do for Him" (LeCroy 2002:57).

For some, practicing social work is part of a personal healing journey. Personal pain is seen as equipping one for the task of social work:

"I did a lot of drinking in those years... I have done a lot of therapy on family of origin issues, relationship issues and everything else over the years... there is a phrase that "the curse becomes the blessing" from a book *The Wounded Healer.* That is how I think of myself now – as a wounded healer" (LeCroy 2002:113).

Social workers seem inspired by the sense that their lives have meaning and purpose. Immersed as they are in client's struggles, social workers seem

guided by questions about the meaning and significance of their lives. Questions such as “why do I live” and “how do I live” seem to surface. By asking such questions, social workers seem to get closer to living an authentic life (LeCroy 2002:154). Social workers seem to take delight in experiencing joy and pain with others and social workers express deep satisfaction in the changes wrought in the lives of others through the relationship itself (LeCroy 2002:155). Indeed, social work may be regarded as a significant privilege (LeCroy 2002:151):

“It still goes back to the care thing. I need to do something that matters, matters to somebody else and matters to me, something that has value. That is a demonstration of caring. That comes in many ways. It could be a one-to-one thing with a kid or a family. It could be advocating... When I think back that is why I originally went into social work” (LeCroy 2002:P35).

The motivations for studying social work reflected in these words are many and varied but there is a core theme of desiring to make a difference, help others and feel one’s life and actions have meaning and purpose. One is left with a sense that the strength of the profession lies within social workers themselves.

3.5 The training of social workers

Previously social work was dominated by white females, but currently the demographics have changed and most social workers are black women (Earle 2008: vii). By September 2005 the SACSSP had 11 111 registered social workers of which 465 (4, 2%) were non practicing. A number of social workers are self-employed in private practice (11, 4%). By November 2009, 14 000 social workers were registered in South Africa (SACSSP).

Becoming a social worker entails completion of a four-year degree, followed by registration with the SACSSP. In 2006 fifteen tertiary institutions, (apart from Hugenout College which is affiliated to Unisa) offered training in social work. The degree is professional in nature. Key components are social work theory, social work practice, research theory and completion of a research

project. Theory is learnt in the classroom or, in the case of Unisa via correspondence, while practical work is undertaken at a variety of welfare organisations, under supervision (Earle 2008:780).

Training at various institutions has been diverse, but as from 2007 a Bachelor of Social Work (BSW) will be offered at all training institutions. The requirements are that 50% of modules taken will be in social work, while the remainder comprise electives from fields such as the humanities, law, economics, public health or administration. Both theoretical and practical components or social work are incorporated into curricula as well as research. The change to a BSW has generally been welcomed. It seems that the revision of the qualification has provided an opportunity to reflect on key issues, such as the pursuit of Africa – specific knowledge within curricula, the development of a problem-posing approach to education, how to cater for students from diverse backgrounds, increasing the uniformity of social work curricula nationwide and complying with Global Minimum Qualifying Standards for social work as outlined by the International Federation of Social Workers. The new curriculum offers the opportunity to prepare students to be developers of policy rather than merely implementers thereof. Efforts are being made to equip students with skills that are consistent with a developmental approach to social work and opportunities can be created to equip students with the financial and project management skills needed to manage the budgets of welfare agencies and community projects (Mamphiswana & Noyoo 2000:22-28). Most students are drawn from previously disadvantaged communities (Earle 2008:3).

3.6 Unisa's Department of Social Work as a training institution

The University of South Africa (Unisa) is at present the largest distance learning institution in South Africa. It caters for students of all creeds and cultures within South Africa, Africa and abroad. It offers qualifications at tertiary level. It also promotes and conducts research and community engagement. The main campus is located in Pretoria South Africa. There are a number of regional learning centres. The Department of Social Work offers training for a professional qualification as a social worker. Practical training is

gained by attending workshops at one of five regional centres. In their final year, students apply the methods of social work, namely casework, group work and community work at welfare agencies, under the supervision of qualified, Unisa appointed supervisors.

At residential universities the number of places for social work are limited so non-academic selection criteria can be imposed. However, Unisa is an ODL institution. This means that non-academic selection criteria cannot be applied in the admission of social work students, so places are theoretically unlimited. Unisa appears to attract working students, students from rural areas, students from disadvantaged backgrounds, those who cannot access residential universities and disabled students. There are those who are under the impression that social work carries prestige and may not be passionate about social work (Earle 2008:93). The extent to which this situation is desirable is debatable. Respondents in Earle's study (2008:93) indicated that there are characteristics that make a good social worker or prospective social worker. There were:

- A person with a heart for people.
- A person with a desire to help others.
- A person with an ability to listen.
- A person who wants to make maximum use of minimal resources.
- A person who is good at making decisions.
- A person who can think on their feet.
- A person who can communicate.
- A person who can work with diverse people.
- A person who is emotionally balanced.
- A person who is not carrying personal "baggage".
- A person who does not suffer from mental illness.
- A person who has a sense of personal responsibility.
- A person will never think there is nothing to be done.

Social workers who entered the profession for status or prestige were seen as those most likely to leave or give the profession a bad name. It seems very important that social workers have a passion for their work (Earle 2008:91).

Training at Unisa is based on the person-centred approach. Students are exposed to the use of the person-centred approach in interaction with individuals, groups and communities. Staff in turn attempt to apply the principles of the person-centred approach in their interactions with students. Theory and practice are integrated. The staff endeavour to foster growth in the students and facilitate the development of a person-centred professional self. This approach to training echoes the findings of LeCroy (2002:149). He emphasises the need for sound theoretical knowledge and skill, but believes that being a competent social worker entails more. He states: “I now know that the work of social workers transcends knowledge and skill. It is often carried out in the form of a calling, a calling that is different for each person but that carries meaning and purpose into the activities of the social worker. It may be important to help people find that meaning so they can persist in the difficult job of social work, develop their true selves or find a greater connection between their work and their existence in the world” (LeCroy 2002:149 emphasis added). The person-centred approach to teaching aims at precisely this self-development.

3.6.1 The principles of participatory, person-centred learning

As part of the distance-education programme theory is taught via correspondence. Students receive study guides and purchase textbooks or access study material online. Progress is monitored via assignments and examinations.

Practical training in social work at Unisa is a participatory learning process. It involves participation in workshops as well as, in fourth level, supervised work with clients at welfare agencies. In participatory learning, students learn together and from one another by engaging in meaningful interaction. It is a process in which the “instructor” plays a facilitatory rather than a teaching role (Louw 2002:49). An effort is made to model the principles of the person-

centred approach in the workshop. The following principles for student-centred learning have been formulated (Rogers 1969:157-166; Louw 2002: 49-51).

- **Human beings have a natural potential for learning**.

This means that people are curious and want to explore. This potential can be released in an atmosphere of trust and respect. The dignity of students needs to be valued and preserved and students should not be humiliated or laughed at.

- **Significant learning takes place when the subject matter is perceived by the learners to be relevant to their purpose and useful to them.**

Learning is person-centred if it responds to the needs of the learners. Learning takes place more readily if it starts with and builds on what people already know. Learners have a wide field of experience and peers can learn from each other (Louw 2002:50). Importantly, the facilitator can learn from the group and his or her voice is not seen as authoritative, but as one among many in the group because learners are respected as knowledgeable. Learners and facilitators are regarded as equal, mutual participants in the process.

- **Learning that involves a change in self-organisation – that is a change in the way one perceives oneself – is perceived as a threat and tends to be resisted or avoided.**

This implies that if one's values are challenged or tension between values or perceptions becomes evident to a person, learning may be resisted.

- **Learning that is threatening to the self takes place most readily when external threats are reduced.**

This safe environment can be created through allowing the learner to engage in self-directed activities and allowing the learner to evaluate him or herself, rather than imposing external evaluation criteria.

- **Much significant learning is acquired experientially, that is through doing.**

The Department of Social Work aims to make participation in workshops is an active process in which students are free to engage in creative activities, role-plays and discussion.

- **Learning is facilitated when the learner participates responsibly in the learning process.**

When learners choose their own direction, formulate their own needs, discover their own resources and live with the consequences of their choices, learning is maximised. The facilitator is not seen as authoritative and informed while students are passive recipients of knowledge and skill. The facilitator becomes a participant-learner **with** the group.

- **Learning that is holistic, involving intellect, feelings and the self is most lasting and pervasive.**

Learning that involves the whole person, that elicits emotion or touches values tends to be lasting and all-encompassing. Therefore, the facilitator strives to respond to feelings and implied meanings as expressed.

- **Independence, self-reliance and creativity are fostered when self-evaluation is more important than evaluation by others***.*

At Unisa, academic standards have to be met to obtain the degree. Examinations and assignments are set and marked.

With practical work, students are involved in a process of self-evaluation and marks attained are a reflection of collaboration between the student and facilitator. Although this is not as free of evaluative-criteria as Rogers suggests, it enables the Department to satisfy the University's requirements while encouraging student's to engage in self-evaluation and monitoring their own growth.

Students are made aware of course-outcomes. They decide for themselves what they need to learn and an attempt is made to deveope workshop programmes with students, not for them. The facilitator and study guide are used as resources, as well as the students themselves.

- **The most meaningful learning is learning to learn***.*

Students are encouraged to discover how to monitor and direct their own growth. This means that growth and change are embraced. Louw (2002:53) points out that participatory learning is an incremental process that involves action – reflection and planning. People need to symbolise what they know and have learnt. Reflection provides the opportunity to learn from ineffective action and to redirect ones steps into more useful ways of being and acting.

3.6.2 The role of the facilitator

Unisa-appointed facilitators are people who have supposedly integrated the person-centred approach as a way of being. The following guidelines for facilitators have been formulated (Rogers 1969:164-166; Louw 2002: 49-51):

- Create a climate of trust, empathy and respect.
- Explore needs with the learners. There is no need for consensus. Allow diversity.
- Rely on the desire of each student to explore what has meaning for him or her as the motivation for learning.
- Make as wide a range of learning-resources available and allow students to choose what to use.
- The facilitator is a flexible resource of the learners.
- As a facilitator be responsive to both intellectual content and emotional attitudes in the learning situation.
- As a facilitator, be a participant-learner.
- Be congruent. Share thoughts and feelings in a non-imposing way.
- Accept limitations.

3.6.3 The value of participatory learning

Participatory learning takes place through seeing and doing. It is considered effective for the following reasons.

People remember 20% of what they hear 40% of what they both see and hear and 80% of what they discover for themselves (Hope, Timmel & Hodzi 1995 (1): 131). Participatory learning focuses on the development of the learner. It develops a sense of worth, control and being responsible for ones direction. It encourages participants to see themselves as valued sources of information. It encourages the exchange of ideas and appreciation of diversity. It helps to stimulate initiative and creativity. It fosters accountability. It creates relationships and practices that promote problem solving as well as acquisition of skills and knowledge. It gives participants a sense of pride in their own knowledge, builds potential and self-image and empowers people to gain control over their own learning (Louw 2002:55). In short it is a process that facilitates growth.

Values such as respect, individualisation, self-determination and faith in the creative power of people cannot be taught, they must be embraced. The person-centred approach ideally places students in a context where these values are practiced and experienced to allow students to decide for themselves whether to make their approach part of the self. Lecturers, facilitators and supervisors attempt to create this learning context with students at Unisa.

4 CHAPTER SUMMARY

In this chapter, an overview of the context from which the majority of social work students come has been presented. Three examples of the challenges facing the country were sketched as examples of the challenges facing both society and the professional social worker.

Political changes over the last two decades have led to widespread changes in social policy and South African society as a whole.

South Africa presents a huge variety of needs that are the focus of social work practice. Poverty and unemployment are widespread and carry associated needs such as malnourishment, lack of access to healthcare and education and family stress. The burgeoning HIV/AIDS epidemic carries with it an unprecedented demand for social work interventions to deal with the needs of the sick as well as the growing number of children requiring statutory interventions. Crime figures have escalated, creating a need for crime prevention as well as trauma counselling for victims.

Changes in the welfare policy have created confusion about the precise role and nature of social work. Although the image and status of the profession is poor, dedicated and enthusiastic individuals respond to the challenge and pursue social work as a “calling”. The strength of the profession seems to lie in the intangible human qualities of the social workers themselves.

Training as a professional social worker requires the completion of a four-year university degree. Such training is offered at Unisa. The philosophy of Unisa’s training in social work is person-centred. Theoretical training is offered via distance education. Practical training takes place in workshops that are participatory in nature. Practice skills are implemented in the field under supervision.

Part of becoming a competent social worker seems to lie in the development of the self and this growth transcends knowledge and technique (LeCroy 2002:143). The aim of the course at Unisa is both to enable students to gain theoretical knowledge and practical skill and to integrate the values of social work. The latter concerns facilitating growth of a person whose conduct is ethical and professional - a person who is inspired by a sincere desire to empower others and serve clients with empathy, respect and confidence in their potential. These principles are the cornerstone of the person-centred approach.

CHAPTER 8

THE RESEARCH PROCESS

1 INTRODUCTION

In this chapter, an account of how the research process unfolded will be presented. The researcher planned each step, implemented the plan step by step, reflected on the outcome of each phase and planned the next step, modifying the plan in response to feedback as each stage of the research was executed. The execution of each stage is presented in *italics*. The theory and implementation of the research is presented in this chapter.

2 THE RESEARCHER'S BACKGROUND

In terms of the person-centred approach, the self of the researcher and the self of the research participants evolve in interaction with each other (propositions 9 and 10). For this reason, the researcher's background and growing awareness of the problem will be described.

The researcher practiced for many years as a physiotherapist. She was involved in a serious car accident and sustained injuries that prevented her from pursuing her occupation. She registered at Unisa to make a career change possible. She graduated from Unisa's Department of Psychology with a Master of Science in research psychology. This qualification did not meet her expectations and she studied social work in order to work as a facilitator and helper with people suffering from chronic pain, expecting to bring her various fields of knowledge together. The researcher is a graduate from Unisa's Department of Social Work. She is in private practice as a social worker and, at the time of the research, was employed part time as a supervisor at Unisa's Department of Social Work. She completed a three-year certificate course in Logotherapy from the Victor Frankl institute in the United States of America. She is a white woman, married with two children.

The researcher had studied the person-centred approach as an undergraduate in social work. This had given her a growth-orientated perspective. She had come to view problems as goal directed attempts to satisfy needs. She had come to respect the uniqueness of people and believed that in a climate of empathy, congruence and unconditional acceptance or positive regard, people can be trusted to make constructive choices. The researcher was also influenced by her training in logotherapy. Logotherapy emphasises, in particular, that painful experiences have meaning and can be opportunities for growth. Logotherapy suggests that people may use their difficulties to discover a meaningful path in life and that one's distressing experiences may equip one for a life task. She perceived trauma as a violent encounter with man, nature or machines.

The researcher wished to expand her knowledge of family therapy. She joined the MA (Mental Health) class for non-degree purposes, as part of her doctoral studies in social work, to gain tuition and supervision in the field of family therapy. This training enabled her to implement the principles of the person-centred approach, as well as principles of the strategic, structural and Milan schools of therapy.

2.1 The researcher's growing awareness of the problem

The researcher became involved as a part-time staff member in the department of Social Work at Unisa, marking assignments and examination scripts and facilitating workshops. As she marked a particular assignment, submitted by the first-level social work students, the sheer volume of distressing experiences described by the students astonished her. Students disclosed their experiences of poverty, exposure to crime, violence, sexual trauma, childhood neglect, family break-up and the effects of HIV/AIDS. The assignment alerted the researcher to the apparent extent of trauma encountered by social work students studying at Unisa. It appeared that many students had been exposed to multiple stressors. The researcher wondered how these experiences impacted the students. The DSM-IV TR criteria for post-traumatic stress may be a useful model for understanding isolated traumatic events. However, its usefulness for capturing

the effects of repeated trauma appears to be limited (Friedman 2006:19). Most studies indicate that exposure to multiple traumas makes coping harder (Friedman 2006:11; Naparstek 2006:58).

As this was discussed, one of the senior staff members, Professor Schenck, expressed concern that many students seemed unable to express empathy, a skill that is central in the person-centred approach, but some students seemed "emotionally numb." On the other hand, other students seemed to be overwhelmed by strong emotions when working with particular clients. The researcher and Professor Schenck wondered whether there is a connection between the trauma described in students' personal history and dissociation, a well-established response to trauma. On the other hand, both wondered whether some students were perhaps experiencing trigger reactions in response to their own personal trauma. These concerns gave direction to the study. The aims of the research were discussed in Chapter one. The research question was formulated as follows: **What are the experiences and effects of trauma in the lives of Unisa Social Work Students?**

The aims of the research, as formulated in Chapter 1 were:

- To provide a context in which students' frame of reference regarding trauma could be heard and respected.
- To gain increased knowledge about the nature and extent of students' traumatic experiences.
- To provide information about the perceived impact of students' trauma on the developing self as a social worker.
- To contribute to students' well being by making this knowledge available to the Department of Social Work for use in developing training and/or services that could promote students' well being and professional development, if needed.

- To transform the finding into a theoretically relevant description, exploring contradictions and commonalities with published research as noted in the literature survey.

The researcher adopted the person-centred approach as the theoretical framework for the research. A mixed paradigm was chosen to answer the research question from a variety of perspectives which would complement each other. The research design encompassed a literature survey and practical component. The steps in implementing the research are the subject of this chapter.

3 THE LITERATURE SURVEY

A hermeneutic method of data analysis was chosen to analyse the qualitative data. Coherence between this method and the person-centred approach were discussed in Chapter 3. A hermeneutic analysis requires that the research phenomenon be considered in light of the wider social, cultural, historical, theoretical and current context. These concerns gave direction to the literature survey that was presented in the preceding chapters. The literature survey is an integral part of research. It is not complete at any point in the research process (Rubin & Babbie 2005:120). It guards the researcher against selecting an irrelevant or outdated topic by identifying what has already been done. Some researchers argue that, in inductive research, the literature survey should be conducted at the end of the study to avoid biasing the researcher's perceptions (Rubin & Babbie 1997:107). Others argue that this approach is not the most efficient use of time (Rubin & Babbie 2005:121).

O'Leary (2005:40-41) highlights the following benefits of conducting a literature review. Reading enables the researcher to:

- Focus his or her ideas and expand his or her knowledge.
- Develop appropriate questions.

- Argue the relevance of the study.
- Understand and use theory.
- Design suitable methods.
- Construct a literature review.

Becoming aware of ethical concerns could be added to this list. The literature review helps the researcher to identify connections, contradictions and other relationships in existing research (Bless and Higson-Smith 2000:20).

4 RESEARCH DESIGN

Research is designed or planned so that it will provide answers to the research question. Research design encompasses decisions about the purpose of the research, the nature of the data, who will participate in the study, ethical concerns, how data will be analysed, and how results will be made known. These concerns are interrelated (Rubin & Babbie 2005:109). Each aspect will be described with reference to the current study.

There are several ways of classifying research. Some distinctions are drawn on the basis of methodology, whether quantitative or qualitative. A second method of classifying research arises from the purpose of the research (Bless & Higson-Smith 2000:37).

4.1 The purpose of the study

Rubin and Babbie (2005:123) observe that the most common purposes in social work research are exploration and description. Some authors view these concepts as types of research (Neuman 2000:22). In this discussion exploration and description are viewed as the purpose of the research. According to Rubin and Babbie (2005:123) social work studies may have more than one purpose.

Relevance to this study

The current study was both exploratory and descriptive. The purpose was to explore the students' perceptions and experience of trauma in order to present a description thereof.

4.1.1 The goal of exploration

No previous research focusing on social work students' personal experiences of trauma could be found. Rubin and Babbie (2005:123) state that exploratory research is conducted to provide a foundational familiarity with a subject when a topic is relatively new and unstudied. O'Leary (2005: 147) has emphasised the importance of "finding out more" about real world problems. This author states:

"In order to solve problems, you need to understand them. Without knowing prevalence…it is impossible to argue the need for or target solutions. Without understanding the cause… you can't work on prevention. Without understanding effects…. you can't work on remediation. Without understanding who's at risk you won't know who to help. Put simply, you need to understand problems before you can deal with them."

Relevance to this study

There was a need to find out more about social work students' experiences of trauma, making exploration an appropriate goal or purpose of this research. The study aimed to investigate the prevalence of trauma, to understand student's perceptions of the effects of trauma on themselves as professionals and what, if anything, had been done to enable them to cope. This information would be used to consider whether interventions were needed. The connection between these aims and the goal of exploration in the above quotation is obvious.

Exploratory studies are rarely definitive according to Rubin and Babbie (2005:124). They generally point to areas for further investigation or suggest methods by which fuller answers may be obtained. Exploratory research usually

focuses on topics where little is known about a phenomenon. Exploratory and descriptive studies are often combined (Neuman 2000: 22). This was the case in this study.

4.1.2 The goal of description

A major purpose of research in social science is to describe situations and events based on scientific observation (Rubin & Babbie 2005:124). The term "description" is used differently in quantitative and qualitative studies. In quantitative studies "description" typically refers to the development of a profile and the characteristics of a population based on quantitative data acquired from a representative sample of the population. Characteristics studied are usually surface attributes that can be easily quantified such as age, sex and income. These are assessed, coded and used as data. In qualitative studies the term "description" refers to "conveying what it is like to walk in the shoes of people described" (Rubin & Babbie 2005:125). The meaning and context of a phenomenon are disclosed. The emphasis on comprehending the meaning that individuals or groups attach to their experiences as perceived by the subjects themselves is one of the defining differences in quantitative and qualitative research. In quantitative research, efforts are made to control variables to ensure generalisability of the research findings. In qualitative research a holistic stance is taken in which the context is included to provide rich descriptions of the subjects' world (Rubin & Babbie 2005; 123). Data is usually linguistic in nature and may be acquired from questionnaires, interviews or direct observation.

Relevance to this study

Problems can be described in terms of a numerical profile or in experiential terms. It was decided to present a picture of students' experiences in both quantitative and qualitative terms. The quantitative data would be used to present the prevalence of trauma in students' lives, while the qualitative data would be used to describe how trauma is perceived. It was necessary to choose a paradigm through which access to both types of data could be obtained.

4.2. The use of a mixed paradigm

O'Leary (2005: 145) points out that when existing data and records are unavailable, primary data needs to be gathered usually by conducting a survey. Primary data may also be collected by means of interviews. Survey data is summarised using statistical procedures to present a numerical picture of the phenomenon of interest. Although descriptive statistics yield a profile of the population, quantitative data says nothing about the experience of being traumatised or the meaning that participants attach to their experience. Trauma is not encountered in isolation, but in the context of a particular life and culture, with unique beliefs, relationships, goals and dreams. This makes each person's encounter with trauma uniquely his or her own. Meaning cannot be measured. A qualitative approach, with its emphasis on understanding meaning in a particular context was deemed to be the appropriate way by which the meaning and definition of trauma could be explored and described.

Atkinson and Heath (1987:10) argue that there is room in the sciences for multiple methods of exploration. These authors suggest that is it necessary to explore alternative strategies in research, each with its own rules for discovery and verification. Use of multiple sources of data is known as "triangulation." Triangulation involves collecting data in as many different ways as possible and from as many diverse sources as possible (Kelly 2006b: 287). "Triangulation" is a term borrowed from surveying the land that says looking at an object from several different points gives a more accurate view of it" (Neuman 2000: 521).

Relevance to this study

In this study a survey was conducted to assess the prevalence of trauma. Descriptive statistical procedures, with their emphasis on proportions and percentages were deemed to be a suitable method by which a profile of traumatic events experienced by students could be obtained. An understanding of the unique meaning and descriptions of trauma could not be accessed using quantitative methods so a qualitative approach, with its emphasis on

understanding and empathy was considered to be a suitable means by which this data could be accessed. Interviews were conducted to yield qualitative data.

4.3 Ethical concerns

As research is planned, attention must be given to ethical concerns. Rubin and Babbie (2005:71) point out that research in Social Work often represents an intrusion into people's lives and asks participants to reveal personal information. Such requests may be justified because of the benefits of research, but information should never be obtained at the expense of the well-being of the participant. Ethics guide the actions and behaviour of the researcher.

4.3.1 Doing no harm

A fundamental principle that underlies all ethical research is that the welfare of participants should be protected. Researchers in the medical and social science fields have an ethical responsibility to make sure that they protect the rights of their research participants (Griffin, Resick, Waldrop & Mechanic 2003: 221). They do so by minimising the risk of harm and maximising the potential for benefit for their participants. In practice, this means that the risk of harm to someone taking part in the study should not be greater than the harm he or she would encounter in the course of his or her normal lifestyle (Barret 1995:29).

Relevance to this study

The topic under investigation was sensitive and could call to mind experiences that participants generally do not think about. The issue was discussed with the researcher's promoter and senior staff in the Department of Social Work. The conclusion was reached that working with clients could also trigger memories of personal trauma and that the risks inherent in the research were no greater than those encountered in the practical work as student social workers. However, no effort would be made to probe for unsymbolised experiences in the research (Lintvelt 2008:22). Participants were never asked to go into detail describing their own experiences (Griffin et al 2003:226).A safe place was created during the

research for participants to disclose their experiences. Provisions were made for follow up if needed.

4.3.2 Privacy, confidentiality and anonymity

Privacy is defined as that which normally is not intended for others to observe or analyse (Strydom 2002:67). Privacy relates to personal privacy. Unless disclosures of sensitive information is crucial for the research goal, it should not be included in the measuring instrument (Strydom 2002:64).

In the social sciences, much research cannot be carried out without some invasion of privacy. This should be negotiated with research participants and their willingness to co-operate or refusal to participate must be respected (Strydom 2002:69).

One way of protecting a research participant from harm is by protecting his or her identity. A participant is regarded as anonymous if a particular response cannot be identified as his or hers, even by the researcher. In the case of confidentiality, it is possible for the researcher to identify a given participants' response, but the researcher undertakes not to do so publicly (Rubin & Babbie 2005:79; Strydom 2002:68). Anonymity is not possible in the case of face-to-face interviews, but confidentiality can be maintained. Information given anonymously ensures privacy (Strydom 2002:67). These issues may be covered in a covering letter attached to questionnaires or should be negotiated with research participants (Strydom 2002:69; Rubin & Babbie 1997:349).

Relevance to this study

The research could not be carried out without some intrusion on the privacy of participants. Therefore it was imperative that participation was voluntary. The researcher introduced herself and told students her background. The purpose of the research was explained as well as procedures for data gathering. All participants were given a covering letter explaining the purpose of the research.

Anonymity was guaranteed. All names have been changed in this report to protect the identity of participants. The location of participants in focus groups is not disclosed along with quotations from these groups to protect the identity of those concerned.

4.3.3 Informed consent

All participants should be aware that they are participating in a study and consent to participate must be obtained. Participants should be informed about the nature and goals of the study and be aware of risks to themselves if any. Sponsoring agencies, if any, should be identified. Participants should be informed about the credibility of the researcher (Strydom 2002:65).

Some researchers have voiced concern that participation in trauma research poses a relatively high risk of harm for participants, especially when the study relates to their traumatic experiences (Griffin et al 2003: 221). Participants may be unable to gauge the degree of distress they may experience and this may imply that they are unable to give fully informed consent (Templeton 1993 cited by Griffin et al 2003:221). However, participants who actually participated in a study on trauma indicated that the majority of women found participation in the research to be a positive experience (Griffin et al 2003: 222). Griffin et al (2003: 226) found that participation in trauma research by survivors of sexual and physical assault did not induce detrimental effects. On the contrary, the experience was viewed as a positive and interesting experience. The finding was true even of participants who displayed strong symptoms of PTSD and in both acute and long-term survivors. The majority of participants reported that they would be willing to participate in a similar study again The researchers concluded: “It seems these data support the growing consensus that research participation for trauma survivors is not harmful and may result in positive perceived benefits” (Griffin et al 2003: 227).

Although researchers are obliged to guard against harming participants, physically or emotionally, effects of a study may be unintended or unanticipated. For example, in social work research, participants may be confronted with aspects of themselves they do not normally consider and may be distressed thereby (Rubin & Babbie 2005:71). Should consequences arise from participation in the research, the researcher should identify and correct the consequence (Barrett 1995:29).

Relevance to this study

Participants gave written consent to participate in the research. Safeguards implemented by Griffin et al (2003:226) were in place. Participants were never asked to go into detail describing their experiences. Participants took frequent breaks. The right to withdraw or not participate was emphasised and respected. The second focus group provided an opportunity for de-briefing. Follow-up counselling was available and participants were informed about these resources. It is believed that the researcher took adequate steps to ensure that no participant was harmed by participation in the study.

4.3.4 Debriefing

The researcher should discuss participants' experience of the research with them so that unintended effects of the research can be identified and monitored. Any required intervention should be made available (Barrett 1995:31).

Relevance to this study

The research was conducted in the context of a workshop so that the effect on the respondents could be monitored. Follow up counselling was made available to all participants if the need should arise.

4.3.5 The right to withdraw

Researchers should make it clear to participants that they have the right to withdraw from the research at any time. Subjects also have the right to withdraw

consent and demand that data pertaining to themselves be destroyed. Participants are entitled to withdraw without any implied deprivation or penalty for refusal to participate (Barrett 1995:32).

Relevance to this study

The right to non-participation or to withdraw was emphasised. In the end, some students did not take part in the study. Others took part by completing the questionnaire, but were unwilling to be part of the focus groups, where anonymity in relation to colleagues could not be maintained. This indicates that students felt free to decline participation if they desired to do so.

4.3.6 Integrity of the researcher

Researchers must ensure that they are adequately skilled to carry out the research. Reports must be honest and errors should be revealed to prevent others from making the same mistakes (Strydom 2002:70).

Relevance to this study

The researcher was skilled in counselling trauma survivors as well as in conducting research. She had practical, supervised training in social work, both as an undergraduate and as part of the Masters level group in mental health at Unisa so she was able to deal with people distressed by trauma. She had obtained a Masters degree in research psychology, so was deemed competent in research. Nevertheless, this was not a perfect study. The process of the research has been described fully. Limitations have been discussed in the closing chapter of this report.

O'Leary (2005:61-68) has emphasised the personal ethical responsibility of the researcher to carry out the research with integrity so that conclusions are not tainted by error or bias. She stresses the need for researchers to recognise and acknowledge their own biases. The researcher should be sensitive to issues, such as race, class and gender. A conscious effort must be made to empower

silent, marginalised voices. She points out that the research-setting may lead to the researcher being perceived as holding a position of power that could undermine trust, biasing the results. Researchers must withhold judgement, particularly when conducting cross-cultural research. It is important to appreciate diversity and hear the marginalised respondents to preserve the completeness and integrity of the report. She recommends checking one's understanding with "insiders," especially in cross-cultural research. The closer the interaction between the researcher and participants the more salient these concerns are likely to be.

Relevance to this study

The person-centred stance adopted in the study ensured that all respondents were treated with respect, regardless of race or gender. The researcher reflected on cross-cultural issues and these were explored in the focus groups.

The researcher has a responsibility to ensure that the methods chosen for the research are suitable and that reliable valid results are produced. The choice of data gathering tools, research participants, treatment of the data and limitations of the study should be disclosed (Du Plooy 2000:116). These matters are discussed in the sections that follow.

5 THE RESEARCH POPULATION

O'Leary (2005: 86) explains that the answers needed to answer the research question are held by a population, that is "the total membership of a defined class of people, objects or events." However, it is seldom practical to study an entire population. The alternatives are to select a sample or use a case study. The use of a "representative sample" is favoured if the goal of the research is generalisation to the population as a whole. However, in the case of qualitative research or case studies, broader applicability may still be a goal of the research, but direct applicability to the population as a whole (generalisation) may not be possible, due to the nature of the data and type of study. In this case the goal is

“transferability.” This term is defined as “whether findings and/or conclusions from a sample, setting or group lead to “lessons learned” that may be germane to a larger population, a different setting or to another group”(O’Leary 2005: 75). A detailed account of the research setting and methods should be presented to enable readers of the research account may determine the applicability of the findings to other contexts (O’Leary 2005: 70). In this study the aim was not to test hypotheses or generalise to all social work students, but to describe and understand the students’ own perceptions of what constitutes trauma and how they perceive their own experiences to impact their studies. It was assumed that the lessons learned from one class could be relevant to other classes of Unisa social work students and highlight needs and perspectives that may require further study.

O’Leary (2005:86) suggests that the goal in the conduct of rigorous research is to determine the best possible means for credible data collection. The answer to research questions found in the real world may be revealed by “insiders” or those with direct experience of the phenomenon of interest. O’Leary (2005: 78) writes: “Finding answers is reliant on finding those who hold answers.” She states that legitimate answers may be accessed from a case study (O’Leary 2005: 79).

A case study is an empirical enquiry that:

- Investigates a contemporary phenomenon within its real life context
- The boundaries between the phenomenon and context are not clearly evident, and in which
- Multiple sources of evidence may be used (Yin 1985: 23 cited in Rubin & Babbie 1997: 402).

Creswell (1998:63) defines a case study as “an exploration of a bounded system of a case (or multiple cases) over time through a detailed, in-depth data collection involving multiple sources of information rich in context”. A “case” is defined as “a bounded system or a particular instance or entity that can be defined by

identifiable boundaries." The same author defines a "case study" as "a method of studying elements of the social through comprehensive descriptions and analysis of a simple situation or case. For example, a detailed study of an individual, setting, group, episode or event" (O'Leary 2005: 79). Case studies are distinguished by their focus on a particular case (or multiple cases in a collective study). Both quantitative and qualitative sources of evidence are used (Rubin & Babbie 2005:440; Fouche 2002: 275).

The goal of case study research is to generate richness and depth in understanding . Exploratory case studies may bring new understandings to light, triangulate other data collection methods and a number of cases may be used collectively to generate new understandings or alternative perspectives (O'Leary 2005: 80). O'Leary (2005: 82) suggests that an analysis of a number of cases promotes representativeness. Using a large number of individuals within the group defined as the case promotes this goal. Data may be gathered from a number of sources and this is known as triangulation. Triangulation enhances the depth of the study and enhances validity.

Creswell (1998: 63) explains that, through an analysis of various types of data, a description of the case emerges. Themes are identified. Assertions about the case emerge. When multiple cases are used, themes within each case are described, yielding a within-case analysis, followed by a thematic analysis across cases called a cross-case analysis. In the final phase, the researcher reports "lessons learned" from the case. Where multiple cases are involved, the study is referred to as "a collective case study."

The criterion for selecting cases for a case study should be" the opportunity to learn," according to Fouché (2002: 275). Sampling in case study research is purposeful (Creswell 1998: 62). Cases may be selected to show different perspectives on the problem, or on the basis of accessibility because the case is unusual.

Selecting the case requires that the researcher establishes a rationale for his or her purposeful sampling strategy. Boundaries must be defined (Creswell 1998: 63). The researcher must be able to justify why those boundaries were set (O'Leary, 2005: 81). Cases may be selected for practical reasons, such as

- The research may be sponsored.
- Accessibility.
- Co-operation from gatekeepers.
- Other reasons for selecting a particular case include intrinsic interest and relevance.
- Ethical concerns shape the selection of cases.

Kelly (2006b: 293) includes the following characteristics of the respondents as consideration when selecting the case. The respondent should have:

- Personal experience of the phenomenon.
- The ability to communicate and describe the experience.
- An openness and non-defensive manner.
- Interest in participating.

5.1 Rationale for choosing a case study

Relevance to this study

In this study it was not known how students defined trauma, nor was the impact of trauma on the student, as a social worker clearly understood. The aim was not to test hypotheses or generalise to all social work students, but to describe and understand the students' own perceptions of what constitutes trauma and how they perceive their own experiences to impact their lives and studies. Variables were too ill defined to make generalisation feasible. However, the results of an in-depth case study could generate transferable findings in terms of "lessons learned" that could illuminate relevant issues and provide rich descriptions that could be applicable to other fourth-level social work classes. A detailed

description of the research setting is provided to enable the reader to determine the applicability of the study to other groups (O'Leary 2005: 70). For this reason a case study was conducted.

The Department of Social Work at Unisa offers training for a professional qualification as a social worker (four-year degree) There were 15,792 students registered for courses offered by the department on 29th February 2008. Not all of these students were studying towards a social work degree, because social work modules can be taken by students from other fields, such as Psychology, Theology, Development Studies and Education. Boundaries for the case were defined. Students participating in the study needed to be completing studies in social work, in particular, not another discipline. The fourth level of study is open only to students who intend qualifying as social workers. For this reason the fourth level classes of 2006 and 2008 were chosen as cases. Students from other levels were not included, because, at first to third level the students were not necessarily social work students and, as stated, the aim of the study was specifically to explore the experiences of social work students. Other criteria were that students needed to be enrolled at Unisa, not other universities. Students needed to give informed consent to participate. Participation was voluntary.

The selection of the fourth-level class was also influenced by pragmatics. Students represented a range of cultures and ethnic groups, coming as they do from all over South Africa, but the students were accessible. Fourth-level students attend workshops at Unisa learning centres, giving the researcher or her co-workers the opportunity to make personal contact. Consent for the research was forthcoming from the gatekeepers who indeed requested that the research should be conducted. The fourth-level class was assumed to be typical of social work students. O'Leary (2005:82) has discussed these considerations in case-selection, placing particular emphasis on accessibility.

In 2006, 106 students were registered for casework. In 2008, 153 students were registered for the fourth-level course in casework (Course code SCK 402 – B). A casework workshop was attended by 106 students in 2006 and 133 students in 2008 at various learning centres. Volunteers from these classes acted as research participants, which comprise dof a group of 98 students in 2006 and 124 students in 2008 who wished to be included in the study. This gave a response rate of 92% and 93% respectively. Reasons for non-participation are not known, because participation was voluntary and no explanation for non-participation was sought.

5.2 Coherence between a case study and the person-centred approach

Case studies are consistent with the phenomenological perspective of the person-centred approach. Proposition 2 suggests that each individual, group or community has a unique perspective so it is not possible to generalise. Generalisation is not a goal of case study research (Creswell 2002:63). Case studies attempt to build a holistic understanding of a phenomenon, and proposition 3 suggests people respond as a whole to their experiences. Case-study research goes beyond the level of understanding that can be attained from a survey (O'Leary 2005: 80). Case-study research relies on a context of trust and rapport for its success, as is consistent with proposition 17 of the person-centred approach.

6 GATHERING RESEARCH MATERIAL

Research material or "data" is defined as "numerical and non-numerical forms of information and evidence that have been carefully gathered according to rules or established procedures" (Neuman 2000: 507). The numerical and non-numerical data provide different perspectives, a process known as triangulation. Triangulation" is a term borrowed from surveying the land that says looking at an object from several different points gives a more accurate view of it" (Neuman 2000: 521). In this study both quantitative and qualitative data were gathered to explore trauma with the students.

The group selected for the case study was too large to allow each participant to be observed directly, therefore the researcher decided to conduct a survey with the group. The survey would be complemented with data from focus group interviews.

6.1 Gathering research material using a survey

Survey research is regarded as the best method for collecting original data from a population too large to observe directly (Rubin & Babbie 2005:283). Surveys and the sampling techniques they employ are not tied to any particular philosophical viewpoint (Fife-Shaw 1995: 100). However, the way in which the sample is drawn will affect the generalisability of findings. Fife-Shaw (1995: 110) states that: “Where the aim is not to estimate population parameters, it may be appropriate to sample groups of people who are most likely to provide insight into the research question.” These considerations indicate that survey research and a case-study are compatible, although results would not be generalisable to the population as a whole. Surveys are flexible in that they are not restricted to particular data-gathering techniques, but may be used in the form of telephone interviews, questionnaires or face-to-face interviews. It is also possible to gather both quantitative and qualitative data within a survey (Fife-Shaw 1995: 100). Surveys are considered appropriate for descriptive studies of a population, so in this study, a survey was deemed appropriate for generating a descriptive profile of the fourth-level class (Rubin & Babbie 2005:283).

The strengths and weaknesses of surveys have been discussed by various authors (Rubin & Babbie 2005:302-393 O’Leary 2005: 104; Fife-Shaw 1995: 100; Neuman 2000: 271-274). Briefly, the strengths of surveys include the following:

- A large number of respondents can be reached.
- The characteristics of a population can be described.
- Multiple variables can be analysed simultaneously.
- Both quantitative and qualitative data can be generated.

- Large samples are feasible within the method.
- Standardised data is generated.

Weaknesses include the following:

- Surveys demand standardisation but there is no guarantee that questions will be interpreted the same way by all respondents.
- Surveys tend to be superficial in their coverage of complex topics.
- Surveys fail to provide information on the context of social life.
- Surveys can only collect self-reports that are difficult to verify.
- Surveys only generate answers to questions that the researcher thought to ask.

Rubin and Babbie (2005:304) point out that the weaknesses inherent in survey research can be offset by combining different research methods. When additional qualitative methods are combined with a survey they can complement each other.

Surveys may be administered telephonically, face to face or via a self-administered questionnaire, each with inherent advantages and disadvantages. The choice of method is influenced by cost and time constraints as well as the characteristics of the respondents. For example, it would be inappropriate to expect an illiterate group to complete a self-administered questionnaire. However, self-administered surveys are cheaper than interviews, they are more cost-effective than interviews when administered on a national basis. Questionnaires are considered more appropriate than interviews when dealing with sensitive issues because anonymity can be assured (Rubin & Babbie 2005:301).

Relevance to this study

In this study the researcher decided to conduct both a survey and focus groups. (The focus groups will be described further on in this chapter.) The researcher

believed that some questions might cover sensitive issues such as child abuse or rape. Therefore, a questionnaire was favoured as the data-gathering tool (Rubin & Babbie 2005:301). The questionnaire could be distributed on a national basis and made it possible to reach students that the researcher was unable to see due to constraints such as cost and time. A questionnaire, compiled in a standardised format would generate standardised data, making comparisons between regions feasible. The weaknesses of the survey would be offset by asking volunteers to participate in focus groups to triangulate the data obtained (Rubin and Babbie 2005:304).

6.2 Compiling the questionnaire

The quality of a survey depends on the quality of the questionnaire on which it is based as well as on the response rate. A questionnaire is "a written document in survey research that has a set of questions given to respondents or used by an interviewer to ask questions and record the answers" (Neuman 2000: 517). Much has been written about questionnaire construction. In compiling a questionnaire, care should be taken to avoid confusion and keep the respondents' perspective in mind.

Bless and Higson-Smith 2000: 113) suggest that, prior to drafting questions. the researcher should list specific research issues to be investigated. The researcher should consider what kind of data is needed to study those issues and only then should questions be formulated. Neuman (2000: 252) describes the formulation of questions as an art. The emphasis is on the clarity and meaning of the questions, and relevance to the respondents. Good questions should be unambiguous, inoffensive and unbiased. Complex terms and language should be avoided. The question should not suggest a desired response or be a "leading question." Double negatives and double-barrelled questions should be avoided. Questions should not be based on premises or assumptions, and should not be beyond the respondents' capabilities and knowledge. Lastly, overlapping categories should be avoided (O'Leary 2005: 107-109; Neuman 2000: 252-255). The questionnaire should form an integrated

whole. Not only is the wording of individual questions important, but the overall layout of the questionnaire should be clear and facilitate answering the questionnaire by including clear instructions. It should be easy to fill in answers unambiguously. The questionnaire should not be overly long. It is recommended that, unless respondents are highly motivated, it should not take longer than 90 minutes to complete. Sensitive items are usually included in the middle, certainly not at the beginning, of the questionnaire (O'Leary 2005: 112-113).

The questionnaire should be tested with a small group for whom the programme is planned and modified in response to feedback. This is known as pilot-testing (Bless & Higson-Smith 2000: 155). A pilot-test enables the researcher to identify any difficulty with the method or materials. Pilot-testing may help to identify any potential difficulties with the analysis (O'Leary 2005: 102). Feedback from the pilot group involves questions about the question clarity, structure, introductory information, instructions and time taken to complete the research (O'Leary 2005: 102). Ethical issues with the research as a whole may come to light in the pilot test (O'Leary 2005: 102).

Bless and Higson-Smith (2000: 116) suggest the following quality checks to be applied to the questionnaire:

- Is the question necessary?
- Is the respondent willing and able to answer it?
- Is the question respondent-centred?
- Will the question mean the same thing to all respondents?
- Is the question unbiased?
- Is the wording unambiguous?
- Is the layout of the questionnaire appropriate?

The feedback from the pilot- test provides the researcher with an opportunity to make changes. If the need for modification is substantial, it may be necessary to start over again (O'Leary 2005: 102).

6.3 Increasing the response rate

One of the concerns of researchers using self-administered questionnaires is increasing the response rate. In quantitative research, the generalisability of results is affected by the response rate, with higher response rates resulting in lower non-response biases. As a rough guide, a response of 50% is considered adequate for analyses and reporting. A rate of 60% is viewed as good and a rate of 70% is very good (Rubin & Babbie 2005:288).

The response rate of questionnaires is influenced by the quality of the covering letter that accompanies the questionnaire, because this is the first thing the prospective respondent reads. The letter should motivate the person to respond. The purpose and importance of the survey should be explained. Any endorsement or sponsorship by an organization should be included. Anonymity should be guaranteed (Rubin & Babbie 2005:79).

7 DESIGNING THE QUESTIONNAIRE FOR THE STUDY

Relevance to this study

The aim of the research was exploratory in nature so primary data had to be collected. The researcher planned to collect both quantitative and qualitative data. The intention was to obtain both types of data from a questionnaire, which was to be mailed to students in 2006. The researcher intended to ask for volunteers to take part in focus groups, to offset the weaknesses inherent in survey research. These plans were modified in response to feedback during the pilot test, as will be explained. The questionnaire and implementation of research was modified as the research progressed.

7.1. The first draft

The procedure advocated by Bless and Higson-Smith (2000:113) was followed to compile a questionnaire. Specific research issues were identified. The type of data needed was defined. The aim of the questionnaire was not to measure trauma nor to generalise to the student population as a whole. Research issues that the questionnaire was designed to address were:

- *To explore how South Africa social work students describe or conceptualise trauma.*
- *To generate a profile of the number of experiences students have had that they regard as traumatic.*
- *To identify what students did to cope with these experiences.*
- *To explore whether these experiences are perceived to impact their work with clients*.
- *To explore whether these experiences are perceived to impact the self of the student currently.*

The emphasis of the study was on the perceptions of the students themselves, in keeping with the person-centred approach (proposition 2). The aim was not to diagnose any disorder or label students, but to understand their perspectives and experiences.

Six third level Unisa social work students, three black and three white students were asked to assist the researcher by listing experiences they viewed as traumatic. These students were assumed to be similar in terms of language ability, experience and culture to student social workers one level higher than themselves at the same university. Each student had experienced something that he or she viewed as traumatic. The list was completed and it was noted that the group had included experiences such as "disruption of relationship with ancestors" and "poverty" that the researcher had not encountered in the literature. Thereafter, the students were asked to list effects of trauma that they had experienced or knew about. This list was used to compile questions

pertaining to the impact of trauma. Thirdly they were asked to list resources for dealing with trauma. All these items were compared with measuring instruments in the literature, namely:

- *The compassion fatigue self test (Figley & Stamm 1996:129-130).*
- *The stress response rating scale (Weiss 1996:311-316).*
- *The impact of event scale revised (Weiss 1996:187).*
- *The TSI life event questionnaire (Pearlman 1996:421-429).*
- *The trauma symptom checklist (Briere 1996:376; Briere & Runtz 1989:151-163).*

These sources were used as a framework for compiling the research questionnaire. Because the emphasis was on the perspective of students themselves items supplied by students such as "caring for a family member with AIDS," disruption of relationship with ancestors," "infertility" and "taxi violence" were included although they did not appear in any of the written resources consulted. Items which were included in resources consulted such as "earthquakes" and "war" that did not feature in students' lists were excluded. In this way a uniquely South African list of possible traumas was compiled. A contingency question for each of the 54 items supplied by the students was compiled. The question gave access to information about whether or not a specific incident had been experienced and whether the respondent had encountered single or multiple incidents of this nature. The respondent was given the opportunity to rate each item on a scale of 1 to 5, where one was "not traumatic" and five was "devastating." This rating scale gave students the opportunity to indicate whether they viewed the example as trauma or not. Space was provided for comments.

Questions relating to demographic details were compiled by the researcher. A statistician was consulted who helped the researcher to build a coding system into the quantitative items with a view to future data analysis. Attention was given

to the layout of the questionnaire. Sensitive items were placed in the middle of the instrument. Thus the first draft of the questionnaire was completed. The first draft of the questionnaire contained both quantitative and qualitative items covering

- *Demographic details*
- *Students' descriptions of trauma*
- *Specific instances of trauma in the form of a contingency question containing both quantitative and qualitative items*
- *A section regarding the impact of trauma*
- *Help received.*

This questionnaire underwent extensive revision, as will be explained.

The questionnaire was distributed to students in fourth level, in 2006. Initially the fourth level class of 2006, comprising only social work students, was chosen as a case study, but plans were revised as the research proceeded. The researcher's intention was to send out a questionnaire by post and then to ask for volunteers to participate in focus groups and/or individual interviews. This plan was modified in response to the feedback when the questionnaire was pilot tested in 2006. The process unfolded as follows.

7.2 The pilot test

In 2006 the first draft of the questionnaire was distributed to 11 MA social work students at Unisa for comment and pilot testing. These students are one level higher than the sample chosen as a case study, so were deemed to be similar to the target population, except that they are in practice as social workers. Although the MA students are qualified social workers, students in fourth level work also with clients under supervision. Therefore both groups are impacted by working with clients and in turn have an impact on the people they see as service providers. Therefore the groups are similar in terms of their exposure to vicarious trauma. The pilot test group made changes to the wording of some items in the

questionnaire, coming from various cultures and communities that differed from the researcher.

The researcher discussed whether the questionnaire should be simplified by asking respondents simply to give examples of their own traumatic experiences, rather than presenting a list of possible traumas. The pilot test group were adamant that, without the list of items in the questionnaire, much information would be lost. They commented that their own inclination had been to give the most recent or most intense examples that could be recalled, but that when specifically asked about particular experiences, they were less inclined to avoid including them. They also believed that it was beneficial to ask specifically about sensitive issues such as rape and abuse that may not be disclosed in a less specific questionnaire. They felt that a more accurate profile of the extent to which students had been affected would be obtained by including the extensive list of examples that made up the instrument. However, the pilot-test group commented that there was a possibility that simply answering the questions could trigger strong emotional reactions in the respondent. The pilot test group suggested that an opportunity for debriefing should be built into the research. The researcher was concerned about the ethics of the research. The matter was discussed with her promoter as well as independent staff members. The risks were assessed and the conclusion was that the requirements of "doing no harm" rests on the notion that the research participant should not be exposed to any risks greater than what he or she would encounter in the course of his or her normal activities. This requirement is referred to by Barret (1995:29). The staff and pilot-test group agreed that students were exposed to trauma in the lives of clients and that in itself could trigger strong emotions, so the risk of harm in the research was not greater than that in the normal course of his or her practical work. However, certain precautions were put in place that modified the implementation of the research. The researcher decided against a mail-survey. The research would be placed in the context of a workshop so that the impact of the research could be monitored. The following precautions were put in place:

- *Certain questions were changed so as to reframe trauma as an opportunity for growth.*
- *A covering letter was compiled informing students fully about the research.*
- *It was decided that students should complete the questionnaire in the presence of the researcher or other qualified staff, so that reactions could be monitored.*
- *Participation would be voluntary.*
- *Students were given the right to withdraw.*
- *The process would be followed by a debriefing session.*
- *Arrangements were made for follow up counselling if needed.*
- *The research would be placed in the context of a trauma workshop. Two focus groups would be conducted, but care would be taken not to access the student's own issues, but would focus on ideas on about trauma. The second focus group would focus on coping with trauma and a strength-based stance would be adopted.*

These precautions were based on ethical concerns discussed previously (section 7.3 of this chapter).

7.3 The first trial in 2006

The researcher was given the opportunity to conduct the research during a workshop on trauma that is part of the curriculum each year. The workshop programme would include facilitation of the learning of skills in dealing with trauma. Arrangements were made with the social work MA students, the Department of Psychology, students in logotherapy at the Unisa Centre for Applied Psychology and Famsa for follow up therapy for any student who felt the need. The researcher ensured that students at each learning centre had a resource available, should the need arise.

The researcher and five other staff members facilitated the workshop in 2006. That year the questionnaire was distributed and 98 students out of a class of 106 completed the questionnaire, which was analysed by the researcher, together

with a statistician. Students' feedback on the workshop was positive and no one seemed unduly disturbed. Two students made contact with the researcher after the workshop. One had a family problem, unrelated to the research, but, when the offer of free therapy was made she decided to make use of the opportunity to resolve the issue and attended two sessions with the researcher. The other student had formerly been in the researcher's class and was struggling to pass his practical work. He felt he was being held back in his practical work and could not understand why. His problem seemed typical of the scenario that had motivated the study. He attended six counselling sessions.

Much valuable qualitative data describing trauma was obtained in this investigation with the class of 2006. Students had worked with some clients and could reflect on the experience. This data was retained for incorporation into this report. However, several problems came to light with the questionnaire that were not obvious in the pilot study.

- *Firstly, several categories in the original questionnaire seemed to overlap confounding the analysis.*
- *Respondents saw some experiences, such as "drug use" and "own suicide attempt," included in the questionnaire, as a response to trauma, not a trauma in itself.*
- *Students added other experiences such as "witnessing a kangaroo court," "being responsible for the harm or death of someone else," "losing a child in a custody dispute" and " political violence" to the original questionnaire, but excluded other items such as "substance abuse."*
- *The original questionnaire was too long. (It took 90 minutes to complete).*
- *One item in particular was interpreted differently by the pilot group, who were qualified social workers and about half the students. The item asked respondents to complete the sentence "when I talk to someone who has had the same experience I…" The pilot-test group assumed themselves to be in the role of the social worker while many students assumed the role of the*

client. This meant that the researcher was not always able to uncover the impact of the experience on the respondent as a social worker.

- *It was difficult to discuss so many discrete instances of trauma. The researcher attempted to group the items, but it was very difficult, because the questionnaire had not been planned that way.*
- *Certain qualitative items about the impact of trauma did not draw a response from most students.*

The researcher reflected on the feedback received during this exercise. She decided to make extensive changes to the questionnaire in the interests of delivering a more credible report and to repeat the study with another fourth-level class in 2008. She decided to view the data from 2006 as a large, preliminary study. The first trial had proved to be a valuable learning experience that had highlighted difficulties with the process. The discussions in the workshop and the qualitative data in the questionnaires sensitised the researcher to themes connected to trauma. The students' feedback was used to compile a new final draft of the questionnaire.

- *Care was taken to make categories discrete.*
- *Categories were grouped into themes.*
- *New items were added and redundant items were eliminated.*
- *The questionnaire was shortened.*
- *The qualitative items were reformulated. Participants were asked to reflect on one instance of trauma and answer questions about its effect.*
- *The revised draft of the questionnaire was pilot-tested by three social workers and no changes were deemed necessary.*

This draft is included in the appendix.

7.4 The final draft of the questionnaire

The final draft of the questionnaire consisted of the following:

- *A covering letter informing participants about the study, with a tear-off slip giving signed consent.*
- *SECTION A comprising eight items about demographic variables and one qualitative item in which respondents described trauma themselves.*
- *SECTION B comprising 47 funnel questions about specific traumatic experiences. Each question asked whether the person had experienced the event, whether one or multiple instances had been encountered and how traumatic the experience was perceived to be. An example is given here.*

<table>
<tr><td colspan="5">19. As a child (under 18) I was physically abused in my home</td><td>OFFICE USE</td></tr>
<tr><td>1 Yes</td><td>2 No</td><td>If no, please go to next question</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">If yes please tick</td><td>1 Once</td><td>2 Many times</td><td></td></tr>
<tr><td colspan="2">1 By a family member</td><td colspan="3">2 By a non family member</td><td></td></tr>
<tr><td colspan="5">Please indicate how distressing the experience was by ticking the scale below</td><td></td></tr>
<tr><td>Devastating
5</td><td>Severe
4</td><td>Moderate
3</td><td>Mild
2</td><td>Not traumatic
1</td><td></td></tr>
</table>

- *Section C consisted of 10 qualitative items about the impact of trauma on the self and how participants coped.*

It took about 40 minutes to complete the questionnaire.

The sequence of questions ensured that students give their own description of trauma before any items suggested by the questionnaire were encountered. In this way the researcher endeavoured to avoid biasing their responses. Sensitive items were placed in the middle.

The questionnaire was distributed during the trauma workshop in 2008. It was combined with focus group discussions held with volunteers during the workshop. The theory behind focus group interviews will now be discussed.

8 GATHERING RESEARCH MATERIAL USING INTERVIEWS

Although descriptive statistics yield a profile of trauma as defined by the researcher who compiled the questionnaire, it says nothing about the experience of being traumatised, or the meaning that students attached to their experience. Meaning cannot be measured. A qualitative paradigm, with its emphasis on understanding meaning in a particular context, was deemed to be the appropriate means by which the meaning and definition of trauma could be studied. Interviews gave access to this data.

An interview involves direct, personal contact between the research and research participant who is asked to answer questions about the research problem (Bless & Higson-Smith 2000:104). Non-scheduled interviews are valuable in exploratory research and in case studies (Bless & Higson-Smith 2000:105). Kvale (1994:106) regards exploratory and descriptive studies, using qualitative interviews as important contributors to social science in their own right. He states that interviews give access to nuances and rich descriptions of the social world. Interviews are commonly used in the interpretive approach to research (Kelly 2006b: 297). With its phenomenological perspective, interviewing fits with a person-centred approach where the participant is best understood from his or her own frame of reference (proposition 7). Interviews enable the researcher to discover how participants think and feel. Interviews vary in their degree of structure; they may be completely unstructured, or compiled like a survey with set questions or semi-structured where a list of key topics serve as a guide.

Principles for good interviewing have been articulated (Kelly 2006b: 299):

- Listen more, talk less.
- Follow up on what the participant says.
- Ask questions to clarify your understanding.
- Invite the subject to “tell me more about that”.
- Explore, don’t probe.
- Avoid leading questions.

- Ask open-ended questions.
- Avoid why questions.
- Avoid asking too many questions.
- Do not interrupt.
- Keep participants focused.
- Ask participants to rephrase when meaning is not clear.
- Tolerate silence to allow participants to think.
- Tape record the interview (consent is required).
- Keep process notes.

Interviews give access to information concerning knowledge, attitudes, beliefs and experiences (Bless & Higson Smith 2000:107).

The usefulness of the interview is influenced by:

- The skill of the interviewer.
- The willingness of respondents to co-operate.
- The willingness of respondents to express what they perceive as their reality rather than what they wish their reality to be, or think it ought to be, or what they think the interviewer wishes to hear.
- The participant must be able articulate his or her answer (Bless & Higson-Smith 2000:107).

In light of these influences, interviews should be conducted in a people-centred way. Factors such as time constraints, fatigue and social norms should be considered. For example, in many African cultures, sexual issues are taboo and may not be discussed in the presence of members of the opposite sex.

Interviews have the advantage of flexibility. The disadvantage is that, if interviewers are not skilled, they may introduce biases. Interviews are time-consuming and costly, because they involve direct, personal contact. Interviews necessarily exclude a large part of the research population. (Bless & Higson-

Smith 2000:108). Recording the interview is a delicate matter and transcription is laborious and time-consuming (Kelly 2006b: 302). It can be difficult to discern the influence of race and gender on the interview. It is difficult to conduct interviews with widely dispersed samples. It is not possible to preserve anonymity (O'Leary 2005:114).

Interviews generate rich in-depth qualitative data and are flexible as a means of exploration (O'Leary 2005:114).
Interviews may be conducted with individuals or groups and some of the constraints inherent in interviewing can be reduced by interviewing groups.

Several objections are commonly raised against the use of interviews in research. Qualitative interviews are frequently dismissed as being "non-scientific." However, Kvale (1994: 150) observes that science may be defined in a number of ways and there is no generally accepted, unequivocal definition of science. "The characterisation of qualitative research as scientific or unscientific will depend on which definition or science is used" (Kvale, 1994:150). He states that if science is viewed as the methodical production of new, systematic knowledge, science becomes the creative search to understand better and uses whatever means are responsive to the research question. Any method that produces understanding that is deeper, fuller or more useful than previous understanding is scientific. He points out that the qualitative interview provides access to the linguistically constructed world. It is often claimed that the qualitative interview may be affected by the biases of the interviewer. However, the effects of interviewer biases may be countered or counteracted by efforts on the part of the researcher to formulate and reflect on his or her presuppositions and to disclose them in the research report.

8.1 Focus groups

The term "focus group" is the name generally given to a group interview. A focus group is a discussion-based interview, involving simultaneous use of multiple

respondents that generates qualitative data (Millward 1995:275). “A focus group is typically a group of people who share a similar type of experience, but a group that is not naturally constituted as an existing social group” (Kelly 2006b: 304). Working with groups can give access to experiences shared by a community of people and can be used to identify differences within the group. Focus groups can be helpful in cross-cultural survey research, where the group can clarify and re-define certain concepts (Millward 1995:278). They are used to aid the formulation of surveys and in their interpretation (Millward 1995:278).
The goal of a focus group is not to serve as a support or therapy group, neither is the aim to gain consensus. The intent is to gather information based on the group’s interactions. Whereas individual interviews capture the ideas of one participant, focus groups produce multiple stories and access diverse experiences (Brown, 1999:112).

The aim of focus groups is to get closer to participants’ understandings and perspectives (Millward 1995:276). One of the assumptions on which focus groups rest is that people will become more aware of their own perspective when confronted with active disagreement. This may prompt the person to analyse his or her views more intensely than during individual interviews (Millward 1995:277). Focus groups have the advantage of decentring the researcher. In this way focus groups provide research participant with greater ownership of the research process (Kamberelis & Dimitriadis 2005:904). Multiple meanings and perspectives are elicited.

8.1.2 The size of focus groups

The intention of focus groups is not to yield data from which inferences about the population as a whole are made, using statistical procedures. Therefore random sampling is not required. The sample is chosen on theoretical grounds (Millward 1995:279). Sample size (*not group size*) varies from 21–744 members. It is advocated that groups comprise 6-8 members. It seems that the data generated after about 10 sessions is largely redundant (Millward 1995:279). Large groups

tend to retard the free flow of conversation and are difficult to tape-record (Millward 1995:281). The participants' convenience and comfort should be kept in mind when a location is chosen. It is recommended sessions should last one to two hours (Millward 1995:281).

8.1.3 The role of the facilitator

Millward (1995:281-286) has discussed the role of the facilitator in focus group research. The facilitator has a crucial impact on the focus group. He or she should be sensitive to the research issues and the need for methodological rigour. The facilitator must be able to elicit a response from the group members. The aim is to draw the participant in to become a co-enquirer rather than a research subject (Kelly 2006b: 304). Facilitation in focus groups rests on participant empowerment. Millward (1995:282) suggests that free discussion in likely in a permissive, non-judgemental climate. It seems the conditions for facilitation as articulated by Roger's proposition 17 and conditions for successful focus groups are the same. Facilitation should focus on process rather than content. Focus group interviews may vary in their degree of structure, depending on the nature of information required. The less straightforward the required information, the less structured the interview (Kelly 2006b: 304). Millward (1995:284) advocates the use of a topic guide, to help the facilitator recall key issues. The guide should not be used as an interview schedule. The facilitator should avoid using leading questions. Open questions are preferred to closed questions because the former invite exploration. The facilitator needs to explore the topic with participants. The facilitator needs to be able to hear the implied message (Millward 1995:285-286). These skills are also inherent in the person-centred approach.

8.1.4 Collecting data

Focus groups may be the sole means of gathering data or supplement other strategies. Qualitative research frequently relies on "texts" as research material that is analysed. "A text is any record of life held over after the moment of its

production for later comprehension and interpretation. This may refer to visual material but could also be artifacts or any remnant of a context which it is the researcher's job to interpret" (Kelly 2006b: 286).

The qualitative data obtained in focus groups is generated from transcripts of audio or video-tapes of the session. Audio-tapes have the disadvantage of missing non-verbal communication, but can be supplemented by notes of the observations made by the facilitator. However, note taking during the session may alienate and inhibit the group members so most researchers rely on audio taped recordings of the discussion supplemented by field notes. Consent for the taping must be obtained from participants (Millward 1995:287). Tapes are transcribed. The data is then analysed.

Brown (1999:110) suggests that focus groups are useful when a line of enquiry has not yet been explored and may be the sole means of gathering data or supplement other strategies. This made focus groups an appropriate method in the current study. Whereas individual interviews capture the ideas of one participant, focus groups produce multiple stories and access diverse experiences. In qualitative research, data analysis is inductive and recursive as data is collected. The goal of the analysis is not to support or reject hypotheses but to generate rich descriptions of the phenomenon or generate theory (Moon et al 1990:362).

9 IMPLEMENTATION OF THE RESEARCH PROJECT IN 2008

In 2008 the researcher was given the opportunity to conduct the research during a workshop on trauma that is part of the curriculum each year. This meant that the research was carried out at five regional learning centres (Cape Town/Western Cape, Durban/Kwa Zulu Natal, Polokwane/Limpopo Province, Bloemfontein/Northern Cape/Freestate and Johannesburg/Gauteng and at the main campus in Pretoria/Gauteng). Students from Mpumalanga usually attend the workshops in Pretoria or Johannesburg, as do students from North west province. Students from Eastern Cape generally go to Durban or Cape Town.

This means that the learning centres accommodate students from all nine provinces. The research therefore covered a wide geographical area and is fairly representative of the country.

Social work students from Unisa are required to do practical work in their communities throughout South Africa under the supervision of Unisa-appointed Supervisors. In addition, they attend workshops at the main campus or at one of the regional learning centres. This research was conducted during one of the practical workshops. As said previously, the philosophy on which this training is based is person-centred. Students studying social work at Unisa are trained to use the person-centred approach, a theory initially articulated by Carl Rogers. The training model used in the department is based on Carl Roger's principles. Carl Rogers formulated tentative hypotheses with respect to ***education and training*****.** Specifically, Rogers (1951:384-388) suggested that the principles of client-centred therapy and the principles of student-centred learning are fundamentally similar. The central theme is that the teaching situation is structured to release the student's inherent capacity for growth. The instructor's goal in student-centred training is to act as a facilitator, who aims to create an atmosphere of acceptance, understanding, respect and empathy.

9.1 The workshop programme

Relevance to this study

An effort is made to implement these principles in workshops offered by the Department of Social Work. By the fourth level, students have been exposed to this approach to learning for at least three years. The research was conducted again at the trauma workshop in 2008 in which these principles were applied. The workshop was planned with the aim of:

- *Enabling students to reflect on trauma and to provide their own definition thereof.*

- *Hearing and meeting student's training needs.*
- *Equipping students with skills to assist current and future clients to deal with trauma.*
- *Obtaining a profile of the students and their experiences for research purposes.*
- *Establishing whether students had found ways of dealing with trauma.*
- *Discussing approaches to dealing with trauma so that the researcher could discover how trauma is dealt with in the South African context.*
- *Providing an opportunity for debriefing after answering the questionnaire.*
- *Providing an opportunity for exploring alternative ways of dealing with trauma (e.g. cultural practices).*

Although the research was conducted during a workshop, participation in the study was voluntary and students who did not wish to participate were not obliged to do so.

The researcher introduced herself and explained her role as facilitator and researcher. The students' right to participate or not participate or to withdraw from the study at any time was explained. The researcher explained the purpose and risks of the research. Consent was obtained to tape record focus groups with participants.

Students' needs were ascertained. Needs revolved around the need to understand trauma, its impact and to acquire skills to assist traumatised clients.

The programme commenced with a discussion about the meaning of trauma and its effects. This was part of the students' own learning, but the discussion was tape-recorded when permitted for the research. Rogers (1951:390) suggests that students are respected as knowledgeable and competent. Usually the group is seated in a circle, or small groups with the facilitator as one of the group. Students are invited to define their needs. The group is used as a resource in

stimulating discussion, free exchange of ideas and practicing skills in an effort to meet the group's own needs. These principles were applied in the workshop.

Students were given the option of participating as research participants or forming a separate learning group. Some students chose to take part as research participants and others did not. This discussion was facilitated either by the researcher herself or, in the case of very large groups, or distant groups, by staff members from the Department of Social Work. All facilitators were experienced social workers who are experienced in facilitating person-centred groups. All were briefed prior to the sessions with respect to the aims of the research. However, training needs of the students remained paramount.

Each session was approximately an hour in duration. This was followed by a demonstration of trauma counselling aimed at equipping students with skills for assisting clients after a traumatic incident. Students were given the opportunity to practice these skills in pairs.
Guiding questions for the first focus group were as follows:

- *What is your understanding of trauma?*
- *Do certain kinds of experience cause more trauma than others?*
- *What makes an experience traumatic?*
- *How do traumatic experiences differ from other experiences?*
- *How do trauma and stress differ?*
- *Are there experiences related to culture that are traumatic?*
- *Are there specific experiences that are seen as trauma in your culture? What are these experiences and what makes them traumatic?*

There was a break. Thereafter, students were able to watch a role play of a session with a client. This was followed by a practice session in which students role played with each other. Thereafter students were invited to complete the questionnaire. The researcher followed this sequence so that students arrived at their own definition of trauma prior to seeing the questionnaire. This format was

followed to avoid influencing the respondents' responses. If they had seen the questionnaire first, they may have attempted to formulate their description in a way that fitted the items suggested by the questionnaire. Students were informed that there would be a break after completion of the questionnaire. If anyone did not wish to complete the questionnaire, this enabled him or her to leave unobtrusively. Participation in this activity was voluntary and anonymous. Out of 133 students, 124 chose to complete the questionnaire. A "lucky draw" for a small prize was held at each centre for those who participated and this incentive may have increased the response rate. The response rate was 93%.

The students had a tea break but were asked not to discuss the questionnaires. Completed forms were placed on a table near the door and consent slips were torn off and placed in a separate container, so all participants remained anonymous. After tea a follow-up focus group session was held. Students expressed their responses to completing the questionnaire. A discussion was facilitated with each group that considered ways of dealing with trauma. Questions that were raised during this session were as follows:

- *How did you feel after completing the questionnaire?*
- *What thoughts and emotions were triggered by responding to the questions?*
- *What helped you to deal with these experiences?*
- *Tell me more about how you deal with trauma?*
- *Do you think that going through trauma is always negative or can it be a stimulus for growth?*
- *What is the most important thing you learnt from your own trauma?*
- *Is there a need to provide support for students to deal with their own trauma?*

These questions were guidelines and each group followed its own course in this discussion. During the afternoon a therapeutic story was read and the use of stories and metaphors for dealing with trauma was discussed (Davis 1996:27-

28). The day ended with a session on guided imagery as a debriefing exercise (Naparstek 2006:229-256).

Focus groups were conducted in 2008 for the purposes of the research. At this time, the workshops in Polokwane, Limpopo Province and Johannesburg were facilitated by the researcher herself. The researcher and a colleague facilitated the process in Pretoria. The workshop in Bloemfontein was facilitated by the researcher and a colleague via video-conference. The workshop in Durban, Kwa-Zulu Natal was facilitated by two colleagues, both experienced Unisa staff. The Cape-Town workshops were also facilitated by two colleagues. All involved were briefed beforehand and the co-facilitator in Pretoria as well as the facilitator in Durban had been involved in the previous trial in 2006.

The researcher's perceptions of each focus group were as follows:

- ***Polokwane – 10 students***

The discussion in Polokwane was very lively. One student had experience as a counsellor in the field of trauma and she stimulated much discussion. Another student had been in a recent attempted hijacking (five days previously) and it was important to the researcher to contain her distress. She volunteered to go through a session that was conducted in front of the class by the researcher instead of a role-play. The students commented that they seldom have the opportunity to observe a session and seemed very respectful of their colleague and empathetic with her pain. The student said she found the session helpful. She had contact with a psychologist who was available for follow up. Students in this group seemed to have a high level of cohesion and were supportive of each other.

The pace was relatively slow. One student in the group was very vocal and unwilling to accommodate perceptions that differed from her own. Students informed the researcher that there is no word for trauma in Pedi or Venda and

there was considerable disagreement about the meaning of the concept and how trauma differs from stress and a crisis. Finally students agreed on distinctions.

No one seemed distressed by participation in the workshop. In fact, students reported they had benefited. One student commented that it had made her aware of her own strength and she was proud of all she had survived. One of *the students in the group found guided imagery a new and strange concept but reported surprise at the level of relaxation she had reached in the exercise. The participants reflected on their needs and concluded that they had been addressed by the workshop.*

- **Johannesburg – 20 students**

The Johannesburg group was somewhat large. The facilitator who normally works with the group was ill, so the researcher was alone. To her surprise, all the students wanted to participate in the research focus group.

The group was very involved in the topic. Two male students in particular stimulated discussion. One seemed to play devil's advocate and provoked a lively exchange of ideas within the group. He was willing to disclose a personal experience of trauma and this seemed to move the discussion to a more personal level on the part of the other students. The discussion was seldom directed at the researcher and took place mainly between group members. The black students seemed particularly keen to invite the researcher, a white facilitator, into their world and spent much time explaining different aspects of their various cultures as they pertain to trauma. This provided insight into the coping strategies and challenges that the students perceived to be part of their particular culture. The researcher felt that the participants really wanted to support her in her research. The participants seemed to benefit greatly from the workshop, in terms of understanding the unique and personal nature of trauma. They also felt they had deeper understanding of other cultures. One student

commented that the workshop was useful, but far too short. At the end of the workshop participants reported that the needs had been addressed.

- **Pretoria – 54 students**

The Pretoria group was facilitated by a white male colleague and the researcher. There were fifty-four students present in all. The researcher introduced herself and explained the purpose of the workshop and research. Consent forms and the covering letter were distributed. The researcher sensed a tense atmosphere. This was explored, using immediacy. Two students said they were willing to complete the questionnaire, but did not want to be part of the focus groups. One of the students said he was concerned about how much personal information may come out in the group and was threatened by that, especially if it was tape-recorded. Other students agreed. As the discussion progressed, it became evident that students felt that completing a questionnaire was fine because it is completely anonymous, but they were reluctant to speak on tape or be too exposed in front of colleagues. Although the questions for the focus group were on the board and did not require any personal disclosure, it was very important to the researcher to respect the participants' right to non-participation. The needs of the group were put first and she removed the tape recorder and continued the workshop without it. The students seemed satisfied and participated enthusiastically. The students' bond with the researcher seemed strengthened by this action and two students came and spoke her later stating they had been through a lot of upsetting situations recently and wanted to deal with these issues. Arrangements were made for follow up counselling.

During the course of the workshop, students were invited to complete the questionnaire. The right not to participate was stressed. Even though the students had declined to be part of the focus groups, most were willing to answer the questionnaire where anonymity was assured. Forty-eight questionnaires were completed out of a total of fifty-four distributed to this group. Participants who did not wish to take part in the research simply left a blank questionnaire on the table

and went to tea. In light of the students' right not to participate, no data from this focus group has been included. It is noteworthy that 2 students from this group contacted the researcher about therapy for pre-existing problems and arrangements were made for both to have counselling at no cost. Both students did attend counselling.

- ***Durban- 34 students***

For practical reasons, the research in Durban was facilitated by two colleagues of the researcher in Durban. Both are Unisa supervisors. One facilitator had been part of the first part of the study in 2006, at which time the researcher had traveled to Durban to facilitate the workshop. At this time, it was apparent to the researcher that the participants in the focus group conducted by their own facilitator were more comfortable than those with her. It was apparent that the Durban-based facilitators had a strong rapport with the students. They had conducted all the workshops with the group from first year and the students seemed to feel safe in the group. The researcher decided to enlist their help with the research. These facilitators conducted the workshop according to the same guidelines that were used elsewhere. All the students present decided to take part in the focus groups. The facilitators seemed very interested in the topic and participants seemed to share freely. There was a lot of discussion about culture in the group, particularly between White, Indian and Black participants, with the White participants asking questions of their black colleagues. The diversity in the group seemed to generate a rich description. The two facilitators in Durban reported they were very sensitive to the well being of the students, some of whom had been through traumas that were known to the facilitators. They reported that students had enjoyed the workshop and experienced it as very worthwhile. The participants said that their need to understand trauma and to acquire the needed skills to work with clients had been met.

- **Cape Town - 5 students**

For practical reasons the researcher was unable to travel to Cape Town for the workshop, which was facilitated by a colleague. Although she received a tape of the sessions, it covered only the feedback at the end of the small group discussions. The tape was inaudible and could not be included in the research. The questionnaires were completed and findings included in this report. The facilitator's feedback was that difficulties were encountered with managing the tape recorder during the workshop.

- **Bloemfontein – 5 students**

The Bloemfontein focus group was conducted via videoconference, for practical reasons (i.e. distance). This made it difficult for the students to sit in a circle, so initially much of the interaction was directed at the researcher. It also created some stress for her because using the video was unfamiliar and tape recording the discussion was difficult. These feelings disappeared rapidly as the workshop progressed and the researcher realised that the participants seemed invested in the topic and seemed to be a cohesive group. Students became more animated about the topic as the discussion progressed. The discussion shifted to involve the whole group, where participants talked between themselves.

Their facilitator, who is based in Bloemfontein and who knew the students well was present at the learning centre and that seemed to aid the smooth flow of conversation, as she was able to clarify comments as the discussion proceeded. The conversation proved to be lively.

Participants indicated that they find their supervisor in Bloemfontein very perceptive and supportive. They indicated that she had helped them to symbolise the effect of their own experiences on their own work with clients, which they found very helpful and important.

Students reported having enjoyed the workshop. Time was limited, so the timeframe of the workshop was adapted. The researcher had planned to do a role-play of a session with a crime victim, but this was very awkward via video. The group decided that the role-play was to take place on another day with their supervisor in Bloemfontein. The researcher sent a DVD down as a case study, as well as therapeutic stories. The session ended with a guided imagery exercise. The researcher mentioned to the students that some people do not regard trauma debriefing as demonstrated on the video as person-centred.

The researcher was most surprised and touched to receive a letter from four participants after this workshop offering comments on how they experienced the process as seen on the DVD. The facilitator in Bloemfontein reported that the participants seemed indignant that anyone could say the researcher was not person-centred. Participants decided to write to her saying why they felt the process was person-centred. The participants indicated that they felt equipped to deal with clients who have been through a traumatic incident. The researcher had the impression that the letters were a gesture of support.

The researcher concluded that, although the workshop was used to assist with the research, the participants had benefited and it had been a useful learning experience to equip them in dealing with traumatised clients.

9.2 Provisions for follow up

At the end of the workshop groups were given contact numbers for the researcher and other professionals in each area who could assist any participant who may have needed therapy. In practice, in 2008, two students contacted the researcher. One student had experienced recent trauma and was seeking therapy. She was referred to a psychologist in her hometown, who offers a free service, after missing two appointments with the researcher due to transport problems. A second student was contacted by the researcher because the co-facilitator recommended she should seek therapy for a recent problem. She is

currently receiving counselling. No other problems arose. None of the difficulties mentioned here were attributable to the research itself, but students were grappling with pre-existing issues and when free assistance was offered, they availed themselves of the opportunity to make use of it.

9.3 Focus groups in this study

Relevance to this study

Conducting workshops at different times at different learning centres afforded the researcher the opportunity to listen to the preceding tapes and begin to transcribe them during the process of data collection. Emerging insights could be explored. During interviews, the emphasis was on exploring the topic of trauma. Care was taken to focus on questions the participants could answer. The researcher asked discovery-oriented questions. Focus groups gave participants the opportunity to elaborate on written responses. The researcher maintained a student-centred stance.

10 APPLYING A HERMENEUTIC APPROACH TO THE DATA ANALYSIS

The researcher transcribed the tapes of the focus groups and typed up the qualitative responses from the questionnaires. Then she applied a hermeneutic approach to the analysis.

Terre Blanche et al (2006a: 321) state that in qualitative research data collection and analysis processed simultaneously, with collection fading out as the analysis predominates.

At the start of the study, the researcher regarded trauma as a violent encounter with man, nature or machines. As suggested by Terre Blanche et al (2006a: 321) the researcher began by bracketing her pre- conceptions. This means that the researcher made an effort to put previous knowledge and pre conceptions aside and focused on "hearing" what the participants were saying in the texts.

10.1 Immersion

Terre Blanche et al (2006a: 322) state that the first step in analysis is to become familiar with the topic and to become immersed in the data. During 2006, the researcher exposed herself to the students' perceptions by facilitating the trauma workshop in Pretoria, Johannesburg, Polokwane and Durban (along with the supervisor in this area). She was also involved in co-facilitating the workshop with her colleague in Bloemfontein, via videoconference. These workshops are part of the curriculum each year. The first round of questionnaires were completed at this time (2006) and group discussions were held during these workshops. These group discussions (from 2006) are not part of this research, but the researcher paid careful attention to the discussions, which sensitised her to participants' perceptions.

The 2006 questionnaires formed part of the study. The responses to the questionnaires were typed out and the researcher started to analyse them to discern themes concerning the description of trauma and, participant's examples of trauma and she compared these with perspectives from the literature. Themes were developed and this preliminary study was used to re-design the questionnaire for use in 2008. In this way the recursive character of a hermeneutic analysis was maintained.

When questionnaires were completed in 2008, the researcher immersed herself in the new data by typing out the participants' responses to qualitative items on the questionnaire, listening to the tapes of the focus groups and transcribing them as well as making notes as the research was conducted at each learning centre.

10.2 Induction

The researcher engaged in the process of inducing themes in the data from the time she first received replies to the questionnaire in 2006. These themes

emerged from the data, as a bottom-up approach was used as advocated by Terre Blanche et al (2006a: 323).

In 2006, 98 completed questionnaires were returned. The researcher went through the students' descriptions of trauma to identify themes using coloured pens and paper. She also noted the examples of trauma supplied by the respondents. These were used to compile the questionnaire used in 2008. This meant that the questionnaire that was distributed in 2008 had been modified in response to the feedback received in 2006. The second questionnaire itself created a degree of structure within the data, around which themes seemed to cluster. Themes evolved around particular concerns namely:

- *What are the core features of trauma?*
- *What experiences to participants present as instances of trauma in their own lives?*
- *What was the impact of trauma on the participants' perceptions of the self? What was the impact of trauma on the participants' perceptions of the "phenomenal field" including others, the world and the future? (Proposition 2).*
- *How do participants cope with trauma?*
- *How does trauma influence the person's interaction with others?*
- *Did the participants' experiences of trauma influence his or her decision to study social work?*

When the researcher approached the workshop in 2008, her focus was on hearing the students' perspectives on trauma. Reflexivity is important in a hermeneutic study. The originator of a text influences it's meaning as well as the researcher, who poses particular questions or creates a particular context in which the research is conducted. The workshop was planned so that the first focus group discussions were held prior to distributing the new questionnaire, because the researcher did not want the participants to read the questionnaire and the examples of trauma it contained before giving their own perspectives, in case their responses would be biased by the content of the questionnaire.

In the focus groups, although guiding questions were used, the discussions were less structured than responses to the questionnaire and each group tended to take on a life of its own. This gave participants the opportunity to highlight issues that the researcher did not raise in the questionnaire. Focus groups did, however, also enrich the data acquired from the questionnaires.

10.3 Coding

As themes were developed, the data was coded. This entailed marking different sections of the data as being relevant to one or more themes. The researcher started out by using coloured pencils to do this, but this method was abandoned in favour of the use of a computer package, namely Atlas ti. The researcher needed a more efficient way of managing the data from so many sources.

10.4 Reasons for using Atals ti to code the data

The acronym CAQDAS refers to computer assisted qualitative data analysis software (Lewins & Silver 2007: 6). A number of packages exist. Atlas ti version 5 was chosen to assist with the analysis of qualitative data in this research.
It should be emphasised that CAQDAS packages provide a means of managing data. These programs do not replace the intellectual or intuitive skill of the researcher. Terre Blanche et al (2006a: 325) state: “We need to be circumspect about what computers can do. It is absurd to imagine they can know and summarise in words what it might mean to have suffered personal tragedy for example. And a computer cannot know how to search creatively for associations between different aspects of an account. A computer cannot formulate and re-formulate research questions for us.” Atlas ti proved to be a valuable tool in managing, coding and retrieving the qualitative data.

Computer-aided data analysis was used in this research because the response rate in both 2006 and 2008 was far greater than anticipated (92% and 93% respectively). The questionnaire automatically structured the data around specific issues, facilitating the analysis of each question to focus on a specific aspect of

trauma. The software enabled the researcher to capture all the data in a reasonable period of time and then to highlight quotations that were particularly descriptive.

Atlas ti was considered appropriate for use in this research because it allows the researcher complete freedom concerning the structure of the coding and thematic schema (Lewins & Silver 2007: 7). This was viewed as appropriate in light of the exploratory nature of the study, where no previous research on South African social work students' traumatic experiences could be found, so there was no pre-existing scheme on which data analysis could be based. When Atlas ti is used, codes can be renamed, split, merged or deleted. Codes or themes can be structured in a hierarchical fashion. As themes are identified it is possible to write memos simultaneously so that coding, analysis and interpretation can be carried out together. Memos and themes can be analysed to facilitate a circular analysis of data.

Atlas ti works by creating what is called a "hermeneutic unit". This hermeneutic unit acts as a container for and connector to all data relevant to the study. The documents containing the responses to questionnaires or transcripts of interviews remain outside the software. The documents need to be saved in rich text format and are called 'primary documents." These documents are "assigned" to the software, which creates a pathway whereby the document may be accessed.

Once the path is created from the software to the document, by assigning the document to the project, the data is displayed on the left hand side of the computer screen. Thereafter, "codes" or themes may be created, which are displayed on the right hand side of the computer screen. It is possible to highlight sections of the text and "create a free code" which is then linked to the highlighted text. Once created, these codes can be linked to other questions by highlighting the relevant text, clicking on the icon and clicking on the appropriate

code or theme. The researcher may change the coding scheme at any time and unlink one or many quotations from a code, delete codes, rename, split or merge codes. In addition a hierarchical structure may be created by creating a code family.

Atlas ti also provides an auto coding option. Once key words pertaining to a theme or code are identified, the researcher may use the mouse, click on codes-auto-coding, enter the code, and enter search words separated by ” |” (shift plus \). The researcher may decide whether to assign a word, sentence or paragraph related to the code. The software will search the assigned documents for the search terms and code them appropriately.

The researcher may decide whether to search all the assigned documents or whether to apply a filter and thereby search specific documents.

Once themes or codes have been created, the researcher may request the programme to “create output.” This means that codes and attached quotations are gathered into a document that is sent to what is known as the “text editor.” The name of the theme or code is given together with all the relevant quotations that may be copied into Microsoft word and then printed, edited or saved.

10.5 How the qualitative data was coded

Data for each question was typed up and saved as rich text format for use in Atlas ti. No pre-existing structure was imposed on the data. Responses to each question were saved as separate primary documents. Each focus group was transcribed and saved as rich text format as a separate primary document. The analysis required a weaving back and forth between the responses from 2006 and 2008.

The researcher typed the responses to the questions “please give your own description of trauma” and “please give your own example of trauma” that were

obtained in 2006. These were entered into Atlas ti. The procedure for open coding was used to enter themes previously identified. This meant that the researcher went through the responses from 2006 sentence by sentence, highlighted the text, and assigned the relevant code. This proceeded until the data was saturated that is no new insights emerged. As this was being done she noted key terms related to each code. Thereafter, she imported the data for the same questions from 2008. The auto coding function was used. The researcher entered the code, followed by key words or descriptions related to that code and instructed the programme to auto code the 2008 responses. Each response from 2008 was fitted into at least one of the assigned codes used in 2006. This was taken as an indication that the data was saturated and that responses in 2008 were not dissimilar to those obtained previously in 2006, with respect to the description of trauma. The researcher began searching the focus group transcripts for descriptions of trauma, using open coding. She proceeded until the point of saturation was reached.

Thereafter, each question in the questionnaire was analysed in turn. The researcher began the analysis of each question by filtering the particular document containing the responses to that question (i.e. only that document was displayed). She used a process of open coding until no new themes emerged within that theme. Thereafter, she used auto coding. The code was entered with search terms. Once the document was coded the researcher read through it, checking for the relevance and appropriateness of codes, unlinking codes that did not fit and writing analytical notes as she proceeded. Next, she examined any sections of the data that may not have been coded and assigned them to the appropriate categories. As a last step, she re read the transcripts of the focus groups and coded any quotations that would thicken the description provided in the questionnaires. The programme was instructed to "create output" for each code. Quotations for each theme were exported to the text editor and saved as a word document. This meant that each code and its associated quotations were

saved as word documents to enable the researcher to write an analytical discussion.

The description of trauma was derived from the 2006 and 2008 questionnaire. Reasons were given in the previous chapter. Responses to all other questions a came from the data from 2008. The researcher used the procedure for open coding until no new themes emerged. This was taken that a point of saturation had been reached and further analysis was redundant. Responses from the focus groups were analysed in a similar way. Once the focus groups from Johannesburg, Bloemfontein Polokwane and Durban were included, themes became repetitive, so it was evident that a point of saturation had been reached (Kelly 2006c: 371). Therefore, focus groups from 2006 were not transcribed and included in this report.

The analysis was firmly grounded in the data. It emerged from the students' own perceptions and experience. Atlas ti allowed the researcher complete freedom in developing codes or themes as they emerged from the data itself.

10.6 Elaboration

Once the data was coded, the researcher proceeded with elaboration. Coding the data brought together insights and remarks that were far away from each other at first (Terre Blanche et al 2006a: 326). This highlighted similarities and differences within themes. The codes were revised until the researcher saw no further significant insights. It seemed the codes were saturated.

10.7 Interpretation

The researcher wrote an account of the phenomenon of trauma, from the perspective of the Unisa social work students. She related their perspective to the wider context and theory.

The idea of a hermeneutic analysis is that, in the interpretation of a text, the parts should be considered in relation to the whole. It is also emphasised that the whole cannot be understood as the sum of its parts (Kelly 2006a: 355). The particular may be understood using empathy. It is then related to the wider context and to theory. Both commonalities and discrepancies are valued in interpreting the phenomenon of interest (Kelly 2006a: 355). It is important to pay attention to distinctive features of particular contexts.

Using empathy, the researcher attempted to capture participants' perspectives by presenting participants' perspectives in the form of verbatim quotations from the text.

Kelly (2006a: 357-359) describes the process of writing a hermeneutic account. He suggests that three processes are involved, namely immersion, unpacking and associating. Using his work as a guide the researcher proceeded as follows. She became immersed in the themes she had identified. She used atlas ti to "create output" for each theme, meaning that the programme printed all the quotations for a particular theme from all the documents analysed, each theme under its own heading. She read and re read these documents, searching for recurrent words and phrases and highlighting quotations that seemed to illustrate the particular theme for her. She then engaged in unpacking the themes, by making a list of each theme. During the elaboration phase, she looked for ways in which the themes related to each other. The extent to which they seem linked made the writing very difficult because participants frequently gave a condensed response to a question incorporating more than one theme. When she wrote the account she needed to present things in a sequence and it felt as if she was trying to fit a wheel into a straight line. She decided to start by looking at what participants saw as the core features of trauma, followed by the results from the quantitative data concerning the extent of their own experiences. Some terms such as "taxi violence" would be readily understood by local residents, but may be meaningless to someone who is unfamiliar with this context, so the researcher

made an effort to clarify these terms in the account. Thereafter she looked at themes relating to how trauma had impacted the person. The researcher explored how participants cope with trauma and how it impacts their relationships with traumatised people, an issue that is crucial to their work as social workers. She was guided by research questions in making these decisions.

It was apparent that participants' description of what constitutes trauma did not fit the dominant discourse in the literature and the researcher made an effort to present the data as it was disclosed to her, changing categories to fit the data rather than trying to fit the data into preconceived ideas about the meaning of trauma, as advocated by Kelly (2006a: 359).

Quantitative data was entered into SPSS and analysed with the assistance of a statistician. Descriptive statistics were used to produce a profile of the group.

Finally, an account of the phenomenon as relevant to this particular group was written. These results appear in the next section.

11 CHAPTER SUMMARY

In this chapter the story of how the research process unfolded has been described. The implementation of the research unfolded as a planning-action-reflection cycle in which the research was modified in response to feedback and difficulties encountered. The theory and its application have been presented in this chapter in the form of a dialogue between the theory and research process. The researcher became aware of a need to find out more about trauma in the lives of social work students. The staff of the Department of Social Work were interested in knowing whether students were struggling with unresolved trauma. The research question was formulated as follows: **What are the experiences and effects of trauma in the lives of Unisa Social Work Students?**

The research was conducted from a person-centred perspective and was designed to understand the students' perspectives from their own frame of reference. The research was exploratory and descriptive in nature. A preliminary literature review was conducted. Thereafter a mixed paradigm was chosen for the study.

A case-study was conducted with the fourth level students. The researcher developed a questionnaire to be used as a survey instrument. The questionnaire contained both quantitative and qualitative items. Focus groups provided an alternative perspective.

The questionnaire was pilot-tested with MA social work students in 2006. This group acknowledged the value of the questionnaire, but suggested that it should be administered during a workshop, not by mail, due to the sensitive nature of the topic. The ethics of the research received considerable attention and the questionnaire was revised in response to feedback from the pilot test group. The questionnaire was distributed to the fourth-level class of 2006 during a workshop on trauma. Focus groups were conducted at this time. Several problems with the questionnaire came to light after this trial. The questionnaire underwent extensive revision. The final draft was distributed to 133 students in 2008, who were in their fourth level of study in social work. Participation in the research was voluntary. A total of 124 questionnaires were returned and analysed. This gave a response rate of 93%.

Focus groups were conducted with volunteers from the 2008 fourth-year class. These groups were used to triangulate data from the questionnaires. These interviews served to sensitise the researcher to themes and provided diverse perspectives on trauma.

Qualitative data was analysed using a statistical package to yield a numerical description of the groups' experiences. The impact of trauma was assessed from

both quantitative and qualitative data. Qualitative data was analysed using an interpretive-thematic approach. Emerging themes were compared with the literature not to confirm or validate these themes, but so that commonalities and discrepancies could be disclosed.

The research process has been described in detail. The extent to which findings are transferable may be assessed by the reader based on this report. The outcome of the research is presented in the next chapter.

CHAPTER 9

RESULTS-PART 1

1 INTRODUCTION

There were two ***phases*** to the research. The first phase took place in 2006 and the second in 2008. On both occasions, the research took place during a trauma workshop. The research was planned this way as discussed in Chapter 8 describing the research process. A safe place was created to allow participants to disclose their experience of trauma. Each time the participants completed a questionnaire. Qualitative data from 2006 was used to compile the final questionnaire used in 2008. This questionnaire contained both quantitative and qualitative items.

There were also two ***aspects*** of the research, one quantitative and one qualitative and the results come from a number of sources. Quantitative data were collected from the quantitative part of the questionnaires. Qualitative data was collected from two sources, namely the qualitative part of the questionnaires and focus groups. In 2008, almost all students (93%) responded to the questionnaires. Of these, 69 students took part in focus groups in 2008, giving a response rate of 51.87%. Participation was voluntary and reasons for non-participation were not sought. Qualitative data from focus groups was used to give students an alternative voice to gain a richer description and enhance the researcher's understanding of their experience of trauma. This meant that data was gathered from the same students in different forms, which facilitated the generation of a thick description of the participants' experiences and perceptions of trauma, using triangulation.

The research process involved weaving back and forth between the data obtained at different times from various groups at each learning centre where workshops were presented for the fourth level social work students to provide a thick description of students' perceptions and experience of trauma. The researcher had the opportunity to explore emerging issues as the research progressed.

The following table indicates which issues were addressed:

Data 2006	**Data 2008**
Quantitative data from questionnaires to describe demographics	Quantitative data from questionnaires to describe demographics
Qualitative data from questionnaires to provide description of trauma	Qualitative data from questionnaires and focus groups to provide a description of trauma
	Quantitative data from questionnaires to provide profile of: Specific traumatic experiences. Frequency of repeated trauma. Intensity of trauma.
	Qualitative data from questionnaires regarding the effect of trauma on the participant as a person
Qualitative data from questionnaires to describe the effect of trauma on the participant as a social worker.	Qualitative data from questionnaires to asses whether participants tend to avoid clients with trauma that is similar to their own.
	Quantitative data from questionnaires to see whether help was received.
	Qualitative data from questionnaires to see if help was useful.
	Qualitative data from both questionnaires and focus groups to see how participants cope with trauma.

The type of data collected was rich in variety and evoked a rich description of students' experiences, the impact of trauma and resilience. In this chapter, results pertaining to demographics and the description of trauma will be discussed. Results relating to the effects of trauma and coping with it will follow in the next chapter.

2 RESPONSE RATE

Although the questionnaire was completed in the workshop, participants could choose whether to participate or not. All responses to the questionnaires were anonymous. In 2006 a total of 98 questionnaires were returned, out of 106 giving a response rate of 92%. In 2008, of the 133 questionnaires that were distributed, 124 were returned, giving a response rate of 93%.

Focus groups were conducted in 2008. A total of 74 participants took part in focus groups, giving a response rate of 55,63% in this part of the research. One group, comprising 5 participants had to be excluded, because of the poor quality of the tape recording. This means that responses from focus groups comprising 69 participants (51.87%) are included in these results. (Reasons for non-participation or exclusion of some data was described in the previous chapter.)

2.1 Comments about response rate

There is a difference in the response rate to the questionnaires (92-93%) and the focus groups (55.63%). Participants in Pretoria were willing to respond to the questionnaire, but were afraid of exposing too much in front of colleagues in the focus groups. Their wishes were respected. Data from questionnaires completed in Pretoria were included in the research, but no focus groups from this region are included. Strydom (2002:69) points out that much research in the social sciences cannot be carried out without some invasion of privacy. One way of protecting the person is by protecting his or her identity, meaning that the participant remains anonymous. In the case of anonymity, a particular response cannot be linked to a particular participant, even by the researcher (Rubin & Babbie 2005:78-79). In the case of confidentiality, it is possible to identify a particular person's response, but the researcher undertakes not to do so publicly. These were salient issues with respect to the focus groups. The questionnaire was wholly anonymous, whereas a focus group took place between colleagues who would meet again, so participants may have felt more exposed in the group than when filling in the questionnaire. This discrepancy in the response rate may be an indication of the sensitive nature of the topic.

Completing the questionnaire in the context of the workshop may have increased the response rate. The workshop was scheduled as a trauma workshop, so the topic was probably already on participants' minds. The session began with a discussion of the meaning of trauma, so this created an atmosphere of sharing exploration. The fact that participants had been exposed to the theory of the person-centred approach throughout their training might have influenced the language and concepts used to describe trauma. The norm in the workshops is that a safe context is created. Using the workshop also provided protection for the participants, because there was an opportunity for de briefing and vulnerable participants could be identified and referred for follow up counseling if needed.

Rubin & Babbie (2005: 289) state that, in a survey, a response rate of 50% is considered adequate for reporting, a rate of 60% is viewed as good and a rate of 70% is regarded as very good. The number of respondents is not as much of an issue in qualitative research, because the aim in this type of research is to generate a rich description, rather than generalisability. The response rate of 92% - 93% to the questionnaires seems to indicate that participants saw the topic as important and were willing to invest time in participating in the research. There is no indication of why participants who did not respond to the questionnaire chose not to take part. The workshop was structured so that non-participants could leave for the tea break unobtrusively, with no explanation, so that no one would feel embarrassed or coerced into taking part in the research. This protected the person's right to non-participation. Throughout the process the right not to participate or to withdraw was emphasised and yet the response rate is particularly high.

The high response rate may stem from the person-centred nature of the training where participants may have wanted to assist the researcher and facilitate her success in completing the study. The lucky draw incentive may also have contributed to the high response rate.

3 ANALYSIS OF QUANTITATIVE DATA

The raw data from the first group (i.e. the fourth level class of 2006) was captured on a Microsoft Excel spreadsheet and imported into SPSS for Windows. This programme was used for the analysis. A statistician was consulted for assistance with the analysis. Qualitative data were typed out and perused for themes and examples, which were used to compile the final questionnaire for the 2008 group.

The raw data from 2008 was captured on a Microsoft Excel spread sheet and imported into SPSS for windows. The statistician who had assisted previously was unavailable, so another statistician was consulted for assistance with the analysis, which was carried out in the presence of the researcher. The procedure was as follows: Labels were assigned to all variables and values. The data was cleaned. Missing values were noted. Data capturing errors were noted in eight questionnaires, that is 6% of the total. Any data that fell outside the range was noted and the relevant questionnaire was verified manually by pulling out the questionnaire and checking the response. Data capturing errors were corrected. All the errors that were found fell within one question. No questionnaire contained more than one error. It seemed that the errors were neither systematic nor pervasive so it was concluded that the overall capturing of the data was sound.

The questionnaires were checked for missing data. The rate of missing values was less than 5% for all items so it seems that no particular item was systematically avoided by respondents. All respondents had worked through the questionnaire to the end.

4 THE OUTCOME OF THE ANALYSIS

4.1 Demographics

Demographic details are presented for both the 2006 and 2008 groups. Similarities and differences between the 2006 and 2008 groups are presented in the description of the demographics of each group.

4.1.1 Learning centre

The research was conducted at six venues, namely the Unisa learning centres in Bloemfontein, Cape Town, Durban, Johannesburg, Polokwane and the main Unisa campus in Pretoria. These six learning centres include students from all nine provinces. The number of respondents in each centre is given in table 3 and figure 6.

Table 3- Learning centre

Learning centre	Percentage 2006	Percentage 2008	n 2006	n 2008
Bloemfontein	3,0%	4,0%	3	5
Cape Town	2,0%	8,1%	2	10
Durban	35,7%	27,4%	32	34
Johannesburg	16,3%	13,7%	16	17
Polokwane	4,0%	8,1%	4	10
Pretoria	41,8%	38,7%	41	48
Total	100	100	98	124

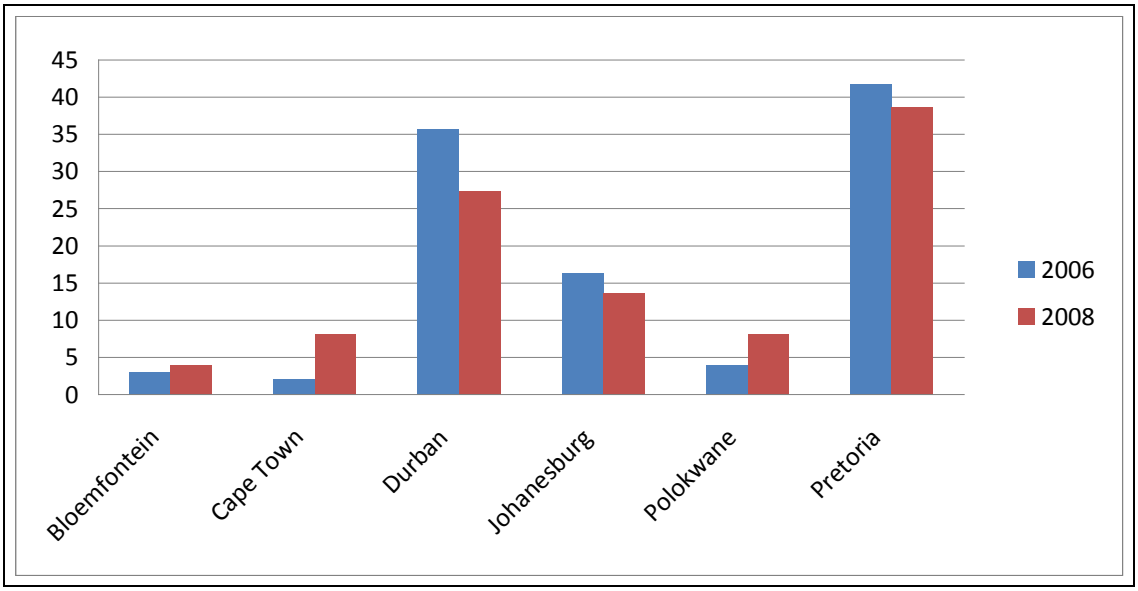

Figure 6-Learning centre

The table and graph represent how many participants were in each region. Participants were not equally distributed at each Unisa learning centre. Visual inspection of the data suggests that the trends in the student distribution was similar in 2006 and 2008. Due to the small number of participants in some centres such as Bloemfontein, Cape Town and Polokwane it was not possible to conduct a statistical analysis on a regional basis. Participants' responses were analysed as a whole. No information is given about the participants'

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location in this report, because it would then have been possible for one participant to identify the response from a colleague, for example, in Cape Town, where there were only two participants in 2006.

Unisa focuses on serving people who would not otherwise have access to education for financial reasons, because they are employed, they live in remote areas or they cannot access residential universities due to disability (Schenck 2008). Workshops are provided by the Unisa Department of Social Work at various Unisa learning centres to accommodate students who live far away from the main campus.

4.1.2 Gender

Table 4 and figure 7 represent the gender of the participants.

Table 4 – Gender

Gender	Percent 2006	Percent 2008	n 2006	n 2008
Male	13.8%	17.1%	13	21
Female	86.2%	82.9%	81	102
Missing			4	1

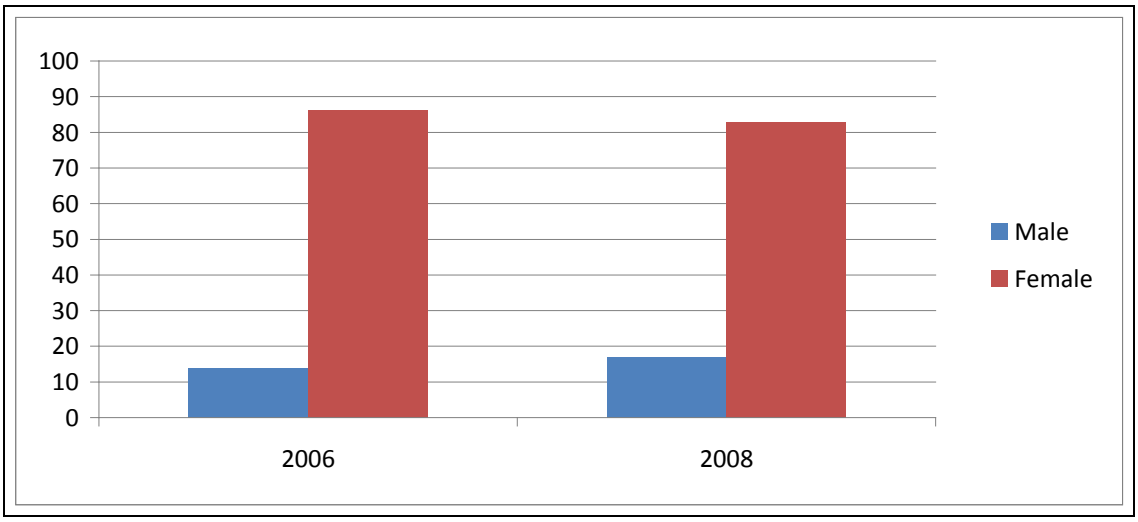

Figure 7 - Gender

Social work has traditionally been known as a woman's occupation. This is reflected in the groups. Over 80% of participants were female.

According to Earle (2008:130), like many caring occupations, social work is seen as an extension of what is perceived as women's work in the community.

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The majority of qualified social workers are women but the majority of management posts are filled by males. Social work has been described as a "female – majority, male- dominated" profession (Earle 2008: 130). Male social work students frequently use social work as a stepping-stone to other occupations. Male social workers tend to gravitate towards managerial positions or posts in probation work, civil service and community work (Earle 2008: 140). The low proportion of males within the profession has been linked to comparatively low salaries for social workers. Earle (2008) notes many women within the profession are prepared to work for low pay because they view men as the primary breadwinners and see their income as supplementary. Some male social work students said that gender roles associated with the profession are so strong that they were suspected of being homosexual for entering the profession (Earle 2008: 140).

Naparstek (2006:54) states that women are consistently more vulnerable to post traumatic stress disorder than men. She says that in any general population the rate of post- traumatic stress disorder amongst women is 10%-12% compared with 5% of men. She states that this is true despite the fact that men are exposed to significantly more traumatic events than women. She emphasises that this finding holds across cultures, but does not say which cultures were included in the research. No figures related to South Africa were found, but it seems that women may be more susceptible to the deleterious effects of trauma than men. The composition of the research participants in the study suggests that social work students, with the predominance of women, may be a vulnerable group.

4.1.3 Age

Table 5 and figure 8 represents the age of participants.

Table 5 - Age

Age	Percent 2006	Percent 2008
15-19	0 %	0.9%
20-24	22.05%	18.81%
25-29	29.41%	25.22%
30-34	29.41%	22.52%
35-39	7.35%	18.01%
40-44	2.94%	4.5%

Age	Percent 2006	Percent 2008
45-49	2.94%	3.6%
50-54	2.94%	4.5%
55-59	1.47%	0.9%
60-64	0%	0%
65-70	1.47%	0%

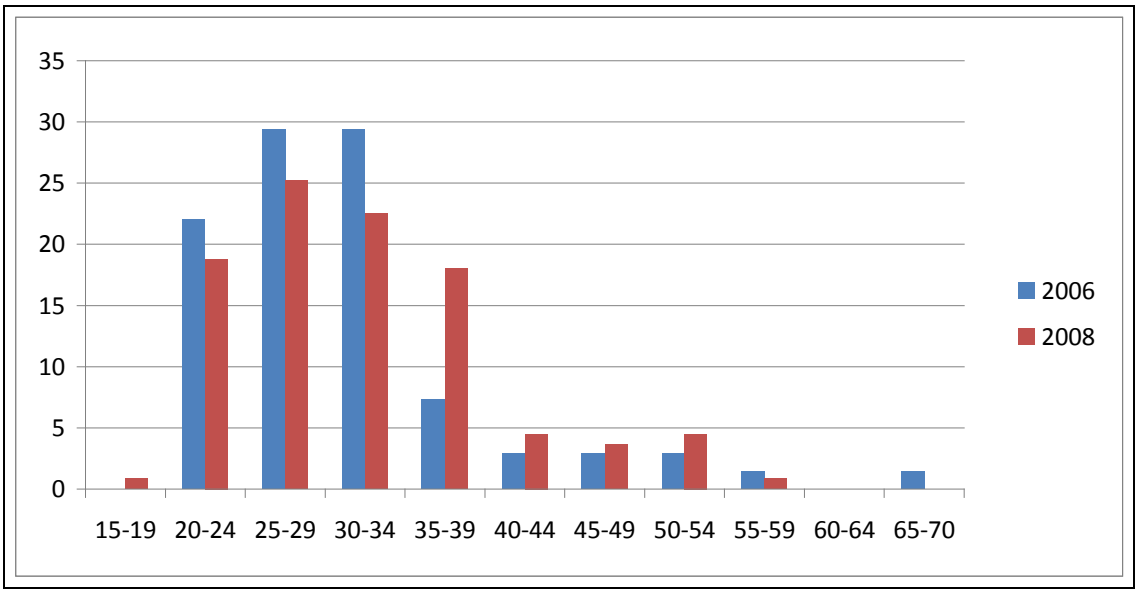

Figure 8 - Age

The mean age of participants in 2006 was 31,01 years. In 2006, participants ranged in age from 21 to 65 years. The median was 29 years. In 2008 participants range in age from 19 to 57 years, the median age being 30 years.

It is interesting to note that Unisa students tend to be older than students at other residential universities, where the average age of fourth–level students is closer to 22 years (Schenck 2008). This means that Unisa students may have different experiences to those at residential universities.

4.1.4 Cultural group and language

According to Grobler et al (2003:9) the self is formed in interaction with significant others. The family is normally the first encounter one has with other people. This expands to include the extended family, which brings an sense of culture (Lintvelt 2008:32). This implies that culture influences the self.

For the sake of clarity, the English names for cultural and language groups have been used in this report. Just as one would ask “do you speak German?”

not “do you speak Deutsch?” when enquiring about the language of a person from Germany, the term “Zulu’ has been used instead of “isiZulu” and so forth, although it is recognised that a Zulu speaking person would refer to “isiZulu” when speaking his or her mother tongue.

The cultural groups with which participants identify are reflected in table 6 and figure 9.

Table 6 - Cultural group

Cultural Group	2006 Valid Percent	2008 Valid Percent	2006 Frequency	2008 Frequency
Afrikaans White	6.3	7.3	6	9
English White	10.5	6.5	10	8
Coloured	2.1	3.3	2	4
Indian	7.4	4.9	7	6
Ndebele	2.1	4.9	2	6
South Sotho	3.2	4.1	3	5
North Sotho	15.8	22.0	15	27
Swazi	3.2	4.1	3	5
Tsonga	9.5	8.1	9	10
Tswana	11.6	4.9	11	6
Venda	0.0	2.4	0	3
Xhosa	4.2	4.1	4	5
Zulu	18.9	22.8	18	28
Other	5.3	.8	5	1
Total	100.0	100.0	95	123
Missing			3	1
Total		100.0	98	124

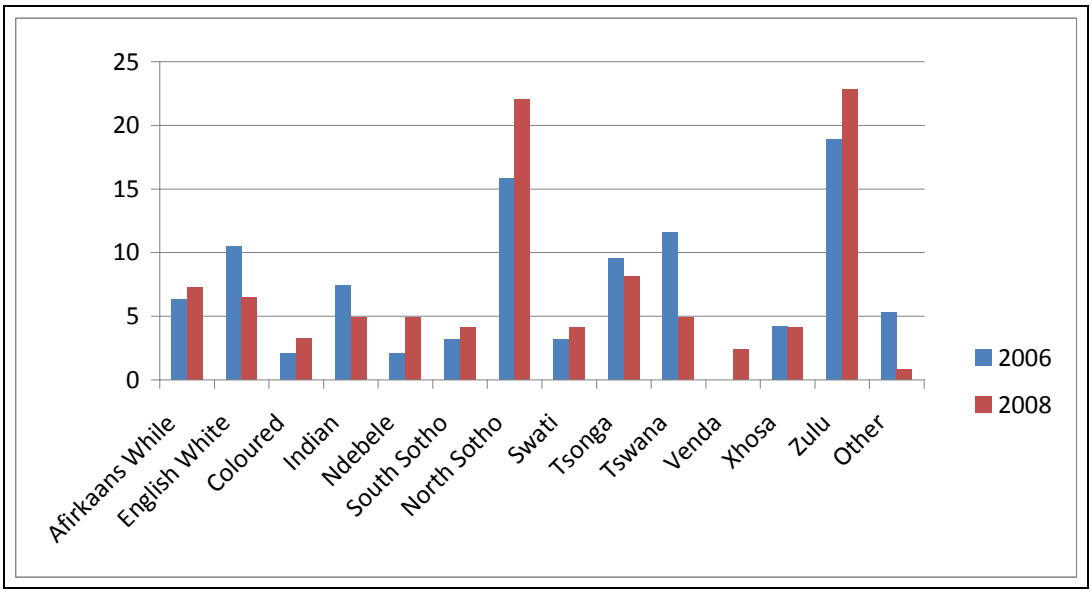

Figure 9 - Cultural group

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The largest cultural Groups are Zulu (18,9% in 2006 and 22,8%; n=18 n=28 respectively) and Northern Sotho (15,8% in 2006 and 22% in 2008 n=15; n=27 respectively). These results indicate that data was collected from a diverse group of South African people, creating an opportunity to explore a variety of perspectives and cultural views.

Lintvelt (2008) studied the personal contexts of undergraduate students studying social work at Unisa in 2006. In Lintvelt's (2008:32) study, participants felt that cultural differences should be respected. Respect is a core value of the person centred approach. The person-centred nature of the workshop made an atmosphere of respect possible.

4.1.5 Mother tongue

Culture is closely tied to language South Africa is a multi- lingual country, with eleven official languages. It is estimated that 45% of the population has a speaking knowledge of English, but it is the mother tongue of only 8.2% of the population. Figure 10 and table 7 show the distribution of language groups. Figures for the country as a whole, provided by South Africa.info (2008) are included for comparison. (as discussed in previous section, all names of languages are in English)

Table 7 – Mother tongue

. Language	2006 Valid percent	2008 Valid percent	Stats SA Percent	2006 Frequency	2008 Frequency
Zulu	22.1%	24.4%	23.8%	21	30
Xhosa	4.2%	4.1%	17.9%	4	5
Tsonga	7.4%	8.1	4.4%	7	10
Venda	0%	2.4%	2.3%	0	3
Swati	2.1%	3.3%	2.7%	2	4
Tswana	12.6%	5.7%	8.2%	12	7
N sotho	15.8%	18.7%	9.4%	15	23
S. Sotho	3.2%	8.1%	7.9%	3	10
Ndebele	1.1%	3.3%	1.6%	1	4
Afrikaans	9.5%	10.6%	13.3%	9	13
English	18.9%	8.9%	8.2%	18	11
Other	3.2%	2.4%	0.5%	3	3
Missing				3	1
Total				98	124

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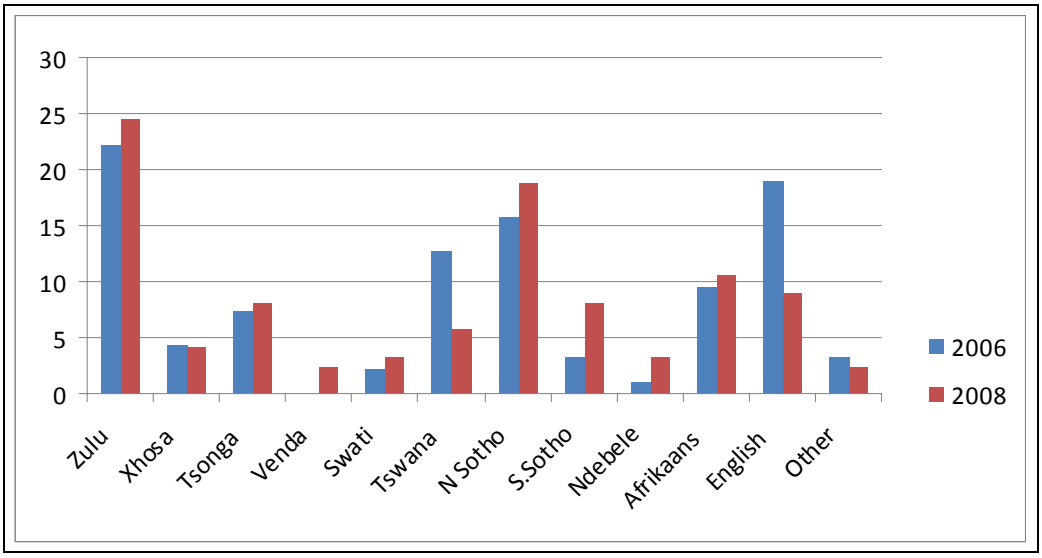

Figure 10- Mother tongue

The most widely spoken mother tongue was is Zulu (22,1 in 2006 and 24,2 in 2008; n-= 21 and n=30 respectively). These figures parallel that of the population as a whole. It is noted that 23,8% of South Africans identify Zulu as their mother tongue. Zulu is widely spoken in Kwa Zulu natal as well as around Johannesburg and Pretoria (South Africa. info 2008). Most participants came from Kwa Zulu Natal, where Zulu is the main language. This tongue is also widely spoken around Johannesburg and Pretoria (South Africa. info 2008). Pretoria area is also largely Northern Sotho speaking so the predominance of these languages parallels the distribution of participants in various learning centres.

English was identified as the mother tongue by 18,9 %of students in 2006 and 8,9% in 2008. Sesotho sa Leboa (also known as Pedi) was spoken by 15,8% in 2006 and 18,7% in 2008 (n=15 and n=23 respectively). This language is widely spoken in Limpopo province, where the Polokwane learning centre is located.

The diversity of languages in South Africa makes it impossible to offer the course in all 11 official languages. English is the medium of instruction at Unisa. Communication is intrinsic to the practice of social work. A key concern with respect to language is that it is a legal requirement that court reports for statutory work are written in English. Many agencies expect the notes to be

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written in English (Earle 2008: 138). Many social workers report serious difficulties with this requirement and many social work educators express concern about the language skills of students (Earle 2008: 139).

Schenck (2008) states that it is well known that the ability to read and write in English is a challenge to most students. She points out that 82% of students studying at Unisa in 2006 said English is a second language. In this study only 8,9% of participants said English is their mother tongue in 2008, although the figure was higher in 2006 (18.9%). This means that 80-90% of participants in this study were responding in a second language. This may have influenced the way that questions were interpreted and understood. It may also have limited some participants' ability to express themselves fully when answering the questionnaire or participating in focus groups.

4.1.6 Marital status

Details of marital status are given in table 8 and figure 11.

Table 8 - Marital status

Marital status	2006 Valid Percent	2008 Valid Percent	2006 Frequency	2008 Frequency
Single	61.1	60.7	58	74
Married	30.5	32.8	29	40
Divorced	3.2	2.5	3	3
Separated	3.2	0.0	3	0
Cohabiting	1.1	3.3	1	4
Widowed	1.1	.8	1	1
Total	100.0	100.0	95	122
Missing			3	2
Total			98	124

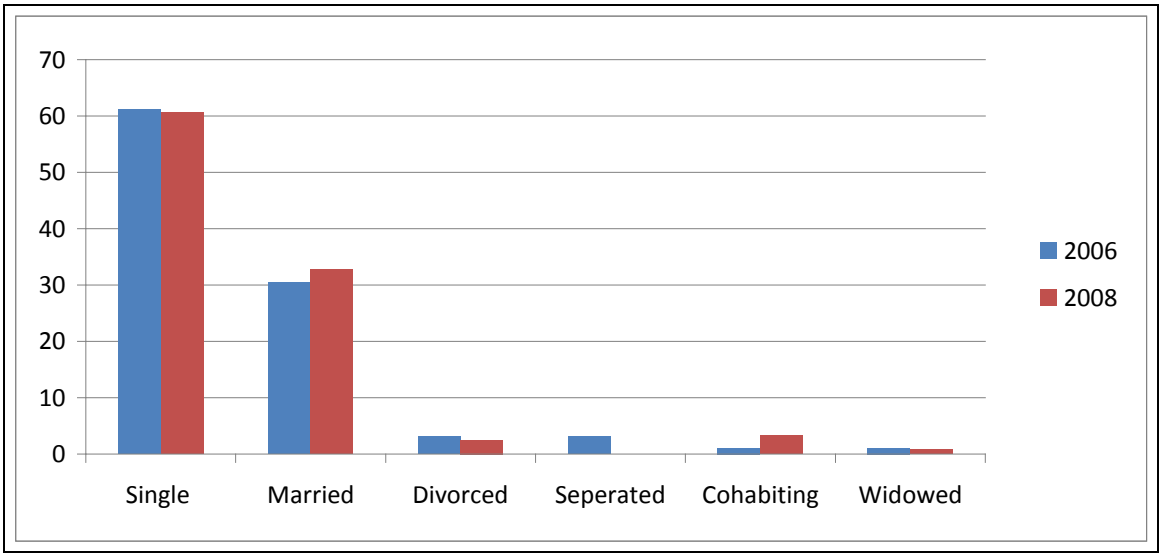

Figure 11 - Marital status

The marital status of both groups was similar. Most participants were single (61.1%% in 2006 and 60,7% in 2008;n=58 and n=74 respectively). About one third of the participants were married or co-habiting. One participant in each group was widowed. In 2006 responses indicate that 3,2% of the sample were separated and the same percentage were divorced, while in 2008 results indicate that 2,5% were divorced. These figures have implications for the extent of the participants' support systems, which may influence the impact of trauma. Naparstek (2007:59) states that people who are single, divorced or never married are more at risk for the deleterious effects of trauma than those who are married. The majority of participants fell into this category.

Lintvelt (2008:48) reported that 53% of participants in her study were parents, 14% had three or more children and 68% of the children were younger than sixteen years. In the present study, no data were gathered with respect to children, but these results indicate that participants may have more family responsibilities than students who are younger and studying at residential universities.

4.1.7 Level of education

Table 9 and figure 12 show that most participants already had some qualification and were busy with further studies.

Table 9 - Education

Education	2006 Valid percent	2008 Valid percent	2006 Frequency	2008 Frequency
Std 10	34.5%	51.3%	30	59
Certificate	18.4%	7.8%	16	9
Diploma	11.5%	8.7%	10	10
Bachelor	29.9%	27.0%	26	31
Post graduate	5.7%	5.2%	5	6
Missing			11	9
Total			98	124

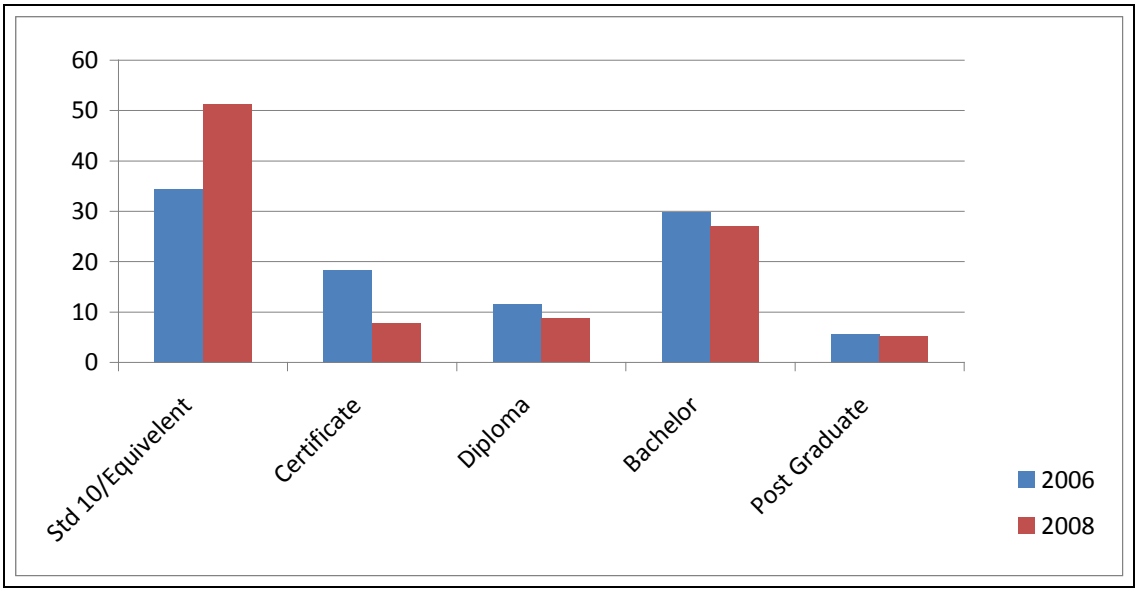

Figure 12 - Highest qualification

In each group, 5% of students reported holding a postgraduate qualification. It is interesting to note that almost 30% of participants already have bachelor's degrees and are busy with a second qualification (29,9% in 2006 and 27% in 2008). The results show that 34,5% of the participants in 2006 and 51,3% of participants in 2008 identified Std 10 or equivalent as their highest qualification. This means that almost half the participants in 2008 and more than 65% of participants in 2006 had some form of qualification already. It also indicates that most students in these groups started to study social work later.

Naparstek (2006: 58) states that the well-educated are less vulnerable to the deleterious effects of trauma than the less well educated. The reason for this is not clear, but she suggests that education may stimulate greater ease with abstract thinking, which in turn modulates impulses and reactivity in the more

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primitive centres of the brain that are most intensely affected by trauma. This suggests that the effect of trauma on the social work students may be modulated by their level of education.

4.1.8 Employment status

Work responsibilities may make full time study at a residential university impossible. Unisa aims to make education accessible to people who are employed, although many students who do not work also register because of reduced costs of correspondence study or because they have other responsibilities (Schenck 2008). The employment status of participants is shown in table 10 and figure 13.

Table 10 - Employment status

Employment status	2006 Valid percent	2008 Valid percent	2006 Frequency	2008 Frequency
Employed	41.1%	46.8%	39	58
Unemployed	58.9%	53.2%	56	66
Missing			3	0
Total			98	124

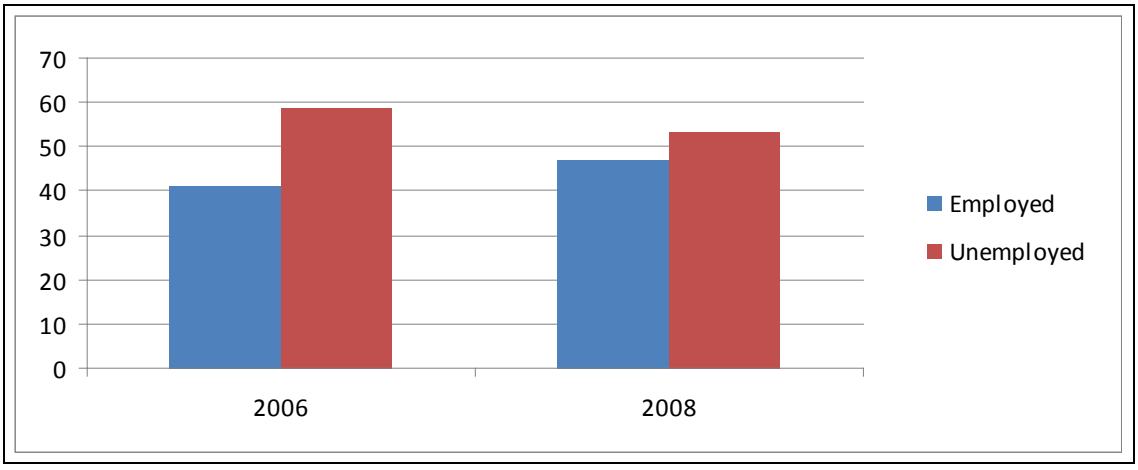

Figure 13 - Employment status

In 2006, 58,9% of participants reported they were unemployed and 53,2% were unemployed in 2008. A weakness of this study is that it is not clear whether participants are in full or part time employment. Lintvelt (2008: 17) found that 39% of her participants in her study of Unisa fourth level social work students were working full time, 22% were not working, 26% were working part time and 11 % were not working, but taking care of family.

4.1.9 Occupation

Students may be full-time students. Others may be occupied with other voluntary or part-time work. In 2006, 54.4% of participants were studying full time and 14.4% were studying part time. In 2008 these figures were 45.4% full time students and 22.7% part time students. Figure 14 and table 11 show the distribution of full-time students, part-time students and students employed in professions, clerical, sales and other work. The questionnaire did not ask whether such employment was full-time or part-time.

Table 11 - Occupation

Occupation	2006 Valid percent	2008 Valid percent	2006 Frequency	2008 Frequency
Full time student	54.4%	45.4%	49	54
Part time student	14.4%	22.7%	13	27
Professional	6.7%	13.4%	6	16
Clerical	8.9%	1.7%	8	2
Sales	1.1%	2.5%	1	3
Other	14.4%	14.3%	13	17
Missing			8	5
Total			98	124

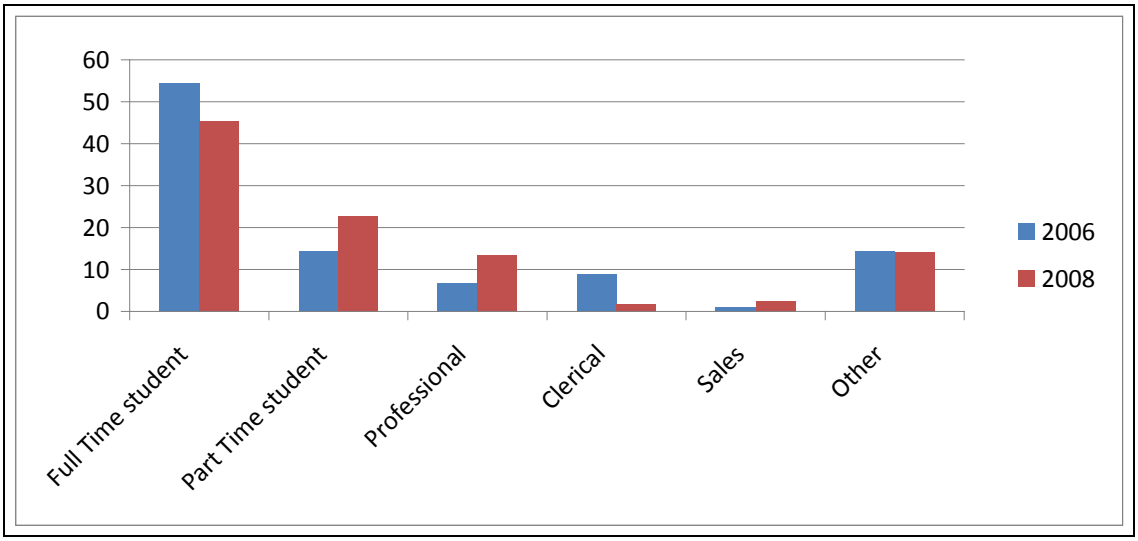

Figure 14 - Occupation

About half the participants were studying full time. The rest were employed or studying part time, possibly because of other responsibilities. This shows that Unisa students differ from students at residential universities, where the course is offered full time.

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4.2 COMMENTS ON THE DEMOGRAPHICS OF THE TWO GROUPS

Krefting (1991:216) states that the applicability of qualitative findings to different contexts rests on transferability. This criterion is met if there is a high degree of similarity between the two contexts. The degree of similarity between the two groups is demonstrated by the demographics provided here. Visual inspection of the tables and graphs presented previously suggests that the demographics of the two groups were similar. For example, over 80% of participants in each group were female. The median age varied by one year. Most participants were responding in a second language. Most students were busy completing a second qualification. The pattern of scores for language group, cultural group, employment, studies and qualifications was deemed to be similar. The proportion of students in Bloemfontein and Polokwane varied slightly, but these groups formed the minority of the total number of students. The theoretical orientation of the two groups was similar, because both groups were schooled in the person-centred approach.

The groups differed in terms of their exposure to clients in that the 2006 group had seen clients for longer than the 2008 group. The context in which the research was carried out was similar in that the research was conducted in the context of a workshop on trauma, but at times it was necessary to involve a different facilitator. All facilitators were briefed before the workshop and were experienced in the use of the person-centred approach. Therefore including them may be regarded as a form of triangulation (Krefting 1991: 218).

In light of the similarities between the groups, qualitative data were used from both groups to deepen the researcher's understanding of trauma.

5 THE QUALITATIVE DATA

Qualitative research involves the researcher in an interpersonal situation using empathy as a means of enquiry. The emerging account depends on the perceptions and insights triggered in the researcher. In other words, distance and objectivity are not possible or desirable in qualitative research (Puttergill 2000:27).

Using empathy, the researcher attempted to capture participants' perspectives by presenting participants' perspectives in the form of verbatim quotations from the text. It should be remembered that almost all participants were responding in a second language, so the English grammar in these quotations is not perfect. However, the researcher chose to leave the wording as it was presented to her, to remain as close to the voice of the participants as possible. Any changes thought necessary for clarification are indicated by the use of [square brackets].

Responses from focus group participants are indicated by the abbreviation **"FGP"**. **Certain focus group participants who shared personal experiences have been given pseudonyms**. It seemed that the richness of their contribution would be lost if it was not possible to trace their responses through the themes.

The researcher was moved and shocked by the nature and extent of the trauma disclosed in the texts. She has included extensive quotations in an attempt to show the reader the nature and extent of participants' experiences through these quotations. Some participants may have come from other countries to reside in South Africa, so it is possible that some of these incidents may not have happened in South Africa. Nevertheless, they are still part of the life experience of the person concerned.

Kelly (2006a: 355) emphasises that a hermeneutic account creates a tension between the empathetic perspective that is close to the participant (the insider account) and the more distant perspective that relates to the context and theory (the outsider perspective). Kelly (1997:410) refers to the researcher's reflection on the participants' responses within the wider context as "distanciation." The report is structured to reflect the movement between empathy and distanciation by giving the participants' perspective, followed by a discussion from a distanced perspective.

6 THE INITIAL DESCRIPTION OF TRAUMA

This section focuses on the researcher's perceptions of what participants regarded as the core, distinguishing features of a traumatic experience. In other words it attempts to answer the question "what makes an experience traumatic/in what way is a traumatic experience different to other experiences?" The participants' responses are given, followed by an account of how their description fits with the literature on trauma, that is the theme is discussed from both an empathetic and a distanced perspective.

6.1 HELPLESSNESS OR POWERLESSNESS ARE CORE FEATURES OF WHAT MAKES AN EXPERIENCE TRAUMATIC

6.1.1 The participants' perspective

Participants said that trauma invades ones' life. They emphasised that it is thrust upon a person and one does not seek to be subjected to it:

- **[With trauma] I'm doing something I was not supposed to because I'm going through something that is forcing me to do this.**
- **It is an incident(s) that <u>invades</u> your private space and has an impact on your life in such a manner that it influences your normal day-to-day life. It leaves you feeling helpless without control.**

The key seems to be that the person who is traumatised loses his or her sense of competence and control. Participants emphasised that helplessness and powerlessness are core features of trauma. The participants said that trauma could be brought on by a host of events such as a death, loss of financial support, being removed from home in childhood, receiving a fatal diagnosis, poverty or being victimised in a criminal attack, but it is the perception that one is powerless to alter the circumstances that makes the experience traumatic:

- **[My worst trauma was] witnessing a close friend of mine being mugged – not having the power to protect her, being helpless.**
- **Trauma is an experience a person has that is accompanied by emotions which cannot be controlled by oneself… I'm traumatised by my parents who used to fight now and then. [Now] there is no**

end … [The fighting and swearing are] removing the family's dignity and respect. It traumatises me. I cannot help it. I don't want them to divorce. I love them all.

This participant feels powerless to prevent the divorce. In a similar vein, participants living in poverty seemed to experience a sense of helplessness brought on by their circumstances:

- **My father was killed by one of our neighbours, he then ran away. When my father passed away, I felt that it was end of the world. He was the breadwinner; me and my Mom did not have source of income in that I relied on my father. I loved my father more than any other thing. It affected me as a person in that I had to start looking for a job. I played his role at home. I'm taking care of everything in the house. I sometimes hate the significant others in that I expect them to play my father's role.**

Poverty seems to create a sense of powerlessness and entrapment. This participant does not seem aware of her resilience in taking responsibility for the family.

- **I had to leave home after my grandmother passed away; there was no one to support me, to pay for my school fees.**

- **At home we could not support ourselves and slept without food. The worst part was when children at school bullied me and talked about how poor we were at home.**

A participant used the word "watching," implying her own powerlessness, as her mother faced death:

- **My worst trauma was watching my mother die from cancer; [I] watched her waste away and suffer for 2 months, after battling the disease for 3 years.**

Participants emphasised that they felt vulnerable:

- **What I understand about trauma is that someone is experiencing a painful moment and that leaves a wound inside their hearts and they are unable to do anything about it and they feel like it is the end of the world**.

- **For me, the core of trauma I would say is, the hijacking of the emotions and your feelings at that time of the incident … the vulnerability. – The experience is traumatic for you, because you find yourself like helpless, you cannot do anything, you're out of control,**

you can't control the situation and there is nothing you can do. You are just caught up in an unexpected position where you cannot help defend yourself and things like you just cannot take control of anything that is happening at that time, or that you fear. I think that's what makes it traumatic.

Participants came to the conclusion that it is the perception of helplessness that distinguishes trauma from stress. The group in Polokwane had a lively discussion about the meaning of trauma, stress and a crisis. It is interesting to note that the language difference between the participants and the researcher seemed to intensify the discussion in this group, because they told her that there is no word for trauma in the local languages (Venda or Pedi) and they seemed very intent on clarifying the distinctions between trauma crisis and stress. The researcher had a sense that they had first-hand experience of what they were talking about from the way they described these concepts.

Stress was seen as something that can be overcome. There is a solution. With trauma one is trapped:

- **FGP 1 Right now, I'm unemployed, ne, I'm stressed because I'm unemployed. If I get that job, the stress can disappear. But with trauma, it's something different, because you have questions that you cannot get answers for, you see.**

- **FGP 2- Okay, let's take it my child is here is going to die… let's take a person's experience in death - okay - the first thing. Once you hear about it, the first thing which comes to you is stress and, <u>because you cannot solve death,</u> - it's going to be a turned into a trauma.**

They felt trauma comes from within while stress comes from outside:

- **FGP 3- Stress I think is something that pressurises you just for a while. Maybe it pressurises you into stress and then, it just disappears. It's not a wound. It doesn't' hurt you inside. It's just something that is pressurising you, like too much of an overload on your shoulders. But with trauma, it's something that's in your mind.**

- **FGP 4- I think stress is differentiated into two - there is a good stress and a bad stress, but with trauma, there's only one <u>bad</u> trauma. If you're traumatised you don't have any choice in the matter, but if you are stressed, there's a way to deal with it… you can find a way to deal**

with stress. …There are a few types of stress. There are the everyday hassles, which we call stress and which we can just ignore and be fine, but there is no every day trauma. You just experience it once and it comes over and over and again. It's automatic, it's - it's controls itself. But - but I think the difference is that you are in control of stress - you can control stress, but with trauma, Nah - you don't have control.

Participants indicated that the loss of control over the situation gives trauma an intrusive quality that is experienced as a personal violation. This suggests that trauma is a threat to the self:

- **Trauma is a personal violation – physically or psychologically. It is an experience that leaves the victim feeling hopeless, helpless and filled with horror, anxiety and fear..**

- **Trauma can be understood as a threat to the physical, social and emotional well being of a person. This threat has a degree of impact on the person, which, at that point in time, seems unbearable to the person.**

Participants suggested that trauma takes over, rendering one powerless to keep the self intact:

- **For me, trauma is a wounding of the mind. We all have coping skills, ways of being and personalities and trauma is a cut of a knife into this place in our minds.**

- **Trauma is a very destructive disease. It takes over your entire being and breaks you as a person bit by bit. You are left with flashbacks that would haunt you forever**.

- **Traumas are those painful experiences in a person that leaves them unable to function physically, emotionally, and psychologically. It is reflected in the changes in their personality, [everyday] functioning, their relationships with others, their behaviours and their perception about themselves and the world. Trauma slowly undermines and breaks the individual's self and their values. It negatively affects the individual.**

As indicated before, Black participants seemed eager to invite the researcher, as a white facilitator into their world and to tell her about the influence of beliefs in the Black cultures that can relieve or create trauma. Participants indicated that cultural beliefs can intensify trauma because of the perception

that the cause is supernatural and beyond one's control. This creates a perception of powerlessness:

- **FGP - Sometimes if a traumatic event has happened, you go to the grave and talk to the ancestors. Yes, some people might think that the ancestors can protect them, at the same time, they can even view the ancestors as the ones who are causing the traumatic event.**
- **FACILITATOR - So … if they see it that way, if you feel it's the ancestors causing the event, what happens then inside?**
- **FGP - <u>You feel like you don't have control over whatever is happening… you become more traumatised</u>, because you can't go to the person and say, "well what you are doing here is traumatic to me." You don't know how to sort this thing out, it's like it's beyond your control - you don't know what to do.**

The belief that one is powerless in the face of trauma seemed to extend to dealing with trauma as well. Many participants believed that trauma cannot be overcome without help:

- **[Trauma] might get worse, if you don't receive any help after the events.**

- **Traumas are unforgettable experiences which happened in the past and *which if left untreated* may hamper the person's life.**

6.1.2. Powerlessness and helplessness from a distanced perspective

Participants indicated that trauma is an experience that leaves the self feeling overwhelmed and out of control. Words such as "personal violation" convey its invasive nature. The intrusive quality of trauma suggests that the person's capacity to protect and defend the self is undermined. The trauma is experienced as an overwhelming response that wells up within the person. This differs from stress, which is perceived as arising from outside. Participants suggest that the self is distorted or broken by the experience. Words such as "a cut of the knife" to our coping mechanisms or "breaking the self" were used to describe it. For this reason, trauma may be seen as an overwhelming threat to the self that leaves one powerless.

As these themes emerged, the researcher constantly reflected on what should be included in a questionnaire on trauma. The DSM IV criteria for post

traumatic stress disorder include powerlessness or helplessness (APA 2000:467-468). In order to receive a diagnosis of PTSD according to this frame of reference, one must be exposed to “an event that provokes extreme fear helplessness or horror.” Several measuring instruments have been developed in an attempt to measure exposure to trauma (Goodman et al 1998: 522; Kubany et al 2000: 210; Norris 1992: 409). These instruments tend to equate traumatic events with those that may elicit PTSD. These questionnaires define traumatic events as those that “pose a threat to life and limb or those involving violent encounters with nature, technology or humankind” (Norris 1992: 409). Participants did not exclude violent encounters of this kind as events that are traumatic, but included other non-violent events that carried a sense of helplessness and powerlessness, such as poverty, watching a loved-one die of a terminal illness, or being distressed by a parent’s impending divorce. Their perception was wider than those included in the questionnaires in the literature. The quotations above suggest that an experience such as being removed from home in childhood is a traumatic event that is accompanied by a feeling of being out of control. Death was seen as trauma because one is powerless to prevent it. Poverty was seen as trauma because one may feel overwhelmed and powerless to control one’s fate. Can one say that the participant’s’ sense of powerlessness when she was removed from home was any less profound than a person’s feeling of helplessness when held at knifepoint? The researcher decided not to impose those limitations on the data and to accept the participants’ frame of reference, including all their examples in the questionnaire. This stance is in keeping with the person-centred approach, which holds that a persons’ own frame of reference is respected and accepted (Grobler et al 2003:89-96). These considerations point to the conclusion that whether an event is traumatic or not can only be determined by the victim him or herself and there is no definitive list of traumatic events.

When one feels powerless the locus of control is outside the person. Naparstek (2006:64) states that the impact of trauma is mediated by the perceived degree of control one has. She says that this is one of the reasons why children are more susceptible to the harmful effects of trauma than older people. Events which may be manageable as an adult, such as death of a

relative may be traumatic to a child by virtue of the child's greater vulnerability and dependence.

Participants described regaining control as "finding answers" or "finding solutions." If one can "find answers" the situation is regarded as stress, but if one cannot find a solution, they concluded it is trauma. This suggests that the core feature of trauma is that it is a threat to one's capacity to solve something and regain control. Roger's proposition 4 suggests we are motivated to preserve and actualise the self. The inability to regain control in a traumatic situation seems to be experienced as inability to defend the self. So the core of trauma seems to be that it is an experience that is a threat to the self that leaves a person feeling overwhelmed and incapacitated.

6.2 TRAUMA IS PAINFUL AND THE PAIN IS PERSISTENT

6.2.1 The participants' perspective

Participants said that one of the defining characteristics of trauma is that it is a traumatic experience is painful. Participants used metaphors of injury or disease to describe it. Trauma was likened to an ache, bleeding inwardly, a wound, a disease and inner death, indicating that trauma has a range of intensity. The pain of trauma seems deep and persistent. The terms "wound'" and "disease" suggest it inflicts prolonged suffering on a person:

- **Trauma is a wound or a painful experience that you will never forget. You can get healed from a traumatic experience but you will always talk about it.**
- **Trauma is a life changing experience that causes you to bleed inside.**
- **[Trauma is] Something that aches the heart. An experience that is difficult to forget. Something that windmills over and over again in your head.**
- **[Trauma is] a painful experience that re-occurs, gives terrible dis-ease which doesn't go away.**

Trauma is experienced as something which is carried inside the person:

- **I still carry elements of the perpetrator of the hijacking with me**

- **I would like to say, that stress comes and goes, but with trauma, it's different, because if you lose a child, eh, you will accept [it], but you will never forget. So it will still last, it will still remain within yourself.**

- **Ja, [yes] I think trauma is an experience that is so painful; it's like a wound that it destroys your inner being. It destroys your relationship with other people and even with yourself.**

The ongoing nature of trauma gives it a quality that is particularly difficult to bear:

- **It's a wound that stays within you at all times that you have no control over it.**

- **…you just want to ignore it but it just doesn't go away - it keeps haunting you.**

6.2.2 Pain from a distanced perspective

The aspect of pain as part of trauma seems largely overlooked in the literature. As stated previously, researchers in this field seem to have equated trauma with incidents with the potential to trigger post traumatic stress as it is understood within the framework of the medical model. The person-centred approach does not engage in diagnosis and labeling of disorders or mental illness, as does the medical model on which the DSM-IV-TR (APA 2000) is based. Nevertheless, it is interesting to compare participants' perspectives with those in the literature.

When trauma was first introduced as a construct in the DSM, it was thought that trauma could be defined exclusively in terms of catastrophic events that were rare and overwhelming. It was thought that these catastrophic stressors differed qualitatively from common experiences such as death, business losses or marital conflict. It was assumed that anyone exposed to "catastrophic events" would in turn be "traumatised." However, it became apparent that it is not exposure to a catastrophe per se that is significant but the response to it (Friedman 2006: 2). Participants in the research concurred with this. They did not describe trauma in terms of the event itself, but in terms of how it is perceived and experienced. According to the criteria suggested by the DSM – IV TR, the response which qualifies one as "traumatised" is fear helplessness or horror. Friedman (2006:3) states: "Only people who respond

to catastrophic events with fear helplessness or horror have been traumatised as defined by the DSM-IV(TR.)" The inclusion of pain as a key feature of trauma broadens the concept considerably and does not limit it to events that provoke fear helplessness and horror. This is at odds with other writers in the field. Matsakis (1996: 16) states:

"Trauma in the technical sense of the word, refers to situations in which you are rendered powerless and great danger is involved. Trauma in this sense refers to events involving death and injury or the possibility of death and injury. These events must be unusual and out of the ordinary, not events that are part of the normal course of life. They are events that evoke a state of extreme horror, helplessness and fear, events of such intensity that they would overtax any human being's ability to cope. For example, although the loss of a job or a parent may change your life forever, these events are not considered traumas because they are expected life losses."

In contrast to this, participants conceptualised trauma far more broadly. Painful events *were* seen as trauma. In fact participants included some seemingly "ordinary" life events such as poverty and caring for a sick family member as trauma. In terms of their perceptions, trauma is an event that provokes fear, helplessness horror ***or*** pain. This broadens the range of events that can be construed as trauma considerably.

Naparstek (2006:96) suggests that sorrow and deep grief permeate the emotions of people who have suffered trauma. They mourn their lost innocence, their lost childhood, their future hopes and dreams or a reasonable, safe world. Less abstract losses include lives, homes, income, limbs, loved ones and abilities. Others may mourn their loss of faith in God or their fellow man. These considerations suggest that a wide variety of events, including "expected life losses" may be experienced and conceptualised as trauma.

6.3 TRAUMATIC MEMORIES DIFFER FROM EVERYDAY MEMORIES IN WAYS THAT PERPETUATE THE TRAUMA

6.3.1 The participants' perspective

Just as the trauma itself is beyond the control of the person, traumatic memories are not recalled at will, but pop up uninvited. This perpetuates the

sense that one has lost control. Participants said that their own memories of trauma have a unique quality in that they involve a re-living and re-experiencing of the pain and, as the participant above said, trauma is always bad:

- **My trauma is a wound occurred during an accident, an emotional wound which always visits my mind when I see that place the accident occurred at.**

An Indian participant from Kwa Zulu Natal, who did not disclose his occupation, described an incident that had remained vivid in his mind;

- **For me a traumatic experience was whilst at work. We came on duty and got an incident of shooting in a particular area. As we got to scene we found about twenty-three people hacked to death along road about two kilometres. We found them along the entire road about few metres apart. They were sort of chopped in layers. The last person was a child. She was about a year. Although she was dead her eyes were open. I can still see her looking at me.**

- **FGP 1- Traumatic memories come in dreams - in a flashback form. You are out of control of the traumatic memories, whereas on the daily memories when you're in a good mood, you mostly remember the thing that happened when you were in a good mood, … you are in control of your daily memories. They are not as automatic as [memories of a] traumatic experience – but you re-live those traumatic experiences and fear and emotions and stuff. But the daily memories, you can think of those and say, 'oh, that day was horrible,' but you're not feeling horrible anymore.**

One of the participants in the focus group suggested that just as the traumatic event has an intrusive quality, so do memories of the event. She also indicates that memories of trauma are destructive to the self:

- **FGP 2- There is a difference between everyday memories and trauma[tic] memories. Everyday memories are based on your actions. They are based on your choices and your decisions and you have control over them. You can pull them out at any time, and review them, reflect on them and, as she said, it will help you to grow and realise your errors, your mistakes or when you have excelled. But with, trauma unfortunately, it is not [there] by choice, it is something forced into your mind. It is not there because you want to put it there, or you want to have it in your memory or in your database, it is something like a virus that's not supposed to be on your computer system. Something that you were not supposed to experience. As if**

someone held a gun to your head and put it there. So what happens, it's the same way a virus will slowly start to eat every program in your mind and it affects the functioning of you. That's the difference between memories and trauma memories.

Participants said that a peculiar feature of traumatic memories is that they have the capacity to stay latent but may be triggered unexpectedly and seemingly spontaneously.

- **And the other thing is that trauma is not just the experience that you experience now. You can experience the event long time ago and you start feeling it after a year, because at the time it happened at you distort it and then after a year, you experience it- you start feeling the bad things, and like your life is helpless and everything changed - just at that time.**

Jaco disclosed that he had been through a horrific hi-jacking where he was abducted and held in the boot of the car for three days:

- **I was hijacked and it only came out two years later that I was suffering from posttraumatic stress. The day afterwards, I got into another car and I just drove off like nothing happened, and two years later…**

It did not seem to be only memories of frightening events that could re surface after a period of time, maybe not in the lived form of memories of painful events, but with intense pain nonetheless:

- **I was raised by adoptive parents and when I was a teenager they both died. I had difficulties dealing with it. After two years it hit me and I was hospitalised for six months. I realised that I did not deal with that trauma. The fact that my biological mother died also made it even harder. I thought that everyone that I love automatically would die. Loss is a major thing to me. For a long time I was afraid of dying, thinking that I don't want my kids to go through the same experience.**

- **The death of my parents in a car accident was and still is a traumatic experience for me. When my younger brother lost his son, this triggered all the emotions that I had at the time I lost my parents.**

6.3.2 Traumatic memories at a distance

The processing of memories was discussed in Chapter 5. Much research in the field of trauma has been carried out on animals that were subjected to frightening or life-threatening situations (LeDoux 1994: Seligman 1975; Van

der Kolk et al 1996a; Van der Kolk & Fisler 1995). These studies have demonstrated that memories of everyday events and those of frightening events are processed differently. LeDoux (1992) has shown that fear leads to the activation of a “short cut” in the memory system, bypassing the cortex and leading to the formation of an iconic rather than a narrative memories of frightening events (Van der Kolk et al 2001: 25). It appears that emotionally charged non-threatening events do not trigger the cascade of chemicals such as adrenalin and endorphins that characterise the response to terrifying events (Van der Kolk et al 2001:17). Memories of fearful events seem qualitatively different to other painful or everyday memories in that they do not fade. Van der Kolk et al (2001:27) note: “Their [trauma victim’s] bodies may respond as if they are being traumatised again, with the secretions of the various neurohormones that are mobilised on those [trauma-related] occasions, but the retrieval of the memory is dissociated, and the victim does not seem to be able to “own” what is happening.” Beauleau (2003:36) says that under non-threatening conditions the memories laid down are explicit and can be symbolised. LeDoux (1992:277) has shown that when a threat is encountered, memories are implicit and unsymbolised, because the amygdala lay down memories of emotional experiences independent of the cortex, so they are not fully integrated.

Participants indicated that memories of traumatic events differ from other memories. However, the specific events to which they were referring are not specified. It is not clear whether they were suggesting that events such as poverty or illness had the recurrent, intrusive quality that is described within this theme. As discussed in Chapter 5, the literature suggests that one of the distinguishing features of terrifying events is the discharge of chemicals such as adrenalin, nor-adrenalin endorphins and encephalins that change in memory processing. This cascade of chemicals seems unique to emergency situations. The associated changes in memory processing seem unique to emergencies as well. Traumatic memories of emergency situations have a unique quality in that they persist as flashbacks and may remain latent. They have a lived quality that seems lacking in other painful memories. This seems to place emergency situations in a class of their own when considering what

constitutes trauma and these events may be a basis on which the definition of trauma may be narrowed.

Participants did indicate that when there is a theme of loss for example, similar emotions may be triggered in each situation, but they did not imply that these memories were in the form of flashbacks and bodily experiences as in the case of memories of emergencies. One of the key features of traumatic memories, whether these are memories of frightening or other painful events seems to be that pain is perpetuated by the memories and this is the key feature of traumatic memories.

6.4 A core feature of a traumatic stressor is unpredictability

6.4.1 The participants' perspective

The outcome of traumatic events is unpredictable. Participants also felt that a core feature of trauma is that it creates uncertainty and that triggers uncertainty, anxiety or fear. The uncertainty may revolve around the incident itself, including whether or not one will survive. Ricky, an Ndebele participant who had moved to Johannesburg, told the focus group how he was held at knifepoint, was stripped of his clothing and robbed. The perpetrators were two Zulu men. He describes his sense of terror and feeling of uncertainty as he could not predict whether he would live or die:

- **All of a sudden, you just find yourself caught up into that web. You are begging for your life, "Oh please, Guys, don't kill me. Please Guys don't kill me!"…. – Ja [yes], I walked away with life- like I begged for my life Jaco. And now I value life man! I begged for my life. I knelt down and then you know what, they also took my clothes off! I was left with an underwear. And when I was wearing an underwear, they also peeped inside the underwear to see whether I had money or not! You understand, you can see how traumatic it is... the other one was saying, "man, let us kill him and throw him in the dam" - you understand, in the dam, inside the reeds, so that is when I started to beg him "man, I've got a daughter, eh, I've got parents I'm looking after…"**

As long as the outcome of the event remains unpredictable, the person is unable to get closure and remains anxious and watchful. This causes the trauma to linger:

- **My neighbour was bombed and the grandparents and two grandchildren died. My family was suspected and we were living in fear because that family promised that they would take revenge. Every time we hear a noise we think it's them coming back to attack us. Every time [we hear a noise] we have flashbacks of what happened to our neighbour that day. We still live in fear that something might happen anytime.**

One may expect a painful experience such as death, but the timing thereof may be unpredictable. In a similar vein, if one is ill, one may experience the course of the illness and the intensity of suffering associated with it as unpredictable.

Participants emphasised that their cultures varied widely and that they themselves did not necessarily hold to traditional beliefs. One focus group participant, Rose, described how her family were traumatised by being told by a traditional healer that they would all die, but not knowing when. The uncertainty seems unbearable. This Pedi woman described the trauma in her family after the death of her mother in law. The traditional healer told the family the dead woman had become a *zombie.* As it was understood by the researcher, the belief is held that a person's spirit may not depart to be with the ancestors, but may wander in a lonely in-between state. The body is thought to be merely an image of the real person. The real person is believed to be a zombie, a being in a state of "living deadness," unable to speak because he or she has no tongue. This zombie is believed to be capable of causing suffering or to return and take family members to join him or her as a zombie. She said there are no helpful rituals to ward this off. When her mother in law died, she felt that the Inyanga (traditional healer) had caused trauma by creating fear and uncertainty in the lives of the children. This quote from the focus group discloses her distress and outrage about the suffering caused by beliefs that she no longer subscribes to:

- **FGP - I think I once shared with Ricky, because he knows- spiritually we shared a thing, we have this problem whereby my mother in law died in December, and at the moment, because the family are consulting inyangas [traditional healers], they're saying, she is somewhere behind the door with this big snake! Can you imagine how traumatising it is for her kids, you know, to hear that their**

mother is somewhere behind the door - you know - with this big scary snake! I mean, snakes are scary - imagine having to stay with that python or is it a python or anaconda? Nobody knows! The children are remaining behind and they hear that, you know, they[the healers] say 'your mother is alive, she is somewhere with this big snake behind the door and her tongue has been cut off so that she mustn't talk, [cannot talk] she mustn't say anything [cannot say anything].' You know these things are traumatizing the kids! You know, although they are big, it's traumatizing having to think about it - imagine your mom - I mean, it's a person you love, you know - thinking that she's sitting there somewhere with a snake! - Maybe the snake is licking her, who knows what's happening behind that door! … You go back home, you sleep, you have those nightmares and then you wake up and then you think about it - she is out there - you know - I don't think it's the truth. And then he [the healer] says to you - the inyanga [healer] goes on saying, "okay fine, I'm going to help you" then the question is, how are you going to help us? Are you going to kill that person because you're saying that person's alive? Or are you going to bring back that person? When you bring back that person, are we not going to be scared, because we saw that person lying in the coffin?

- **FACILITATOR - The uncertainty is worse?**
- **FGP - Exactly! Exactly! The uncertainty is worse, so the trauma stays with you there, … you know the kids, they are three boys, so they are saying, through your conservative years, you are going to have death in your family - three remaining boys, so it means you are going to follow each other dying - (big commotion in group) - really it's traumatizing!**

These participants were clearly distressed by the feeling something bad is going to happen but not knowing when. Many students all talked at once, agreeing with Rose about the distress caused by the explanation of the traditional healers in this case. There seemed to be a commotion because most students appeared to be cynical and angry about such beliefs. It is however not possible to hear and transcribe these comments from the tape.

Participants suggested that they were on the lookout for danger. After being mugged two respondents said:

- **I am wary of people, always watching my back, also I mistrust others.**.

- **I'm always on the lookout for strange faces. I don't trust people when I walk in the street**.

*

The unpredictability of the incident leaves the person alert and watchful, on the lookout for danger and trying to ward off future incidents. This is discussed more fully in the next chapter on the effects of trauma.

Traumatic experiences come as a shock. Life does not follow a predictable course. One's expectations are shattered. Although one may, for example, assume one is "going home," one suddenly finds one's home no longer standing, as happened to one participant:

- **My worst trauma was when a truck full of bricks turned over and drove over our house. It destroyed everything in the accident. When I came back people had stolen our stuff at the gate. I didn't know what happened or where to go for that matter.**

One may be deeply shocked by the brutality or cruelty of others:

At first the researcher thought that participants were saying trauma is a sudden event. However, closer examination of the data seemed to show that it is the *unexpected* nature of the event, rather than the suddenness that is the core feature of trauma

- **[My worst trauma was] The loss of a close loved one - my grandmother about 80 years, [was] raped in the fields by 15 young boys with condoms and thrown in a ditch still alive. [She] landed in ICU when found and died a few hours later. Men are now changed into creatures, which women have to fear. [They are] no longer there to protect, but to destroy.**

.Events that do not fit with one's expectations were described as traumatic. When one is deeply disappointed in life or people, one's perceptions about the good faith of others may be shattered:

- **My sister took care of her boyfriend (he was sick) and paid his school fees but when he completed his school he dumped her leaving her with three kids. It was so painful for her that she became aggressive. She did not want to talk to anyone. She could not eat, her work was affected and she could not function.**

- **I separated with the father of my two kids, whom we were together in our customary marriage for decades. Our relationship broke in 2001. He did something that I never though he would do, burning property**

(two microbuses) of my parents. My family became so angry. I was also shocked. Since then to date we have never met, he doesn't have any contact with his children. At this moment I want him to have a fatherly relationship with his daughters and maintain them. But at the same time, I have this fear inside. Since he has done arson, I perceive him as dangerous, capable of burning [things] and being insensible [behaving senselessly]. … I was the one who heard the cars exploding and saw the flames. That thing cannot go away from my mind.

Betrayal seemed intensify the trauma:

- **When I was twelve years old I was sexually molested by my father. This was very traumatic to me, because I trusted him and loved him because he had adopted me and taken me in when I desperately needed the security - (my mother abandoned me and I never knew my father). I later found out that my biological mother passed away from Aids.**

Participants indicated that trauma shatters one's expectations. It seems that prolonged trauma such as living with abuse or chronic illness may not be sudden or unanticipated, but it still does not fit with one's expectations of what things should be like:

- **My worst experience was being traumatised by people whom you think are the one who are meant to help you.**

Cherished values such as faith in God may be questioned as expectations are thwarted:

- **I was traumatised by having a miscarriage. I blamed God for not looking upon me. He should have prevented it.**

- **A painful trauma was when I lost someone i.e. breadwinner in the family because he was the one who was responsible for everything for me. I can't stop remembering him because I remain lonely and hurt. I blame God for what happened to him and [ask] why He let him die.**

Trauma does not fit with assumptions about life, the future or others. It feels as if nothing is the same as one formerly believed. There is a loss of previously held convictions and loyalties, which are questioned or rejected:

- **Trauma brings with it a strong feeling that leaves you shaking to the core of your being. It changes the way you look at life, people around you, yourself and the systems of government.**

- **Trauma slowly undermines and breaks the individual's self <u>and their values</u>, and negatively affects the individual.**

A participant whose 80-year-old grandmother was raped and left in a ditch to die said:

- **Trauma changed my behaviour and perception of the world I live in. I kept on hearing this voice in my head which made it bad for me to live in this world. I just wanted to isolate myself from people.**

Trauma is an experience that does not fit with the self. One may behave in ways that leave one feeling that the self is unpredictable and alien.
One participant indicated that being a perpetrator is traumatic:

- **I somehow feel guilty about something I did to someone. A kind of guilt which turned out to be trauma because I felt as if it was not me, but anger which perpetuated in me or anger that was living in my memories [that did it]. I sometimes think about killing myself, but I recently started therapy.**

The discrepancy with self may extend to one's failure to meet expectations within the family or culture. One participant described the impact of bearing a stillborn child like this:

- **I am not accepted in the family because I broke the family's rule.**

An experience that does not fit with the self can elicit distressing feelings of guilt:

- **In my home domestic violence was something that I experienced on a daily basis. My Mom was the so-called "father" - she worked very, very hard to [get] us educated. God please forgive me but I prayed day in and day out that he should die and things would change at home and we could be happy. But my life changed when my dad was shot and killed and the first thought that went through my mind was "now we will have peace at home." It killed me inside because I could not share this with anyone and now I miss him terribly and I pray to God to forgive me for this horrible thought that ran through my head everyday.**

A participant who had an abortion, which turned out to be against her values said:

- **[I had an abortion and it] affects me badly. I regret it everyday of my life, even though I know God has forgiven me because I was not a Christian at the time. I still feel like a murderer. When I speak about it I feel trapped, threatened and [have] lots of regrets. I actually feel condemned.**

The discrepancy between her belief that she is forgiven and her feeling of condemnation is obvious as well as the perceived discrepancy between her actions and her view of herself as a Christian, which cause deep distress.

Participants indicated that trauma changes one's perception of oneself and others:

- **Trauma is a bad experience that happens in one's life and leaves one with feelings like anger, fear or horror. Those feelings makes you feel empty inside, helpless and always doubtful of anything and everything. It's an experience that changes your entire life, your perception of yourself and other people.**

It seems that this alteration in perceptions has lasting effects on the person.

- **It actually affects the self in a way in that you are never quite the same again.**
- **Trauma can change a person from being optimistic to being so negative and hopeless.**

The impact on the self concept and inability of the self to defend and protect itself links up with the theme of powerlessness and loss of control as core features of trauma:

- **It works in a way that it changes your concepts, the way that you see yourself. As human beings we develop a self-concepts as we go along in our daily lives and when our self-concept is threatened, we tend to defend our self and when you are in a trauma - when you experience something that's traumatic to your 'self', I believe it's when all your defence mechanism have failed. You are unable to defend your self-concept and it has been shaken or altered in a way**

that doesn't fit with who you are or how you see yourself. You're seeing something different from how you [used to] see yourself.

These ideas suggest that trauma is an overwhelming threat to the self. Participants suggest that trauma is a life-changing event. From these quotations, it may be seen as a "self-changing event." Changes in the self cannot be escaped or left behind and perhaps this accounts in part for the persistent nature of trauma.

6.4.2 Unpredictability at a distance, as supported by the literature

Naparstek (2006:52) states "Behavioural psychology has long demonstrated that a distressing event that can be counted on to come and go with regularity is far less destructive than one that follows no rules" Predictability allows one to prepare and adjust one's behaviour, giving a sense of control. Unpredictability robs one of control and puts one on the defensive. The threat to the person is therefore intensified by unpredictability.

Participants' perceptions that trauma is an event that alters convictions and shatters perceptions is similar to the findings of Janoff-Bulman and Frieze (1983). It is interesting to note that participants living in South Africa came to similar conclusions to these overseas researchers. Their research suggests that being victimised disturbs one's beliefs about the fundamental goodness of people, the benevolence of the world and view of oneself as invulnerable. A person who is traumatised is confronted with a sense of personal vulnerability, leaving the person afraid that the incident could strike again. The person may wonder why he or she was singled out for such suffering. Some may conclude that the trauma is punishment for some perceived wrong. Others may conclude that they will always be victimised. It may seem as if the world is no longer reasonable and orderly, where bad things happen to bad people and good things happen to good people. If it were so, one could avoid future pain by being careful and good.

Trauma brings vulnerability to the fore and this may be experienced as weakness (Matsakis 1996:87). People may blame themselves for actions

taken during the incident. A person for example who is molested and co-operates with the abuser may seriously question," how could I have been part of that?" These factors may combine to damage the person's self-image (Matsakis 1996:87).

Predictability fosters trust, while capriciousness undermines it. When God or others are perceived to act in ways that are uncertain and unpredictable, the person may lose trust in God, the government, a person or cherished ideals. These losses seem to add to the emotional pain of trauma (Naparstek 2006:97).
In particular, betrayal seems to add to the intensity of the trauma (Naparstek 2006:50). This is aspect of trauma breaks one's security and trust, intensifying the threat to the self.

It seems to be the *discrepancy* with the self rather than the incident itself that makes the event traumatic. For example, emergency workers, paramedics and fire-fighters may be exposed to incidents that are painful and distressing and emerge with no ill effects because their perception is "I am there to help. This is part of what I do" (Friedman 2006:11). If however the person is unable to save someone, the event may be transformed into trauma, because it does not fit with the self as a rescuer. A person who is a parent may experience the death of a child as trauma because it does not fit with the self as a parent-being a parent is defined by having a child.

The idea that trauma is an experience that does not fit with the self can account for the wide variety of responses that individuals display to seemingly similar events. These responses depend on the unique perceptions of the person. Participants agreed that although perceptions of what is or is not traumatic may differ from person to person, the experience of pain is a universal experience that is shared by us all.

6.5 TRAUMA IS BOTH INDIVIDUAL AND UNIVERSAL

6.5.1 The participants' perspective

Participants emphasised that whether an experience is traumatic or not can only be determined by the person him or herself. There is no list of incidents that can cover all instances of trauma, nor is trauma limited to specific experiences. It all depends on how the experience is perceived by the individual:

- **Trauma is the way I give meaning to things**

The comments made by two participants with respect to having an abortion illustrate that the same experience may be given different meanings, depending on how it fits with the person, in this case how it fits with their values:

- **I get very angry with people who are so strongly pro-life that they'll rather have starving street children than abortions … it was the right thing for me then, it may be completely different under different circumstances.**

- **As we know that killing is against God's law, I always feel that I am a killer. I never discussed this with anyone as I don't feel good about it.**

Participants felt that whether something is traumatic or not rests with the individual him or her self;

- **FGP. I don't think that for a woman that has been abused or a man that has been abused, domestically, physically, emotionally, socially, whatever - it is any different to a once off isolated hijacking, robbing, whatever. I think the self has been twisted and turned …- never put a degree on how deeply the self was changed or touched or affected by this trauma - I think each and every case should be not judged, but assessed or listened to by merit…what is traumatic for that experience or that person at that point of time should be allowed. If it's isolated just to my hijacking or your domestic violence, I don't think you can pin a degree of severity or impact on it… I think to be on the safe side, trauma's trauma, no matter how it's experienced - no matter what the impact - no matter how prolonged the impact of this trauma to the person. I can even expose myself to my own trauma . I don't think we need to box things.**

Nevertheless, the pain of trauma seems to reach into the heart of our humanity and trauma was seen as a universal human experience:

- **FGP 1- At the end of the day we are human beings, and we reflect our emotions in the same way… And the way we experience trauma is the same, because of the pain - everyone feels pain no matter what race, colour or creed you are. Especially, everyone cries in the same way, everyone feels loss in the same way, so to me, trauma has no boundaries of colour or race at all.**

- **FGP 2- I think trauma is the same in all cultures. We said before that trauma comes from the bad experiences that one has, the bad experiences in the person's heart - not on the outside - not in the person's bag - but in the person's heart - so I think everyone experiences trauma in the same way.**

As Rogers, cited by Cain (1990:93) said "that which is most personal is also most universal."

6.6 TRAUMA MAY BE INTENSIFIED BY OTHER FACTORS

6.6.1 The participants' perspective

Participants said that certain factors can intensify trauma. (Some of these ideas may have been mentioned in the literature survey.)

Dehumanisation of the victim intensifies trauma

Jaco, the participant who had been hijacked and abducted was kept captive in the boot of the car for three days said:

- **And the experience is real - that experience is real … the day that it happened and I got back home and I was full of grass and whatever, being dumped and I lost my one finger nail and I was full of car grease because I was pushed into their car's bonnet and they drove off with me and I was gone for three days. Can you imagine having to go to a toilet and you can't, you're in a car's boot? You're not fed; you're not given water-anything**.

Proximity and gruesomeness intensify trauma

Participants indicated that trauma can be intensified by the gruesomeness of the incident. Participants also noted that the more personally affected one is, the greater the trauma:

- **It's the level of violation, because with the rape scenario, what really happed, is this person is violating your inner being. Everything inside of you- it's a physical attack on your "self". But in terms of just stealing your handbag and running away, you know, he may have touched something of yours, but he never touched <u>you</u>. The inner you is still protected.**

- **In my location there was one family, where the husband just decided to just burn all of them - the mother the sister and the two other children. He locked the house, put the key there and he just burned the whole house. … With me it affected me, but it was not traumatic as such. It affected me for that whole week, because they were people that I knew. I kept thinking about them and what it was like being in there …I just imagined myself. <u>It's only when you start rehearsing it through yourself that it affects you, and you start thinking, what if this were to happen to my family?</u>**

Empathy for the victim may intensify trauma
Participants noted that one might be traumatised by other people's experiences, not just your own, depending on the degree of empathy for the victim:

- **FGP 1- I had a case where I had a client of 17 years old. She explained to me that she was waiting on the other section at Umlazi and she was approached by 7 guys. These guys took her to the abandoned house and all of them - 7 of them, raped her and they started by tearing everything on her body, by using the knives and she was - I don't know how I can explain this, and then they raped her- all of them, then they left her alone there. When she woke up, she was all alone, having nothing to dress up herself. She was absolutely alone and I till today, if I think of that case, it's a shock to me!**
- **FGP 2- wouldn't it have affected you the same way if you experienced it on television?**
- **FGP 1- I ah - I don't know about television, but the client coming to you as a therapist, <u>you put yourself on that person shoes and then you feel trauma- ja [yes].</u>**

One participant said he felt traumatised by living in South Africa, where constant crime and violence were affecting his perceptions about life:

- **FGP - For me, in a way you are traumatised in such a way that you look at people in a different manner. – there are children that look up to us as adults, as people that should protect them, so it shakes your belief in people. It shakes your trust in people, and it shakes your self**

-image as an adult. As somebody who should be there to protect those that cannot protect themselves. So somehow, for me - for me, it's very traumatic. … somehow I'm a part of that family. I'm part of that community. I become a part of those people and it really shakes me. So for me, it's very traumatic.

- **FACILITATOR - So you're feeling that there is this - this just knowing about these events, being part of a society where these events happen is altering the way you think, the way you feel - your assumptions about ... and the world.**
- **FGP –Exactly.**

Self-blame intensifies trauma

When one feels personally responsible for the harm that came to someone else or felt unable to protect someone, the effect of the experience is worse:

- **FGP - And another thing for me, it's how you relate that incident to the self. I, for example, last year I was involved in a car accident. It was a taxi accident, but the experience is not so traumatic as the day when I was a driver and I had a car accident and I hurt some passengers, and one of the passengers was a pregnant mother and that experience lives with me.**
- **FACILITATOR - So when one feels - somebody also spoke about when you feel responsible for somebody or someone hey, and you feel you haven't been able to carry that out, it just makes it so much harder.**

Duration affects trauma

Participants said that duration influences trauma. Although trauma may be intensified by prolonged exposure, they noted one may become desensitised to trauma.

- **FGP - I think that the expectance of something like hijacking is not the same than say incest where you live in this house, you know this is going to happen, you somehow you ease yourself into it, where hijacking is totally unexpected and that moment you are totally overwhelmed! But maybe for the first time when incest happened, you can have the same experience, but if it happened over a period of time, you get used to it, as bad as it is, but you get used to it and you are buffing yourself against it – ne?**
- **FACILITATOR - So you feel if it's an ongoing thing you potentially become more, um, almost numb or desensitised to it?**
- **FGP – Ja [yes] - totally desensitised.**

Silencing the victim intensifies trauma

Participants related that when the pain of the victim is not heard or respected the trauma is intensified. This seems to perpetuate the powerlessness and helplessness discussed previously:

- **I was molested when I was 10 years old and when my mother found out at a later stage my father denied that incident. My family looked at me like an unworthy child who wanted to separate the family. My grandmother said we must keep it to the family and not involve the police. Now I have a daughter and it scares me to see my father putting my child in his lap. It reminds me of what he did 16 years ago.**

Participants explained that the perpetrator may be exonerated, by performing a ritual and paying compensation to the family, while the victim is left suffering in silence:

- **FGP 1- In our culture - Zulu cultures, you know, when people like a father rapes his daughter, or an uncle sodomises his nephew, then they call it Ishlazo! [a disgrace]. So to minimise the incident that person can pay [by performing] some sort of ritual because the ancestors are now angered, but the survivor of that, can't get nothing there!**
- **FGP 2 (White woman)- Sorry, can I ask a question? Does that mean that by paying that money to the family, does that make it okay then, that he's done what he's done?**
- **FGP 1 - No, it's like you know - … you broke the boundary, you can't touch your blood [relative] like that - you can't have sexual intercourse with someone whose your blood [relative].[If you do] then your ancestors are angry against you, so you have to maybe pay - maybe income, maybe one cow to cleanse that person. But to deal with the emotions and all that sort of things, no.**
- **FGP 2- Does nobody deal with the emotion? (No) Nobody? (No)...**
- **FGP 3- No - I wanted to answer C - no it doesn't make it [morally] right, but it's a way of apologising to that family, because mainly in rural areas, - they don't like the thing to be exposed, you know - they just like to keep everything in that family, if it was a family member, but other neighbours they don't have any idea of what happened. So that's the only way of dealing within the family, paying that kind of compensation. The person should pay in order to cleanse that person. Usually you pay a sheep, saying that you're cleansing the family. But then it still doesn't make it right.**
- **FGP 4- Okay what had come up for me is that this paying things doesn't resolve feeling the trauma to the child. It just resolves the trauma to the family. They don't care about the child who is experiencing this trauma, so the trauma will always be there, it's just**

that some cultures are ignorant about dealing with the trauma with the child.

- **FGP 5 And there are some communities where the door is still closed; "let's deal with this here, okay. You were raped, it's fine, you're not pregnant and it's fine. Let's go on with life!"**

Disrespect intensifies trauma

Participants felt that insincerity and gossip adds to trauma:

- **FGP 1- Ah, in case of the support of the community, I don't think it happens with all cases of trauma. Mostly it's in the case of death where the community would come in and they would be sincere about their condolences and stuff like that, but not in other traumas. Okay, some years back - more than 15 or so roughly more than 10, I was in a divorce and then the people came in. At first it looked as if it was for support, but then, eh, I was traumatized and they put me again under another trauma. It was the trauma from the divorce and another one from the community, because now, they came in they were just fishing for information. Then they were taking this information - spreading it, and then some of the people got the information, spiced it up and then it was - wow - just a big ball of fire that was going about…- I reached a point where I broke down**
- **FGP 2- Well, just to add onto what K was saying as well…, but in most communities people just have something to say. They just always talk - they love indaba [discussion.] They can come to you all nice like, "ah, I mean, so sorry!' they go outside, "SHOUTING YOUR BUSINESS" (laughter from group) seriously, you know, they just spread the news and they don't want to tell it as it is, they have to spice it up, with a little sugar, and make it worse!**

Blaming the victim intensifies trauma

Participants also felt that trauma is compounded by blaming the victim. Certain experiences seemed to carry a stigma and the victim was left isolated and misunderstood: Ricky, who had been held at knifepoint and robbed was upset that people criticised the way he responded:

- **FGP - Some of the people when you undergo a traumatic experience, they will tell you, 'why you didn't fight those thugs?' you know? - and at that time they say, 'they pointed a gun to you, you did not do anything to them!' - people say you are powerless, you know, they say you are weak - they perceive you as you are weak - and you start to be angry with everybody… 'Why you didn't fight back? You are powerless, you are soft, you are weak.' That is the perception you find from family and friends.**

- **Trauma [is] something that may also makes you self-conscious - after a car accident I was involved in, my face became scarred. I lost self-confidence because [others] were gossiping and staring at me, saying some hurtful things like [that] I got injured because I was involved with someone's husband and that person stabbed me with a knife.**

Participants shared some cultural beliefs that contribute to blaming of the victim and marginalisation of women:

- **FGP 1 - Yes, … I understand that culture it has got the bad and the right, (Lots of laughter) so here we are trying to look on the bad side of the culture, which is contributing to the increase of the pain of the trauma. Like another example, you find that in my [Zulu] culture, lets say I'm the husband of somebody and I die now, through a car accident. Generally you find that they blame my wife, saying that she bewitched me, you understand? If my wife dies, they will not come and finger point *me*. It means that when she's still grieving, for me, they also put blame on her. You know, those are some of the dilemmas…**
- **FACILITATOR - It adds to the trauma.**
- **FGP 2- Ja [yes], exactly. When it's the man who's dead, then they blame the wife. Normally, it's from the fact that women used to depend on men. They will work and work and work and so they will be thinking that maybe the wife killed the husband so that she can be rich and then enjoy [herself] with other men. But if it's the wife who's dead, the men are not to be blamed at all.**
- **FGP 3- They even tell us to get married again!**
- **FGP 2- They tell us to get married so many times.**
- **FGP 3- But woman are not allowed to**
- **FGP 2- Barbara, [facilitator's name] another example is that eh - let's say my father is 90 years old, you know like in my [Pedi] culture, if he passed away when he was 93 years old , the belief in my culture is this: Whenever anybody has died, they go and consult [the traditional healer, believing there must be a reason - it's either a witch - somebody has bewitched that person – or they say that there was a noise in the house - conflicts in the household, you know, jealousy - stuff like that. They don't actually just believe that it's natural you know. He was 93 years old! - He had lived his life! - So when my mother is still grieving, some other people are going to consult the sangomas [traditional healer] and they will tell you that "ah no, no he's not dead that person, that person might be a zombie somewhere' –[implying that he was bewitched by his wife]**
- **FACILITATOR - A zombie …**
- **FGP 1- Ja, you understand - it means that when she's trying to heal, this is another trauma on top of the other one.**
- **FACILITATOR - Another worry.**

- **FGP 1- Ja,…even these sangomas, they cause a lot of conflicts - they cause a lot of conflicts.**

6.6.2 Intensification of trauma from a distance

Matsakis (1996:90-91) warns that people who do not understand the trauma victim's situation may be cruel and insensitive. She refers to this as "secondary wounding." She suggests that secondary wounding occurs in various forms. People may respond to the person with disbelief, denial or discounting. Commonly, the person's account is disbelieved or the magnitude of the trauma is misunderstood. Participants referred to this as they described how the victim may be silenced. People may blame the victim for the trauma or question what they did or did not do during the incident. Ricky has described this. The person may be stigmatised for his or her reactions to the trauma. Comments such as "you should be over it by now" or punishing the victim rather than the offender can be deeply wounding. This phenomenon was described in relation to widows in certain cultures. Trauma victims may be denied help or expected services.

Matsakis (1996:93) says that secondary wounding seems to be related to ignorance. People who have never been hurt may have difficulty understanding those who have. In addition, she says that some people deny the negatives in life and ignore the fact that injustice, loss and pain are as much a part of life as joy and goodness. Trauma survivors confront such people with parts of themselves that they have chosen to deny. This may occur too when one survivor disparages another. A person who is trying to deny or suppress his or her own trauma may need to block out the suffering of another trauma survivor to keep his or her own denial system in tact. This consideration is particularly relevant to social work students, who will be working with other survivors. Another factor that is relevant to social work is burnout. Helping professionals may be suffering from burnout and feel the cost of caring. They may be emotionally depleted and as a result unable to offer the needed compassion and empathy. Participant seemed aware or their own potential to suffer the deleterious effects of trauma work as they considered the role of empathy in eliciting powerful emotions in themselves.

Secondary trauma may arise as an effect of the “just world” philosophy.” The belief is held that people get what they deserve and deserve what they get. The assumption is held that if one is careful, smart or good enough, one can avoid misfortune. It has been suggested that this way of thinking arises from the need to feel in control of life. The idea that life is fragile and unpredictable is frightening to many people, who, in turn assume that they would not be stupid, bad or careless enough to be harmed. This is a way of protecting oneself, but may lead to disparaging those who are harmed. The basis of victim-blaming is that an unjust world is a threat to the self (Baron & Byrne 2000:63).

Participants indicated that the more personal the trauma and the more prolonged it is, the greater the intensity. Both these factors seem to intensify the threat to the self.

The themes in this section, with the exception of empathy as a factor that may intensify trauma, seemed to revolve around disrespect towards the victim. Dehumanisation, judgement, denying the seriousness of the event to the person or discounting its severity, blaming or silencing the victim all imply disrespect for the person’s experience. The person-centred approach suggests that a climate of respect is crucial in creating a safe environment in which the self may be explored (Grobler et al 2003:990). This implies that disrespect is a threat to the self. The participants’ perspective suggests that the greater the disrespect, the greater the threat to the self and the more intense the trauma.

7 THE CONNECTION BETWEEN THE THEMES

Kelly (2006a: 357-359) suggests that themes should be associated with each other in a hermeneutic account. Overarching themes are sought. As the description of trauma was written, the idea that trauma is a threat to the self seemed to emerge naturally from the data.

Participants emphasised that trauma is a **painful** experience. In fact, they seemed to equate pain and trauma. The aspect of pain seems largely

overlooked in the literature. It seems that researchers who are orientated towards the medical model describe traumatic experiences as those that have the potential to trigger post traumatic stress disorder, as it is understood within that paradigm. Indeed, in the literature, the distinction between “being traumatised” and developing PTSD is not always clear (Retief 2004: 15-17; Friedman 2006:10; Matsakis 1996:13-36). The participants in this research were *not* orientated towards the medical model and did not see trauma as restricted to events that have the potential to trigger PTSD. Coming from a person-centred perspective, they were not concerned about limiting trauma to specific symptoms. Whether the broad or narrow definition of what constitutes trauma is valid or not depends on the theoretical orientation of the person making the judgment. It may be argued that participants’ description is so broad that it encompasses any upsetting experience. However, from a person-centred point of view, trauma cannot be narrowed down to a list of events compiled by someone other than the suffering person him or herself.

The overarching theme seemed to be that **trauma is an experience that does not fit with the self**. Seeing trauma as a threat to the self accommodates all the core features of trauma that the participants identified. Specifically:

- A core feature of trauma is that it is intrusive. The victim seems to have a sense of powerlessness or helplessness. The inability to defend the self makes the experience a threat to the self.
- Trauma was described as pain. Pain is a noxious stimulus that is threatening to the self. The way that trauma is described as an inner wound suggests that the self has been injured.
- Traumatic memories are beyond the control of the person. They may involve intense re-living or re-experiencing of the original event, particularly frightening events. However, new experiences can trigger painful recollections of previous trauma, such as past losses, re-exposing the person to the threat of pain.

- Unpredictability was seen as a core feature of trauma. The lack of predictability undermines a person's perception of control and makes it harder to defend the self. As a result, the greater the perceived unpredictability the greater the perceived threat to the self.
- Trauma may be intensified by other factors. The more personal or prolonged, the greater the intensity of trauma. Trauma may be intensified by a strong empathy with the experience of another. Disrespect, blaming and silencing the victim may all intensify the trauma. These responses convey disrespect, which is a threat to the self.
- Trauma may be intensified by cultural beliefs and practices. The perception that one is in the grip of powerful spiritual forces over which one has no control can be highly threatening to the person.

The researcher wrote the following description of the core features of trauma, based on these themes:

Trauma is an experience that does not fit with the self or one's existing values assumptions and perceptions. It is a painful experience that cuts to the core of the victim and the pain is ongoing. The experience creates uncertainty, as previous assumptions are challenged. It undermines a person's sense of control and competence. Traumatic memories are experienced as being out of control of the person. The experience of trauma is unique and individual, depending on the perceptions of the person and the way he or she ascribes meaning to the event. Nevertheless the pain of trauma is universal, touching the core of our humanity.

8 HOW THESE THEMES WERE USED TO DEVELOP THE QUESTIONNAIRE

Personal reflections

Reflexivity is a key component of hermeneutics, since the account is constructed by the interaction between participants and the researcher. The

researcher knew that when she presented the participants with a list of stressors she would be implying that these experiences are instances of trauma. The concerns expressed with respect to secondary victimisation had an impact on her in compiling the questionnaire. Participants gave their own examples of trauma for the questionnaire. It was noted that although frightening incidents such as criminal attacks, rape and accidents were included, examples were not restricted to frightening or horrific events or incidents. Participants included poverty as trauma. The death of a loved one was cited frequently. Long-term problems such as removal from home as a child, having a long term illness or disability, divorce and separation were included. Some examples seemed particularly pertinent to the South African context. These included witnessing a kangaroo court, taxi violence and disruption of relationships with ancestors. These terms may require clarification.

The term “taxi war” or” taxi violence” refers to the violent conflicts that arise between rival associations and individual owners of mini bus taxis in South Africa. It is estimated that these taxis carry over 60% of South Africa’s commuters. Competition is fierce and the industry is largely unregulated (Wikipedia 2009). Taxi owners band together to control various routes and resort to mafia-like tactics and gang warfare to protect their turf (Wikipedia 2009).

Political violence refers to violence that serves a political end. During the apartheid era, any acts that rendered the black townships ungovernable were perceived as an act of political protest (Hunt 2003). Protests and civil unrest were frequently quelled by the police or army, often resulting in violent clashes.

Kangaroo courts refer to illegal trials of presumed offenders by members of the community. Justice is meted out by these illegal courts and may include flogging or execution (Corpun 2008).
Disruption in one’s relationships with the ancestors has a particular meaning to African people where it is believed that the deceased relatives have a part

in events in one's life in the present. If appropriate respect has not been shown to the ancestors by performing required rituals, it is believed that they may remove their protection, opening one up to trauma (Bodibe 1992:151).

Existing questionnaires did not take these examples into account, so the researcher considered it important to compile a questionnaire in which such items were included. Working from a person-centred perspective, she decided to incorporate all the students' examples. Who was she as a person who had, for example, never experienced extreme poverty or a life threatening illness to decide that such experiences are "not trauma" when participants who had been through such experiences perceived them as such? Would she not be guilty of denying or discounting participants' perceptions as invalid if she restricted the items on the questionnaire to "violent encounters with nature, machines or human kind" as some researchers have suggested? (Norris 1992: 409; Matsakis 1996:17). Would this not constitute secondary trauma, in which the victim' perspective was denied, discounted or silenced? These considerations guided her in compiling the questionnaire. However, she was aware that perceptions of events might vary between people and what is construed as trauma by one person may not be traumatic to another. With this in mind a rating scale was attached after each item. The aim of the scale was not to rank the events or determine whether one experience is worse than another, but to see whether the item was in fact traumatic to the respondent him or herself. Only items that were endorsed as trauma by participants in 2006 were included in the final questionnaire. The questionnaire presented participants with a list of stressors as supplied or endorsed by the 2006 participants and the respondent was asked to indicate whether he or she had experienced this stressor and to rate whether it was traumatic or not.
The researcher looked at the examples supplied by participants and noted that when participants referred to their *own* personal encounters with trauma, the description was richer and fuller than when they gave ideas or thoughts that were impersonal impressions to do with others or general ideas about trauma. Based on this, the researcher decided that the participants should be asked to reflect on specific trauma they had experienced as the basis of responses to qualitative items on the effect of trauma in the final

questionnaire. There were indications that trauma has an *effect* on an individual's perceptions and that the experience was described in terms of its effect, rather than the event itself. For these reasons, the final questionnaire explored the effects of a specific experience on the participant as a person and as a student social worker.

Respondents were asked which traumatic experience they had gone through was the worst and to reflect on the following questions:
How did the trauma affect you as a person?
How did it impact your view of others?
How did it affect your view of the future?

The literature indicated that traumatised people might try to avoid reminders of the trauma. This could have a deleterious effect on a social worker working with clients whose experience is similar to their own. To explore the possibility that participants may avoid clients whose experiences are similar to their own participants were asked, "are there any clients you would avoid working with if possible?" Data was also analysed with respect to the question "when I am speaking to someone who has been through the same experience I…"

Participants indicated that it is difficult to recover from trauma, so the questionnaire inquired about whether help had been received and whether it was beneficial. The questionnaire also explored what participants do to cope with trauma.
Having established what participants perceived as core features of trauma, the nature and extent of participants traumatic experiences are discussed in the next section.

9 INCIDENCE OF SPECIFIC STRESSORS

Participants were presented 61 possible stressors and were asked to indicate whether or not they had experienced specific stressors and, if so, to rate the extent to which the experience was traumatic on a five-point scale. As stated above, the purpose of the rating scale was not to enable the researcher to

rank certain items as more traumatic than others, but to see whether the individual who had the experience perceived it as traumatic.

Every participant responded to at least one item, so it appears that the list was relevant and all participants had gone through some trauma as defined by the questions. Pileup refers to the accumulation of stressors in a person's life. The frequency of stressors in the lives of each individual are given in table 12 and figure 15.

Table 12 - Pile up

Number of traumatic experiences	Frequency	Percent	Valid Percent	Cumulative Percent
1	1	.8	.8	.8
2	3	2.4	2.4	3.2
3	3	2.4	2.4	5.6
5	4	3.2	3.2	8.9
6	7	5.6	5.6	14.5
7	9	7.3	7.3	21.8
8	7	5.6	5.6	27.4
9	8	6.5	6.5	33.9
10	7	5.6	5.6	39.5
11	8	6.5	6.5	46.0
12	11	8.9	8.9	54.8
13	7	5.6	5.6	60.5
14	4	3.2	3.2	63.7
15	10	8.1	8.1	71.8
16	3	2.4	2.4	74.2
17	4	3.2	3.2	77.4
18	4	3.2	3.2	80.6
19	4	3.2	3.2	83.9
20	2	1.6	1.6	85.5
21	4	3.2	3.2	88.7
22	3	2.4	2.4	91.1
23	1	.8	.8	91.9
24	3	2.4	2.4	94.4
25	2	1.6	1.6	96.0
26	1	.8	.8	96.8

*

Number of traumatic experiences	Frequency	Percent	Valid Percent	Cumulative Percent
27	1	.8	.8	97.6
28	1	.8	.8	98.4
30	1	.8	.8	99.2
32	1	.8	.8	100.0
Total	124	100.0	100.0	

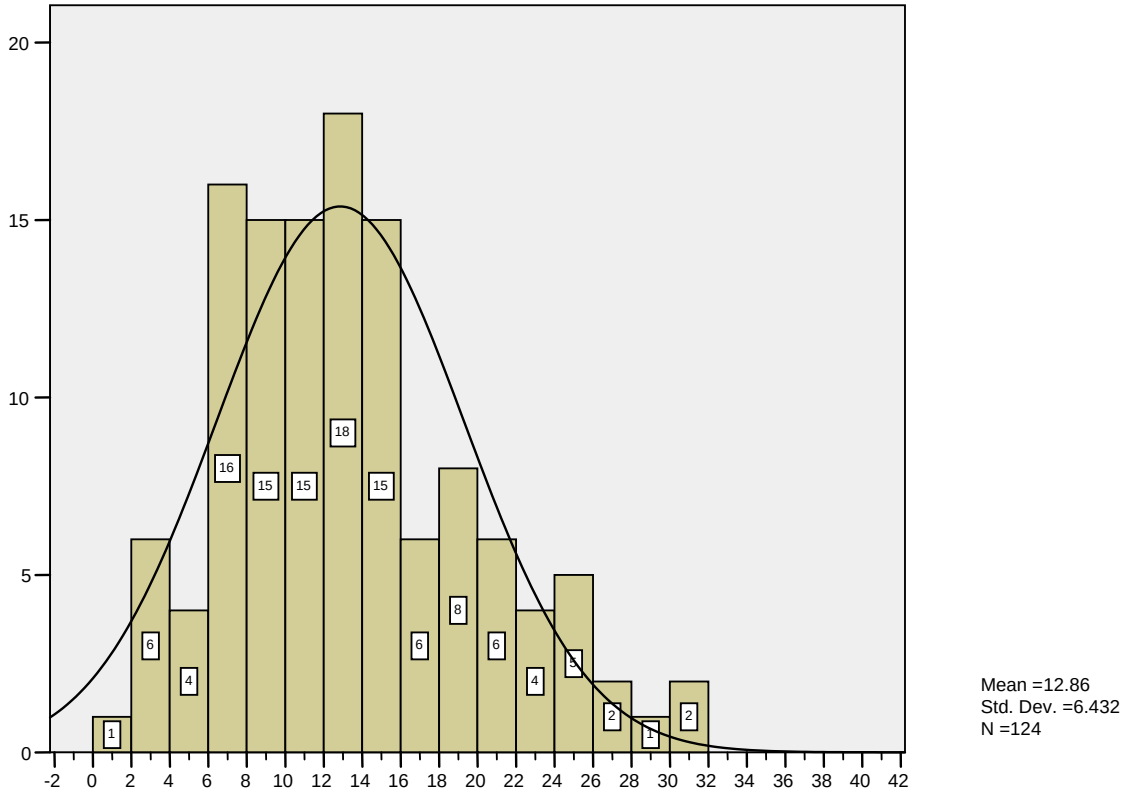

Figure 15 - Pileup

The highest number of stressors as listed that were experienced by an individual was 32 and the lowest number was 1. The mean was 13 with a standard deviation of 6.5. This shows that the average number of stressors experienced by an individual was 13, with a small minority participants who had faced less than 6 of the experiences listed and a small number who had experienced more than 19.

The graph is skewed to the left. It presents three main sections-those with few stressors (11 people on the left of the curve-, the majority of participants with

*

a moderate number of stressors (about 79 people in the 6-16 stressors range) and then a sizeable number of people (34) with 16 or more stressors**.**

Friedman (2006:3) states that traumatic events are not rare. He states that over half American men (60.7%) and women (51.2%)are likely to be exposed to at least one catastrophic event in their lifetimes. Norris (2006: 409) found that 69% of her sample was exposed to at least one threatening event over a lifetime. Her research was conducted in four American cities. Lifetime exposure was higher among men than women.

A national study with a randomised sample to ascertain the prevalence of PTSD was undertaken in the United States of America (Kessler et al 1995: 1052). The researchers state that “many of the stressors that are likely to cause PTSD are common” and so the stipulation that trauma must be “outside the range of human experience” is difficult to defend. In this study they found 60,7% of men and 51,2% of women reported at least one traumatic event. They also noted the majority of people with some form of lifetime trauma reported two events. This means that 23,9% of men with lifetime trauma and 26,4% of women with lifetime trauma suffered two traumatic events. The descriptions of trauma in the American study were considerably narrower than the current study so direct comparison of results is not possible. However, these figures indicate that traumatic events are not rare. Kessler et al (1995: 1037) found a lifetime history of PTSD in 7,8% of the population.

Kessler et al (1995:1037) imply that it is not only terrifying events that are traumatic. The study explored exposure to 12 traumas, namely, combat exposure, life threatening accidents, fire, flood or natural disaster, witnessed killing or injury of another person, rape, sexual molestation, physical attack, childhood physical abuse, neglect, held captive, other event someone close to respondent suffered one of the events on the list (Kessler et al 1995: 1052). However, it is important to note that the estimated prevalence of PTSD did not increase much when the criteria for the trauma were relaxed to include non-qualifying events reported in response to an open ended question “any other terrible experiences most people never go through” were included. The

authors note we have no way of knowing how often events such as chronic illness, job loss and marital difficulties, are associated with PTSD (Kessler et al 1995: 1037). The authors note people may develop traumatic stress symptoms in response to such events, although others may not class them as traumatic.

Kessler et al (1995: 1058) note that more than 10% of men and 6% of women reported four or more types of lifetime traumas. In some cases, an assessment of a lifetime history of trauma would involve 20 or more traumas. The number of cases for whom this is true was not specified.
The incidence of trauma is influenced by the definition of trauma. Norris (1992) and Kessler et al (1995) were using a narrower definition than the current research. Norris (1992: 411) notes in her study, over the previous year alone, 21% of the sample experienced a *violent* event. She points out that risks accumulate over the years and this is significant because previous exposure to trauma intensifies subsequent levels of distress (Norris 1992; 416). These findings confirm that exposure to trauma is not rare and that the risk increases with age.

The pileup in the current study indicates that all the participants reported at least one incident of trauma, and the tendency was towards more incidents rather than less than the norm. The high incidence may be influenced by the broad definition of trauma adopted in the study. Nevertheless, the fact that 34 participants reported 16 or more stressors and 79 people reported between 6 and 16 stressors confirms the intuitive perception that Unisa social work students have been exposed to a wide range of distressing events and most participants had been exposed to an accumulation of stressors.

10 FREQUENCY OF SPECIFIC STRESSORS

The frequency of individual stressors is given in table 13. These stressors have been ranked in terms of prevalence.

Table 13- Prevalence of each trauma

Trauma	Yes	
	Frequency	Percent
Significant other died	99	79.8%
Witnessed verbal abuse as an adult.	65	52.4%
Witnessed stranger rape as an adult	64	51.6%
Witnessed verbal abuse as a child	63	50.8%
Beaten at school as a child	58	46.8%
Parent died	57	46.0%
Experienced addiction in family as an adult	56	45.2%
Victim of emotional abuse as a child	54	43.5%
Witness of physical abuse as a child	54	43.5%
Witnessed accident	53	42.7%
Experienced extreme poverty	53	42.7%
Experienced unwanted unemployment	51	41.1%
Caring for family with HIV/AIDS	45	36.6%
Witnessed sexual abuse as child -not family	45	36.3%
Witnessed suicide attempt as child	44	35.5%
Victim of verbal abuse as adult	43	34.7%
Victim of school Bullying as a child	42	33.9%
Crime Victim: Theft	42	33.9%
Witnessed suicide attempt as adult	41	33.1%
Witnessed physical abuse as an adult	40	32.3%
Crime Victim: Street Robbery	40	32.3%
Crime Witness: Street Robbery	36	29.0%
Experienced addiction in family as a child	34	27.4%
Caring for ill/disabled family member	33	26.8%
Crime Witness: Assault	32	25.8%
Divorced	30	24.2%
Victim of physical abuse as a child	28	22.6%
Crime Victim: House Robbery while away	25	20.2%
Felt responsible for an accident	22	17.7%
Crime Victim: House Robbery while home	22	17.7%
Crime Witness: Taxi violence	22	17.7%
Removed from home as a child	21	16.9%
Victim of attempted rape as an adult	19	15.3%
Witnessed rape of family as an adult	18	14.5%
Witnessed sex abuse of family as a child	17	13.7%
Involved in accident	15	12.1%
Victim physical abuse as an adult	15	12.1%
Victim sexual abuse (at home) as a child	15	12.1%
Crime Witness: Political violence	15	12.1%
Parents divorced	13	10.5%
Crime Victim: Assault	13	10.5%
Crime Witness: Hijacking	13	10.5%
Experienced loss of home	12	9.7%
Victim sexual abuse (not at home) as a child	11	8.9%
Lost pregnancy	10	8.1%
Crime Victim: Political violence	10	8.1%

*

Trauma	Yes	
	Frequency	Percent
Partner died	9	7.3%
Relationship problems with Ancestors	9	7.3%
Crime Witness: Murder	9	7.3%
Crime Witness: Kangaroo Court	9	7.3%
Crime Witness: Other	9	7.3%
Experienced illness (self)-not HIV/AIDS	8	6.6%
Adult - victim of rape as an adult	8	6.5%
Crime Victim: Taxi violence	6	4.8%
Child died	5	4.0%
Crime Victim: Hijacking	5	4.0%
Crime Victim: Other	5	4.0%
Infected with HIV/AIDS (self)	4	3.3%
Child disabled	3	2.4%
Self disabled	3	2.4%
Lost child in custody dispute	0	0.0%

The only stressor that no participant had experienced was loss of a child in a custody dispute, so it seems that the stressors listed were relevant to the participants. To facilitate discussion of these stressors, they have been grouped into categories. Boundaries between the categories are arbitrary and were determined by the researcher in consultation with her promoter and the statistician who assisted with the analysis. Others may have grouped these stressors differently. The prevalence of each **category** of trauma was calculated and is presented in table 14. Some categories contained more questions than others. To avoid weighting these categories, if a participant had experienced more than one stressor in a group, he or she was only counted **once**. The table therefore shows the frequency with which participants reported at least one experience of each of these traumas. Totals are ranked to show the prevalence of the category as a whole. The frequency of each individual stressor appears in the last column of table 14.

Table 14 - Categories of trauma

CATEGORY	Percent who responded to at least 1 item in category	Prevalence of individual stressor
Victim of Domestic/School Violence And Abuse	**87.9%**	
As a child (under 18) a close family member abused/drugs/ alcohol/ gambling		27.4%
As a child (under 18) I was verbally/emotionally abused in my home		43.5%

*

CATEGORY	Percent who responded to at least 1 item in category	Prevalence of individual stressor
As a child (under 18) I was physically abused in my home		22.6%
As a child (under 18) I was beaten by authority figures at school		46.8%
As a child (under 18) I was bullied by learners		33.9%
As an adult (18 and over) a close family member abused drugs/alcohol/gambling		45.2%
As an adult (18 and over) I was verbally/emotionally abused in my home		34.7%
As an adult (18 and over) I was physically abused in my home		12.1%
Loss of a Close Family Member	**79.8%**	
My close relative died (not parent/caregiver/spouse or life-partner)		79.8%
I have experienced problems in my relationship with ancestors		7.3%
Witness of Domestic Violence And Abuse	**78.2%**	
As a child (under 18) I saw or heard verbal abuse of a loved one		50.8%
As a child (under 18) I saw or heard physical abuse of a loved one		43.5%
As a child (under 18) I saw or heard a suicide attempt of a loved one		35.5%
As an adult (18 and over) I saw or heard verbal abuse of a family member		52.4%
As an adult (18 and over) I saw or heard physical abuse of a loved one		32.3%
As an adult (18 and over) I saw or heard a suicide attempt of a loved one		33.1%
Victim of Crime or Violence	**67.7%**	
Crime Victim: House Robbery when I was away		20.2%
Crime Victim: Theft – e.g. belongings when I was absent		33.9%
Crime Victim: House Robbery when I was there		17.7%
Crime Victim: Assault (not domestic violence)		10.5%
Crime Victim: Street Robbery, e.g. mugging		32.3%
Crime Victim: Hijacking		4.0%
Crime Victim: Taxi violence		4.8%
Crime Victim: Political violence		8.1%
Crime Victim: Other		4.0%
Negative life experience	**62.1%**	
I have lost my home.		9.7%
I have experienced extreme poverty/bankruptcy		42.7%
I have experienced unwanted job loss/prolonged unemployment.		41.1%
Experienced Physical or Emotional Loss of Significant Other	**58.95**	
My Parent/Caregiver (not spouse) died		46.0%
I lost my parent/Caregiver due to divorce (not spouse)		10.5%
As a child (under 18) I was removed from home e.g. sent to live with a relative/in a children's home/Foster care etc.,		16.9%
Witness of Sexual Trauma	**57.3%**	
As a child (under 18) I saw or heard sexual abuse of a loved one within my home		13.7%
As a child (under 18) I saw or heard sexual abuse of a non family member		36.3%
As an adult (18 and over) I have witnessed/heard the rape of a family member		14.5%
As an adult (18 and over) I have witnessed/heard the rape of a stranger		51.6&
Illness or Disability (Family Member)	**56.1%**	
A close family member is living with HIV/AIDS		36.6%
A close family member is living with a life threatening illness (not HIV/AIDS)		26.8%
My child has a disability (e.g. Paralysed, blind, deaf, retarded		2.4%
`Witness of Crime or Violence	**55.6%**	
Crime Witness: Murder		7.3%
Crime Witness: Hijacking		10.5%
Crime Witness: Assault (not domestic violence)		25.8%
Crime Witness: Street Robbery, e.g. mugging		29.0%
Crime Witness: Taxi violence		17.7%

*

CATEGORY	Percent who responded to at least 1 item in category	Prevalence of individual stressor
Crime Witness: Political violence		12.1%
Crime Witness: Kangaroo Court		7.3%
Crime Witness: Other		7.3%
Victim of Sexual Trauma	**54.8%**	
As a child (under 18) I was sexually abused in my home by a family member/non family member		12.1%
As a child (under 18) I was sexually abused outside my home environment (i.e. at school/church/friend/stranger		8.9%
As an adult (18 and over) I was raped		6.6%
As an adult (18 and over) someone attempted to rape me but it did not take place (I escaped/rape was prevented		15.3%
Accidents	**52.4%**	
I have been involved in an accident where people were killed or seriously injured(Not a parent/child/spouse).		12.1%
I have witnessed a car or bus accident where people were killed or injured.		42.7%
I felt responsible for the death/injury of someone else		17.7%
Loss of Life Partner	**28.25**	
My life-partner died (husband/wife/sexual partner)		7.3%
I lost my life-partner due to separation/conflict		24.2%
Illness or Disability (Self)	**11.4%**	
I am living with HIV/AIDS		3.3%
I am living with a life threatening illness (not HIV/AIDS)		6.6%
I have a disability (e.g. Blindness, paralysed, deaf, etc.,)		2.4%
Loss of Your Child	**10.5%**	
My Child died		4.0%
I lost my child due to problems related to my pregnancy, or my partners		8.1%
I lost my child in a custody dispute		0.0%

The level of violence to which participants have been exposed is alarming.

- **Domestic /school violence and abuse**

These results show that almost 88% of participants report being victims of at least one instance of abuse or violence in their immediate environment, namely the school or home and 78% report witnessing this stressor. The category was broad and incorporated physical abuse, verbal abuse and substance abuse. Closer examination of the results for individual stressors reveals that 22.6% of participants were physically abused by a family member (n=28). As adults, 45,2% had lived with a family member who is an addicted to substances or alcohol. 43.5% had experienced emotional abuse as a child, and the same number had witnessed or heard physical abuse of a family member. Half the participants (50.8%) had seen or heard the verbal or

emotional abuse of a loved one in the home as children and 43.5% has seen or heard a loved one being physically abused in the home while they were children (i.e. under 18).

- **Sexual trauma**

It is striking that over half the participants (54,8%) reported at least one instance of personal sexual trauma and a similar number (57.3%) had witnessed sexual trauma. The sexual trauma category has been broken down into its components and these figures are presented in table 15.

Table 15 - Incidence of sexual trauma

Sexual Trauma	Frequency	Percentage
Stranger Rape – adult witness	64	51.6%
Sexual Abuse (not family) - child witness	45	36.3%
Attempted Rape – adult victim	19	15.3%
Family Rape – adult witness	18	14.5%
Sexual Abuse home – child victim	15	12.1%
Sexual Abuse not home – child victim	11	8.9%
Raped – adult victim	8	6.4%

Eight students in the sample reported they had been raped as adults (6.4%). In two cases the perpetrator was a stranger, in three a date, in one a spouse, one person reported being gang raped and one did not say who the perpetrator was. Fifteen participants (12.1%) had been sexually abused at home, eight by family members and four by non-family members. (three respondents did not say who the perpetrator was). A further 11 students (8.9%) had been sexually abused outside the home. Participants who reported witnessing rape of a stranger numbered 64 (a surprising 51.65% of the sample) and 45 participants (36,5%) reported witnessing sexual abuse of non-family member. These latter two figures may be inflated, because the question may have been interpreted in such a way that if participants had *heard* about the rape or sexual abuse, they responded “yes” to the question, although they may not have actually seen or heard the incident directly themselves.

- **Crime**

Consistent with the high levels of crime in South Africa, 67.7% of the sample had been victims of crime and 55,6% had witnessed crime or violence. Detailed figures relating specifically to crime are given in table 16.

Table 16 - Participants who have been victims of crime

Crime Event	Frequency	Percentage
Theft – victim	42	33.9%
Street Robbery – victim	40	32.3%
Street Robbery - witness	36	29.0%
Assault – witness	32	28.8%
House Robbery While Away	25	20.2%
House Robbery While Home	22	17.7%
Taxi Violence – witness	22	17.7%
Political Violence - witness	15	12.1%
Assault – victim	13	10.5%
Hijacking – witness	13	10.5%
Political violence – victim	10	8.1%
Murder – witness	9	7.3%
Kangaroo Court – witness	9	7.3%
Other Crime - witness	9	7.3%
Taxi Violence – victim	6	4.8%
Hijacking – victim	5	4.0%
Other Crime – victim	5	4.0%

When these instances are examined more closely, results reveal that robbery and theft are the most frequently encountered crimes. According to the South African Police service (SAPS 2007), most crime in South Africa is classified as contact crime. Contact crimes are usually violent in nature and include robbery, aggravated robbery, assault, murder, attempted murder and rape. Such crimes account for 32.5% of reported crime in South Africa. Consistent with this, participants had been subject to robbery, mugging, murder and assault. The level of violence to which participants have been exposed is reflected in results that show that 7.3% (n=9) have witnessed a murder and the same number saw a kangaroo court. With respect to murder, some participants seemed to find the impact so painful that when asked how it affected them they responded **"I do not know."** Other respondents said:

- **I am feeling guilty although I did not contribute.**
- **I can't speak about it because I am still scared because of what I saw.**
- **I was a bit terrified to see someone dying in front of me. He was been shot on his heart. I was just a child then. I would actually think back on that day when that man died. He just went pale in front of our eyes. I was really crying.**

Participants referred to witnessing a kangaroo court as traumatic. These courts are intimately associated with the history of the struggle for

independence in South Africa. Initially, provision was made for the chief or headman in rural areas to punish offences according to tribal laws and customs in 1927 under a law the Black Administration Act No 38. The system was restricted to rural areas and was regulated by the chief or headman. During the 1970's use of these courts took a sinister turn when "crime busting groups" called *makgotla* came into prominence. These were illegal groups of vigilantes who held their own trials on patches of open land or classrooms in schools. On the spot floggings were administered (Corpun 2008). Offences that were dealt with included breaking boycotts, family squabbles, and common assaults (Corpun 2008). Flogging is cited as the most common sentence, which is referred to as "*siwasho*" the Zulu term for "cleansing medicine." It is reported that these courts arose as an attempt to establish a form of alternative government in the black townships during the period of the struggle against apartheid. Physical punishment was chosen as the sentence, because the option of putting the offender in prison was unavailable. Sentences laid down in the Ivory Park People's Court code of punishment include;

- Adultery-500 lashes.
- Rape- Paraded naked before receiving 500 lashes or execution.
- Child abuse- 500 lashes.
- Burglary- 200 lashes for first offence: if items are not returned a further 300 lashes.
- Assault- 90 lashes.
- Assault by man on his wife- 50 lashes.
- Contempt of court- additional 40 lashes and 2-year banishment from the area.

This court was still operating in 1998 despite the change to democracy. Hunt (2003) states that there is growing support for groups that take the law into their own hands. In 2000, a vigilante group called Mapogo a Matamaga claimed to have a membership of more than 50 000 people.

These courts were known for their brutality.

Results show that 7.3% of participants (n=9) have witnessed a kangaroo court. Participants commented:

- **[I have witnessed] multiple murders, Kangaroo courts. The effect on me – I do not know. – When I speak to someone who has had the same experience – I feel sick.**
- **The violent crime I have experienced is mob justice. It does not affect me now but it is a bad thing and I hate it.**

The term “political violence” refers primarily to the violence of politically motivated acts such as insurrection and repression of opposition. Political violence is also termed “unrest” in South Africa (Turton, Straker & Moosa 1991: 77). Political violence was cited as a trauma experienced by 8.1% of participants (n=10).

Another feature of South African society to which participants had been exposed is taxi violence. This refers to violent conflict between rival taxi owners or associations of taxi drivers. It is estimated that 60% of commuters in South Africa make use of minibus taxis (Wikipedia 2009). Results show that 17.7% of participants (n=22) participants had witnessed taxi violence and 4.6% of participants (n=6) had been victims. With poor public transport systems in the country, most of the Black population has no alternative but to use such taxis and cope with the risks involved. This form of crime was more prevalent than motorcar hijacking, which had affected 10.5% of respondents as witnesses (n=13) and 4% as victims (n=5). These figures probably reflect the predominance of Black people in the group, who rely on taxis rather than their own vehicles for transport.

Herman (1997:121) suggests that exposure to prolonged and repeated trauma has deep-seated effects on a person. Alterations in relations with others, include:

- Isolation and withdrawal.
- Disruptions in intimate relationships.
- Repeated search for rescuer (may alternate with isolation and withdrawal).

- Persistent distrust,
- Repeated failures of self-protection.

She suggests that the person who is repeatedly victimised may suffer a loss of sustaining faith and sense of hopelessness and despair. It is also suggested that exposure to incidents of trauma such as rape, murder and violence may leave a person with symptoms of numbness and withdrawal, or hypervigilance and hyper arousal. If present, such effects may have a deleterious effect on participants' functioning as social workers where empathy and warmth are essential components of the helping relationship.

This study is exploratory in nature. A full investigation of the impact of these horrific experiences was beyond the scope of this study, but these considerations suggest the need for further investigation.

- **Poverty**

Poverty and unemployment were discussed in Chapter 7.

Poverty was cited as trauma by participants. This was not something that could be found in the literature and the researcher can only speculate as to why it was seen as an instance of trauma.

Results show that 42,7% of the respondents said they had experienced extreme poverty (n= 53) and a further 41.1% had experienced unwanted unemployment (n=51). A weakness of the study is that the parameters of extreme poverty were not clearly defined. Poverty is a prevalent phenomenon in South Africa. It is estimated that 50% of the population are living below the poverty line (CIA fact book 2009). Hunt (2003) states that as many as 60% of youth who graduate from school in South Africa cannot find jobs. The unemployment rate in South Africa is estimated at 22.9% (CIA fact book 2009). Schwabe (2004) notes in the past poverty in South Africa was related to race but is currently being defined by inequality within race group. He notes that the poorest households in South Africa have not shared in the proceeds

of economic growth, so the inequality between the rich and poor has risen. The country's poverty and wealth profile is skewed to favour the white population (Advagmeg 2008). It is noted that 40% of the households with the lowest income in the country earn less than 6% of the total income while 10% of households with the highest income earn more than half the total income (Advagmeg 2008) The discrepancy in wealth between Blacks and whites is seen as a legacy of apartheid, a period where Blacks were oppressed politically and economically (Advameg 2008; Schenck & Louw 2009:364)). Pilisuk and Tennant (1997) relate poverty to structural violence in society that perpetuates inequality between rich and poor. The social exclusion view of poverty links it to oppression and the deliberate marginalisation of people (Schenck &Louw 2009:357; 364). This suggests that poverty may be linked to perceptions and feelings about apartheid, a form of societal violence in Pilisuk and Tennants' (1997) terms. The perception that apartheid and the violence and injustice associated with it is responsible for widespread poverty may explain why poverty is equated with trauma in this country. This explanation is speculation, and warrants further investigation.

Like other forms of trauma, poverty may carry with it the threat of death from starvation, malnutrition and disease (Schenck & Louw 2009:361). It may carry with it a perception of helplessness, which may manifest in a culture of silence (Schenck & Louw 2009:358). Suffering is intrinsic to extreme poverty (Schenck & Louw 2009:361). When the experience of poverty is compared with the description of trauma given by the participants, the following commonalities are apparent:

- Poverty causes suffering. It is a painful experience. Trauma was described as pain.
- According to participants, the pain of trauma is ongoing. Poverty may be described in terms of entrapment.
- Participants indicated that trauma creates uncertainty. Poverty may create uncertainty about the future and one's survival and well being.
- Poverty may create a sense of powerlessness and having no voice. Participants said that trauma brings with it a sense of powerlessness.

- Like other forms of trauma, poverty may be the result of violence, in this case structural violence within a society, which deeply wounds the individual and the country as a whole.

Therefore it is not surprising that poverty was identified as trauma by this group.

The notion that poverty may be viewed as entrapment struck the researcher as similar to Herman's (1992:377-391) idea that what she terms "complex traumatic stress" is a form of captivity. (Schenck and Louw (2009:357) discuss that the poor may be *trapped* in a cycle of disadvantage) It may be interesting to explore whether Herman's (1992) notions about this form of trauma would incorporate long-term poverty. This suggests an area for further investigation.

Hunt (2003) from the centre for the study of violence and reconciliation suggests that the root cause of violence in South Africa has not changed since the apartheid era. He believes that South Africa's high rate of crime is just as closely related to economic and social marginalisation as it was in the 1980's. He suggests that crime may be viewed as an opportunity to gain status and opportunity. He believes that, from a certain perspective, involvement in violent gangs can actually be an expression of resilience. It seems that apartheid itself is viewed as violence against the person and community and the discourse linked with it in relation to poverty makes poverty a trauma in itself.

- **Loss of significant others.**

Results indicate that most participants had lost significant others as indicated in table 17.

Table 17- Loss of significant other

Significant other	Frequency Number of participants who responded yes	Percentage
Significant other died	99	79,8%
Parent died	57	46,0%
Divorced	30	2.4%
Removed from home as child	21	16,9%
Lost pregnancy	10	8,1%

*

Partner died	9	7,3%
Child died	5	4.0%

Most participants had lost close family members (79.8%). A number had lost their life partners 2.4% due to divorce and 7,3% due to death. Some had been removed from home in childhood (16.9%), so it is likely that many students are dealing with trauma with impaired social support. Some of these losses were the result of violence. The results revealed that five students had a parent murdered, a further three participants said their life partner had been murdered and another twelve reported the murder of a close family member other than a parent or spouse. Five had lost close relatives in taxi violence and a further four in political violence. Three said a parent had committed suicide and one person's partner died for this reason. Four had lost a parent in an accident, two due to HIV. Twenty-four lost parents due to other illness and sixteen due to other causes. Fifteen students had lost a parent in childhood. In addition, 16.9% of the sample reported being separated from parents during childhood. Reasons were poverty (n=6), abuse (n=1), neglect (n=7) and other reasons (n=8). Five had experienced the death of a child. One child died in an accident, one committed suicide one died due to illness and two participants did not specify the cause of the loss. Ten participants reported the loss of a pregnancy, two due to stillbirth, one abortion, six due to miscarriage and one respondent did not give the cause.

It has been shown that people who have social support fare better after trauma than those who do not. When social networks are disrupted as a result of trauma, such as political violence, or being a refugee, victims are more prone to PTSD (Naparstek 2006: 59). Resilience to trauma is positively correlated to secure attachment (Simeon, Yehuda, Cunill, Knutelska, Putman & Smith 2007:1151). Results concerning the extent of participants' losses imply that many may be coping with trauma with little social support.

11 LEVEL OF DISTRESS

Participants who had experienced each stressor were asked to rate their experience on a scale of one to five , where one indicated that the event was

not traumatic and five indicated that it was devastating. The extent to which the experience was distressing to the participants is presented in table 18. The last column indicates the mean rating of the intensity of the trauma. This table ranks the level of distress associated with each stressor. A limitation of the questionnaire is that it is not clear whether this refers to the distress at the time of the event or currently. This weakness is offset by reference to the qualitative data regarding the effects of trauma in the next chapter.

Table 18 - Trauma-related distress

Trauma	Frequency	Percent	No Trauma	Mild Trauma	Moderate Trauma	Severe Trauma	Devastating Trauma	Mean Trauma
Child died	5	4.0%	0.0	0.0	0.0	0.0	100.0	**5.00**
Crime Victim: Hijacking	5	4.0%	0.0	0.0	0.0	0.0	100.0	**5.00**
Self disabled	3	2.4%	0.0	0.0	0.0	0.0	100.0	**5.00**
HIV/AIDS self	4	3.3%	0.0	0.0	0.0	25.0	75.0	**4.75**
Child sexual abuse not at home	11	8.9%	0.0	0.0	0.0	27.3	72.7	**4.73**
Adult raped	8	6.5%	0.0	0.0	14.3	0.0	14.3	**4.71**
Child sexual abuse at home	15	12.1%	0.0	0.0	13.3	13.3	73.3	**4.60**
Adult witness rape family	18	14.5%	0.0	0.0	0.0	44.4	55.6	**4.56**
Child witness sex abuse family	17	13.7%	6.3	0.0	0.0	31.3	62.5	**4.44**
Partner died	9	7.3%	11.1	0.0	0.0	22.2	66.7	**4.33**
Child disabled	3	2.4%	0.0	0.0	33.3	0.0	66.7	**4.33**
Accident responsible	22	17.7%	0.0	4.5	9.1	36.4	50.0	**4.32**
Negative Life Experience- Poverty	53	42.7%	1.9	1.9	11.3	32.1	52.8	**4.32**
Crime Witness: Political violence	15	12.1%	0.0	0.0	10.0	50.0	40.0	**4.30**
Adult abuse physical	15	12.1%	0.0	6.7	6.7	40.0	46.7	**4.27**
Negative Life Experience - Home loss	12	9.7%	0.0	0.0	16.7	41.7	41.7	**4.25**
Crime Victim: Taxi violence	6	4.8%	0.0	0.0	0.0	75.0	25.0	**4.25**
Other illness self	8	6.6%	12.5	0.0	0.0	25.0	62.5	**4.25**
Crime Victim: Assault	13	10.5%	0.0	0.0	20.0	40.0	40.0	**4.20**
Adult abuse verbal	43	34.7%	4.7	20.9	25.6	48.8	0.0	**4.19**
Crime Victim: Political violence	10	8.1%	0.0	0.0	16.7	50.0	33.3	**4.17**
Child abuse emotional	54	43.5%	0.0	5.6	14.8	38.9	40.7	**4.15**
Parent died	57	46.0%	3.7	3.7	20.4	16.7	55.6	**4.14**
Lost pregnancy	10	8.1%	11.1	0.0	11.1	22.2	55.6	**4.11**
Significant other died	99	79.8%	3.2	7.4	11.6	31.6	46.3	**4.11**
Child abuse physical	28	22.6%	0.0	3.7	14.8	48.1	33.3	**4.11**
Parents divorced	13	10.5%	0.0	7.7	30.8	7.7	53.8	**4.08**
Child witness physical abuse	54	43.5%	1.9	5.6	18.5	31.5	42.6	**4.07**
Adult attempted rape	19	15.3%	5.6	11.1	5.6	27.8	50.0	**4.06**
Adult witness physical abuse	40	32.3%	0.0	10.3	12.8	41.0	35.9	**4.03**
Other illness in family	33	26.8%	6.1	3.0	15.2	33.3	42.4	**4.03**
Negative Life Experience- Job loss	51	41.1%	0.0	6.0	20.0	40.0	34.0	**4.02**
Ancestor relationship problems	9	7.3%	0.0	0.0	33.3	33.3	33.3	**4.00**
Child witness suicide attempt	44	35.5%	2.3	7.0	11.6	46.5	32.6	**4.00**
Adult witness suicide attempt	41	33.1%	2.4	2.4	19.5	43.9	31.7	**4.00**
Child witness sex abuse not family	45	36.3%	2.3	4.5	25.0	27.3	40.9	**4.00**

*

Trauma	Frequency	Percent	No Trauma	Mild Trauma	Moderate Trauma	Severe Trauma	Devastating Trauma	Mean Trauma
Child family addiction	34	27.4%	2.9	2.9	23.5	38.2	32.4	**3.94**
Adult witness verbal abuse	65	52.4%	1.5	6.2	20.0	41.5	30.8	**3.94**
HIV/AIDS family	45	36.6%	7.0	7.0	16.3	25.6	44.2	**3.93**
Crime Witness: Kangaroo Court	9	7.3%	0.0	0.0	50.0	12.5	37.5	**3.88**
Child witness verbal abuse	63	50.8%	0.0	8.1	21.0	46.8	24.2	**3.87**
Divorced	30	24.2%	6.7	10.0	20.0	23.3	40.0	**3.80**
Adult family addiction	56	45.2%	1.8	8.9	23.2	39.3	26.8	**3.80**
Adult witness stranger rape	64	51.6%	44.4	55.6	44.4	55.6	44.4	**3.79**
Crime Witness: Hijacking	13	10.5%	11.1	11.1	11.1	22.2	44.4	**3.78**
Removed from home	21	16.9%	4.8	4.8	23.8	42.9	23.8	**3.76**
Accident involved	15	12.1%	0.0	20.0	13.3	46.7	20.0	**3.67**
Crime Victim: Street Robbery	40	32.3%	0.0	13.8	27.6	27.6	31.0	**3.67**
Crime Victim: House Robbery while home	22	17.7%	5.9	17.6	17.6	23.5	35.3	**3.65**
Child School Bullying	42	33.9%	7.1	7.1	28.6	28.6	28.6	**3.64**
Crime Witness: Taxi violence	22	17.7%	7.1	14.3	14.3	42.9	21.4	**3.57**
Accident witness	53	42.7%	1.9	11.5	32.7	34.6	19.2	**3.55**
Crime Victim: Theft	42	33.9%	6.7	16.7	26.7	30.0	20.0	**3.40**
Crime Witness: Street Robbery	36	29.0%	9.1	27.3	13.6	18.2	31.8	**3.36**

Table 18 indicates that all the experiences covered by the questionnaire were considered to be *more* than moderately traumatic by respondents who had actually experienced the event (the mean rating if the intensity of trauma was always greater than 3). The most frequent traumas are not necessarily the most upsetting. Although the loss of a child was the least prevalent trauma, it is rated as one of the most distressing. Participants rated being hijacked as devastating: five participants had actually been hijacked. Being disabled oneself was considered devastating, but was not prevalent.

One of the stressors that is both prevalent and distressing is HIV/Aids. 3,3% of participants (n = 4) reported being HIV positive themselves and 36,6% of participants reported that they are caring for a family member with HIV/AIDS. Participants regarded being HIV positive as severe or devastating trauma. Caring for a family member with AIDS was regarded as a traumatic experience, with an average rating of 3,93 on a scale where 3 = moderate trauma and 4 = severe trauma. An incidence of 36.65% among family members and 3.35% of participants may be compared to the fact that Aids is linked to 47% of all deaths in the country (Noble 2008: 5). This suggests that many participants are carrying the burden of dealing with the illness in their

families. Van Dyk (2003: 282) states, “nothing can be more stressful and draining on a care giver’s resources than caring for or counselling patients or clients with HIV infection or AIDS.” Van Dyk (2003: 288) points out that many caregivers lack outside support because of the secrecy and fear of disclosure that surrounds those infected. This implies that many of the Unisa students may be involved with family members who are HIV positive, but have little support themselves. This is an area that warrants investigation because the percentage of students who responded to this item is relatively high and it may be a field at which intervention should be aimed.

The results indicate that exposure to violence, crime, poverty, sexual trauma and HIV/Aids are both prevalent and distressing in this group. Similarly, loss is experienced as severe trauma and may undermine the person’s ability to cope. These considerations suggest areas at which intervention may be aimed, possibly by instituting group work to assist with various types of trauma.

12 CHAPTER SUMMARY

The response rate of 92% - 93% to the questionnaires and the level of enthusiasm in the focus groups seems to indicate that students were motivated to participate in the study and regarded the topic as self-relevant. The response rate may have been influenced by the person-centred nature of their training, in which they were willing to help the researcher. Most students were single females and the majority were Black.

Participants provided a description of the core features of trauma. They said that trauma is a painful experience ranging in intensity from an ache to a wound in the heart to a disease to an inner death. Helplessness and powerlessness were key features of a traumatic experience. The experience is perpetuated by the nature of traumatic memories which are intrusive and beyond the control of the person. Unpredictability is a feature of trauma. Existing beliefs, assumptions and perceptions are shattered. Trauma is experienced as a threat to the self. Participants explained that each person’s experience of trauma depends on the unique perception of the person him or

herself. Nevertheless the pain and grief of trauma is a universal human phenomenon that knows no boundaries of race or colour.

Most participants had experienced multiple stressors. The highest number of stressors experienced by an individual was 32. The average was 13.

A large percentage of students had been subject to domestic violence (87,9%) Many had been victims of crime (67,7%), or had witnessed crime (55,6%), and almost half the group (54,8%) reported at least one instance of sexual trauma while 57,3% had witnessed this type of trauma. These figures indicate that the lives of the majority of the students in this group have been touched by violence.

Results indicate that most participants had lost close family members (79.8%). some had lost their life partners (2.4% due to divorce and 7,3% due to death). Some had been removed from home in childhood (16.9%), so it is likely that many students are dealing with trauma with impaired social support.

Every stressor listed was regarded as more than moderately distressing. The most common trauma is not necessarily the most distressing and the death of a child, being disabled and being hijacked were rated as the worst, although they were the least prevalent. Sexual trauma is both common and distressing suggesting that it may be useful to target this area for intervention along with the distress generated by domestic violence and crime. However, a limitation of the study is that it is not clear whether the distress refers to the current level of distress or distress at the time of the incident. However, the fact that participants still rated the incident as distressing may indicate that they still find these events upsetting. This important concern requires further investigation. This limitation is offset to some extent by the qualitative data in the next chapter.

CHAPTER 10

RESULTS PART 2

THE EFFECT OF TRAUMA

1 INTRODUCTION

The results presented in the previous chapter indicate that participants had all experienced trauma. Each person responded to at least two items on the questionnaire. It is also important to note that all items were rated as more than moderately distressing. This implies that the items on the questionnaire were perceived as traumatic and were relevant to the participants. The question now arises as to how these experiences impacted the participants. This is relevant to the person-centred approach because the approach is based on the *relationship* between the self of the client and the self of the facilitator (Rogers 1990:238). Participants in this study were trained in the person-centred approach. One of the central tenets of this approach is that the relationship is a respectful, meaningful and empathic encounter between two persons (Rogers 1990: 238). Rogers (1990: 238) emphasises that the facilitator needs to be congruent and non-defensive in the relationship if it is to be helpful. Results in the previous chapter indicate that trauma is a threat to the self so non-defensiveness may be difficult to maintain if one is dealing with unresolved trauma. Rogers (1951:515) suggests that the self tends to protect itself against threats. The literature study shows that trauma may trigger emotions and experiences associated with the event if these have not been fully symbolised and dealt with. (This was discussed in Chapter 5). Reminders of trauma may trigger responses that were part of the original reaction to the trauma. How then, do participants respond when confronted by or empathising with people whose experiences are similar to the helper's which may trigger memories of the helper's own trauma? How have traumatic experiences impacted the participants' view of future and others? How have they dealt with these experiences or have they been unable to do so? These questions were explored and the results are presented in this chapter.

The self emerges from our experiences. It follows therefore, that a traumatic experience may have an impact on the self. The impact of trauma on the student social worker has implications for the helping relationships which they establish with clients. It is important therefore to consider what "the self" means.

2 THE SELF

Rogers (1951: 497) states "a portion of the perceptual field gradually becomes differentiated as the self…an organised, fluid but consistent pattern of perceptions of characteristics and relationships of the' I ' or the 'me.'" Baumeister (1995: 52) suggests that the self refers to the self-concept, or a person's idea of who he or she is. He suggests that part of the self-concept relates to awareness of one's physical being. The self-concept also incorporates roles e.g. "I am David and John's mother." The self also involves an awareness of traits or characteristics. The balance between these aspects of the self is influenced by culture, in that independent cultures place more emphasis on traits and interdependent cultures tend to give precedence to roles (Markus & Kityama 1991). The self has many interconnected facets. (Baumeister 1995:53). These include the body, social identity, social roles, membership in various groups, interpersonal roles, traits, values, priorities and a concept of one's potential. Baumeister (1995:59-60) notes that it is possible to for people to hold somewhat contradictory beliefs about themselves. Many contradictions seem to go undetected by the person. He notes also that the self may be perceived differently in different situations. For example, Joe may act one way with colleagues at work, a different way with his wife and children, yet a different way with his drinking buddies and never perceive that these ways are inconsistent simply because he may never compare them with each other. Only part of the self-concept seems to be conscious at a time, so these inconsistencies may not be perceived for some time (Baumeister 1995:60). People have a view of the ideal self (the way one thinks one "should" be) and the possible self (the way one "could" be), which may motivate and guide behaviour. This suggests that the self can change or grow.

Unity, continuity and change are intrinsic to all concepts of self. The self is an "interpersonal tool" in that human interaction requires an awareness of "you" and "I" and that these identities remain relatively stable over a period of time, otherwise there would be no difference between interactions between intimate friends and a series of brief interactions with strangers (Baumeister 1995: 54). Nevertheless, self-concepts do change. According to Baumeister (1995:68) self concepts change in response to internalising feedback from the effects of one's interaction with the environment, situational forces and interaction with others. This relates to Rogers' ('1951:498) propositions 9 and 10.

Baumeister (1995:52) states that the self is an active agent in making decisions. The self influences and guides one's motivations (Baumeister 1995:69). The self therefore is the awareness of who one is as well as what one can become or what one is striving for i.e. the self is a "knower" as well as a "wanter." Baumeister (1995: 53) suggests that the "possible self" and the "ideal self " relating to the way the self could be in the future may trigger change and growth in the self. A person may strive towards these goals, so the perception of how one could or should be may be a powerful source of motivation. (Baumeister 1995:70). These ideas seem to be linked to self-actualisation as described in proposition 4 (Rogers 1951:487).

The self-concept and behaviour are related. Rogers (1951:491) suggests that behaviour is a goal directed attempt to satisfy perceived needs. According to proposition 12, behaviour may also be an act of self-expression (Rogers 1951:507). Rogers (1990: 403) emphasises his belief that mankind can be trusted to act in ways that are "positive, forward moving, constructive, realistic, and trustworthy." He believes that people are motivated to act in ways that maintain and enhance the self (Rogers 1951:487). In a similar vein, Baumeister (1995:72) suggests that people are motivated to maintain a stable consistent self-concept and that they seek to verify the self-concept. For example, he suggests that if a person with low self-esteem receives positive feedback, he or she may be sceptical or mistrustful of it. He

suggests that the self is motivated to enhance the self as well as to avoid threats.

The person-centred approach suggests that behaviour may be motivated by unconscious experiences (Rogers 1951: 509). This is relevant to the current study, because, as discussed in Chapter 5, the effects of trauma may remain unsymbolised. Unconscious experiences were not *actively* studied in this research. Participants filled in the questionnaire and participated in focus groups, which means that they disclosed conscious experiences and no effort was made to uncover unconscious experiences or bring them to symbolisation. However, the researcher has reflected on the implied messages in these responses and presents them in this chapter according to the theory of the person-centred approach. In this chapter, the emphasis is on the effect of trauma on the participant as a helper implementing a person-centred approach.

Rogers (1967:39-40) views the helping relationship as one in which at least one party has the intention of promoting the growth maturity improved functioning and improved coping with life of the other. He adds that this means that one party intends that the other should appreciate and express latent inner resources more and more (Rogers 1967: 39). Helping relationships encompass a wide variety of relationships, such as those between parents and children, teacher and student, doctor and patient and that between facilitator and client.

In this study, the effect of trauma on the self was explored by asking participants to reflect on their own worst traumatic experience. They were asked to disclose what this experience was and then to say how it affected their view of themselves, perceptions of others and the future.

As student social workers, participants are forming a perception of the self as a *social worker*. This aspect of the self was explored. Participants were asked what motivated them to do social work. (What were their needs?) They were asked how what they experienced when talking to someone who had gone through a similar traumatic experience to their own. Participants were also

asked whether there were particular clients they would avoid seeing if possible, to see whether they would steer away from reminders of their own trauma.

Rogers (1990; 407) suggests that help is needed to deal with threatening, denied or distorted experiences. With this in mind, participants were asked whether they had support in dealing with trauma and whether the help was beneficial.

Rogers (1951: 485; 525) suggests that the self responds as a whole to one's experiences and is impacted by one's perceptions of these experiences, because the self emerges from one's experiences as perceived (Rogers 1951:486). This suggests that the self of each person is unique since no two people have the same experiences or concept of self (Rogers 1951:484). Each person perceives the world around them differently and each person's encounter with trauma is unique and can only be understood in the context of a unique life with its own goals, relationships and dreams. The researcher can merely identify patterns and themes in the data and offer her own interpretations of these. This does not imply that all participants will experience all these effects. It also implies that all interpretations are the researcher's own perceptions of the data presented to her. These insights will now be presented.

3 THE EFFECT OF TRAUMA ON THE PERSON

3.1 Trauma affects the whole person

Participants explained that trauma affects the whole person. The effects manifest physically, socially, cognitively and spiritually:

- **Trauma is a word that seeks to describe the certain stage of life where the person experiences a kind of situation which is <u>devastating [to] the soul, body and mind</u> and hinders his or her functioning. In other words, trauma happens after something or some experience <u>broke down all his or her sense of being</u>.**

- **Trauma is an experience that creates a wound in someone's soul and [it] affects them emotionally, psychologically, and physically.**
- **Trauma is something which affects a person without thinking about it. It might affect you emotionally, physically and also socially. It is not easy to avoid it or forget it.**

3.1.1 The distanced perspective

Trauma was seen to affect the self as a whole. This fits with Rogers (1951:486) proposition 3, which states that people respond as a whole to their perceptions. This implies that trauma may affect a person's perceptions, behaviour, needs, self-concept, feelings, relationships and spirituality.

3.2 Trauma is perceived to distort the self

In the previous chapter, trauma was described as an experience that is a threat to the self. It was viewed as a personal violation and something that was thrust upon the person. It was likened to a bleeding, inner wound that does not heal spontaneously. Participants also described it as a disease. These metaphors suggest that trauma invades the self and has destructive effects. There is a change in the self, but this change is not perceived as growth, but as a stunting or distortion of the self. They suggest that trauma may injure, incapacitate, deform or handicap the self. The self is left feeling infected and tainted by the experience:

- **[Trauma is] an extraordinary event so sudden, it renders [one] helpless, and hopeless. *You see yourself as a piece of something not a human being. You lose self-trust and the trust in the people around you or the whole environment*. It leaves emotional and psychological scars on top of the physical scars. The experience is not culture bound but the coping skills are culture bound.**

- **You just feel distorted.**

Jaco the participant who had been hijacked and held in the boot of the car for three days said:

- **Jaco- I think the self has been twisted and turned - infested with [the perpetrator] - because I still carry elements of the perpetrator of the hijacking with me.**

Participants suggested that the extent of the distortion varied and they felt overwhelmed to varying degrees. They suggested that the effect of one trauma after another is cumulative. The strain may be perceived to overwhelm one's defences and deform the self to the point where the self is perceived as crushed, broken or dead:

- **Trauma is a very destructive disease. It takes over your entire being and breaks you as a person bit by bit. You are left with flashbacks that would haunt you forever.**

- **When I first had my traumatic experience I didn't know what to do with it. I was too young to be able to classify it as anything. But all the symptoms that I had been traumatised were there. I was violated so much that I went with this feeling to my adulthood or adult life. It tainted my behaviour, my way of being. The more traumatic experiences I had through life, the more [they] intensified the first experience, until I shattered and broke. I couldn't take it anymore. I wanted to end it all. I wanted to commit suicide. The traumatic experiences had become too much.**

The breakdown in one's defences may be experienced as an inner death:

- **That person can actually feel that he or she is like in a shallow grave… and they don't see the meaning of living, you know - they don't see anything which is nice about life, they are just caught in a web of that event, and they're struggling to come to terms with that.**

- **Trauma is something which has destroyed you inside… you feel like you're dead if you are traumatised.**

3.2.1 The distanced perspective

Participants indicated that trauma changes the self in undesired ways, at least initially, because it is perceived as a distortion, disease or injury. This links up with the perception that trauma is an experience that poses a threat to the self.

Rogers (1990: 412) describes defensiveness as a person's response to experiences that do not fit the symbolised self. Some experiences that do not fit with the self are denied. The person may deny that the experience ever took place or may deny the emotions and perceptions that went with it. This

may be the feeling that participants describe as an inner death or being in a shallow grave. Other experiences that do not fit with the self will be distorted or re-defined so that they do not threaten the self too much. If however, the experience is so overt or obvious that one is unable to defend against it or deny it, according to Rogers (1990:248) “the gestalt of the self-structure is broken by this experience of the incongruence in awareness. A state of disorganisation results.” Participants seemed to relate to this by describing the self as “broken, ” “twisted and turned.” Rogers (1990:248) goes on to say that at times behaviour is consistent with the symbolised self, with its distorted perceptions and at others it is consistent with the threatening experience. The participants bore this out in the quotations given above.

3.3 Trauma and the haunted self

Participants suggested that trauma leaves the self feeling haunted and vulnerable. Memories of the trauma are readily triggered. One participant described what this haunting feeling is like:

- **It make[s] you anxious. The moment that it happens - like the victims are explaining, it gives you that [sensation]- like the whole stomach pulls together - that frightened feeling in the stomach, and you start sweating and some of them start shivering. You become anxious - You feel like you want to run away - if you maybe sit in a taxi and you hear a voice and it sounds like the voice of the perpetrator, you just want to get out. Reactions like that is – where [as] if you smell food and you think, “Ahh, that smells like my grandmother’s kitchen” it’s a nice feeling, but once you are traumatised and you recall these feelings, it is a <u>bad</u> experience for you. Your whole body reacts with anxiousness.**

Things are not the same as one formerly believed and there is a loss of previously held convictions and views. Participants said they had reconstructed their view of the world to form a more negative impression. Rogers (1951:513) suggests that an experience that does not fit with the self may be symbolised and in this process a new self-concept is constructed incorporating the experience. This may involve a change in the self-concept, change in perceptions or a change in behaviour so that the new experience, the self and behaviour become congruent once more. Many participants

indicated that their perceptions changed and that their altered perceptions were more pessimistic than before the trauma:

- **Your perception has to change, the way you saw the world before. Now it's like changing your interaction with people, your behaviour also changes, because of that particular trauma… <u>your perception of the world becomes more negative</u>. …I'm walking here every day, it's a better place to walk in and now I'm raped. It's like it changes my perception. I'm having this belief [that] all men are [the] same, they treat women the same. Immediately I'm raped, I'm like suspecting every man to be a rapist, so it changes everything.**

- **[My worst trauma was] – a hi-jacking. It changed my world and reconstructed my view of a "good" world.**

Participants indicated that they never felt free of the experience. It seemed to dominate their thoughts actions and feelings. They felt haunted and dogged by the effect to the experience. The experience intruded in their lives.

- **Trauma for me, it's a shock … in a way that you can't even take it away from your mind…You keep on thinking about it. It's like this experience, you're still <u>living</u> it each and every day.**

There is a sense of lost power and control and the traumatised person is constantly on the lookout for danger:

- **[My worst trauma was a house robbery (although nothing was stolen. My domestic servant fought off the criminal). I felt my private space (my home) had been violated. I felt unsafe in my home. I carried a panic button with me at all times - in the house and garden. I became fanatical about home security.**

- **I must always be alert because everything is possible at any time.**

Some had become obsessed with concern over the safety and well being of significant others:

- **I think losing my dad hurt me a lot. [He died of a disease when the participant was 11]. When I think about the manner in which he died I feel distressed. I've become more protective of my family; I'm aggressive when people interfere with them.**

- **My mom's home was broken into while she was there with my sister, and she was pointed with guns and money was demanded and she was threatened that they would kill her. Mom's incident made me**

very angry, it made me be[come] more involved in her life and check up on her constantly.

3.3.1 The distanced perspective

Participants indicated that trauma had led them to construct a more negative view of the world. These participants indicated that they were distracted and on the lookout for danger, because of a pervasive need to defend the self. This may hamper the participant's ability to function with openness and receptiveness in helping relationships. Rogers (1990:68) sees openess as a key element in useful helping relationships. He states that openness to experience is the polar opposite of defensiveness (Rogers 1990: 412). The sense of being haunted by trauma with diminished openness to experience has implications for social workers, who need to be open and receptive to all a client's experiences in order to listen effectively.

Social workers who are anxious and on the lookout for danger may be hampered in the discharge of their duties such as going into communities that they perceive as dangerous.

Retief (2004: 36) suggests that this state of tension is exhausting. Living in this state of tension may pre dispose the social worker to burnout or stress-related difficulties.

3.4 The haunted self and distrust of others

The need to protect the self and guard against danger may lead to distrust of other people:

- **Your view of people has changed. When suddenly someone commits this hideous crime against you, violates you in some way, your belief in people as good and well meaning, or just in your fellow human beings is completely shattered**.
- **My abuse (sexual) has had a huge impact on my life and my thought and my behaviour. I don't trust men easily. I [am] not comfortable with physical contact sometimes even with the same sex.**
- **[My worst trauma was] being traumatised by people who you think are the ones who are meant to help you. I got the evidence that I can**

never trust any human being no matter how nice he/she may seem to be.

3.4.1 The distanced perspective

Rogers (1967: 43) indicates that trust is an essential component of helping relationships. Clients who felt liked and accepted by the helper showed more positive change than when trust was absent. Most growth in helping relationships was produced when the helper truly trusted and believed in the client. Rogers (1967: 55) believes that in helpful or useful helping relationships the facilitator accepts and sees the other (i.e. the client) in terms of his or her *potential*. He says the person is viewed as someone who is becoming, someone who is growing. The helper is not preoccupied with the person's past. The person is not seen as someone trapped and fixed in a pattern laid down by the past or his or her history (Rogers 1967: 56). Mistrust of a person may undermine the helper's capacity to believe in the client, the core of the person-centred approach.

3.5 Altered perceptions of others and stereotyping

Distrust of others seems to create biased perceptions and lead to stereotyping of others. Perceptions generated in relation to the perpetrator seem to colour perceptions of others. People who may bear some general similarity to the perpetrator such as gender are no longer viewed as unique individuals and are stereotyped. Powerful emotions of anger and fear as well as scorn and hate are elicited:

- **[My worst trauma was] when I was molested. It made me hate males and not to trust them. If you are involved in a relationship they only love to be sexually active and not committed in the relationship.**

Ricky, an Ndebele participant who was held at gunpoint and robbed said: said:

- **I was robbed by two African men of my belongings and they also threatened to kill me. I had problems with Zulu speaking men and generalised that they are born to do crime.**

Other participants described their experience as follows:

- **[My worst trauma was] when my mother left home and left us with father who physically abused us. [I concluded that] most men are cruel.**
- **[My worst trauma was] being raped and infected with the HIV virus. I used to hate men because to me every man was a potential rapist and I didn't want anything to do with them.**

- **The worst traumatic experience I had is when my mother left me and never came back for me. I tend to hate <u>all</u> those mothers who allow their children to be raised by a stepmother because you don't know how is that child treated.**

- **[My worst trauma was] when my husband was pointing a gun at me and shooting the wardrobe, choking me and throwing things at me. I see all men as being the same and useless… It made me hate all men and it also affected my school performance, because I am always angry.**

- **[My worst trauma was] The loss of a close loved one - my grandmother [of] about 80 years, [was] raped in the fields by 15 young boys with condoms and thrown in a ditch still alive. [She] landed in ICU when found and died a few hours later. Men are now changed into creatures, which women have to fear. [They are] no longer there to protect, but to destroy.**

The participants' ability to accept all people as unique (proposition 2) and worthy of respect (proposition 17) was clouded by their own defensiveness or rage, which seems to filter perceptions. In contrast to the PCA value of respect, there seemed to be a tendency to scorn others who had been stereotyped.

- **[My worst trauma was] my father leaving my mother. I harshly hate people who leave their families especially where children are involved.**

- **[My worst trauma was] my father physically and verbally abusing me…I have scorn for women who stay with men who abuse their children.**

- **[My worst trauma was] When I was molested. Men are nothing but piece of ******. It better to be single than being involved with somebody who will pregnant you and leave you with the baby or [let you] get HIV/AIDS from him.**

- **[My worst trauma was] when I was emotionally, physically and psychologically abused by my father. It made me to perceive men as rubbish and useless beings.**

3.5.1 The distanced perspective

Participants indicated that they tend to stereotype others and then scorn them. One wonders how students who have stereotyped others will be able to accept a client as unique or different to the perpetrator of his or her own trauma. Rogers (1990: 230) has stated that one of the necessary and sufficient conditions for therapy is that the helper is experiencing unconditional positive regard for the client. He also describes this as prizing of the person. Grobler et al (2003: 89-96) stress that respect is a core value of the person-centred approach.

In his discussion of beneficial helping relationships (Rogers 1967: 44) states that the helper needs to be able to enter the client's world so fully that he or she loses all need to evaluate or judge it (Rogers 1967: 53). The client needs freedom to be what he or she is if the relationship is to be effective (Rogers 1967: 53). The client experiences complete acceptance of all his or her experiences in the *absence of any threat such as criticism or rejection*. Participants who scorn certain classes of people may have great difficulty in creating this warm, accepting and facilitative climate.

The responses within this theme indicate that participants seem to be responding to unsymbolised experiences that threaten the self and are likely to have difficulty implementing the value of respect and granting stereotyped others unconditional positive regard, to the detriment of the helping relationship.

3.6 Stereotyping and distrust of others leads to a diminished capacity for intimacy

Pervasive mistrust and stereotyping seem to create a need to defend the self, leading to a loss of potentially meaningful relationships and reduced capacity for intimacy (Proposition 15). Some participants described themselves as watchful and defensive in relationships. Some participants alienated themselves to defend against potential hurt.

A participant whose father died of an illness when she was eleven years old says:

- **I don't know why but I become very attached to people even if I've only met them for a day - I feel sad when I'm alone. On the other hand, I suspect people secretly may not like me so I decide not to like them first.**

Other participants say:

- **[My worst trauma was] - when I was emotionally, physically and psychologically abused by my father. It altered my perception about a family and I was scared to fall in love because I thought all men were the same.**

- **[My worst trauma was] my parents' death. It caused me to avoid people and attachment. [I am] unable to form relationships and mostly become withdrawn with the fear of losing someone close to me.**

Intimacy seemed frightening. Participants felt that their lives had been impoverished by trauma.

- **My abuse (sexual) has had a huge impact on my life and my thought and my behaviour I [am] scared of physical contact, intimate contact with the opposite sex. I want it but I'm terrified of what might happen.**

One participant put it like this:

- **Other experiences build relationships, but trauma ruins relationships.**

These responses suggest a deep loneliness in participants. It is also important to note that nurturing relationships in one's personal life can be an important buffer against the stress of working with traumatised clients (Radey & Figley 2007: 209). This may be an unmet need for these participants.

3.6.1 The distanced perspective

Rogers (1967:44) concluded that the attitude of the facilitator, rather than his or her theoretical orientation, was a crucial component in making the relationship detrimental or useful to the person needing help. Remoteness and distance were found to be detrimental to the helping relationship (Rogers 1967: 43). Participants who are struggling with intimacy may find it difficult to

establish the warm relationship in which the client may disclose his or her deepest, darkest secrets. Rogers (1967:51) indicates that when a person is unable to accept the client fully, it is because the helper's self is threatened in some way by what the person has brought into the session. This indicates that some participants may be struggling with unsymbolised threats within themselves.

3.7 The haunted self and unresolved emotions

The self may be burdened with unresolved emotions. Emotions associated with the trauma seemed to linger. Some participants who had been harmed by another were left with unresolved hate and anger.

- **[My worst trauma was] the time my own uncle was sexually abusing me, although I'm not sure how old I was but this feeling or experience usually comes to my mind. I think I was under 4 years, but it comes to my mind] It affects me psychologically, emotionally, because I always think about what he did to me. He died a long time ago, <u>but I still hate him.</u>**

- **[My worst trauma was] being abandoned by both parents. Being a mother of 2 sisters, I was forced to leave school. I developed a love for children, but hatred for men. I developed the feeling of hate.**

These responses point to the need for participants to be aware of the type of clients they cannot work with.

Some participants struggled with unresolved guilt.

- **Losing my child was the worst and hardest thing that I ever had to deal with. I understood the complications I had but still it was hard. Funny thing is the pregnancy was unplanned but losing her was like a piece of me [being] ripped off. I blamed myself for not wanting the baby in the first place and I took her death as punishment for the negative feelings I had when I realised I was pregnant. The trauma that I went through was somehow part of me punishing myself and being unable to forgive myself.**

- **[My worst trauma was] the night my dad went mad and beat my Mom. My siblings and I had to sleep with the neighbours. I loathed my dad. It made me feel guilty of not being there for my mother when she needed help.**

3.7.1 The distanced perspective

One of the difficulties that a helper may experience when working with traumatised clients is that the client's experience may trigger unresolved emotions in the helper. Non-acceptance of a client's experiences may arise from the helper's feelings of fear or because the helper is threatened in some way by the client's experiences (Rogers 1967: 54). If a facilitator is threatened by his or her own emotions when empathising with a client, the warmth needed for facilitation may be blocked by the facilitator's need to defend the self (of the facilitator), hampering his or her ability to understand, communicate empathy and thus to help. Rogers (1967: 52) says this need to defend the self may manifest by hiding behind professionalism or treating the client as an object.

Being consistently real or genuine in the context of the relationship is a core component of helpful relationships (Rogers 1967: 50). If one is unaware of one's own feelings, congruence is inhibited (Rogers 1967: 51). Rogers (1967: 51) suggests this is a consequence of defensiveness.

3.8 Loss of self worth

Perceptions of one's own worth may be shaped or altered by trauma. Some participants said that they felt stigmatised because of their experience.

- **[My worst trauma was] being raped and infected with the HIV virus. It limits my wishes and dreams, for example one day I would like to get married and have kids of my own but now that dream seems faint because of the virus. Also I have lost a lover because his mother discovered I was [HIV] positive and she threw a tantrum about it and I felt double victimised even though I don't see myself as a victim but at times I just feel like one.**

- **I am describing rape or attempted rape as painful/traumatic because I was the victim of rape and attempted rape on different occasions. It leaves emotional scars. You might be infected with incurable infections. *You lose your self-trust. It results in low self-esteem, hopelessness and helplessness.* You become paranoid and you have suicidal thoughts [that] keep coming back in your mind.**

- **[My worst trauma was] being sexually abused… I always expected others to have a motive for wanting to be close to me, especially**

guys. I always thought they wanted a piece of me. And I felt women saw a slut in me.

For some the self was constructed as bad or inferior:

- **[My worst trauma was] when my father beat up my mom with a heavy stick on the head. We were living on the street because the conditions were not favourable in home. It caused me not to have confidence in me. I almost feel unfit towards other peers and unable to trust family other members.**

3.8.1 The distanced perspective

The difference between one's perception of oneself as one actually is and the ideal self seems to be related to self esteem (Baron & Byrne 2000: 174). The greater the discrepancy, the more defensive one is and the lower one's self esteem. Trauma may elicit responses that are contrary to the "ideal self" as perceived by the person. Matsakis (1996:73-74) states that it is not uncommon for survivors of trauma to blame themselves for the trauma or its negative outcomes. She believes that powerlessness and helplessness are two of the worst feelings that a person can experience. Her perception is that, because people prefer to think that they can control their lives, it is easier to blame themselves for negative events than to acknowledge that life can be unfair and capricious. However, self-blame lowers self-esteem.

Survivor guilt may result in loss of self-esteem. Survivor guilt is the bad feeling that arises when one made it through the trauma and others did not or when one was less hurt than someone else. It can be difficult to admit that one is grateful one survived when others did not. It may seem heartless to the person to admit "if someone had to die I'm glad it was not me!" However hard this feeling is to face, it is an expression of the desire to survive (Matsakis 1996:73-74).

It seems that living in a culture where self-confidence, self-actualisation and independence are valued may add to self blame (Matsakis 1994: 80). Being a victim of trauma brings feelings of vulnerability and helplessness to the fore. Feeling powerless represents a large discrepancy in the person's value system. This very discrepancy may lower self-esteem. It is possible that

participants were reluctant to ask for help because of a fear of seeming weak or unable to deal with difficulties independently.

Low self-esteem is related to the discrepancy between the self as perceived and the ideal self. The discrepancy between the actual self and the ideal self can be reduced in a number of ways (proposition 15). The person may become convinced that the actual and ideal self are actually much closer than originally believed. Or the self can become more like the ideal. Alternatively, unrealistically high standards for the ideal self can be reduced to lessen the discrepancy (Baron & Byrne 2000: 174; Rogers 1951: 515).

Brandon (1994:3) points out that we cannot be indifferent to our self-evaluation. He states "self esteem is the experience that we are appropriate to life and to the requirements of life. More specifically, self-esteem is:

1. Confidence in our ability to think, confidence in our ability to cope with the basic challenges of life and
2. Confidence in our right to be successful and happy, the feeling of being worthy, deserving entitled to assert our needs and wants, achieve our values and enjoy the fruits of our efforts" (Brandon 1994:4).

He asserts that high self-esteem correlates with rationality, realism, intuitiveness, creativity, willingness to change, willingness to admit and correct mistakes, benevolence, and co-operative ness. He goes on to state that low self esteem correlates with irrationality, inappropriate conformity, fear of the unfamiliar, defensiveness and over-controlling behaviour, as well as fear or hostility towards others. Self-esteem affects all spheres of life. Low self-esteem, in his view, is linked to the reduced capacity for intimacy discussed in the previous theme. He suggests that a major barrier to romantic relationships is the belief that one is undeserving of love. He points out that the perception that one is unlovable makes the experience of being loved confusing, since one believes that the feeling of being loved cannot be real, reliable or lasting (Brandon 1994:8). He speaks about "happiness anxiety." He suggests that experiences that are contrary to the self-concept may activate inner voices saying, "I don't deserve this," or "it will never last." This can result in self-

sabotaging behaviour to bring experience and the self-concept back in line with each other. When we doubt our minds or the worth of our ideas, we tend to discount its products (Brandon 1994: 14). Such unconscious perceptions can lead to behaviour that undermines relationships or one's success in any field. Thus a person's life may be impoverished by low self-esteem. He believes that people sabotage themselves when success clashes with their implicit beliefs about what is appropriate to them (Brandon 1994:15). This fits with proposition 13, which suggests that behaviour may be motivated by unsymbolised experiences (Rogers 1951: 509).

Both Brandon (1994:17) and Rogers (1990:245) describe self -esteem as a need. Proposition 10 suggests that self esteem is developed from our own direct experience, but may be introjected by taking over the values of others with respect to the self. It is the need for approval that frequently results in conforming behaviour, that is the root of incongruence within the self. The cornerstone of the person-centred approach is its belief that people have inherent worth. Rogers (1990:246) postulates that our own awareness of our worth as human beings may be distorted as we strive to gain approval or positive regard from others.

Baumeister (1994: 77) states that self-esteem and anxiety are inversely related, suggesting that self-esteem buffers one against anxiety. He believes that anxiety has its roots in concerns about belongingness and social exclusion. Threats to belonging such as romantic rejection, loss of employment, and bereavement, in his view lead to anxiety because they imply a loss of connectedness with others. He believes that high self-esteem is comforting because it implies one has qualities that make one attractive or acceptable to others (Baumeister 1994:78). This suggests that low self-esteem signifies that the self is under threat of rejection, disapproval or loss of connectedness with others.

Rogers (1951:515) suggests that when the self is threatened, it becomes more rigidly organised. One clings to values taken over from others in an effort to retain positive regard. The result is diminished capacity to accept the

values of others. One of the cornerstones of the person-centred approach to helping relationships is that the helper does not take responsibility for the client but allows him or her to develop their own values and solutions. Rigidity in the self-structure of the facilitator, due to feeling threatened and having low self-esteem may interfere with this ability.

Although these perceptions may sound discouraging, it must be kept in mind that these participants are studying social work. They are making an effort to actualise and enhance the self. This may be an indication of their resilience and refusal to be defeated by these painful experiences.

3.9 Alienation from the self and numbness

Participants were left feeling alienated and disconnected from the self.

- **The pain is so great that you detach from yourself – you do not own your own body and you have no real feelings. It is difficult to organise or arrange anything – gone are all the skills and abilities – even the intelligence. You are living in a vacuum.**

Participants indicated that trauma may be so painful that one is left feeling anaesthetised. In an effort to defend the self, one may lose touch with one's inner being and feelings. Participants said that the numbing effect of a traumatic experience is related to the threat to the self. One may be left with unsymbolised experiences and emotions:

- **I dissociated from my childhood trauma totally. I started working at a Welfare Organisation, because I've got this passion, especially with children. And after that I started my therapy. Only then I could realise what is this is about. I was always projecting all my feelings towards the children. And then I started my studies, because I know that this could affect other children too … What I just want to say, is, if you fill in this form, if you didn't know about your trauma, you can really mark" no", that you are not aware of something in your life but sit with that feeling, feeling that it *is* there, but you can really answer "no."**

- **You learn to dissociate, so dissociation became part of your functioning, so you can easily disassociate from other things too in your life, …I think you can decide if the event is so traumatic that you can't cope with it, you can totally block it … it depends on your capability to handle the issue.**

These comments point to a limitation of the study. The researcher can never know what is not disclosed, whether intentionally or unintentionally. The questionnaire can only reveal tendencies, but the extent of trauma cannot be measured or known with certainty, even to the participants themselves.

Numbness can leave one disconnected from one's personal history:

- **Can I share something? My father committed suicide when I was 9. Actually, I was well before that. We were staying on the farm and playing. My mother was also working so we children were staying with the lady that was working for us and that wasn't really a problem, but when my father died, my whole life collapsed. - I went into like a sleep phase. I cannot remember very much from that age until about standard 6… the fact that I cannot remember anything from that phase is because it was so terrible. It's like a nightmare that was so terrible, that I cannot really remember anything…<u>When my father committed suicide it left me lonely in this life - "I fell asleep."</u>**

It can leave the person feeling he or she is going through the motions of living:

- **I'm nervous to embrace life fully.**

Participants suggested that trauma diminishes one's self-awareness.

- **Being raped stole my sense of being me.**
- **[My worst trauma was] the emotional, verbal abuse and neglect by my parents. I grew up with low self-esteem and wasn't aware of my own values, desires and needs. I just survived. The birth of my daughter and studying PCA cut open these traumas.**
- **[My worst trauma was] being sexually abused. I felt so helpless, powerless …. It completely changed me. I believe I would have been a different person. I went through life feeling like a shadow of what I was meant to be until it was too late. I only started being me at 28…**
- **Trauma actually removes your "self." You lose your entire self. That part of your "self" is still lost – so that you can't say who you are all the time… you lose your sense of self; you are unable to trust others and most of the time you're always miserable and you self-control and self-esteem- you lose them.**
- **Trauma destroys the self. Once you could have been a self-motivated, courageous person and then all of a sudden, day 24 of this month you actually experience something so traumatic that you**

almost - if you feel you've lost your sense of self, and the things that you could do before the trauma and the things that you're doing now after the trauma is completely different. It's - it's a breakdown of everything that you were. Your self could have been controlled, calm, collected, but after the traumatic experience you have no control. You're no longer calm, you're always vigilant, you always ah - you're always looking for sincerity from people. You already have this doubt that they don't have it [sincerity] and they're out there to get you, so the self is damaged. Once [the self was] protected – Now protection is breeched and the self is vulnerable.

The person may feel that part of the self is dead:

- **Trauma is something which has destroyed you inside… you feel like you're dead if you are traumatised.**

3.9.1 The distanced perspective

Rogers (1990: 137) notes that he is at his most effective when he is in touch with his intuitive self. He suggests this is being in touch with the self so fully that it is sensed as being aware of the transcendental core of the self so that he is a "presence" to the client. Alienation from the self would interfere with this process. Rogers (1951:17) emphasises that the more fully the facilitator has symbolised his or her self, feelings, perceptions and values and the more accepting he or she is thereof, the better able the helper is to create appropriate conditions for facilitation of growth and self- actualisation for the client (Proposition 17). According to propositions 18 and 19 he or she is able accept other and their values better (Rogers 1951:520-522). Rogers refers to this as "congruence." Congruence is the state of realness or genuineness that emerges when one has explored the experience of one's own self and has accepted the truths that have been discovered in the process (Van Dyk 2000: 34). Congruence pre-supposes that the helper's feelings and perceptions are, as far as possible available to his or her awareness. Dissociation interferes with this process.

Congruence is shown in genuineness or sincerity. Rogers (1967; 16) states: "In my relationships with persons I have found that it does not help, in the long run, to act as though I were something that I am not. It does not help to act

calm and pleasant when I am actually angry and critical… It does not help to act as though I were full of assurance, if I am frightened and unsure."
A congruent person is at home with him or herself and can be authentic in interactions with others. The opposite "incongruence" is "wearing a mask" in relating to others.

Incongruence is an unconscious process. It does not mean that a helper is purposely insincere or phony. It is a way of protecting the self from painful or threatening experiences.

Rogers (1990:247-249) has described the process of overcoming incongruence as the goal of his interactions with clients. It is also something to which the facilitator needs to attend in relation to him or herself to be effective as a facilitator. He has described the characteristics of what he termed "a fully functioning person." The quotations cited thus far differ from his description, suggesting that many participants' lives have been restricted by trauma. Briefly, Rogers (1990:410-416) believes that a fully functioning person:

- Is open to experience.
- Lives fully in the moment.
- Trusts him or herself and his or her own experience.
- Is willing to be flexible.
- Is creative.
- Experiences all his or her feelings intensely, creating greater richness of life.
- Experiences deeper self-awareness.
- Is positive, forward moving and constructive.
- Relies on his or her own evaluation, rather than that of others.

Rogers (1990:75) believes that when experiences are available to our awareness, behaviour tends to be in line with that awareness. This implies that congruence is related to self-actualisation. The more fully a person is aware of him or herself, the more fully he or she can express, maintain and enhance the self as stated in proposition 4 (Rogers 1951:487).

Rogers (1967:17) states “I believe that I have learnt this from my clients as well as within my own experience-that we cannot change, we cannot move away from what we are until we thoroughly *accept* what we are. Then change seems to come about unnoticed.” It is also significant to note that he does not believe that it is possible to achieve this level of congruence without the experience of a facilitative relationship (Rogers 1990:407). This suggests that the person-centred training offered at Unisa may be of personal value to participants in providing a context for change. Unisa’s Department of Social Work attempts to create a person-centred climate for students. One wonders the nature of the training at Unisa is affecting the participants. Is this context sufficient to produce the growth enhancing climate Rogers (1990:407) suggests is needed to facilitate change? How is the person-centred training perceived by the students? This suggests a focus for further research.

3.10 Impact on the student self

Baumeister (1995:53) suggests that part of the self is the perception of what one may be in the future. He refers to this as the “possible self.” He states this can be a powerful source of motivation. The research shows that, despite many obstacles, participants in this study persisted in their studies and are in their fourth level of study. Participants in this research were working towards a professional identity as social workers. However, pre-occupation with trauma had hampered progress for some for a time. Trauma may have precipitated a temporary loss of motivation. It may have cut off sources of financial or emotional support. The person may be thrust into new roles for which he or she was unprepared:

- **[My worst trauma was] - being abandoned by both parents. Being a mother of 2 sisters, I was forced to leave school. At first I gave up with life. I felt lonely. I used to cry when my sisters were at school.**
- **[My worst trauma was] - Physical violence on a family member. I lost concentration on my studies since I was doing my second year.**
- **I had to leave home after my grandmother passed away; there was no one to support me, to pay for my school fees.**

- **[My worst trauma was that] - I was in poverty. They sent me to the relatives but they didn't treat me nicely and they were cursing me. It affected me psychologically and emotionally as I was not even concentrating at school and I failed.**

- **[My worst trauma was] - death of family member. The death was during my exams and I failed the module. That prevented me from registering for another level. I was feel that I was used and that person took advantage of my background because he is a Dr.**

- **[My worst trauma was] – my verbally abusive marriage, my husband's relationship with a co-worker and my discovery of it. It devastated me. I cancelled part of my modules and received medical treatment for anxiety and depression.**

3.10.1 The distanced perspective

Adamson (2005: 66) points out that the current construction of trauma knowledge is located predominantly within a biomedical perspective. She suggests that this has created a short-sighted focus on the physical and behavioural responses to trauma, ignoring the wider social and ecological impact. Trauma's impact is holistic and the effects can extend far beyond the immediate physiological and behavioural responses. She suggests that the impact of trauma on later experience or other aspects of life is largely ignored (Adamson 2005: 74). In line with these comments, participants indicated that they were hampered in the pursuit of their studies as an aftermath of trauma. This has implications for South Africa where there is a critical shortage of social workers (Earle 2008:45). If the students are unable to qualify, the problem will be compounded. The throughput rate at Unisa is notoriously low. For example in 2007, only 6% of students graduated. The throughput rate in the Unisa Department of Social Work is in keeping with the rest of the university (Schenck 2008). Earle (2008:122-123) conducted a case study at the Universities of Stellenbosch and Limpopo. One of the participants is quoted as saying "sometimes you'd be surprised…it has nothing to do with the intelligence of that person or the dumbness of that person because even those we think are intelligent do fail." It seems that failure is related to factors other than academic ability. Earle (2008:123) noted that students' family circumstances, poverty and exposure to crime, alcoholism and drug use in the family, teenage pregnancy, the breakdown in family units as parents leave

children with grandparents and move in search of work, lack of role models and lack of early education, lack of academic support from uneducated parents or grandparents and lack of access to technology and educational resources all contributed to social problems that burdened the students to such an extent that they could not cope with their studies. These findings support the view that trauma occurring in the wider social context has a noticeable impact for prolonged periods of time and may hamper the participants' ability to qualify and break out of the cycle of disadvantage in which they find themselves, prolonging the trauma. This study focused only on participants who had reached fourth level. It was beyond the scope of this research to investigate why other students had dropped out and whether circumstances of poverty, abuse, bereavement or other trauma is a contributing factor, but the evidence presented thus far suggests that this is very likely to be the case. This may be a fruitful area of enquiry for future research.

3.11 A bleak future

Perceptions of the world and the future were reconstructed. Some participants constructed a perception that the future is bleak and uninviting. This seemed to diminish the person's motivation:

- **When I had to leave home after my grandmother passed away, there was no one to support me, to pay for my school fees. I was subjected to living with a family friend. She wasn't caring for me; I was a slave for her. You feel like there is a big black cloud, no hope for tomorrow, sometimes you attempt to commit suicide because you see that there is no bright future shining through your eyes.**

- **My traumatic event was when I lost my mother while I was young and there was a huge responsibility on my father to look after me and I was missing the love I have never experienced. The trauma affected the future in a way that I view the future as the dark and become hopeless.**

- **[My worst trauma was] - the death of my sister who was very sick. It made me think that [there is] no need to study and have a lot of money because in the end you are going to die early.**

- **[My worst trauma was] - my abusive marriage. It left me with a shaky view of future; loss of previous certainties; I don't care about**

financial welfare; I'm just concerned about now; I feel rejected as a person and as a woman.

Negative perceptions of the world and the future mean that the future may be viewed with trepidation as belief in personal power and efficacy is undermined:

- **[I believe] the future is out of my control. [I have an] external locus of control.**
- **Because of my parents' death, I am always asking myself a question as to how I am going to cope in future?**
- **[My worst trauma was] being removed from home due to political violence. I thought my life would be unstable, that I shall have no control over my life but will rely more on other people to decide my fate.**
- **[My worst trauma was] when I was robbed in my home at gunpoint… It makes me feel numb and helpless. It makes me not trust anyone anymore, especially strangers. [with regard to the future] I always have room for disappointment in life. [I expect disappointment in life].**
- **[My worst trauma was] being raped and infected with the HIV virus. Sometimes and most of the time I doubt I will ever get married and have children. In fact I have that fear of how long will I live before the virus takes its toll, but on the other hand, I still have that hope and belief that it's all up to me to live longer and healthier. I am not sure about my future as far as starting a family is concerned.**

3.11.1 The distanced perspective

Participants seemed to have reconstructed their view of the future to make it congruent with their experience. Participants were left with diminished hope for the future. The loss of hope seems to spring from the perception that one is powerless to alter one's fate or gain control over one's circumstances. This ties in with the theme that a core feature of trauma is the perception that one is powerless. This experience seems to have a lasting impact on the self-concept. It undermines self-esteem, which according to Brandon (1994:4) is the experience that we can feel confident in our ability to cope with life.

Trauma may result in what has been termed "learned helplessness." This phrase was coined after a series of experiments in which animals were

subjected to a series of inescapable electric shocks (Seligman 1975: 37). No matter what the animals did or did not do, they could not escape the pain. At first the animals fought and tried to get away, but then sank into listlessness and behaved passively. Later on in a second series of trials, the same animals were shocked again, but this time they could terminate the shocks by some voluntary action such as pressing a lever or jumping over a barrier. But they made no effort to do so. They had learned to be helpless. It seems that due to their previous experience of being trapped and powerless they were too defeated to take protective action. This theory has been tested with human subjects and applied to traumatised people, particularly when the trauma is prolonged. Seligman (1975: 46-51) concluded that when an organism has experienced trauma it cannot control, its motivation to respond in the face of later trauma wanes. Moreover, even if it does respond, and the response succeeds in producing relief, it has trouble learning, perceiving and believing that the response worked. Finally, its emotional balance is disturbed; Depression, passivity and anxiety, measured in various ways, predominate.

Rogers (1990:248) speaks about overwhelming experiences. If an experience threatens the self, it may be denied or distorted to fit the self-concept. If however, the experience is so overt that it cannot be dealt with by denial or distortion, the self-concept may be altered to fit the experience. It seems that trauma had created a sense of powerlessness for some participants that wads so overwhelming and prolonged, that the self had been re constructed as helpless, resulting in a diminished capacity for the motivation and behaviour needed to actualise and enhance the self.

3.12 Trauma diminishes the capacity for self-actualisation

One of the cornerstones of the person-centred approach is that human beings have an innate tendency to actualise the self (Rogers 1951: 487-492). Participants seemed divided as to whether trauma helped or hindered this process in the long term. However, participants indicated that trauma always starts out as an obstacle:

- **Trauma is an obstacle. It is unnecessary for personal growth and development.**
- **Trauma is an obstacle because when you are traumatised you can't do anything and feel helpless.**
- **Trauma is an opportunity for obstacles because it mess[es] up the whole of your life.**
- **[Trauma is] an obstacle – most of the time it brings back pain and loss of identity.**
- **Trauma is an obstacle – it makes life difficult and it is difficult to achieve a goal while traumatised.**

3.12.1 The distanced perspective

Trauma may diminish a person's capacity to actualise the self. This is an overarching theme. Trauma was perceived as an experience that wounds, infects or distorts the self. These metaphors suggest that the person's capacity to function and actualise the self is impaired. Participants experienced the self as distorted or twisted, indicating that the traumatised self did not correspond to the true self. This implies that the capacity to express the true self is impaired.

As the person becomes pre-occupied with noticing and avoiding threats, the person feels haunted and vulnerable. He or she is on the lookout for danger and this diminishes the capacity to remain open to experience. Other people are viewed with suspicion and mistrust, diminishing the capacity for intimacy. Participants seemed intent on keeping safe and avoided getting too close to others. This implies that the person may lose out on engaging in potentially meaningful relationships. Thus the capacity to actualise the self in intimate, meaningful relationships is impaired.

Participants suggested that self-esteem is lowered by trauma. Brandon (1994: 14) indicates that low self-esteem can generate behaviour that results in self-fulfilling prophesies with negative outcomes for the person, confirming the

negative self image. This finding suggests that the capacity to actualise and enhance the self is hampered.

An important feature of trauma, according to the participants, is that it creates a sense of alienation from the self and numbness. The numbness of trauma seems to be deeply unpleasant, as opposed to a pleasant euphoria. Because part of the self is unsymbolised, the capacity to actualise the self is hampered. Rogers (1951:507) contends that most ways of behaving are consistent with the symbolised self (proposition 12). If part of the self is unknown it cannot be expressed. He also contends that behaviour may be motivated by unsymbolised experiences, but such behaviour is not owned by the person and creates stress (Rogers 1951: 510).

The self may be burdened with unresolved emotions that are readily triggered. This diminishes the person's ability to be flexible and engage in new, challenging situations that are needed for growth. The person may become bound up with a need to protect the self (Brandon 1994:6).

Participants indicated that self-actualisation as a student may be hampered. Many participants were struggling with lack of resources or were required to assume additional responsibilities due to the death of significant others. It is known that social support acts as a buffer against the detrimental effects of trauma (Naparstek 2006: 59). Many participants seemed to have lost important people in their support system such as parents, grandparents or siblings.

Participants' responses indicate that trauma has the capacity to alter one's perceptions. The perception of the self is changed. Perceptions of others as good and well-meaning are shattered. The future is viewed as gloomy and hope is diminished. This has an impact on motivation. Baumeister (1995: 53) has pointed out that the self is a "wanter" and can visualise how one wishes to be in the future. Constructing the future as bleak and uninviting reduces this capacity to actualise the self and to strive to enhance the self, as suggested by proposition 4 (Rogers 1951: 487; Seligman 1975: 56).

An important aspect of this study concerns how trauma has affected the participant as a future social worker. Students at Unisa are trained to apply the person-centred approach in their interactions with clients. The relationship between the self of the helper and the self of the client is the foundation upon which this approach rests. Rogers (1990:62) indicates that the self of the helper is a very important part of the equation. The results indicate that participants may have much difficulty in applying the person-centred approach. Participants indicated that trauma may distort the self. It creates a sense of alienation from the self and numbness that may make it impossible to be congruent as a helper. Participants tended to stereotype and scorn people who reminded them of their own trauma, lessening the capacity for empathy and respect that are hallmarks of a person-centred relationship. The capacity for intimacy is hampered, which may make it difficult for the helper to create a warm climate for facilitation.

Participants experienced defensiveness as the self was haunted by reminders of the trauma and unresolved emotions. Participants said they felt wary and mistrustful in relationships. The person-centred approach suggests that when the self is threatened in some way it becomes more rigidly organised and less able to accept the value system of others. This may hinder the student's ability to allow the client to develop his or her own value system or find his or her own solutions to problems.

Traumatic experiences may lower self-esteem. This has implications for the personal growth of the student, who may be reluctant to engage in new tasks or experiences needed to grow as a person. It may decrease the participants' confidence in working in new situations or with diverse people.

Participants seemed to view the future as bleak and uninviting. The self was seen as powerless and the locus of control was frequently placed in others, rather than the self. This has implications for the person's motivation. In addition, hope and belief in the client are core features of a person-centred stance. If the student regards the future as hopeless, his or her ability to adopt an optimistic stance with the client may be thwarted. In all it seems that the

trauma that many participants have experienced poses a significant obstacle to their ability to working with clients using a person-centred approach.

The overarching theme with respect to the impact of trauma on the self is that it diminishes the capacity to actualise and enhance the self, at least initially. However, the next theme will show that the deleterious effects of trauma can be overcome.

3.13 Trauma may be a catalyst for personal growth

The researcher has paid much attention to the ways in which trauma may hamper participants' ability to establish the type of helping relationship suggested by the person-centred approach. Although trauma presented an obstacle for some participants this was not true of all respondents. People are unique and not all participants experienced trauma in this way. Indeed some experienced it as a catalyst for growth.

Participants indicated that when one goes through trauma, you may have support, but you suffer alone in that no one can suffer for you or take your place. It is the person him or her self that has to transform the self into a survivor:

- **Well, I agree with Z, no matter how much other people try to help you through this experience, in my case, I realised it was me. I tried hard enough and I got through it on my own. - I feel that there's nobody who really can help you –They may have guided you through the process, they support you, but to overcome the experience, you have to do it on your own.**

<u>Surviving trauma can enhance self awareness</u>

Participants indicated that trauma can trigger numbness and leave one disconnected from the self. As survivors, participants said that trauma can enhance self awareness:

- **You make contact with parts of yourself that you did not know about**.
- **And the other thing is that if you are experiencing trauma, it's makes you realize your weakness and your strengths and then you know**

how to move on - how to deal with these things and you can even help someone who is experiencing trauma. I think it makes you very, very strong.

Surviving trauma may alter self-perceptions, enhancing self esteem

It seems that participants who viewed trauma as a challenge and emerged as a survivor experienced enhanced self-esteem and felt good about themselves:

- **I see trauma as an opportunity for growth and reflection, because now I can say that I am so proud of myself. I came from rural areas, look where I am now. I am doing what I like, I am going to make different (difference) to others, and I am sure those memories won't haunt now and forever.**

- **Trauma teaches you about yourself because after coping you feel in control and many accolades are sent back to the self for making it.**

- **[My worst trauma was] when my father beat up my mom with a heavy stick on the head. We were living on the street because the conditions were not favourable in home. [It] Empowered me because I have created this world most of people never do.**

Surviving trauma gives one greater flexibility and openness

Some participants experienced a greater acceptance of others and of the uncertainties of life in general:

- **Discovering that my close family member is HIV positive [made me realise] it is not possible to predict all your life's events, but it is important to learn how to cope with the events that one faces in future.**

- **Trauma helped me have depth as a person. Helped me to overcome and push through obstacles and think of others.**

Appreciation of others

Participants who had been nurtured and supported through their pain held a positive view of others and experienced deeper appreciation of others.

- **[My worst trauma was] the murder of my father and the death of my life partner]. I respect and care for other people - without people I would be devastated**.

The participants valued time with precious people. Some seemed to experience a greater appreciation of others:

- **I have been through some traumatic events - quite a few in my life, and then it has taught me to appreciate everything that I have. it has taught me to appreciate my daughter more - sometimes I took it for granted [that] she's my daughter she should understand –[that]I love her and then stuff like that - but having gone through some of those traumas has taught me to tell her often during the day, I love you. And then it has taught me to say that to all the people that are close to me. To not take it for granted [that] they know I love them, but to tell them and make sure that they know.**

Surviving trauma deepens the capacity for empathy

Participants said that going through trauma can give one greater empathy and compassion for others:

- **The rape, death of my mother gave me greater empathy and understanding.**

- **Watching my mother die from cancer; watched her waste away and suffer for 2 months, after battling the disease for 3 years and the suicide of my brother when I was 18 made me more compassionate and less judgmental. It made me want to make a difference, even in a few people's lives. It made me stronger.**

Deeper appreciation of life

Although some participants said that trauma had created the perception that the future is precarious and uncertain, others suggested that they had become aware that the fragility of life makes time precious and valuable:

- **I learnt that life is too short to waste. Something might happen unaware and then you will regret it for the rest of your life, so live as much as you can. Live your life in full.**

- **Ja,[yes] trauma can be a growth [experience]- ja, because sometimes as people, we don't appreciate life - we don't value it, but once your life have been put at risk - or once you find yourself at risk, that is when you see how blessed you are just to be alive.**

Some participants said that the fact that life is finite and one's lifetime is limited motivated them to live more consciously. They were more selective about how they spent the life that they have:

- **I think about death a lot, but maybe just because of my Christian religion, that we not living forever on earth.**

- **You can also start to appreciate life in general. Sometimes in life we just do things not thinking, but then after that, whatever you get involved into, you think first critically analyse what you're going to do and then you look at the pros and cons of your own actions, and then you also start to appreciate life. In my case, I was shot and then I was started to really think thoroughly - like what if I could have been dead by now - so right now, each and everything that I do, I do it with my whole mind and - you know - my whole heart, so I think ja,[yes] for me it was a lot of growth.**

Some participants were spurred on to make the most of life:

- **Losing my Mom, my brother, and my sister's child within a short period of time made me take everything seriously and see that life is too short to be wasted.**

Renewed trust in others

Although trauma can destroy trust in others, receiving support can deepen appreciation and faith in our fellow men:

- **You must remember when you went through something bad, it's not only you who suffers, it's the people around you. It is your family and sometimes they are the most supportive people who are around you, and you basically you need to have a very clear view after you come out of the trauma, of the people around you, all the support that you've given and then you need to say, "You know, these other people really do motivate me in life" and you know what, that's where your choice comes in - do I choose to make myself a victim, or do I choose to go on, because if I choose to be a victim, then I am bringing those around me down as well, and that's sometimes the most closest people to you.**

New tasks and challenges

Some participants felt that their trauma had given them new tasks and challenges. It triggered a search for one's direction in life. This seemed to trigger a desire to actualise the self once more:

- **It makes you reflect on what your purpose is.**

- **FGP At the end of any trauma when you're reflecting, you choose - you have a choice to feel sorry about yourself - to curl up in a little cocoon and hide away somewhere, or you have a choice to say, "you know what, I am not going to make this phase me out," because if you [are] religious, you will say," I have greater purpose, I was put here for a reason," and you will assess yourself. I basically assess myself when it comes to being very spiritual. I always say, "I was put here for a purpose." You need to find that purpose, and no matter how small a role you will play in life, if it is to someone, somewhere out there, it was meant to be. Even to a little animal, even if you never meant to have a purpose for any other human being, but or you will help maybe just being kind to an animal. So you have some purpose. So me it's about choices - you are put [presented] with choices and you have to make [the choice about] which path you will follow.**

It seems as though trauma was a baptism of fire for the participants. Some were still smarting with pain and loss. Although there were jewels to be found among the ashes, participants would not seek trauma or its pain for the benefits it gave. Growth was attained at a high price as these participants show. One focus group participant put it this way:

- **Trauma is the best thing that ever happened to you, but you would *never* want to go through it again.**

3.13.1 The distanced perspective

The extent of the growth participants experienced cannot be known to the researcher because it cannot be observed or assessed. These responses indicate that participants who felt they had overcome trauma perceived themselves to have been able to reverse the deleterious effects described previously. For example, in contrast to mistrust of others, these participants experienced renewed faith in their fellow man. In contrast to numbing and a sense of alienation from the self, they experienced deeper self-awareness. In contrast to stereotyping and scorning others, they said their capacity for empathy and understanding others had deepened. Instead of experiencing low self-esteem, they indicated that viewing oneself as a survivor enhanced self-esteem. In contrast to feeling haunted and vulnerable, they suggest they

experienced a greater appreciation of life and deeper flexibility and openness to experience. Trauma may also present new directions for the future self.

This optimistic view is in line with the contention that we choose the self we want to be (Grobler et al 2003: 10). We actualize the potentialities within the self despite the challenges and obstacles in the way. We have the capacity to choose how we will respond to our circumstances. We choose what perceptions we hold.

Participants who regarded trauma as a catalyst for growth seemed to manifest many of the characteristics that Rogers (1990: 409-420) suggests are part of the fully functioning person. These findings imply that no one is bound by the past. No one is trapped by trauma. It implies that people have the capacity to grow and develop in spite of trauma.

Linley and Joseph (2004: 11-21) studied positive growth after adversity. They termed this phenomenon adversarial growth or posttraumatic growth. They suggest that adversity may propel a person to a higher level of functioning than existed before a traumatic event. Situations that were studied included chronic illness, HIV/AIDS, rape, sexual assault, military combat, disasters, plane crashes, tornadoes, shootings, bereavement injury and parenting a disabled child. Factors that promoted posttraumatic growth were identified. Greater perceived threat and harm were associated with greater growth. Higher levels of education and income were also associated with more growth. This seems relevant to this group, who tended to be well educated (most participants were busy with a second qualification). Extraversion and openness to experience as well as conscientiousness were positively associated with growth. Acceptances of the incident as well as positive re interpretation (creating new perceptions thereof) were positively associated with growth. Religious activities and intrinsic religiousness were associated with growth.

Focusing only on the deleterious effects of trauma may lead to a biased understanding of posttraumatic responses. The participants indicated that

trauma may affect one in positive ways and stimulate growth and deepen the capacity for empathy. It may inspire one to take on new tasks, such as becoming a helper. It was beyond the scope of this study to explore all the factors that promote resilience and growth, but these findings suggest an area for future research.

4 THE EFFECT OF TRAUMA ON THE SELF OF THE PARTICIPANT AS A SOCIAL WORKER.

Participants in this study were in the process of forming a self-concept as a social worker. In this section the focus is on results that relate to the effect of trauma on the participant's professional identity.

4.1 Motivation for doing social work

The person-centred approach suggests that behaviour is a goal-directed attempt to satisfy needs. The researcher asked participants what had motivated them to do social work. The researcher wondered whether participants may have been inspired to help others by overcoming trauma themselves or whether some were seeking their own healing through their studies. A number of reasons and themes emerged.

Some participants went into social work because of an awareness of the needs of others. These reasons included a desire to give back to the community, a desire to serve others, wanting to empower others, a desire to help others or make a difference in the lives of people. Some participants entered the profession because of existential needs:

- **I want to be a purposeful human being.**

Some participants viewed social work as a calling:

- **I was unemployed and read a book called "Purpose Driven Life"! I began becoming aware of social issues facing society and one night**

my minister looked me in the eye whilst preaching and said, "We need more social workers in this country!" So I did it.

Certain participants had chosen the occupation because of personal qualities such as caring, an interest in people or leadership. Many said it was because of a love for people and a desire to help. Some participants who had worked as volunteers wanted to improve their skills. One participant said his or her choice was based the many job opportunities available as a social worker and one said it was because of the status of the profession.

Participants had given poverty as an example of trauma. Many participants said they had grown up in poor, disadvantaged circumstances and wanted to uplift these communities:

- **I grew up liking social work because I grew up in a very disadvantaged environment – by doing social work I was hoping to change my situation.**

- **Poverty motivated me to do social work. I used to live with very poor people where I used to share everything I have with the neighbours. In fact my family used to provide for other families and as a child I ended up hating those people because I didn't understand.**

Some participants related their choice of social work to their own experience of trauma:

- **My background played a great role in me choosing social work profession. I felt women need to be empowered. My mother stayed in abusive relationship for many years, when angry she would say things that she should do to escape the situation but she never took the initiative.**

- **I was sexually abused as a child. I could see growing up that no one understood what happened to me, no one could sense that I was broken up inside, so I felt since I had first hand experience I would be able to help.**

Some said they went into the occupation for personal healing.

- **I wanted to help others and to grow and heal myself.**

- **[I chose social work] to heal myself from the negative experiences that I have come across.**

Others said they had been helped by a social worker and this had inspired them to enter the profession:

- **Because of the experience I have been through I wish to help others to go through the trauma I have been [through]. I want to make a difference. Because I was able to recover after I talked to the social worker, it motivated me to be the social worker.**

There were a variety of needs that led to the choice of social work as an occupation. It is significant to note that many students were entering the profession to uplift the communities from which they came, to alleviate poverty or to overcome their own pain. These findings attest to the actualising tendency, demonstrating that many participants were motivated to overcome obstacles in their past and to enhance the communities with which they identify. Some were meeting existential needs. Others saw it as a way of expressing personal qualities (proposition 12).

These findings are similar to those of LeCroy (2002: 142-143). He found that participants in his study entered the profession because it was perceived as a calling (LeCroy 2002:62). Participants were motivated by a desire to help and to work with people (LeCroy 2002: 35). Some participants were motivated to give something back to society, especially if the person had been helped by a social worker (LeCroy 2002:61). Others wished to be advocates for social change (LeCroy 2002:28).

For some social work is a quest for personal healing (LeCroy 2002:113). Some participants had entered the course looking for a resolution to their own pain. It is not clear whether their studies had in fact been therapeutic. This suggests an area for further research.

4.2 Avoidance of specific clients

Participants who are struggling with unresolved trauma may wish to avoid people or situations that trigger associations with the trauma. This could affect

them as social workers, exposed to clients with similar issues. Participants were asked to indicate whether there are any clients they would prefer not to see as social workers if they can avoid it. Responses were coded and analysed to see if there is a relationship between any of the trauma categories experienced by the participant and the clients to be avoided, using a chi-square analysis.

Chi-square compares a set of observed frequencies with a set of expected frequencies. Observed frequencies are those calculated from empirical data reflecting the actual distribution of the variable in the sample. Expected frequencies are generated on the basis of theory or expectations about the distribution of the variable in the population.

The researcher examines whether differences between the observed and expected frequencies are statistically significant. The null hypothesis states that there are no differences between the observed and expected frequencies. In this research the null hypothesis suggests that there is no association between students own trauma and the tendency to avoid clients going through a similar experience. Students who have experienced a stressor were compared with those who had not in terms of their reluctance to work with clients in the same category. The null hypothesis suggests there is no difference between the two groups. A test statistic, chi-square is calculated to obtain a p-value. A large chi-square suggests that the observed frequency varies widely from the expected frequency under the null hypothesis, yielding a small p-value. The smaller the value of p, the stronger the evidence against the null hypothesis. If the p-value is less than 0,05, results are considered statistically significant and it is assumed that the probability of obtaining these results by chance alone is so small that it was m ore likely that the results can be explained by other reasons. In this case, a small p value would show that students who have experienced a particular trauma are more likely to avoid clients with the same difficulty than students who have not experienced this stressor (Diamatopoulos & Schlegelmilch 1997:154). Results are presented in table 19.

TABLE 19 Avoidance of clients

	Trauma experienced by student x avoidance of client group	Traumatised participants	Nontraumatised participants	Chi-square	*p*
1	HIV/AIDS (Self) x HIV/AIDS Client	14,3%	10,1%	0,000	0,985
2	HIV/AIDS (Family) x HIV/AIDS Client	11,6%	9,3%	0,015	0,902
3	Victim of sexual trauma x not willing to work with victim	14,0%	4,3%	1,821	0,177
4	Witness sexual trauma x not willing to work with victim	6,9%	13,0%	0,520	0,471
5	Witness sexual trauma x not willing to work with perpetrator	18,3%	16,7%	0,000	1,000
6	Witness sexual trauma x not willing to work with perpetrator	19,4%	14,9%	0,139	0,709
7	Victim sexual trauma x not willing to work with victim or perpetrator	11,8%	3,6%	3,062	0,216
8	Witness sexual trauma x not willing to work with victims or perpetrator	5,6%	11,3%	1,701	0,427
9	Victim crime or violence x not willing to work with murderers	9,8%	0,0%	2,736	0,098
10	Witness crime or violence x not willing to work with murderers	7,5%	5,5%	0,000	0,938
11	Victim crime violence x unwilling to work with criminals	2,6%	0,0%	0,981	0,776
12	Witness crime and violence x not willing to work with criminals	3,1%	0,0%	0,323	0,570
13	Victim crime and violence x not willing to work with criminals or murderers	11,9%	0,0%	3,698	0,054
14	Witness crime and violence x not willing to work with criminals or murderers	10,1%	5,5%	0,386	0,535
15	Victim domestic violence x not willing to work with victim	3,8%	0,0%	0,000	1,000
16	Witness domestic violence x not willing to work with victim	4,3%	0,0%	0,205	0,651
17	Victim domestic violence x not willing to work with perpetrator	1,9%	6,7%	0,046	0,830
18	Witness domestic violence x not willing to work with perpetrator	2,2%	3,7%	0,000	1,000
19	Victim domestic violence x not willing to work with victim or perpetrator	1,0%	0,0%	0,000	1,000
20	Witness domestic violence x not willing to work with victim or perpetrator	1,1%	0,0%	0,000	1,000
21	Accidents x not willing to work with accidents	3,1%	1,7%	0,000	1,000
22	Parents divorced x not willing to work with divorce	0,0%	3,6%	0,000	1,000
23	Own divorce / separation x not willing to work with divorce	3,3%	3,2%	0,000	1,000
24	As a child Family abused substances x Unwilling to work with addictions	0,0%	1,1%	0,000	1,000
25	As an adult family abused substances x unwilling to work with addictions	1,8%	0,0%	0,010	0,922
26	Experienced poverty x unwilling to work with poverty	0,0%	1,4%	0,000	1,000
27	Removed from home due to poverty x not willing to work with poverty	0,0%	1,0%	0,000	1,000
28	Lost parent due to suicide x not willing to work with suicide	1,8%	0,0%	0,007	0,935
29	Lost child due to suicide x not willing to work with suicide	0,0%	0,8%	0,000	1,000
30	Partner dies in suicide x not willing to work with suicide	0,0%	0,9%	0,790	0,779
31	Significant other died in suicide x not willing to work with suicide	1,0%	0,0%	0,000	1,000
32	Death of parent x not willing to work with bereavement	1,8%	0,0%	0,007	0,935
33	Death of child x not willing to work with bereavement	0,0%	0,8%	0,000	1,000
34	Death of partner x not willing to work with bereavement	0,0%	0,9%	0,000	1,000
35	Significant other died x not willing to work with bereavement	1,0%	0,0%	0,000	1,000

All of the Chi-square tests were nonsignificant. This indicates that there is no significant relationship between participant's personal experience of trauma and an inclination to avoid clients experiencing a similar stressor. For example, there was no statistically significant relationship between personal experience of HIV and avoidance of clients with HIV (X^2 = 0,000; p = 0,985). From the cross tabulations, 14,3% of participants who did suffer from HIV illness or disability indicated they would avoid similar clients while 10,1% of clients who did not suffer from such illnesses indicated they would avoid similar clients. There was no significant difference between sufferers and non-sufferers with respect to their avoidance of similar clients.

At the time of the research, students had very little experience of working with clients, because they had only just begun their practical work. These results reflect the way the students perceived themselves in relation to similar clients, but may not be based on actual experience with such clients. They may not have been fully aware of their responses to clients yet because of their limited client-contact. With this in mind, it is noted that none of the analyses showed significant difference between those who had and those who had not experienced any of the stressors with respect to the tendency to avoid clients who are going through specific trauma.

4.2.1 The student social worker's experience when speaking to someone whose trauma is similar to their own

Participants in 2008 had not had the opportunity to work with clients because the workshop was scheduled early in the year to accommodate the training needs of students. Previous groups had requested that the trauma workshop should be the first workshop, since students saw this topic as central to all their work and with high levels of crime and violence they were frequently asked to see clients who had been victims of such events. The workshop in 2006 however, was the last workshop that year so participants had worked with clients and were in a position to reflect on their experience. In the questionnaire used at that time, at the end of the questions about each stressor, the participant was asked to complete the sentence "when I speak to someone who has been through a similar experience…" The pilot test group

had all assumed that the respondent was speaking to a client as a *social worker*. Participants, however sometimes interpreted the question to mean he or she was a social worker and sometimes they assumed they were the client. Unfortunately, this variation in interpretation was not picked up in the pilot test. However it was obvious from the answer which way the participant had interpreted the question. The variation in interpretation was noted after the first workshop and the participants were verbally instructed to respond from the perspective of the social worker. However, a number of participants still answered as if they were clients. It is also important to note that help may have been given or received from someone other than a social worker. It is not clear whether these conversations refer to a professional or social context. As these responses are read, it should be kept in mind that they are drawn from the *preliminary* questionnaire that was distributed in 2006. The study was exploratory in nature and the questionnaire was modified as the research progressed. The intention was to modify this question on the basis of feedback. However, the researcher did not get the opportunity to refine this question, because of the timing of the workshop. Participants in 2008 did not have enough experience with clients to be able to answer it. Nevertheless the responses gained in 2006 shed some light on how those respondents felt and behaved when talking to someone whose trauma resembled their own. They have been presented here because of their relevance to the experience of the participant in a helping relationship. The results should be read with the shortcomings of the question in mind. The responses were thought to be relevant because Rogers (1967:37) contends that the principles of the person-centred approach are relevant to *all* helping relationships, including those between teacher and learner, minister and parishioner, and friends. In fact, Rogers (1990:231) points out that the principles of the person-centred approach apply in all relationships, not only helping relationships.Themes were extracted and results are as follows:

Applying person-centred skills

Some participants said that they were able to listen with empathy and respect to a person who had been through a similar trauma. This was a dominant theme:

- **I get angry, but in a counselling situation, remain neutral.**
- **I can sometimes empathise with the pain and hurt they may be feeling, but also sometimes come close to wanting to avoid the topic.**
- **I feel sad for the person, offer empathy and support, hope if possible, realistic hope.**
- **I offer empathy and am genuine about my responses to the person.**
- **I try to support them with empathy because every person's experience is different. I am sensitive to the person's loss and respect their experience and empathise.**
- **I focus on their situation to avoid talking about mine.**
- **I am able to separate my experience from theirs, be objective, and provide the genuine support needed.**
- **I am sensitive to the person's loss and respect their experience and empathise.**
- **I would do what the client needs.**

Participants indicated that they believed they were able to respect the client's frame of reference and put their own perspective aside. This is in keeping with the person-centred approach (Grobler et al 2003: 140).

Drawing comfort from speaking to another about trauma

Some participants said that sharing their own pain with someone else who understood the experience was an empowering and comforting experience. It is apparent the respondent was speaking from the perspective of being a client. Importantly, the person felt connected with another and that he or she was not alone. This was a dominant theme:

- **I become motivated and it sometimes changes the way I see things and behaviour.**
- **I get very emotional, but experience freedom. It is more easy to speak to someone that had a similar experience. I don't bring it up otherwise.**
- **I become encouraged, knowing that some things are out of our control and it happens to anyone.**

- **I felt relieved after I have spoken to someone in a similar situation.**
- **I am not alone, someone else can feel what I felt and understand.**
- **Makes me feel good about myself because I'm not alone.**

Being able to cope

Participants who felt they had come to terms with their experience said that they felt comfortable relating to others who had gone through a similar experience:

- **I don't have problems. It doesn't hurt anymore.**
- **I don't have difficulties in communicating since such things, it not hurting. I think I accepted it and it's fine with me.**

Earle (2008:123) reports that educators in her study repeatedly stressed the need for students to deal with their own trauma before they could adequately accept and deal with the problems of others. The accepting, non-judgemental stance required of social workers by their clients' demands examining and working through their own biases. These participants seemed to recognise the value of obtaining help and seemed to have had an opportunity to share and reflect their own experience. Many perceived themselves to have integrated the skills of the person-centred approach. Participants who had shared their experience as the helpee seemed to recognise the value of sharing their experience in a context where they really felt heard. They said they found this experience helpful. Many participants said they had emerged from their experience with enhanced capacity for empathy. These results are similar to Earle's (2008:123) findings. In her study it was noted that students who had worked through personal problems generally made very good social workers and were aware of the complexities involved in such issues. However, educators said a number of students were still wrestling with personal issues and many were blunted to the problems that others faced. She states "instead of helping them out of their situations they helped them instead to accept their situations"(Earle 2008:123). This is contrary to the person-centred approach, with its emphasis on growth and self-actualisation.

In contrast to those participants who said they could apply the skills they had learnt, many participants in the current research seemed to have great difficulty in applying person-centred theory and skills.

Avoiding the topic

Some participants indicated that they prefer to avoid the topic of their own trauma. Trauma remained a threat:

- **I don't talk about it. I avoid it as much as possible.**
- **I feel guilty and wish to avoid the topic.**
- **I do not talk about it often. I just make small conversation or I just shut up because I could not even talk to my family about it and so they also avoid the subject.**
- **I do not talk about my trauma because I think it's going to affect me more.**
- **Ek raak numb. Ek raak gespanne en wens die onderwerp verander [I become numb and wish the subject would change].**
- **I feel trapped, threatened, and lots of regrets. I actually feel condemned.**
- **A participant who had an abortion said "It becomes worse it seems as if I am a killer, that pain comes back."**
- **I cannot speak about it, because I think it is my fault it happened.**

This suggests that some participants may be struggling with unresolved pain. One of the core features of the person-centred approach is its emphasis on empathy. Rogers (1967:61) describes empathy as the ability to understand what it is like to be the client. He sees it as the ability to enter the person's world so fully that one loses all need to judge or evaluate it. This stance pre supposes the ability to enter the other person's frame of reference and to really hear the other person. It is noted that some participants said that, when speaking to someone whose trauma was similar to their own they wished to avoid the topic. This indicates that a core condition for facilitation may be out of reach for these particular participants.

Giving advice

One of the cornerstones of the person-centred approach is that the person seeking help should be empowered to find his or her own solutions (Grobler et al 104-105; Rogers 1990:67). It seems that, when confronted with a situation that was similar to their own, many participants tended to give advice. It seemed to be difficult for participants not to impose their own frame of reference on the other person. This was a dominant theme:

- **[Referring to domestic violence] I encourage them to stand up against it [abuse] because they deserve better! I did!**
- **[Referring to domestic violence] I feel pity for him/her. I try to advise him/her what to do.**
- **[Referring to separation from intimate partner] I tell them to be strong and cry if they want to and to accept that it is over.**
- **[Referring to disabled child] I would advise that person to accept the situation as it is and not put blame on anyone because God gave that person (a disabled child) to that family.**
- **[Referring to robbery] I advise her/him not to spend money on expensive things rather to buy more food and save the money for their children because we are sharing our belongings with lazy thieves [referring to a robbery].**
- **[Referring to separation from intimate partner] I tell them that life is full of surprises. That you should not put all your trust in somebody.**
- **[Referring to retrenchment] I encourage them to work hard and improve their effort in her/his work and give advice.**
- **[Referring to domestic violence] I tell them to get out of that situation as quickly as possible. That they should not look back.**
- **[Referring to abuse] I tell them to forgive and forget and move on.**

Some participants were judgemental about the other person:

- **[Referring to teenage pregnancy]. I just tell her the disadvantage of being a mother before time.**
- **[Referring to abortion] I always tell them that [abortion] is not a solution but the initiation of other problems. It is hard to forgive myself.**

These responses contradict those noted earlier where participants said they would apply person-centred skills, showing a discrepancy within the group and their responses.

The person-centred approach is known for its non-directiveness. Rogers (1942: 115-126) believes that the actualising tendency can be most reliably released when the client takes responsibility for the counselling process.. The focus is on the client as a person not the problem It follows, therefore that the facilitator does not focus on suggesting solutions or giving advice in a person-centred approach (Rogers 1942:127). Participants indicated that they had difficulties applying these principles and freely acknowledged giving advice or telling the client what to do.

Reassuring the person

Some of the participants said that they were inclined to reassure the victim:

- **[Referring to infertility, I say] I understand that you feel sad because of you being infertile, but the doctors can help you by doing insemination if you feel free to do that.**

- **[Referring to miscarriage I say] I understand how painful it to lose a baby but this is not the end of the world. God may provide you with another child.**

- **[Referring to death of a child] I would tell them just to trust in God because He has allowed it to happen that He has a better plan for him/her.**
- **[Referring to being HIV positive] I keep on telling them that HIV is terminal disease, yes, but you can still live more [many] years if you take treatment.**

Rogers (1942:165) is convinced that reassurance is not helpful to the client and is in fact unhelpful. He writes “cheery reassurance that the client’s problems are nor serious, or at least that he in much more normal than he feels, or that the solution to his problems is easy, has a thoroughly bad effect on therapy. It denies the client’s own feelings and makes it well nigh impossible for him to bring his anxieties and conflict and sense of guilt fully into the conversation when he has been assured they should not exist. No amount of reassurance will eliminate the fact they do exist.”

Sympathising

Some participants indicated that they identified with the other person and this elicited sympathy:

- **I can sympathise with them and encourage them - it is only a temporary setback.**
- **I feel sorry for him/her, as I know that flashbacks, dreams, memories will always come back to his/her mind until he/she accepts the situation.**

Rogers (1967:43) notes some of the characteristics that were experienced as detrimental to the helping relationship. These were lack of interest, remoteness, distance, and an over degree of sympathy, direct advice and an emphasis on past rather than present problems. Reassurance and sympathy are contrary to the person-centred approach. Reassurance minimises the person's distress so the principle of empathy is violated (Grobler et al 2003:92). Sympathy is offered from the frame of reference of the facilitator, not the client, so it denies the client's frame of reference (Grobler et al 2003:156)**.** This means that participants who said they gave sympathy and reassurance were not applying the principles of the person-centred approach

Comparing notes.

Some participants found themselves comparing their own experience with that of the other person. This was often a source of comfort, as the person concluded, "my experience was not that bad." Some told the other person their own story in an effort to encourage him or her:

- **I realise that I am better off than others.**
- **Vergelyk my situasie in my kop. [Compare my situation in my mind].**
- **I get angry. Sometimes I just share my experiences as a challenge.**
- **I speak about how I overcame the situation.**

Rogers (1967:62) also points out that the principle of empathy may be misunderstood to mean "I've been there too so I know how you feel." He emphasises that each person's experience is unique and personal and that

sharing one's own story or experience is inappropriate in a helping relationship. Self-disclosure might be used if it is for the benefit of the client.

One's own experience may be triggered.

Many participants said that their own experience was triggered by speaking to someone else who has experienced something similar:

- **I tend to similarise[compare] the events or situations to mine, and if she or he does say something, it clicks back my past.**
- **I feel like crying because it reminds me of my experience. It makes me remember what I don't like.**
- **I detach myself from it. I listen as though I never been to a situation. But after that my thoughts are hurting.**
- **I feel sad knowing what they are going through. I get depressed as it brings my own memories flooding back.**
- **I remember all that has happened to me, I re-live the experience.**
- **I feel insecure. I think [that] this can happen to me again.**
- **I just listen patiently without adding or subtracting because it hurts me more inside, so I just try to hide what I feel.**

Becoming emotional

Some participants indicated that they felt overwhelmed by powerful emotions when dealing with clients:

- **I get emotional like wanting to cry and share the pain.**
- **I feel like punching the assaulter and grabbing my client to hug her [referring to domestic violence].**
- **I don't even know what to say - lots of pain.**
- **[Referring to domestic violence]I get angry and develop hate for the person that is hurting them. I can relate to the situation and my own feelings come back**

One participant wanted the client to share his or her feelings:

- **I am aware of my own anger - I want them to be angry too! I feel aggrieved.**

Rogers (1967: 52) says the boundaries between the helper's feelings and those of the client need to be clear for the helping relationship to be useful to the client. The helper needs to own his or her feelings as something belonging to him or her and separate from the client. The helper is not afraid of the client's fear or engulfed by the client's dependency for example. Participants indicated that their own trauma and emotions associated with it may be triggered in dealing with a person in a similar situation.

4.2.2 The distanced perspective

Participants were asked to consider how their experience of trauma affected them currently when answering the question. This is important, because the workshop in which this questionnaire was given out was the last one of that year, so participants had already almost finished their practical work with clients at that time. Some participants said they felt comfortable with speaking to someone who had been through trauma, but others indicated they felt distressed. Although it is not clear whether participants interpreted the question to mean that they were in the role of the social worker, it seems many had difficulty responding from a person-centred perspective.

The results imply that while many participants believed they were able to listen with empathy and implement the person-centred approach by putting their own frame of reference aside and "remaining neutral" or "doing what the client needs," many participants indicated they found this very difficult. These difficulties seem to relate to a history of trauma, but may also arise from poor understanding of the theory.

Although the quantitative results show that participants would not actively avoid clients whose trauma is similar to their own, these results indicate that many participants may interact with such clients with great inner discomfort and may have difficulty in applying person-centred skills.

5 COPING WITH TRAUMA

Rogers (1951:520) suggests that if a person is able to integrate his or her experience into a congruent relationship with the self, one becomes more open to all one's experiences as well as those of others. Participants indicated that trauma cannot easily be overcome without help. Rogers (1967: 407) also suggests that help is needed to integrate trauma. He states: "It has been my experience that though clients can, to some degree, independently discover some of their denied or repressed feelings, they cannot on their own achieve full emotional acceptance of these feelings. It is only in a caring relationship that these "awful" feelings are first fully accepted by the therapist and then can be accepted by the client."

This raises the issue of what help was available to the participants and what they did to overcome trauma. These issues were explored both quantitatively and qualitatively.

5.1 Coping strategies

Data from the questionnaires shows a variety of coping strategies that participants said they used to deal with trauma. Individuals may have more than one coping strategy. These strategies were entered in Atlas ti and the frequency of each response is presented in table 20 and figure 16.

Table 20 – Coping strategies

Strategy	Frequency
Spiritual resources	58
Music	30
Productive activity	27
Counselling	19
Dependency	17
Talk to someone	12
Reading	11
Avoid the memory	09
Exercise	04
Social support	04
Destructive activity	03
Forgiveness	03
Leisure activities	03
Not able to cope	03
Sleep	03
Crying	03
Self-talk	01

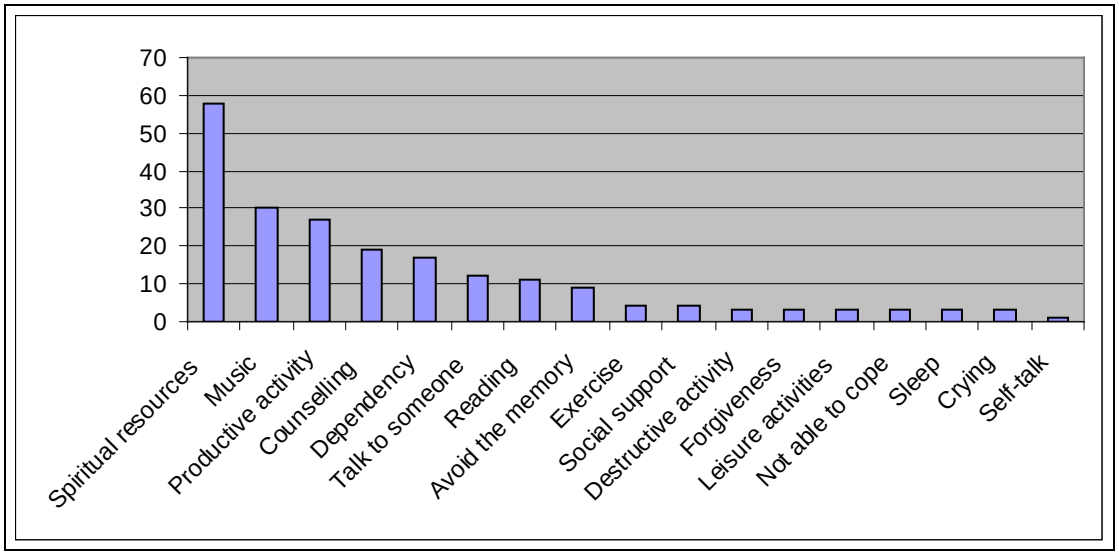

Figure 16- Coping strategies

The most frequently cited coping strategy was "spiritual resources." These resources included reading the Bible, praying, meditation and Yoga. Some comments were:

- **I just bow on my knees and pray to my counsellor (God) because I trust in Him.**
- **Just praying to my God to let the memory go away.**
- **I go to church.**
- **I never went to counselling because didn't know where to go. I prayed to God since I am a Christian. I like Gospel music. My pattern of eating deteriorated. I lost my appetite.**
- **Meditation (religion) because inner strength comes from faith and faith comes from a higher being who has a bigger purpose for you despite the trauma one goes through.**

It is interesting to note that participants did not refer to traditional beliefs here. Many participants used music. This strategy included Gospel music.

- **Playing music very loud (maximum volume).**
- **I listen to music, especially those songs which uplift my spirit.**

Some participants used counseling:

- **Counselling, getting professional people to help me cope with my situation.**
- **Counselling – it is the best way to deal with trauma.**

Some participants acknowledged various forms of dependency, including over-eating, abuse of alcohol and drugs as a way of coping:

- **I eat too much as it helps me not to think about it.**
- **I take alcohol although I know it bad for me.**
- **I ate too much; I smoked; I became obsessed with religion; Now I go to counselling; I do Yoga and I meditate and eat heartily.**
- **I eat unhealthy foods and I read because they are comforting to me.**

Some participants talked to trusted friends or family:

- **I talk about it with my husband mostly and my friends and family.**
- **Talk about it to people whom I trust.**

Some participants chose to read, including self-help books. Some made an effort not to think about the trauma. This was often achieved by distracting oneself with other activities:

- **I try to deny the thought by keeping busy with something else or I just lock myself up and cry.**
- **By keeping busy or involving myself in an activity that will take my mind away from that memory.**
- **Keeping busy because I have my mind occupied so the chances of me thinking of the trauma are slim.**
- **I keep myself busy and studying my books.**

Others got involved in playing sport or exercise. A few joined groups for support.

- **I have a very strong support group, which is based on praying for one another and comforting one another with scriptures. It helps again that I come from a family of prayer.**

Three participants said they had engaged in self-harm such as cutting themselves.

- **I harmed myself. I used knives, screwdrivers, but at the end I got counseling.**

For others, forgiveness was a coping strategy.

- **I have even forgiven the murderer of my father who has never been found.**
- **Religion. I pray, I read my Bible; I forgive.**

Participants said they distracted themselves with leisure activities other than sport, reading or music, such as going on the Internet or watching TV. Three participants said they sleep too much to avoid the traumatic memories. Three said they cried and three acknowledged they are unable to cope. Unfortunately, participants did not elaborate on how “not coping” manifested itself.

It is interesting to note that none of the participants referred to cultural rituals in the questionnaire, but this was a lively topic in the focus groups in Kwa Zulu-Natal and Johannesburg. Black participants in these areas seemed very keen to inform their respective white facilitators and colleagues about the dilemmas surrounding cultural beliefs and practices and to offer insight into what cultural resources are available to deal with trauma.

5.2 Cultural rituals to deal with trauma

It would be very inappropriate to generalise about all Black students and their cultural beliefs as if there is one black culture. However, the researcher had the impression that students took delight in explaining to me, as a white facilitator, what their cultural beliefs and practices were with respect to painful

experiences. It must be emphasised that participants varied in the degree to which they embraced these beliefs.

- **I can say the healing of the inner-self which has been hurt, it depends on the individual, it's not specifically on the culture. A person can belong to a certain culture, but you find that by his belief, he can't follow those cultural values or practice the rituals, so depending on what you are believing- If you are believe that counsellor could help you, he could help you, if you believe that a priest can pray for you, and you can reconcile your inner self, then you will gain from that- depending on where your belief [is].**

Themes that emerged were that, when a painful experience is stigmatised, or if the victim is blamed because of cultural beliefs, culture adds to trauma. If however, the victim is supported and integrated into the community, then culture serves as a resource.

Re-connecting with ancestors

The belief is held that trauma is a form of bad luck that can arise because one is removed from the protection of the ancestors by failure to appease them. The situation may be easily remedied by carrying out the required ritual:

- **Ja, [yes] like if you have a problem it is believed that maybe that you no longer have the good relationship with your ancestors. So after you've done that [slaughtered an animal in a ritual], things will be okay, so it's another way of dealing with a traumatic situation.**

Social support

Culture may play an important role in integrating a person into the community as a way of coping with trauma. The community includes the ancestors who may be an important source of support and protection. The belief in the support and protection of the ancestors can be reassuring. Cultural rituals are performed by the community and it seems that the social support that this brings plays an important part in giving the traumatised person the opportunity to ventilate and symbolise feelings:

- **FGP [Zulu]- In our culture, it works like this - if someone has experienced a traumatic incident, there are elders at home - those are**

your support structures. Normally, they would observe that there's something wrong with you, which has affected you emotionally, then they will call you down and talk through the stuff that is troubling you. to give and example, in a case if say, a married woman has lost her husband, then the other women will gather around that mother to give her emotional support. So that's my own understanding. In terms of slaughtering the beast, it has nothing to do in terms of sort of lessening the pain of the being through a very traumatic event. It does it play but a minor role, but it is not so important, but emotional support is there because you have elders at home who have different roles to play. If I'm a young man, then there are older father's, uncles that I can talk to. As a young woman, there are also aunties and the granny's that you can approach and talk about some of these stuffs you know.

- **FACILITATOR - So I think what Sibusisu saying is that with those cultural practices, it integrates you again into the community and there's someone you can talk to. Is it the same in your Pedi culture?**
- **PEDI FGP - Ja,[yes] it's also the same, ja [yes].**

<u>Dealing with the uncertainties generated by trauma</u>

An Ndebele and a Pedi participant elaborated on the point that cultural rituals may be used as a source of reassurance that trauma won't be repeated. This seems to have the effect of relieving anxiety and silencing the "what ifs" and uncertainties that are so characteristic of the aftermath of trauma:

- **FGP-[Pedi] The other point that I wanted raise is the issue like lets say I was robbed. The elders might call you to your homeland and when you arrive there, they might go with you lets say to your father's grave or your granny's grave. They will actually report the incident at that grave to the ancestors you who are asleep: "this is what has happened to Joseph, ja [yes] - please don't allow this thing to happen to Joseph again - protect him and whatever pain he's going through, can you take it away form him? You know, those are some of the practices which are there in our culture.**
- **FGP [Ndebele]- Ja,[yes] in most of the African cultures, the elders can take you to a sangoma, and from there they go and cleanse you - they will say you've got bad luck.**
- **FACILITATOR - So what would they do?**
- **FGP - They might put you in the river ne, and when they put in the river, ja,[yes] they can actually try to cut you with you a razor - Ja,[yes] to cut you with a razor in the river and while he's busy cutting you, he's putting some *muti* [medicine] on and then they are putting some water on you. The blood will be flowing with the river, showing that that bad luck has gone and that pain has gone. "This is the new Barbara."[facilitator's name]**
- **FACILITATOR - So it's like a symbol?**

- **FGP - Ja, it's like a symbol - yes.**
- **FACILITATOR - Is it more than a symbol?**
- **FGP - It's more than a symbol, it's a like a counselling,in that some of them think is a counselling. It is also a preventative method for the future, that something like that [trauma] must not happen again.**

Dealing with survivor guilt

A common reaction in the face of trauma is survivor guilt (Retief 2004:36). The person who survived the incident may feel guilty that he or she escaped while others were killed or harmed. Participants described a ritual in which gratitude to the ancestors rather than guilt is symbolised:

- **FGPin Zulu culture when maybe somebody was involved in a car accident, then the family and the victim heal, by slaughter[ing] a goat to thank the ancestors that she's or he survived. Then after that the trauma is little bit removed.**

Gaining closure, re-integration into the community and forgiveness

Another participant described a ritual after his brother was released from jail:

- **FGP -Okay, I'm thinking of another thing that happened like to fight with the trauma within the family. It's a sort of a ritual. Eh, while I was a young boy my brother was arrested. He was in jail for about 5 years. When he came back, my father slaughtered a goat, he called all the family. it was a sort of celebration that he was back from prison and it's a sort of like you are cleansing him as a present so he won't go to do the same thing and go back again. So I think it was a sort of , counselling or ritual that deals with the counselling within the family, because he was counselled, the elders - the older father's were talking to him at the same time celebrating that he's back from prison**.

Grieving

A bereaved person may receive support from the community:

- **FGP – [Pedi] The only thing which it was most counselled for was in case death. They will give that person a support and if there's a death in that family. Most of all relative - the elderly people, they will spend the whole week sleeping there until the burial, then after the burial they will spend another two weeks sleeping there, being with the bereaved family.**

Using a game to deal with a traumatised child

One participant described a game that she had observed as a way of dealing with trauma:

- **FGP -I've learned at a workshop one time that - but that I've learned from Zulu people and I've seen and a little Pedi girl doing it, but I don't know what it's called in Pedi, but in Zulu, they - or in Natal they call it Top-Top. The girl takes a lot of stones and then the one stone will be the father and the one will be the mother and she will sit and the father will talk to the mother and the mother and the father will go together and they play with the stones. It's play, but it's very therapeutic. We use stones that she chooses, whatever she wants, There you can see the aggressiveness that comes out and the ones that she's angry with are the ugly stones. The ones that are not painted - but the pretty ones are her friends and their loved ones. I think that is something that the other cultures [have] developed amongst themselves - I'm not sure what they call it here.**

Participants indicated that culture can be a resource in dealing with trauma, depending on the frame of reference of the person. It is possible that many participants have become alienated from these sources of support due to urbanisation. The extent to which participants had received support in dealing with trauma is the subject of the next section.

6 HELP RECEIVED

Participants in the focus groups emphasised the need to integrate and accept trauma in order to grow from it:

- **Trauma can be a great obstacle if not dealt with.**
- **It is a growth experience if the feelings, perceptions etc are examined, worked through and incorporated. The help of a professional is essential in my view.**
- **It depends. For some it is growth because in the end they symbolise their pain and to others it is an obstacle because they feel helpless.**
- **Trauma is an obstacle if you don't get help.**

It was important for ethical reasons to explore whether participants felt the need for counselling after participating in the research.

6.1 Response to filling in the questionnaire and participating in focus groups

Although every effort was made to ensure that the research was carried out in a person-centred and supportive way by making use of the workshop as a context and not probing for unsymbolised experiences, the effect of participation in research on sensitive topics cannot be predicted in advance. The researcher needed to know whether participants were upset and to make sure that anyone who was perturbed received additional support.

Participants were asked to reflect on the experience of answering the questionnaire and it was emphasised that follow-up debriefing was available to all participants who may have become aware of unresolved issues.

Some responses were as follows:

- **FGP - Well personally, to me, it wasn't a nice experience, because we have to visit some of the experiences that we didn't acknowledge as such in the past - you know - just sort of confronting those issues again without having any certainty as to what will happen after that, because I'm feeling a bit unsettled.**

Participants were assured of the confidentiality of responses and were informed that responses would form part of a composite report in which no-one could be identified.

- **FGP - I think those questionnaires, they really made me go back in my traumatic experience, I actually felt I was really, reliving the situation that I was put in, and these exercises, I wouldn't want to go back and do them again. They actually opened up our wounds which were closed.**

Two participants from 2006 and two participants from 2008 who became aware of unresolved issues attended counselling at no cost and reported great benefit from that. It is not known whether any other students went elsewhere, as a variety of resources were made available, such as FAMSA, the masters students in the Psychology Depatment, the masters students in social work and qualified psychologists and social workers completing the

course in logotherapy at the Unisa Centre For Applied Psychology, who were spread country wide.

- **FGP - Answering this questionnaire, you don't realise you had a traumatic experience unless the questions are phrased the way they have been phrased, and no matter how um, mild or how severe that fact that it has been a traumatic experience makes you think that you can actually go through your life just covering it as though nothing has happened until you are really, really questioned about it.**

Kubany et al (2000:211) indicate that many individuals will not disclose traumatic experiences unless specifically asked. This response highlights the tendency to avoid traumatic memories and confirms what the pilot group of Master's students said, namely, that respondents would be unlikely to divulge some traumatic experiences unless specifically asked. Using the questionnaire with specific examples seemed useful in identifying the number and range of traumas participants had gone through.

- **FGP - The exercise that we just did now, really makes an individual open up their most inner feelings and you are able to relate with those questions, so it's quite, you know, it's quite um motivational. It does help, it does.**

- **FGP - For me, when doing the questionnaire at first I was counting my blessings, because I could see many of the things I never went through, and I came across this one that I had to go through when I was, I think I was 18 - then, when looking at all these kinds of trauma, all these kinds of experiences, it's such a relief for me to see that, okay, I went through this one - it was so traumatic it nearly killed me, but it's like I'm well - I'm still okay. I'm - it means I'm a warrior, I'm a heroine, because I came through that situation and I'm okay, I can interact with other people. Although I never received any counselling, but um - I healed as time was passing and the questionnaire helped me a lot.**

The questionnaire and focus groups were structured so as to make participants aware of their strengths and ways of coping. In this way, an effort was made to leave participants with an awareness of how they coped and reflecting on themselves as survivors.

During the focus groups participants who had received counselling encouraged those who had unresolved issues to receive help. They felt that

unsymbolised experiences could readily impact their work with clients and undermine their effectiveness as social workers. Jaco, the participant who had been hijacked and abducted commented on his encounter with a hijack victim. He pointed out that, as the therapist you may not be able to avoid working with clients who trigger your own trauma-related responses, because you have no way of knowing why the person is there before the session. He emphasised the need for future social workers to deal with their own trauma, referring to a situation where a client who is attending a session for the first time:

- **FGP 1. She just reported, listen here, there's a client waiting for you… in the waiting room. I've got no background as to what you are here for, and I hear what the lecturers and supervisors and whatever say, "deal with your stuff - deal with your stuff," that is why I made very - very sure when these things rocked up two years later, I knew listen here, you need to deal with these issues, sort them out, because tomorrow a client [with a similar issue] presents themselves in your office. Another example, alcohol and drugs and whatever was rife, during my teenage years, I went and got it sorted out, before I made the informed decision of studying this, because I knew - I cannot use this as a means to get myself healed.**

One participant realised that he had misconceptions about his role as a social worker. He anticipated using his work with clients as a means to his own healing:

- **FGP2- if you were sexually abused, [I was] thinking that [while I am] working with all the clients who have been abused sexually who come to the office, at the same time I will be healing myself. Is it right or wrong guys?**

- **FGP 1- I want to link up with that, in saying, hopefully if you haven't dealt with your issues, this [questionnaire] was a red light that went on for you to say, listen here, tomorrow you might have a client in your office that has gone through the same thing and this client is going to press your buttons and if this client comes to the understanding of listen here, you are feeling what I am feeling, so let's fix one another here - it's not on. Hopefully, this is a sign for you to say listen here, get yourself sorted out.**

Another participant had this to say:

- **FGP - I think it's definitely important to address it, because if you don't address it, you take it with you in your practice and in my case, as I said, I know that I'm projecting when there are children involved then. So if I don't um - what's the word for that - um -**
- **FACILITATOR - Integrate it?**
- **FGP - Ja,[yes] integrate it and really being fine with it. I will always overreact when children are involved.**

Participants however, struggling with inadequate finances, could not afford help.

- **In today's world, therapy and things like that cost money. It just cost's money.**

6.2 Help received

It seemed that many participants realised they needed help but could not afford services from a professional. The questionnaire explored whether or not participants had received help with their trauma and whether the help was beneficial. Half the participants reported that they did receive assistance (see table 21 and figure 17). A limitation of the questionnaire is that it is not clear whether help was given at the time of the trauma or later.

Table 21 - Help received

Help received	Frequency	Percent
Yes	60	49,6%
No	61	50.4%
Missing	3	100%
Total	124	

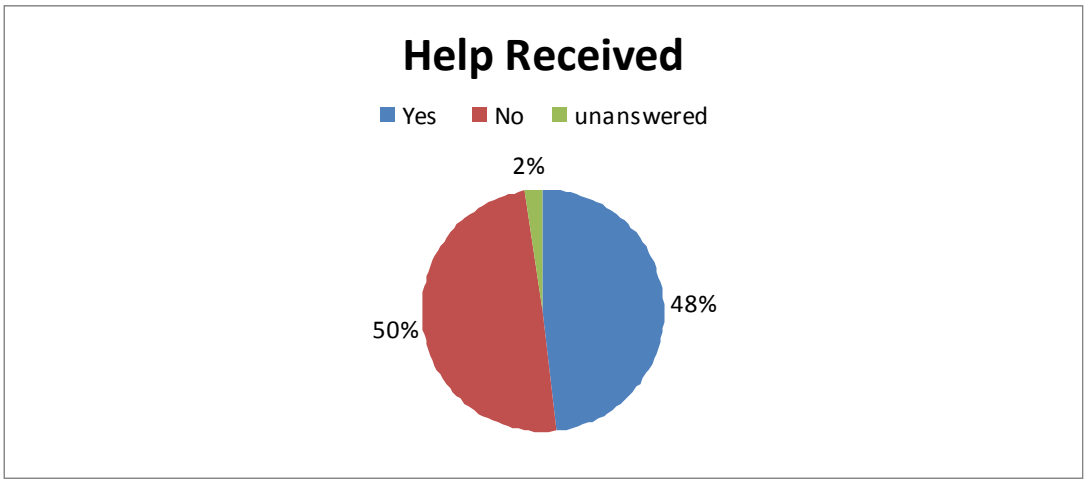

Figure 17- Help received

The most common source of help was family, friends, church or religious figure. Only 18.3% of participants who *did* receive help received assistance from a social worker and 20% of the participants that received help went to a psychologist. When one considers that only half the sample received help at all, these results show that less than 20% of the whole group received professional help. The source of help is presented in table 22 and figure 18.

Table 22- Source of help

Source of help	Frequency	Percent
Family	29	48.3%
Friend	24	40.0%
Religious figure	21	35.0%
Church	18	30.0%
Psychologist	12	20.0%
Social worker	11	18.3%
Doctor	8	13.3%
University lecturer	6	10.0%
Self help group	3	5.0%
Teacher	3	5.0%
University supervisor	3	5.0%
Police	3	5.0%
Lay counsellor	2	3.3%
Hospital staff	2	3.3%
Other	2	3.3%
Traditional Healer	1	1.7%
Paramedic	1	1.7%
Clinic	0	0%
Employer	0	0%

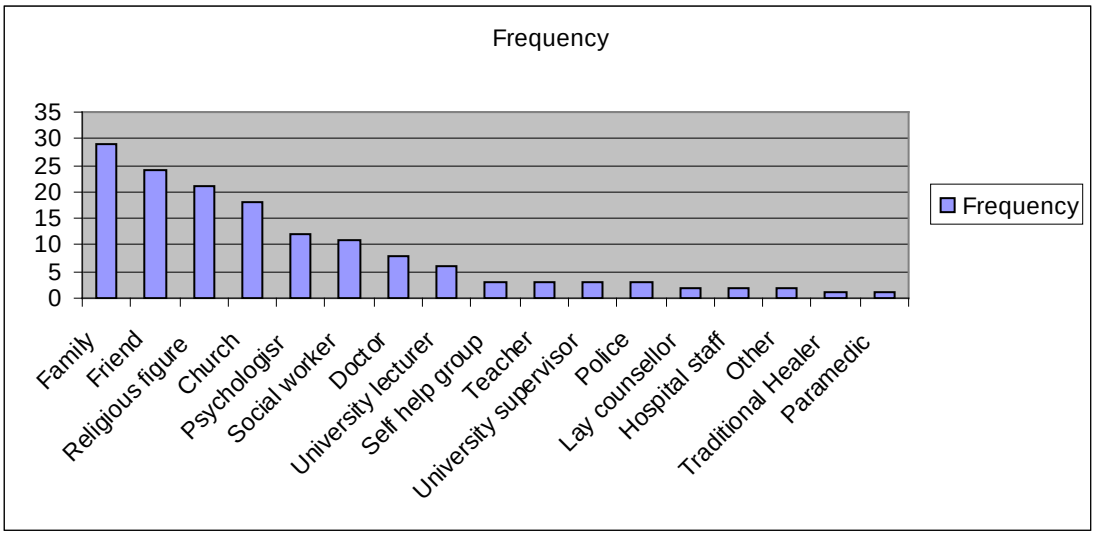

Figure 18- Source of help

The researcher was struck by an anecdote that was told in one of the focus groups. The participant, a Black woman, received help from what she

considered to be a very unlikely source, namely two white Afrikaans speaking men, who fitted the conservative Afrikaans stereotype:

- **FGP Sometimes you get help from the strangest people, because when we were in a car accident, we were in Pretoria, and these Afrikaner guys helped us. You know, [those] who still wear those socks and those shorts and those kaki things and they actually the ones who helped us - called an ambulance - made sure we were okay - while the guy that you know who saw us first having the accident, was a truck - black truck driver - he took his truck and ran, and so you know so, there's these Afrikaner guys and they're like, "Miss, are you okay - are you okay?" And if I had to meet them on the streets, I would run the other way, I wouldn't even make eye contact with them, because it's Afrikaans, so you kind of learn new things and you see things in a whole different way. I'm don't know if I'm racist, but hey?**

South Africa is a country that is already divided along racial lines. Being traumatised may deepen such divisions. Participants said that being victimised could create stereotypes and provoke scorn towards those who resemble the perpetrator, so if the perpetrator is a member of a group that is already stereotyped and against whom one is prejudiced, such divisions may deepen. However, In this case, the participant received help from a member of the out-group, which challenged pre-existing prejudices. Her story offers hope for our country, suggesting that, just as trauma can deepen divisions between people, kindness and concern can bridge the gap. Perhaps reaching out and offering aid to one another in a time of need can heal the divisions in South Africa.

6.3 The extent to which help was beneficial

An important question is whether the help was experienced and perceived as beneficial. Only two participants said they did not benefit from the help they received and three felt they benefited a little. Results from the qualitative data suggest that most students who reported receiving help indicated that this help was beneficial – it is thus of concern that less than half of the sample actually did receive help, and that less than 20% of the sample received *professional* assistance (from a social worker or psychologist). Some comments were as follows:

- **Talking helped to formalise what I was feeling, but as I did not receive professional help I still felt alone and depressed.**

- **[I benefited] a little. I know that she's there but she or they don't really understand.**

- **I have benefited a lot because I have never revisited those memories of pain and even when I speak about them, they are just a part of my experience in life. *They form the highlights of my journey of life.***

- **The best decision I have ever made in my life is to go for counselling.**

- **I don't know how to put it but it gave me a reason to go on - A reason to wake up and say thank you God for today. Instead of the depressing state I was in.**

- **The doctor always gives me the hope and reading books makes me realise that even before [the trauma] problems were there. It is just a challenge. Traditional healers helped me in shaping my future.**

It seems that an important factor was that the helper was caring and trustworthy.

- **[I benefited] very much from some [help. The] Unisa lecturers are very helpful and supportive. But friends should be selected – I made the mistake of trusting a family member who was not trustworthy – it made matters much worse.**

6.4 The distanced perspective

The qualitative data suggests that many participants are suffering from unresolved issues that may hamper their ability to implement a person-centred stance with some clients. At the same time, the data suggest that other participants have grown through their experiences and experience an enhanced capacity for empathy and understanding. Participants disclosed their motivation for studying social work and left an impression that they are generally a caring and motivated group who wish to make a difference, help people and overcome obstacles that characterised their own backgrounds. These aspirations have been viewed as desirable by educators in the field (Earle 2008: 117). Students who graduate need to be able to implement the theory in their interaction with clients and results suggest that many

participants have attitudes and values that make this very difficult. Deciding who is and who is not suitable for entry to the profession is a debate that has not been successfully resolved but seems pertinent to the Unisa Social work students who took part in this study.

The aim of the social work profession is to meet the needs of the society in which it operates and to be responsive to the context (Earle 2008: 25). Training institutions are expected to deliver a professional who can work together with troubled, and marginalised individuals, groups and communities to meet their basic needs and improve the quality of their lives. Principles of respect, social justice and equality are intrinsic to the practice of social work (Schenck 2008). At the same time, individual social workers and students are influenced by their society and culture (Lintvelt 2008: 32). The South African context was discussed in Chapter 7. Results indicate that the social ills that plague South African society have touched the lives of Unisa social work students.

Participants have been affected by other factors that may hamper their ability to complete the degree. Kagee, Naidoo and Mahatey (1997:250) indicate that students from previously disadvantaged groups face challenges that hinder them in completing their studies successfully compared with white counterparts. These obstacles include alienation, psychological complaints such as anxiety and depression, financial matters, housing difficulties and language difficulties. Results of the current study show that Unisa social work students encounter similar obstacles. At the same time, universities are under pressure to recruit and train students who are from previously disadvantaged groups. Unisa in particular attracts students from poorer, disadvantaged backgrounds as an open and distance learning institution (Schenck 2008).

It is noted in the literature that exposure to trauma may enhance or hinder a person's ability to practice social work (Black et al 1993:178-178;Earle 2008: 123). The emphasis seems to be on whether or not the person is burdened with "baggage," unresolved issues, bias or prejudice. However, deciding who is and who is not suitable for the profession is by no means obvious. There

seem to be two approaches to dealing with the dilemma. One is the use of a selection process and the other is the provision of support and counselling.

6.4.1 Selection

Rogers (1951: 434) notes: “The problem of selecting candidates for training as therapists is a perplexing one indeed. It is doubtful if any theoretical orientation has successfully resolved the issue. In our own experience it would seem that while a beginning selection may be made upon certain minimal factors, a considerable amount of self selection is desirable once training has begun. If a group is reasonably well-selected at the outset and if the training programme is free and permissive, some will discover that therapy is not their special forte and drop out. Others realise that the attitudes involved make too heavy a personal demand on them. Such self selection does not seem necessarily wasted.” It seems that the dilemma of selection remains unresolved to this day.

Rogers (1951: 437) puts forward tentative suggestions about the experiences that provide a useful preparation for training as a facilitator. These include:

- A knowledge of a person in his or her cultural setting
- Empathy with others
- A carefully thought-through philosophy of life that provides one with inner security
- Personal therapy
- Empathetic understanding of the dynamics of personality
- Knowledge of research methodology

According to Earle (2008: 93) most residential universities have limited places for social work students and implement a selection process. Apart from certain academic criteria, non-academic requirements influence the selection process. A social worker is expected to be a person with sound moral character (Clark 2006: 87). He does not indicate how that is determined. Social work standards in the United Kingdom make reference not only to the duties required of social workers, but also to the character of the practitioner.

These included conduct both at work and outside that is honest, trustworthy, dependable and not behaving in a way that would call one's suitability to work in social services into question (Clark 2006:87). He adds his own criteria, namely courage, benevolence, companion, loyalty and temperance (Clark 2006:77).

Respondents in Earle's study (2008:93) described a "good" social worker as someone who has a heart for people, wants to help others, is able to listen, knows how to make use of maximal resources, is a good decision maker and who can think on their feet. Communication is intrinsic to social work so a suitable prospective social worker was described as someone who can communicate with a diversity of people, is emotionally balanced, someone who does not suffer from mental illness, and does not carry personal "baggage." A high sense of personal responsibility and optimism were described as desirable attributes. However, selection may turn out badly. Clark (2006: 88) states: "It is nearly certain that those who select candidates for education or jobs in social work possess mental images of the person they are seeking or seeking to avoid, even if they would be hard put to describe the profile or reluctant to admit that one existed. And almost everyone with any substantial experience of selecting for professional education or employment in social work seems to have at least one story of the apparently bizarre individual who, although not obviously disqualifiable against the standard selection criteria, nevertheless deeply impressed the selector as being not the "right kind of person" to admit to the profession." It seems that explicit, measurable non-academic criteria for admission to social work do not exist (Taylor 2000: 258).

The field of psychology is faced with similar problems relating to the selection of candidates as social work departments who implement a selection process. The selection of candidates who perform below standard is an inefficient use of resources and may weaken the reputation of the University and profession as a whole as well as imposing a drain on staff (Edwards & Schleicher 2004: 592). Likewise failure to select and empower suitable applicants results in lost opportunities and loss of valuable human resources.

Selection processes tend to rely on letters of recommendation and personal interviews (Taylor 2000: 257). Both may not detect the best applicants. Letters of recommendation may vary in ways that are independent of the candidate's ability and reflect for example, the literary competence and motivation of the writer as well as the degree of interaction between the applicant and referee. Edwards & Schleicher (2004: 593) suggest that tacit knowledge is an important indicator of performance in one's career as a psychologist. They describe "tacit knowledge" as knowledge that is not often verbalised. It is usually acquired without formal instruction as judgement is brought to bear on ambiguous tasks and interpersonal challenges. Such knowledge is practical rather than academic, informal rather than formal and tacit rather than directly taught. It tends to be procedural in nature. Such knowledge emerges as one gains wisdom in life. Measuring it seems to be elusive. The concept relates to managing oneself which refers to managing one's motivation, ability to organise and one's preferences: managing others which relates to managing relationships with superiors and subordinates and peers and managing tasks which refers to knowledge about how to perform and prioritise tasks (Edwards & Schleicher 2004: 594). Such knowledge seems difficult to gauge in selections, but researchers in Earle's (2008: 119) study indicated that such factors play a crucial role in performance. At both Stellenbosch and Limpopo Universities she states that lecturers and supervisors noted that a proportion of students had "severe attitude problems." These showed up as contempt for authority, disrespect for clients and colleagues, inappropriate communication, making unrealistic demands, non-adherence to professional dress, lacking preparation for planned tasks, sloppy or incomplete work, lack of punctuality and disregard for deadlines and schedules. Students acknowledged not consulting the library and putting in the required effort. These deficiencies seem to be related to poor tacit knowledge as described above.

It seems that explicit non-academic criteria for admission to social work are elusive (Taylor 2000: 258). The relationship between pre-admission data and later problems within the social work course have been studied. The nature of these problems was not specified. It was noted that students with problems tend to be older students and those with more social work related experience.

More experienced students seem to have developed a false sense of competence and were less open to new ideas. Older students tended to be hampered by family responsibilities and struggled to adapt to reduced income. More of the students with difficulties were admitted from the waiting list or had re-applied for admission. Undergraduate marks were positively correlated with subsequent academic achievement and negatively correlated with problems (Taylor 2000: 259).

With respect to the last point, it has been shown that although cognitive ability as measured by marks contributes to students' performance, it is not the exclusive contributor. Motivation, creative and practical abilities are important in achieving real-world success once he or she completes the degree (Edwards & Schleicher 2004: 592). Students who view social work as a vocation rather than a job are more likely to complete the degree and work in the profession. Clark (2006: 82) makes the distinction between people who view their work as a job and those who embrace it as a vocation. He suggests that a vocation is an occupational role with a set of activities one is suited to, strongly identifies with and affirms with commitment, caring and enthusiasm. He suggests there is continuity between the occupational role and one's personal values. Such people are said to carry out their duties with devotion and compassion. He stresses that both professional competence and moral character are essential components of social work but does not explain how such motivation or character may be assessed. In South Africa, educators note that students who tend not to complete the degree are those who are unsure about their choice, those who chose the degree because if seems like an easy option, those for whom social work was not a first choice, those who were pressurised by the family to take the course and those who consider the pay and working conditions to be desirable (Earle 2008: 117).

These concerns are important because universities are under pressure to deliver competent professionals and improve throughput rates (Schenck 2008). Staff at the University of Limpopo considered that abandoning the selection process had a detrimental effect on throughput at the University (Earle 2008:117). They believed these problems are strongly linked to

motivation. Educators believed that selection of candidates is important to protect the reputation of the profession (Earle 2008: 96). Educators seem to have an impression of the type of person who would be deemed unsuitable. Such qualities included lack of life experience, lack of academic ability and persons with the potential to violate professional standards such as persons with a criminal record (Taylor 2000: 256). Clark (2006: 84) asserts that certain characteristics are accepted as making a person unfit for social work. He states: “First, there is no doubt that individuals with a history of grave offences against the person will rightly be accepted for social work only after the most serious and penetrating enquiry as to their present attitudes and character. Secondly, it is standardly accepted that an individual with deep seated and irremediable recent sexist or similar attitudes must be deemed unfit. Third, serious deficiencies of sociability or seeming inability to form constructive working relationships will normally be treated as contra-indications.” He supports selections in his conclusion: “It is right therefore, to attend to the character as well as the technical skill of individuals who wish to work as professionals in the human services” (Clark 2006: 87-88). When one considers that half the students in this study were victims of sexual trauma, 5 had a parent murdered 6,4% were rape victims and almost 88% were victims of violence at home or school, it seems most participants in this group have a history of “grave offences” that have been committed against them. The extent to which these students have undergone “a serious and penetrating enquiry into the effects thereof, “ as suggested by Clark (2006:87) is questionable.

Unisa is considerably more constrained than residential universities in its ability to implement a selection process because, as an open and distance learning institution, places are theoretically unlimited (Schenck 2008). This means that students may be admitted to Unisa who may violate the non-academic standards outlined above. Due to the lower cost of study fees compared with residential universities, Unisa is more likely to attract students from disadvantaged backgrounds who are under the impression that social work is a high-status profession with work related perks and are thus less likely to be passionate about the work itself (Earle 2008: 93). Results of the

current study also indicate that only half of the participants in this study received help in dealing with trauma and just over a third **of this half** report receiving professional help. This implies that a sizeable proportion of students may have unresolved issues. However, selection does not seem feasible. Selection seems to be a largely subjective process and objective criteria on which the process may be based seem elusive and ill-defined. Taylor (2000: 25) alludes to potential claims of discrimination and legal ramifications of denying a person admission to study based on the applicant's values, or unresolved personal difficulties. One of the dilemmas in selection of students is the tension between excluding some individuals and the values of social work as non-judgemental (Taylor 2000: 257). This leads to the consideration of counselling as an alternative.

6.4.2 Counselling

Universities throughout South Africa, including Unisa, are making an effort to make tertiary education available to previously disadvantaged individuals and increase student retention and completion rates (Kagee et al 1997:249; Schenck: 2008). One way of doing so is by offering mentoring and counselling to students. Studies attesting to the value of such programmes are reviewed (Kagee et al 1997; Niemand Brand & Cilliers 2006; Rickinson 1998).

A number of contextual issues influence throughput at South African Universities that offer training in social work. These include:

- The quality of prior education.
- Funding for social work education.
- Access to finance.
- Personal and family circumstances.
- Support for theoretical and practical learning (Earle 2008: 109-110).

Poor language and writing skills have proved to be a significant impediment to students' performance in social work (Earle 2008: 110). Most textbooks are in English (Earle 2008: 137). There is additional pressure on social work students to master English because it is a legal requirement that court reports

for statutory cases must be written in English (Earle 2008: 138). Niemand et al (2006: 260) suggest that many of the impediments to academic success encountered by South African students translate into being from a previously disadvantaged background. The relevance of this to Unisa is obvious. Niemand et al (2006: 266) assert that counselling can play an innovative role in eradicating inequalities arising from previously marginalised status. Kagee et al (1997: 250) assert that when students are provided with social, psychological and academic support by means of information, direction, guidance, empathy and insight into the system and fitting in, there is a greater probability for successful adjustment and success. Nicholas (1996:284) suggests that student counselling runs the risk of neglecting what he sees as the core of counselling endeavours, namely the individual student with a personal problem in a one to one counselling session.

Kagee et al (1997) implemented a programme of peer mentoring at a historically Black University in South Africa, namely the University of the Western Cape. Peer counselling was chosen, using the premise that students often have little access or inclination to seek support from formal professional services, but find fellow students less threatening, and easier to approach (Kagee et al 1997: 252). A mentor is described as a person who acts as a trusted guide or friend who assists the student to achieve maximum benefit from the University experience (Kagee et al 1997: 251). The mentor was a senior student who had successfully negotiated the transition from school to University and was able to connect with the mentee. This was found to boost confidence, allay anxiety and assist the new student to understand and tolerate various ethnic groups (Kagee et al 1997: 250-251). Mentors assisted with orientation of new students, helping students to reflect on their learning approaches, study skills, developing self-confidence and self-reliance by developing a peer network, personal counselling and career and skills development. Opportunities for referral were created (Kagee et al 1997: 253).

It was noted that 73% of students reported on improvement in grades since participation in the mentoring programme (Kagee et al 1997: 256).

Apparently a student-centred approach was adopted. Participants indicated that it was the mentoring relationship itself that was crucial to the usefulness of the programme. Mentors were described as “someone who cares,” “someone who relates to my issues” and “an encourager.” The relationship was described as one which the participant described as “a safe place for students to share their fears, joys, failures and successes.” (Kagee et al 1997: 255).

Peer mentoring benefits not only the client but also the facilitator. Mentors reported increased self-confidence, self-reliance, social skills, assertiveness and problem solving behaviour (Kagee et al 1997: 257).

Schreiber (2007:531) investigated the demographics and concerns of students presenting for counselling at the University of Cape Town South Africa. He notes that most clients were Black, undergraduate students studying in the field of humanities. He notes that historically African first-language speaking students show a higher incidence of having experienced trauma, violence, poverty and illness, which may account for the greater preponderance of black students seeking counselling (Schreiber 2007:532). The most frequently reported concern was difficulties with concentration followed by depression (Schreiber 2007:533) He notes that concentration difficulties as well as other presenting problems such as sleep problems; tiredness and fatigue may be related also to depression. Academic and exam anxiety came next in terms of frequency followed by family and relationship problems. It is important to note that these difficulties related to personal needs rather than career guidance, which is frequently the focus of university counselling. (Schreiber 2007:533). He notes that over a third of the clients said these presenting problems were perceived to affect *academic* performance “a lot.” Almost a third said they affected *social* functioning “a lot.” The author notes: “Academic performance is closely related to students’ psychological functioning and it is of paramount importance to formulate responses to the level of distress and its impact on academic functioning”(Schreiber 2007:534).

Rickinson (1988:23) explored the effectiveness of counselling intervention during the first year of study. At risk students were invited to attend counselling and were followed up during their final year (fourth year). Results showed that *all* the students who participated in the counselling programme progressed to successful degree completion and psychological distress was significantly reduced (Rickinson 1998: 100).

Results from these studies must be generalised with caution. Each took place with a small sample of students at a particular time at a particular institution. Nevertheless, no studies asserting that counselling is unhelpful were found.

Niemand, Brand & Cilliers (2006: 261) argue that student counselling has a valuable role in the holistic development of students. They state that retention figures can be increased by counselling. Likewise, they assert that academic achievement can be enhanced by counselling (Niemand et al 2006: 262). Both career and personal counselling are advocated, rather than focusing only on career counselling (Lewis 2001: 87-88 cited by Niemand et al 2006: 265).

The cost of such services is always a concern. It has been found that the use of Master's level trainee counsellors outweighed the cost of training them. It was noted that such trainees had a positive effect on the quality of services rendered (Niemand et al 2006: 264).

Lecturers and supervisors have emphasised the importance of students confronting and dealing with their personal problems before they can accept and deal with the problems of others (Earle 2008: 123). Rogers (1967:407) suggests that contact with a facilitator in a person-centred environment is needed for this process. The increase in the number of students whose backgrounds pre-dispose them to unresolved issues is cause for concern. Results of this study suggest that many students need help to overcome their difficulties so as to cope with the demands of social work. It seems that selection is not a viable or person-centred way of meeting the challenge of delivering a competent professional. The person-centred approach holds that

no-one need be trapped in the past. The literature suggests that counselling may be an effective way of meeting the students' needs. Kagee et al (1997: 252) note that students often have little or no access to formal professional services. In light of severe financial constraints experienced by the students it is unlikely that most of them would be able to afford to pay for help. There is a physical shortage of social workers, particularly in rural areas where social problems are concentrated (Earle 2008: 147). This implies that help for students is likely to be in short supply, particularly free support. It also suggests that the use of peers or Mentors level students is a cost-effective way in which such and intervention may be implemented Niemand et al 2006).

The question arises as to whose responsibility it is to provide counselling. Does it rest with the University or society?

The literature reviewed on the subject of selection suggests that being a competent social worker entails the development of a particular caring, ethical moral character and embracing the values or respect, acceptance, self-determination and social justice. It involves becoming a particular type of person. The training institution accepts responsibility to deliver a competent professional (Schenck 2008). If part of being a competent social worker entails dealing with personal problems and developing particular values and attitudes, along with skills and theoretical knowledge, these requirements cannot be delegated to others. It is ironical that academic institutions are willing to offer help with language, maths and science, which inhibit students' progress, but are far less willing to become involved in helping them overcome personal obstacles. If it is accepted that dealing with personal problems is part of becoming a capable social worker, it may be argued that it is the University's responsibility to make the facilities available for students to deal with their personal issues.

It is recommended that a pilot project be instituted and evaluated in which students with "baggage" are enabled to go through a process of facilitation/counselling/personal growth. Use of peers or masters level

students would ensure that such an intervention is cost-effective and affordable.

The question arises as to whether students should be obliged to attend such sessions. In terms of the person-centred approach, the timing of such intervention should be in tune with the needs of the student (Rogers 1951:438). Forcing or coercing attendance is contrary to the person-centred approach. Providing support in this way may greatly enhance the students learning and ability to apply the person-centred approach.

7 CHAPTER SUMMARY

Participants indicated that traumatic experiences change a person. There is a loss of previously held perceptions and views, which is experienced as loss. The self seems distorted initially. Trust in others is undermined, diminishing the capacity for intimacy. People bearing some similarity to the perpetrator are stereotyped and scorned. The self may be burdened with unresolved emotions such as hate, rage and guilt. The person may lose self-esteem. In an effort to numb the pain, the person may feel disconnected and alienated from the self. This may carry the price of hampered capacity to actualise the self. The future may be perceived as bleak, further impairing motivation. Nevertheless, trauma may be a catalyst for personal growth. It may trigger a search for meaning and purpose in life. Empathy and self awareness may be enhanced. Surviving trauma may create a sense of triumph and deep satisfaction.

For some participants, trauma had been a motivation to do social work. Other reasons were given, but many participants were left with a desire to help others with their own trauma. Some went into the profession seeking personal healing. Others want to make a difference, believing the occupation fits with personal qualities. Others expressed the need to gain skills. Some were inspired by a social worker, who had helped them.

The results suggest that it is a myth that participants avoid clients going through trauma that is similar to their own. No statistically significant

relationship could be found between participants who had experienced a particular stressor and those who had not in terms of their tendency to avoid clients with similar problems. It may well be that the responses of students to trauma is rather idiosyncratic and not adequately detected by the rather two-dimensional quantitative data collected and analysed in this study. These findings were based on somewhat limited experience in actually working with clients. Qualitative results suggest that participants may work with such clients with considerable discomfort.

Participants revealed a number of coping strategies that they use to deal with trauma. Religion and music seemed to play a dominant role in this group. A number of cultural rituals were described. The results suggest a need for further intervention, particularly as only half the participants report receiving help. Just over a third of this half received help from a psychologist or social worker. Family and friends were the main sources of support. Notwithstanding this lack of counselling, of the 60 participants that received help, 85% reported that the help was beneficial. This suggests a need for further intervention. The factors that promote resilience warrant further investigation.

The controversy surrounding selection of students prior to admission were discussed. In the absence of explicit non-academic criteria for admission, this process is contrary to the person-centred approach. Counselling offers hope as a viable alternative. Peer counselling has been shown to be a cost effective way of implementing such an intervention (Niemand et al 2006). It is recommended as a means of helping students to deal with their issues if needed to foster their growth as social workers.

CHAPTER 11

CONCLUSIONS AND RECOMMENDATIONS

1 INTRODUCTION

The concluding chapter will provide an overview of the study. The appropriateness of the methods used, reliability and validity will be discussed. Limitations will be reviewed. Recommendations arising from the results will be presented.

2 RATIONALE FOR THE STUDY

The rationale for the study was to inform Unisa Department of Social Work about trauma in the lives of social work students. Anecdotal accounts suggested that these students had been exposed to a wide variety of stressors but nothing was known about the extent of trauma, its meaning to the students or its impact on their ability to cope with trauma, their studies or work as social workers.

3 THE AIMS OF THE RESEARCH

The Department of Social Work requested specific information to explore whether there was a need to respond to trauma in the lives of students.

The aims of the research were:

- To provide a context in which students frame of reference regarding trauma could be explored
- To generate information about the nature and extent of trauma in the group.
- To understand the perceived impact of trauma on the self of the student
- To contribute to students' growth by making knowledge available to the Department of Social Work at Unisa for use as a basis for developing training or resources that could promote students' professional development as social workers if needed.
- To transform these findings into a theoretically relevant description, exploring commonalities and discrepancies with published research to add to the body of knowledge in the field of trauma.

Based on these aims the research question was formulated as follows:

What are the experiences and effects of trauma in the lives of Unisa social work students?

This question was broken down as follows:

- How do Unisa social work students describe and conceptualise trauma?
- What experiences have students had that they regard as traumatic?
- How have these experiences impacted the self of the student social worker?
- How have they coped with these experiences?
- Are these experiences perceived to impact their work with clients?

It is believed that these questions have been adequately addressed.

4 EVALUATION OF HOW THESE AIMS WERE MET

4.1 Providing a context in which students' frame of reference could be heard

Reflections on the research process

The person-centred approach was chosen as the theoretical framework for the study. The person-centred approach places emphasis on hearing and respecting each person's perspective (Proposition 7 & 17). This study was exploratory in nature, so a theory that emphasises exploring various frames of reference, rather than imposing a pre-existing perspective on the study was viewed as coherent with the exploratory nature of the research. In this study the researcher became the learner and students became the experts. This seemed to empower the students in that a respectful context was created in which their experiences could be heard and accepted without judgement, criticism or any attempt to "correct" or change their perspectives.

The research process involved decisions regarding gathering of data. A survey was conducted. A questionnaire was constructed and pilot tested. First, the survey questionnaire contained a somewhat lengthy list of possible traumas. It took this form because the pilot test group suggested that participants should be presented with a *list of specific stressors* to gain a picture of the number and variety of stressors in a person's life. They said that

asking participants to select experiences from memory and mention them would generate fewer responses. Participants in the study confirmed this, saying that the questionnaire was an appropriate way of exploring the extent of trauma. Therefore it may be concluded that the use of a survey listing specific stressors was an appropriate means of exploring the extent of trauma experienced by participants.

The Masters students also suggested that the survey and focus groups be conducted in a workshop so that any distress that could arise could be contained. Their advice was heeded and the research material was gathered during a workshop conducted at Unisa. The use of the workshop seems to have been preferable to a mail survey and aided the research. It provided a supportive context in which the respondents' frame of reference could be explored more fully than would have been possible using for example a mail survey. It elicited a high response rate, which was 92%-93% to the questionnaire and 50% for focus groups. These figures seem to indicate that students were willing to express themselves and had a need to be heard. Participants could withdraw or not participate, but took part anyway, so it seems they were not threatened by the topic. A lucky draw was held at each venue for respondents to the questionnaire and this may have raised the response rate. It appears that the participants' experiences in previous workshops, which were conducted from a person-centred perspective, influenced the process. The norms of respect, willingness to listen to others and safety seemed established in the group. Participants seemed to value diversity and were eager to learn from each other. The researcher sensed that the racial difference between herself and the mostly Black participants aided discussion and self-disclosure, rather than hindering it. Self-determination was also evident, because, although the response rate was high, some students felt free to decline participation, or were willing to complete the questionnaire but not be part of focus groups. In retrospect, the use of the workshop for the gathering of research material was a useful way of providing a context in which students' frame of reference could be heard.

The workshop provided an opportunity for de-briefing. It also enabled the researcher to be alert to the well-being of participants. In this way it facilitated the meeting of ethical concerns.

Reflections on ethics.

The difference in response to the questionnaire, which is both anonymous and confidential, and the focus groups, where it is possible to guarantee only confidentiality points to the sensitive nature of the topic. This raises ethical concerns. Efforts were made to ensure that a safe context in which students' frame of reference could be heard was provided.

Care was taken to ensure that participants were exposed to no greater risks than would be present in their daily activities as student social workers. No effort was made to probe unsymbolised experiences (Lintvelt 2008:22). Safeguards implemented by Griffin et al (2003:226) were in place. Participants were never asked to go into detail describing their experiences. Participants took frequent breaks. The right to withdraw or not participate was emphasised and respected. The second focus group provided an opportunity for de-briefing. Follow-up counselling was available and participants were informed about these resources. It is believed that the researcher took adequate steps to ensure that no participant was harmed by participation in the study.

Participants' reflections on how they experienced being part of the research indicate that taking part in the study gave them an opportunity to consider their needs. Some seemed to be grappling with the need to set boundaries between their own emotions and triggers and the experiences of clients. Others seemed proud they had survived and the research helped them to symbolise their strengths and self-concept as "a survivor." The study provided participants with the opportunity to think about their experiences. In asking "when I speak to someone going through a similar experience I...." or "how did this experience affect your view of yourself/the world/others/the future?" Participants were given the opportunity to reflect on their experiences and their implications as a counsellor. In asking "how did you cope?" or "did you grow as a result of this?" participants had the opportunity to recognise their strengths. If participants became aware of things that hamper them, they had

the opportunity to consider remedial action. Resources were made available to these participants. Many participants experienced the research as healing and were proud of their ability to survive.

4.2.1 Gaining increased knowledge about the nature and extent of students' traumatic experience

Reflections on the use of a mixed paradigm

In this study, extensive use was made of triangulation. This met the goal of gaining increased knowledge about the nature and extent of students' traumatic experiences.

Research material was gathered from both questionnaires and focus groups. This means that the topic was explored from a variety of perspectives. Both quantitative and qualitative data were collected. When triangulation is used, data are gathered from multiple perspectives so that distortion that could arise from a single source is minimised (Krefting 1991: 218). The use of multiple perspectives gave participants a variety of means by which their perspectives could be disclosed, increasing the knowledge gained.

The quantitative component provided a profile of students in terms of demographics. It also explored accumulation of stressors in a person's life (pile-up). Results of this aspect of the study indicate that Unisa social work students have been subjected to a wide variety of stressors and most have encountered multiple incidents. The incidence of trauma is skewed with a tendency towards more rather than fewer incidents. Knowledge about the prevalence of trauma was required to determine whether the need is extensive enough to warrant intervention. The extent of the need is demonstrated by these results.

The intensity of trauma-related distress perceived by participants was made visible by means of a rating scale so the relevance of questionnaire items could be ascertained. Results for trauma-related stress indicate that all the items on the questionnaire were rated as more than moderately distressing by participants who had actually experienced the stressor, so it may be

concluded that all items were perceived as traumatic and relevant to the group. Although the questionnaire may be criticised for adopting a broad view of trauma, it was based on students' frame of reference and one of the aims of the research was to understand trauma from the perspective of the participants themselves.

Both the quantitative profile and qualitative, personal comments were needed to address the research question adequately. Figures do not give access to the nuances of meaning that experiences hold for people. This was accessed by the qualitative component of the study. The responses generated provided insights that are often missing in more traditional approaches. In keeping with the person-centred approach, each participant's experience was regarded as valuable and unique. This departs from the positivist assumption that everyone shares the same meaning system and experiences the world the same way (Neuman 1994: 63). Rather than searching for universal patterns, including patterns that confirm existing research found in the literature, the value of the qualitative data presented lies in the description generated, which can provide insight to those wishing to support and empower the participant in his or her goal of entering the social work profession. This met the goal of providing information about the students' perspectives to the Department of Social Work.

4.3 Understanding the impact of trauma on the Self.

The impact of trauma on the self of an individual is known only to the person him or herself and the use of a qualitative paradigm gave access to this realm. Qualitative data captured nuances in different people's response to trauma. Participants indicated that encounters with trauma may be a catalyst for growth. Such participants reported greater self-awareness, openness, flexibility, empathy and appreciation of life. Other participants indicated that trauma had compromised their quality of life. Perceptions of the self, others and the future had been reconstructed to form a more pessimistic outlook. A comparison of the students' responses with the literature suggests that these students may have difficulty in implementing the person-centred approach. This finding is extremely relevant to educators working with these students.

One of the concerns of the University is meeting the urgent need for social workers in South Africa by improving throughput. However, throughput cannot be increased by compromising quality. If students are hampered in their ability to implement the theory, it is imperative that this difficulty is addressed.

Quantitative and qualitative findings complemented each other. For example, although students indicated that they would not actively strive to avoid clients whose trauma is similar to their own, these quantitative findings were complemented by qualitative responses, which indicated that participants may work with such clients amid great inner distress.

4.4 Providing a foundation on which interventions can be based.

One of the aims of the research was to provide a foundation on which interventions may be based. Attention was given to methods of data analysis to ensure that the analysis was coherent with the theoretical approach adopted and that trustworthy findings were produced. It is essential to consider the reliability and validity of the methods used to gather and analyse the data to evaluate the trustworthiness of the findings. Care was taken to provide credible findings, taking reliability and validity into consideration.

4.4.1 Coherence between the exploratory nature of the study and the research process.

In keeping with the exploratory nature of the research, the process proceeded in phases. Each phase was modified in response to feedback. Adopting a flexible design was deemed appropriate in view of the exploratory nature of the study. Rigid planning was not possible because so little was known about the topic and it was necessary to modify the researcher's plans in response to feedback.

The researcher endeavoured to ensure trustworthiness of the findings by revising the questionnaire several times before compiling this report. Items for the first questionnaire were generated by six third-level social work students. This instrument was pilot-tested by eleven masters'-level students and modified in response to feedback. The revised questionnaire was distributed

to 98 fourth-level students in 2006. Demographic data, the description of trauma and responses regarding the effect of trauma were retained and the questionnaire was revised again. This revision was used in 2008 and forms the basis for this report. In 2008 focus groups were conducted to give participants an alternative voice and complement the qualitative responses generated thus far.

4.4.2 Coherence between the hermeneutic approach and the person centred approach.

Qualitative data were analysed using a hermeneutic approach. A hermeneutic analysis focuses on both empathy and distanciation. This is coherent with a person-centred approach, with its emphasis on wholeness (proposition 3) and empathy (proposition 17).

In keeping with the hermeneutic approach, the qualitative aspect of the study presented students' responses informed by the researcher's understanding and interpretation. A feature of the person-centred approach is that it acknowledges that the meaning of any experience is influenced by perceptions and that each person/researcher may perceive things differently (proposition 1 & 2). Another researcher may have constructed the report differently. The study may be criticised for not having adopted a positivist approach and not using existing questionnaires or seeking to diagnose and classify participants, for example, as those suffering from PTSD and those who are not in terms of a widely used classification system such as the DSM IV-TR. Such classifications are consistent with a positivist paradigm and medical model but not with the person-centred approach which emphasises the uniqueness of each person's experience. For example, in a country with as much violence as South Africa, so-called abnormal responses such as hyper vigilance, as described in the DSM IV-TR may be life-saving survival strategies. If a pre-existing questionnaire had been used, many examples of trauma pertaining to a unique context, namely South Africa, would have been missed e.g. the kangaroo court, taxi violence, poverty and political violence. Instead the voice of the positivist, medical model was heard in the literature study as another frame of reference.

4.4.3 Reliability and validity with reference to the study

It is important to consider reliability and validity in a study such as this to establish the trustworthiness of the findings (Krefting 1991:215). (these concepts were discussed in chapter 3).This is particularly important if the study is to provide a foundation for possible interventions so that time and money are not wasted on interventions based on spurious findings.

With respect to the quantitative aspect of the research, care was taken with the construction of the questionnaire to ensure that it posed questions that the respondents could answer (Stiles 1993: 606). Categories were kept as discrete as possible. The instrument was pilot tested to discover any confusion in the wording or meaning. However, the study was exploratory and descriptive in nature and there was no intention to infer anything about the population as a whole. The aim was not to measure trauma, so no tests to establish concurrent or divergent validity with other instruments were needed. The questionnaire did not focus on correlations or other inferential statistics so specific tests of reliability or validity were deemed unnecessary (Fletcher 2006: Personal communication). Demographic data were analysed using SPSS for Windows. The statistics are descriptive rather than inferential.

In qualitative research, transferability is a concern (Krefting 1991: 22). The description provided is deemed adequate to assess the transferability of findings. Krefting (1991: 220) states that the transferability of qualitative data from one group to another may be established by comparing the demographics of the groups in question. Detailed demographic data are presented for the benefit of any other future researchers who may wish to replicate the study.

With respect to the qualitative aspect of the research, much may be said to establish the credibility of the research.
According to Stiles (1993: 601-602) reliability concerns the procedural trustworthiness of the research. The report should convey what another person who was observing the process would have seen. (Krefting 1991: 221)

observes that it is important to provide a detailed description of the research process so that the reader can follow the “decision trail” of the researcher. A detailed description of the setbacks, revisions and changes in the research process are presented in Chapter 8 of this report.

During the interviews, Stiles (1993: 606) states that reliability is enhanced by keeping the focus of interviews or questions that respondents can answer. The emphasis is on what they have experienced rather than why. This was done in both written responses and focus groups.

Reliability is strengthened by repeated interviews (Stiles 1993:606). Conducting focus groups at different times in different places gave the researcher the opportunity to conduct a series of interviews and explore emerging insights.

Stiles (1993: 604) believes that reliability is facilitated by immersion in the material and reading and re-reading the transcripts, moving between the unabridged form and discussion with mentors. The researcher transcribed and listened to the tapes of the interviews, coded the data and re-read the transcripts several times. Doing the research in 2006 and repeating it in 2008 ensured that she was fully immersed in the topic. Her promoter was consulted repeatedly, particularly during the explication of the data. These chapters were re-written several times.

Krefting (1991: 220) suggests that credibility of qualitative research can be strengthened by the authority of the researcher. The researcher acts as a measuring instrument. Trustworthiness of the “researcher as a measuring instrument” depends on:

- The researcher’s familiarity with the phenomenon and setting up of the study.
- Strong interest in theoretical knowledge and the ability to conceptualise large volumes of data.

- The ability to take a multidisciplinary approach and look at the phenomenon from different viewpoints.
- Good investigative skills. These may be developed from the literature review, course work and experience in qualitative research.

The researcher met these criteria. She was familiar with the setting of the study. Her training at Unisa exposed her to workshops as a student. Once she qualified, she had experience in facilitating workshops in the Department of Social Work. She conducted the trauma workshops in 2006 prior to the final study in 2008. Therefore, she was very familiar with the setting in which the research was conducted.

The researcher was able to adopt a multidisciplinary approach, as she used to practice as a physiotherapist. Having a medical background, she was able to grasp concepts from the medical model. She holds a Masters degree in psychology, so had a grasp of psychological theories. She also studied social work, which enabled her to view trauma in its broader societal context. The researcher had strong interest in theoretical knowledge and good investigative skills. She had training in Research psychology and had used qualitative methods in obtaining her Master's degree. Work in private practice had strengthened her skills in interviewing and facilitating groups. These considerations show that she met the criteria listed above. Therefore she may be viewed as a trustworthy measuring instrument.

Validity concerns whether an interpretation is internally consistent, useful, robust, generalisable or fruitful (Stiles 1993: 607). In qualitative research it refers to an account that is grounded in the data. The emphasis is on enabling the reader to understand the subjective world of the participants, rather than on facts. Misinterpretation is a particular danger in qualitative research. This risk is augmented by reliance on limited sources. The risk can be offset by exposing oneself to multiple perspectives (Stiles 1993: 608).
In this study extensive use was made of triangulation. Both quantitative and qualitative data were collected. Qualitative data was gathered from written

responses to questionnaire items as well as focus groups. Perspectives were probed in the focus groups in order to negotiate meaning. The researcher also consulted the literature as an alternative voice in which psychological and medical perspectives were explored.

The validity of qualitative research may be assessed by its impact on the researcher, the theory or participants. It may produce change or growth. The researcher's own ideas were changed by the study. Her view of trauma as a violent encounter with man, nature or machines was altered and broadened to incorporate the participants' view of trauma as a threat to the self. She became aware of the participants' resilience. She was challenged to give greater thought to "resilience" rather than "damage" as an outcome of trauma. Stiles (1993: 612) refers to such changes in the researcher's thinking as "reflexive validity." Her awareness was expanded by the participants, who challenged her to consider the spiritual dimension in coping with trauma.

Stiles (1993: 611) refers to the extent to which the research re-orients, focuses or energises the participants as catalytic validity:

- Participation in the research gave participants the opportunity to develop a concept of trauma and to reflect on a variety of responses and attitudes that were useful in dealing with it.
- Some experienced enhanced self-esteem and joy in seeing themselves as "warriors", "heroes" or "survivors."
- Others had the opportunity to consider their role as social workers and whether they needed support in dealing with their experiences to enhance their ability in this field (Stiles 1993: 611).

The research had a major impact on the researcher. As a former physiotherapist, she had entered private practice with the intention of starting a chronic pain clinic. As a result of the research, her practice was re-orientated to dealing with trauma. She has negotiated a sponsorship with a local security company to offer help to members of the community who go through trauma. She is involved with children from a children's home. She and

a colleague have also assisted members of a previously disadvantaged community to set up a project in which members of the community patrol their area on foot as a crime prevention strategy. The local security company supplied the patrollers with radios and backup. Collaboration with the police is strong. Within the first year, these foot patrollers had recovered nine stolen vehicles. The research made the researcher aware of the contextual societal systemic nature of crime and enabled her to respond to the community as a whole, not just the individual. This was a shift in her thinking and involved practical change. Such validity is referred to as catalytic validity (Stiles 1993: 611).

Stiles (1993: 608) suggests that validity is also established by the coherence of the report that can best be assessed by the reader. This refers to the internal consistency and comprehensiveness of the report and the extent to which elements in the report are related. The report may encompass other accounts confirming them, supplementing them or super ceding them. A thorough and comprehensive report has been presented.This account overlaps with many aspects of the literature study. It also transcended it, offering insights gleaned from the unique context of Unisa social work students living in South Africa, with its partially African culture, apartheid history, the history of the Struggle, Bush war, African belief in ancestors, poverty in the midst of plenty and the students' motivation to better the society in which we live.

These considerations indicate that the findings are credible and trustworthy and that the requirements of reliability and validity have been met.

4.5 Adding to the body of knowledge in the field of trauma.

Social workers are involved with serving traumatised clients, so adding to the body of knowledge in the field of trauma is a contribution to the profession of social work.

The study consisted of two parts, a literature survey and a practical component. The practical component was designed to provide a context in

which participants' frame of reference could be heard and respected. The literature survey provided an alternative perspective to that of the participants. It was not used to validate participants' responses, nor to evaluate or judge them as "right or wrong." The literature study served to equip the researcher with background knowledge of trauma. It also served to highlight unique perspectives presented by the students. The qualitative component placed the research in context. It elicited comments that are linked to the South African situation. These findings were compared with the literature. Some were consistent with published research and others contrasted with it. These perspectives were highlighted by the hermeneutic method adopted for the data analysis. No studies of this kind were found in the published literature, so the research highlights the meaning of trauma in the South African context, as perceived by students studying at Unisa. Therefore this research is of value to social workers serving clients in the South African context. A hermeneutic approach, with its emphasis on meaning in context was seen as an appropriate means by which the influence of the context in which the students operate could be accessed. A hermeneutic approach highlighted features of the participants' world on many levels, namely, that of the individual, that of a student, Unisa's social work training and that of South Africa as a whole. This method of analysis furthered the last aim stated above, namely, that it facilitated an exploration of commonalities and discrepancies between research findings and published research. Thus the study could contribute to the body of knowledge in the field of Social Work particularly with regard to trauma.

4.6 Reflections on establishing the need for further intervention

One of the aims of this research was to establish a basis on which interventions may be implemented if needed. The research indicates that interventions *are* needed, and specific recommendations are made at the end of the chapter. Qualitative data from focus groups suggest that many participants felt the need for help in dealing with trauma but many students indicated that they could not afford to pay for professional help. The most common sources of help available to students were family, friends and religious leaders. Only half the participants had actually received help in

dealing with trauma and of that half only 38.3% received assistance from a psychologist or social worker(less than 20% of the total). This is indicative of the lack of resources in South Africa. This is of concern because only two participants said they did not benefit from the help they did receive and three felt they benefited a little. This indicates that receiving help tends to be useful but participants were limited by the resources available to them. It also implies that it is vital to increase the throughput of social work students because therapeutic social work services are clearly unavailable, so few students have access to professional support.

5 LIMITATIONS OF THE STUDY

Rubin & Babbie (2005:124) suggest that the most commonly stated purposes of social work research are exploration, description and explanation and that research may have more than one purpose. In this study the purpose of the research was both exploratory and descriptive. Description may involve both quantitative and qualitative research. The emphasis was on exploration. Exploratory studies seldom provide satisfactory answers (Rubin & Babbie 2005: 124). They hint at answers and give insight into methods by which fuller conclusions can be reached. Therefore most of the recommendations related to this study point to the need for further research. Rubin and Babbie (2005:124) explain that this is because exploratory studies seldom use samples that are representative of the population. The following limitations to this study were identified:

- The context of the research was limited to Unisa and only social work students in fourth level participated. Different results may have been found elsewhere, with students in different levels or different courses or at other Universities. The results are therefore not generalisable to other groups. Instead a full description of the context and process is provided so that the transferability of findings can be assessed.
- The research was carried out in English. This is the medium of instruction at Unisa so it was presumed that respondents could read and write English. It was too costly and impractical to conduct the study in all eleven official languages. Language may have been a barrier because 80% –

90% of participants were responding in a second language. The use of a second language may have limited some participants' participation in the focus groups.

- Use of a second language may have led to misinterpretation of some questions, which was not picked up in the pilot test. For example, the question "I heard or saw the physical abuse of a family member" seems to have made sense to participants, but "I heard or saw the rape of a stranger" seems to have been understood as "I saw or heard about the rape of a stranger." This may have inflated figures for this item.
- In retrospect, it would have been advisable to define terms in the questionnaire more fully. For example, several participants indicated that they had experienced "extreme poverty" but the meaning of such terms was not clearly delineated. When participants rated their level of distress, it is not clear whether this refers to their current distress or distress at the time of the incident. Similarly, it is not clear whether help was received at the time of the trauma or later.
- Traumatic experiences may remain unsymbolised, so it is possible that a person may indicate that he or she has not had an experience when in fact they have because the person is simply unaware of what happened.
- The research focused on the participants' *perceptions* of the effect of trauma. These effects may not be known to *all* participants, because they may be unsymbolised.
- Some of the groups were very large due to circumstances beyond the researcher's control (e.g. in Johannesburg the co-facilitator was ill). In Pretoria the group was much larger than anticipated). This may have limited participation by some students.
- The timing of the research could have imposed limitations on the information generated. The research was carried out early in the 2008 academic year. At this time students had limited experience in working with clients. They may not have been aware of the influence of their own trauma on themselves as social workers, after being exposed to clients for only a short time. Information about the impact of trauma on the self of the social worker gleaned from the trial in 2006 was limited, because students

interpreted the question relating to the topic in different ways. This aspect of the study requires further exploration.

- The rating scale used to assess trauma related stress has not been validated. It was beyond the scope of this study to construct a measuring instrument which could be applied to the population as a whole. Further testing would be needed to support the validity of this instrument.
- During the first phase of the research (2006) the questionnaire took too long to complete. There were flaws in the construction of the questions in that categories of trauma overlapped making analysis difficult. In the end only demographic data examples of trauma from 2006 were included in the report. Data concerning specific traumas were excluded because of these problems. As a result valuable time and energy were wasted.
- The topic was very broad and this made the study unwieldy.
- The qualitative aspect of the study was time and labour intensive. This made the costs of the study high.
- The researcher selected, interpreted and articulated various themes and meanings from the qualitative data. These were discussed and explored with her mentor. However, the themes disclosed are limited to her grasp of students' meanings. Different meanings and interpretations may have been noted and articulated by another researcher.
- The study may be criticised for not using other methods or existing questionnaires to facilitate comparison with published research. This approach would have been inconsistent with the person-centred approach. If such questionnaires had been used insights pertaining specifically to the South African context would have been missed.
- The broad definition of trauma adopted by the participants may be viewed as one that inflated the results for pile up. Detailed figures for each example of trauma have been provided for the benefit of other researchers who may wish to narrow the list according to their own theoretical perspectives. Using the participants' conceptualisation of trauma rather than a questionnaire that has been used elsewhere limits direct comparison with existing research.

- A limitation of the study relates to the voluntary nature of participation. This may have influenced the results in undetected ways. Reasons for non-participation were not always given but students' right not to take part was respected.

6 RECOMMENDATIONS

The following recommendations can be made:

- South Africa is in dire need of social workers (Earle 2008:51). This suggests that any intervention aimed at excluding potential members of the profession, such as selections, would be counter-productive. Instead, it is recommended that a counselling facility should be established to assist students not only with career guidance, but also emotional issues. Such a facility should be staffed by people other than lecturers, for ethical reasons, namely that dual relationships between supervisors and trainees are not advisable (Adams & Riggs 2008:31). Senior students could assist those at a lower level as peer counsellors (Kagee et al 1997: 252). It has been shown that the use of Masters level students is a cost-effective way of offering counselling to students (Niemand et al 2006:264). It is also noted that students tend to approach peers more readily than others for such help (Kagee et al 1997: 252). A system of support of this kind can provide a valuable learning environment for fourth level students, who could complete their practical work within such an organization. This would make counselling available to students at all the learning centres, overcoming difficulties with accessibility.
- O'Leary (2005: 272) suggests that small incremental change should be implemented. Change can be phased in over a period of time. It is further recommended that student counselling should be approached as a community project within Unisa. A project should be implemented at one or two centres and the effect thereof evaluated. The project could be staffed by volunteers or by peer counsellors. If the latter option is adopted, a funding proposal for skills development should be submitted because the counsellors would be gaining skills while

working on the project. University supervisors could oversee the counselling process. The project could be replicated in other areas once its effectiveness is established.

- Students and supervisors could be asked to identify organisations and resources within their communities where counselling services are rendered at low cost or no cost. These lists would be made available, with contact numbers, to all social work students.
- Workshops dealing with specific counselling needs of students could be incorporated into the training. These groups could take the form of therapy groups. Specific areas of need were identified in Chapters 9 and 10, namely, sexual trauma, violence, crime and bereavement.
- The training offered to Unisa social work students with regard to trauma should be broadened and deepened. It has been noted that adequate skills are a buffer against secondary traumatic stress (Adams & Riggs 2008: 32). The workshop should be extended over more days and deal with several types of trauma including, for example, a specific workshop on suicide intervention, domestic violence and complex traumatic stress.
- More needs to be done to make students aware of the importance of self-care. Students should be required to keep a diary of their own self-care and share their strategies with each other (Radey & Figley 2007: 212; Adams % Riggs 2008:31).
- Supervisors and facilitators should be alerted to indications that a student is suffering from secondary traumatic stress as described in Chapter 7. Such students should be given extra support and referred for counselling.
- During supervision some time could be spent discussing triumphs and successes. This is known to be a valuable buffer against burnout (Radey & Figley 2007:213).
- A number of excellent self-help books are available to assist people who have been through trauma. It is recommended that the library should be requested to purchase a number of these books. A list of

titles could be supplied to students so that they can make use of this resource.

- Findings in this study were compared with published research so that commonalities and discrepancies could be discerned. It was noted that many studies equate signs of being traumatised with those of PTSD. Participants' perspectives were, however, closer to the notions of the person-centred approach in that trauma was viewed as an experience that threatens the self. Western models are frequently criticised as being of questionable value in an African context. The fit between the person-centred approach and students' responses suggests that the person-centred approach is a model that may be readily embraced by South African social work students. It is acknowledged that participants were familiar with the model and this may have channelled their thoughts in that direction. However, participants were not asked specifically to apply the principles of PCA to the research. The link emerged from the data itself. This suggests that the PCA is an appropriate model for training of South African social work students. It is recommended that Unisa should continue to use it as its theoretical base.
- Although not specifically part of this study, students seem hampered by poor English. One can note this when reading written responses and listening to the tapes. It is suggested that the Unisa Department of Social Work and the Department of English could work together to develop a course that is geared for social workers. This course could focus on report writing, compiling process notes from case studies, expanding vocabulary for feelings, experiences, values and perceptions as well as grammar, presentation skills (e.g. case presentations) and advertising social work activities such as groups and community projects.
- O' Leary (2005: 284) points out that, for research to be useful, the findings and recommendations must be disseminated. One of the aims of this project was to provide information to the Department of Social Work. This has been done in the form of a written report. It is

recommended that these findings should be presented to all lecturers and supervisors to raise awareness of the students' needs and to alert them to the possible deleterious effects of students' own trauma on their work clients. It is further recommended that the findings should be made known to the University authorities in the form of a presentation so that thought can be given to appropriate interventions. Findings could also be presented at academic conferences. The outcome of the study could be made known at the South African Council for Social Services Professions, because, if students have experienced trauma, most likely professional social workers have as well. This has implications for the profession as a whole and suggests a need for wider support amongst colleagues.

7 FURTHER RESEARCH

The study suggests a number of lines of enquiry for further research:

- Further research could investigate more fully the needs of Unisa social work students in dealing with trauma. This study indicates that they are a vulnerable group and that few have had access to professional help. Factors that prevented students from receiving care should be identified so that these obstacles can be overcome.
- The research was limited to students at Unisa. It would be useful to repeat a study of this kind at a residential university to see whether students there have been exposed to similar levels of stress.
- The research was limited to the fourth level of study. It would be useful to repeat the research with the remaining social work students to see whether they, too, are a vulnerable group.
- People who have been through trauma are known to select careers in the helping professions, particularly psychology and social work (Adams & Riggs 2008:29; Black et al 1993: 171). It would be useful to compare findings from studies with social work students with those from other occupations to see whether the needs of social work students differ from others, or whether the need for trauma intervention extends to other students in the University as well.

- If Unisa social work students have been subject to extensive trauma, it is plausible that people who have entered the profession have as well. The extent of trauma and help received by qualified social workers should be fully investigated. It is possible that the high level of drop-out from the profession stems from the stress of unresolved trauma within this group. Such a study may provide useful insights into a possible need for intervention to prevent the shortage of social workers from worsening.
- Half the participants received no help and 18.3% of those who got help received help from a social worker and 20% of those who got help saw a psychologist. This finding points to a lack of services within the community. It is possible that the policy changes discussed in Chapter 6 have led to an imbalance between community work and casework within organisations. Findings in this study show that many participants were struggling with personal issues that could not be addressed by community work. The possibility that the need for individual counselling is being overlooked in welfare organizations warrants further investigation.
- It would be useful to undertake a study in which students' performance in the practical work could be linked to the extent of resolved/ unresolved trauma to establish whether there is a causal link between the two.
- The literature suggests that trauma may manifest as physical symptoms in other cultures. Participants in this study did not refer to physical symptoms as an indication of trauma. Perhaps they were unaware of this link. This may be an interesting area of enquiry.
- Participants in this study had come through a variety of experiences and had achieved in their studies right up to fourth level despite the obstacles they had faced. Factors that promote resilience and coping warrant further investigation.

8 THE CONTRIBUTION OF THE RESEARCH

The research has made a contribution to the Profession of Social Work and body of knowledge within the profession.

The research has achieved its goal of providing information about the nature and extent of trauma amongst social work students at Unisa. A comprehensive report on the matter has been compiled together with an account of the procedures and methods adopted. The research process allowed the voice of the participants to be heard so that their needs and experiences could be articulated .Because the focus was on social work students, it has value for the Profession of Social Work.

The researcher's medical background as well as her knowledge of psychology and social work enabled her to articulate a link between the propositions of Rogers' (1951) person-centred approach and the findings emanating from research within the medical model. No previous research linking these disparate models was found. This is a contribution to the theoretical knowledge base of social workers using the person-centred approach.

O'Leary (2005: 6) suggests that research can produce data that can be a catalyst for change on a number of levels. She conceptualises these levels as a pyramid. The base of the pyramid is professional development. The next tier is practice, followed by programmes. The next level is policy. Change at all these levels may influence the culture of the organisation. At the level of professional development, she suggests that research has an impact on the researcher and that personal growth is inherent to conducting research. Moving up the hierarchy, research may impact practice. It may provide data that allows individuals, organisations or communities to reflect on what they do. At this level the research may take the form of a needs assessment, evaluate new practices or try out new ideas. At the level of programmes, the emphasis of the research is to change the projects, procedures and strategies in a systematic way. Finally, research may influence policy, that is, the guiding principles and directions of the organisation or community.

At the level of practice, this research has taken the form of a needs assessment, providing an overview of the situation pertaining to social work students, with a view to determining the need for intervention (O'Leary 1995: 8). The need for such intervention has been demonstrated. Recommendations about how the need may be met have been provided.

The research can impact programmes for change. The research has provided data on the extent of the problem that indicates that the situation warrants attention. Data on the effect of trauma on the self implies that students' ability to acquire skills as social workers may be hampered by their history of trauma. Published research indicates that personal growth and maturity are required to practice social work, irrespective of the theoretical orientation adopted. These concerns suggest that low throughput may be partially addressed by finding ways of assisting social work students to overcome the deleterious effects of trauma in their lives. This would further the goals of both the students and the University. It would also further goals of the profession by increasing the number of social workers to meet growing needs.

Louw (2007: 405) and O'Leary (1995:6) explain that research may influence policy. Here the research goal is to make a contribution to the guiding principles of an organisation. This study suggests that the policy of using the person-centred approach with South African Social Work students should continue. It demonstrates coherence between students' perceptions and the person-centred approach. It suggests that the PCA is a useful model for training social work students. It suggests, that, in keeping with the principles of the PCA, more needs to be done in terms of facilitating social work students' personal growth and the amelioration of the effects of trauma. It suggests changes to the curriculum, such as a more extensive, specific preparation for trauma work and greater attention to self-care. These considerations may assist social work professionals in the long term by preventing burnout and drop out by members of the profession.

O'Leary (1995: 7-8) suggests that research can facilitate the personal development of the researcher. In this study, the researcher is practicing

Social Work. Her knowledge and understanding of trauma were expanded. It re-oriented her private Social Work practice. Her communication skills were enhanced. Her ability to think critically about the literature and existing knowledge expanded. She was able to acquire new research skills, including skills in using Atlas ti.

She was able to produce new knowledge in the field of social work. She was also able to search the literature, integrate it with research findings and engage in evidence-based decision-making when writing recommendations. The research provided her with a pathway to obtaining further qualifications. It also led her to become more involved in the community and crime-prevention initiatives. In this way, her work as a social worker expanded to meet needs in her community which she had not considered or tried before.

However, the research has not only made a positive contribution to the life of the researcher, but also to social work students. Obviously, the promoter of this study, Professor Schenck, was aware of the results and emerging insights long before the completion of the written report. She was able to use this information as part of the motivation to set up a project for student counselling and support in Sunnyside, Pretoria. This project, known as the Bright Site Project opened in 2009. The emotional needs of students can be addressed at this centre. Because some social work students complete their fourth level studies over more than one year, it means that some students who actually participated in this study will be able to benefit from this facility. The aim is to assess the usefulness of this service, with a view to extending it to other learning centres as well. Thus the research has already been used to make a contribution to the well being of social work students, as well as other Unisa students, demonstrating the value of this study.

9 PERSONAL REFLECTIONS

This research involved the researcher in a topic that holds deep personal relevance. So I, the researcher, wish to end on a personal note.

I entered the social work profession as a result of a serious, traumatic car accident. At that time I had no intention of moving out of a career in physiotherapy that I found deeply satisfying. However, as participants point out, trauma has the capacity to alter one's life and re-organise one's perceptions, goals and dreams. I will always be grateful for the academically stimulating training and caring, person-centred environment provided by the Unisa Department of Social Work where I studied. The opportunity provided to me has led me into a new and fascinating field of practice, which I find more satisfying than my former occupation. Importantly it helped me to come to terms with my own experience of trauma and transcend it. It is my sincere desire to see this study used in some way to help my aspiring colleagues to achieve the levels of academic excellence, and personal growth needed, to become social workers. May you be enabled to enjoy the privilege of practicing our profession to the benefit of society as a whole.

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APPENDIX 1

COVERING LETTER AND CONSENT TO PARTICIPATE IN RESEARCH

TRAUMA QUESTIONNAIRE

Dear colleague

I am currently completing my doctorate in Social Work at Unisa. I am looking at painful experiences and how individuals deal with them. My special interest and field of practice is trauma. I would greatly appreciate your assistance with my study.

The nature, extent and meaning of pain/trauma in the lives of social work students has not been investigated. The profession has a responsibility towards both clients and service providers, but the precise extent, nature and effect of trauma amongst the student population is not known at present. Therefore, the purpose of this study is to explore the painful experiences of social work students in order to provide a description of these experiences. Getting inside the students' own experiences may be the key to understanding the meaning of these experiences, how students deal with pain and how they perceive the impact of these experiences. This may indicate whether support is needed and provide the basis on which effective interventions may be based.

All information will be treated as confidential. Your name should NOT appear on the questionnaire so there is no way you can be identified.

Decide if you are willing to complete the questionnaire. If you are willing, you merely have to tick the appropriate box. Please tick **all** that apply to you. Place the questionnaire in the box by the door. If you complete the questionnaire it will be taken as your consent to participate.

There will be a lucky draw for all who participate. If you complete the questionnaire please write your name ON A SEPARATE PAGE and place it in the box marked "lucky draw." DO NOT WRITE YOUR NAME ON THE QUESTIONNAIRE. It must be written on a separate page and removed for the lucky draw. This will ensure that there is **no** way your questionnaire can be identified. A prize will be given to the participant whose name is drawn from the box for the lucky draw. Only students who fill in the questionnaire qualify to enter. The first person drawn will receive R100.00.

The research may also involve participation in two focus groups reflecting how trauma is understood and how it is dealt with.

With these questions we want to determine what painful experiences our students have faced. Social workers deal with pain in others. How many of us have experienced traumatic situations?

I consent to participate in research conducted by Mrs Wade. The purpose of the research has been explained to me and I understand that participation is voluntary.

Signed……..

Please remove this slip and place in the box for the lucky draw if you wish to participate.

APPENDIX 2

LETTER TO CO FACILITATORS

LETTER TO SUPERVISORS CONCERNING RESEARCH

Dear Colleague

Thank you for your willingness to assist me with my research. I am investigating the traumatic experiences of social work students, not necessarily during their studies, but in their lives as a whole. Enclosed is a fairly extensive questionnaire aimed at obtaining a profile of the students and the nature trauma experienced. Although the questionnaire looks very long, only a few questions will apply to a particular person so it should take from thirty to forty minutes to complete. I have pilot tested the questionnaire with the MA students and they suggested that it could trigger traumatic memories for the students. With the possibility that students may access their own trauma in mind it seemed prudent to structure the workshop in a specific sequence. The outline is as follows:

1. Focus group to define trauma (from the students perspective)
2. Role play of trauma debriefing
3. Completion of questionnaire.
4. Focus/discussion group on dealing with trauma

It seems that definitions of trauma may vary in different cultures. Therefore, we would like to start with a focus group to obtain the *student's* definitions of trauma. I would like this discussion to be held before any suggestions are made about our definitions and concepts of trauma. Thereafter the students may role-play a trauma debriefing session. The MA students felt this should come before the questionnaire to avoid too much personal disclosure. Professor Schenck has sent a tutorial letter to them on the topic. Third the students may answer the questionnaire. A lucky draw will take pace to increase the response rate. I have included R100 as a prize for the lucky draw (See instructions on cover page of questionnaire). The participating respondent should write their names on a separate piece of paper. Names for the draw should not be on the questionnaire. The names should be placed in a separate container to the completed questionnaire. The first name drawn will receive the prize. It seems that there may need to be a de-briefing after completion of the questionnaire. For this reason a second focus group will be conducted focusing on dealing with trauma. Would you kindly facilitate this as well? Students in need of further help should be referred to the counselling unit (unless of course you would like to assist if need be). Referrals may be made to FAMSA if student feel they need assistance. The students in Logotherapy at the Unisa Centre for Applied psychology are available as well as the MA students in Unisa Department of Psychology. Please contact me if contact details are needed.

During the focus group the following questions may be useful to initiate the discussion:

First focus group.

- Please give your own description/perception of the meaning of trauma.
- What is the difference between trauma and stress?
- What makes an experience traumatic?
- Do certain kinds of experiences cause more trauma than others? Explain
- How are memories of trauma different to other everyday memories?
- How does trauma impact the self?
- Is trauma the same in all cultures?
- Are there specific experiences that are seen as particularly traumatic in your culture? If so what are these experiences? Please facilitate a discussion of any other aspects which may emerge.

Second focus group (coping with trauma)

Think of a situation which you experienced as painful, tragic or meaningless, a situation you could do very little about. Consider the following:

- What have you learned from it?
- How did you deal with it?
- Has it made you a stronger, more perceptive person?
- Has it given you new tasks or challenges?
- Can you use it to help others in a similar situation?
- Has it made you appreciate things you took for granted?
- What choices do you still have?
- Who helped you? What did that person do?

Thank you very much indeed for your kind assistance.
Yours faithfully

Barbara Wade

APPENDIX 3

2008 TRAUMA QUESTIONNAIRE

2008 Questionnaire

SECTION A

Please answer the following questions by ticking the appropriate box.

		TICK HERE		OFFICE USE
A1			**YOUR GENDER**	
	1		Male	
	2		Female	
A2			**Please write your age (In years) here……..**	
A3			**MOTHER TONGUE**	
	1		IsiZulu	
	2		IsiXhosa	
	3		XiTsonga	
	4		Tshivenda	
	5		IsiSwati	
	6		Setswana	
	7		Sesotho sa Lebowa	
	8		Sesotho	
	9		IsiNdebele	
	10		Afrikaans	
	11		English	
	12		Other(Specify)	
A4			**YOUR CULTURAL GROUP**	
	1		Afrikaans speaking white	
	2		English speaking white	
	3		Coloured	
	4		Indian	
	5		Ndebele	
	6		Southern Sotho	
	7		Northern Sotho	
	8		Swazi	
	9		Tsonga	
	10		Tswana	
	11		Venda	
	12		Xhosa	
	13		Zulu	
	14		Other (specify)	
A5			**YOUR HIGHEST EDUCATIONAL QUALIFICATION**	
	1		Std 10/equivalent e.g. NTC111	
	2		Post high school certificate	
	3		Diploma	
	4		Completed bachelor's University degree	
	5		Completed postgraduate University Degree	
A6			**MARITAL STATUS**	
	1		Single	
	2		Married	
	3		Divorced	
	4		Separated	
	5		Co Habiting	
	6		Widowed	

		TICK HERE		**OFFICE USE**
A7			**ARE YOU EMPLOYED?**	
	1		Yes	
	2		No	
A8			**WHAT IS YOUR OCCUPATION?**	
	1		Full time student	
	2		Part time student	
	3		Professional (e.g. teacher, minister nurse)	
	4		Clerical worker	
	5		Service e.g. waiter, hairdresser	
	6		Sales e.g. shop assistant, cashier	
	7		Other (specify)	

A9	**PLEASE GIVE YOUR OWN UNDERSTANDING OF TRAUMA**.

SECTION B
This section is about pain / trauma in your life. Some of the questions are sensitive so we appreciate your willingness to assist us. Please remember all information is confidential and there is no way you can be identified. Please tick the appropriate box. Thank you for your kind assistance.

ACCIDENTS

1. I have been involved in an accident where people have been killed or seriously injured? (Not a parent / child / spouse)					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many times?			1 Once	2 More than once	
Type of accident	Motor Vehicle		Other		
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

2. I have witnessed a car or bus accident where people were killed or injured?					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many times?			1 Once	2 More than once	
Type of accident	Motor Vehicle		Other		
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

3. I have felt responsible for the death / injury of someone else					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many times?			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

NEGATIVE LIFE EXPERIENCES

4. I have lost my home					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes			1 Once	2 More than once	
Please tick reason					
1 Fire	2 Flood	3 Poverty	4 Natural Disaster	5 Other	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

5. I have experienced extreme poverty / Bankruptcy					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many times?			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

6. I have experienced unwanted job loss / prolonged unemployment					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many times?			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

EXPERIENCED PHYSICAL OR EMOTIONAL LOSS OF SIGNIFICANT OTHER

7. My parent / Caregiver (Not spouse) died					**OFFICE USE**
1 Yes	2 No	**If no, please go to next questions**			
If yes specify your age when it happened ……..			1 one parent	2 both parents	
Please tick cause of death					
1 Suicide	2 Murder	3 Accident			
4 HIV / AIDS	5 Other Illnesses Not HIV/AIDS	6 Other cause of death			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

8. I lost my parent / Caregiver due to divorce (Not spouse)				**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**		
If yes how many times?		1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1

9. As a child (under 18) I was removed from home e.g. Sent to live with a relative / in a children's home / Foster care, etc.				**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**		
If yes how many times?		1 Once	2 More than once	
Reason for being removed from your home - please tick				
1 Abandonment	2 Poverty	3 Abuse	4 Neglect	
5 Other Reason: (Please State)				
Please indicate how distressing the experience was by ticking the scale below				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1

YOUR CHILD

10. My child died					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many children?			1 One child	2 More than one	
Please tick cause of death					
1 Accident	2 Suicide	3 Murder	4 Taxi Violence	5 Political Violence	
6 HIV/AIDS	7 Other Illness	8 Drugs	9 Name Other Cause:		
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

11. I lost my child due to problems related to my pregnancy, or my partners					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many children?			1 One child	2 More than one	
If yes please tick cause of loss of your child					
1 Stillborn Child	2 Miscarriage	3 Abortion	4 Unable to have children		
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

12. I lost my child in a custody dispute					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes how many times?			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

LOSS OF LIFE PARTNER

13. My life-partner died (husband / wife / sexual partner)					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
Please tick cause of death			1 Once	2 More than once	
1 Suicide	2 Murder	3 Accident	4 Substance Abuse	5 Political Violence	
6 HIV/AIDS	7 Illness	8 Name Other Cause:			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

14. I lost my life partner due to separation / conflict					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
1 Break-up or divorce	2 Partner was unfaithful	3 Partner was put in institution	4 Partner was imprisoned	5 Other	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

LOSS OF A CLOSE FAMILY MEMBER

15. My close relative died (not a parent / caregiver / spouse or life-partner) Relationship to you e.g. grandparent / sibling / etc.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 One	2 More than one	
1 Suicide	2 Murder	3 Accident	4 Taxi violence	5 Political violence	
6 HIV/AIDS	7 Other illness	8 Other reason			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

16. I have experienced problems in my relationship with ancestors					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

DOMESTIC VIOLENCE AND ABUSE

17. As a child (under 18) a close family member abused substances / drugs / alcohol / gambling					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

This section refers to your own direct experience of domestic violence where you were the victim

18. As a child (under 18) I was verbally / emotionally abused in my home					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			Once	Many times	
1 By a family member		2 By a **non** family member			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

19. As a child (under 18) I was physically abused in my home					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			Once	Many times	
1 By a family member		2 By a **non** family member			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

20. As a child (under 18) I was beaten by authority figures at school					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			Once	Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

21. As a child (under 18) I was bullied by learners					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			Once	Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

22. As an adult (18 and over) a close family member abused substances / drugs / alcohol / gambling					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

23. As an adult (18 and over) I was verbally / emotionally abused in my home					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

24. As an adult (18 and over) I was physically abused in my home					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

THIS SECTION REFERS TO TIMES YOU SAW OR HEARD ABUSE OF A LOVED ONE

25. As a child (under 18) I saw or heard verbal abuse of a loved one.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

26. As a child (under 18) I saw or heard physical abuse of a loved one.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

27. As a child (under 18) I saw or heard suicide attempt of a loved one.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

28. As an adult (18 or over) I saw or heard verbal / emotional abuse of a family member.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

29. As an adult (18 or over) I saw or heard physical abuse of a loved one.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 Many times	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

30. As an adult (18 or over) I saw or heard suicide attempt of a loved one.					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

SEXUAL TRAUMA

31. As an child (under 18) I was sexually abused in my home by a family member / non family member					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Perpetrator was					
Family member		Non family member			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

32. As an child (under 18) I was sexually abused outside my home environment (e.g. at school / church / friend / stranger)					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

33. As an child (under 18) I saw or heard sexual abuse of a loved one within my home					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

34. As an child (under 18) I saw or heard sexual abuse of non family member					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

35. As an adult (18 and over) I was raped					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Rapist was (Please tick)					
1 Stranger	2 Someone you knew e.g. Date/Friend	3 Spouse / Life Partner	4 Gang (2 or more people)	5 Other	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

36. As an adult (18 and over) someone attempted to rape me, but it did not take place (I escaped / rape was prevented)					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

37. As an adult (18 and over) I have witnessed / heard the rape of a family member					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

38. As an adult (18 and over) I have witnessed / heard the rape of a stranger					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 Once	2 More than once	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

VICTIM OF CRIME AND VIOLENCE

This section refers to crime or violence that does not include domestic violence or rape which were covered above

39. I have been a victim of crime or violence			**RATE TRAUMA FROM 1 TO 5 1 Not traumatic / 2 Mild / 3 Moderate / 4 Severe / 5 Devastating**		**Office Use**
1 Yes	2 No	**If no, please go to next question**			**Rate Below**
If yes please tick					
1 House Robbery when I was away	1 Yes	2 No	1 Once	2 More than once	
2 Theft - e.g. belongings when you were not there	1 Yes	2 No	1 Once	2 More than once	
3 House robbery when I was there	1 Yes	2 No	1 Once	2 More than once	
4 Assault (Not domestic violence)	1 Yes	2 No	1 Once	2 More than once	
5 Street robbery e.g. mugging	1 Yes	2 No	1 Once	2 More than once	
6 Hijacking	1 Yes	2 No	1 Once	2 More than once	
7 Taxi violence	1 Yes	2 No	1 Once	2 More than once	
8 Political violence	1 Yes	2 No	1 Once	2 More than once	
9 other	1 Yes	2 No	1 Once	2 More than once	
Office use					

40. I have witnessed crime or violence			RATE TRAUMA FROM 1 TO 5 1 Not traumatic / 2 Mild / 3 Moderate / 4 Severe / 5 Devastating		Office Use
1 Yes	2 No	If no, please go to next question			Rate Below
If yes please tick					
1 Murder	1 Yes	2 No	1 Once	2 More than once	
2 Hijacking	1 Yes	2 No	1 Once	2 More than once	
3 Assault (Not domestic violence)	1 Yes	2 No	1 Once	2 More than once	
4 Street robbery e.g. mugging	1 Yes	2 No	1 Once	2 More than once	
5 Taxi violence	1 Yes	2 No	1 Once	2 More than once	
6 Political violence	1 Yes	2 No	1 Once	2 More than once	
7 Kangaroo Court	1 Yes	2 No	1 Once	2 More than once	
9 Other	1 Yes	2 No	1 Once	2 More than once	
Office use					

ILLNESS AND DISABILITY

42. I am living with HIV/AIDS					OFFICE USE
1 Yes	2 No	If no, please go to next question			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

43. I am living with a life threatening illness (not HIV/AIDS)					OFFICE USE
1 Yes	2 No	If no, please go to next question			
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

44. A close family member is living with HIV/AIDS					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 One	2 More than one	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

45. A close family member is living with a life threatening illness (not HIV/AIDS)					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 One	2 More than one	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

46. My child has a disability (e.g. Paralysed, blind, deaf, retarded, etc.) Type of disability…					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 One	2 More than one	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

47. I have a disability (e.g. Blindness, paralysed, deaf, etc.) Type of disability…					**OFFICE USE**
1 Yes	2 No	**If no, please go to next question**			
If yes please tick			1 One	2 More than one	
Please indicate how distressing the experience was by ticking the scale below					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	

48. Please tell us about any other trauma you wish to mention	**OFFICE USE**

SECTION C

1. What motivated you to do social work?

2. As a social worker are there any types of clients you would prefer not to see if you can avoid it?

3. When you think back over your own traumatic experiences, which trauma was the worst?

4. How did the trauma affect you as a person?

5. How did trauma affect your view of other people?

6. How did trauma affect your view of the future?

7. What do you do to control the memory of trauma e.g. Eating / Taking alcohol / Work / Religion / Music / Self harm / Keeping busy / Counselling etc. Explain

8. Did you receive help?		**Yes**	**No**	**Office Use**
If yes, who helped you?				
1 Doctor	12 University lecturer			
2 Psychologist	13 University supervisor			
3 Social worker	14 Hospital staff			
4 Religious figure	15 Clinic			
5 Self help group	16 Police			
6 Lay counsellor	17 Paramedic			
7 Traditional healer	18 Employer			
8 Friend	19 No-one			
9 Family	20 Self help books			
10 Church	21 Other			
11 Teacher				
9. How much did you benefit from the help - Please explain				**Office Use**

10. Do you feel trauma as an opportunity for growth / obstacles - Please explain

Thank you for your participation

APPENDIX 4

QUESTIONNAIRE 2006

2006 Questionnaire

SECTION A

Please answer the following questions by ticking the appropriate box.

		TICK HERE		OFFICE USE
A1			**YOUR GENDER**	
	1		Male	
	2		Female	
A2			**MOTHER TONGUE**	
	1		IsiZulu	
	2		IsiXhosa	
	3		XiTsonga	
	4		Tshivenda	
	5		IsiSwati	
	6		Setswana	
	7		Sesotho sa Lebowa	
	8		Sesotho	
	9		IsiNdebele	
	10		Afrikaans	
	11		English	
	12		Other(Specify)	
A3			**YOUR CULTURAL GROUP**	
	1		Afrikaans speaking white	
	2		English speaking white	
	3		Coloured	
	4		Indian	
	5		Ndebele	
	6		Southern Sotho	
	7		Northern Sotho	
	8		Swazi	
	9		Tsonga	
	10		Tswana	
	11		Venda	
	12		Xhosa	
	13		Zulu	
	14		Other (specify)	
A4			**YOUR HIGHEST EDUCATIONAL QUALIFICATION**	
	1		Std 10/equivalent e.g. NTC111	
	2		Post high school certificate	
	3		Diploma	
	4		Completed bachelor's University degree	
	5		Completed postgraduate University Degree	
A5			**MARITAL STATUS**	
	1		Single	
	2		Married	
	3		Divorced	
	4		Separated	
	5		Co Habiting	
	6		Widowed	

		TICK HERE		OFFICE USE
A6			**ARE YOU EMPLOYED?**	
	1		Yes	
	2		No	
A7			**WHAT IS YOUR OCCUPATION?**	
	1		Full time student	
	2		Part time student	
	3		Professional (e.g. teacher, minister nurse)	
	4		Clerical worker	
	5		Service e.g. waiter, hairdresser	
	6		Sales e.g. shop assistant, cashier	
	7		Other (specify)	
A8			**Please write YOUR AGE (In YEARS) here** ……	

A9	**WHAT MOTIVATED YOU TO DO SOCIAL WORK?**

A10	**PLEASE GIVE YOUR OWN UNDERSTANDING OF TRAUMA**.

A11	**PLEASE DESCRIBE WHAT YOU REGARD AS A PAINFUL/TRAUMATIC EXPERIENCE. IT CAN BE YOUR OWN OR SOMETHING THAT HAPPENED TO SOMEONE YOU KNOW.**

SECTION B

This section is about pain in your life. Some of the questions are sensitive so we appreciate your willingness to assist us. **Please remember all information is confidential and there is no way you can be identified.** Please tick the appropriate box. Thank you for your kind assistance.

1	**Have you been involved in a car or bus accident where people have been killed or seriously injured?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

2	**Have you been hijacked?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

3	**Have you been mugged?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

4	**Have you been burgled at home?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

5	**Have you been threatened with a dangerous weapon?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

6	**Have you been shot at?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Were you injured?	1 Yes	2 No			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

7	**Have you been stabbed?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Were you injured?	1 Yes	2 No			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

8	**Have you been raped?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

9	**Have you witnessed murder?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

10	**Have you witnessed other violent crime? (Specify……)**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

11	**Have you had poor relationship with parent or primary caregiver? (Specify)……**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes	1 one parent	2 both parents		
	Please rate how bad this situation seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					
12	**Have you experienced divorce of parents?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

13	**Have you been divorced yourself ?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

14	**Have you lost a significant relationship with a partner (boyfriend or girlfriend) who was not married to you?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

15	**Have you been separated from parents e.g. sent to live in children's home or with relative? (specify)……**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	Please rate how this seems to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

16	**Have you been living with infertility?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	Please rate how this seems to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

17	**Have you had a miscarriage?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the worst incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

18	**Have you had a still born child?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

19	**Have you had to deal with teenage pregnancy (self)?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad this situation seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

20	**Have you had an abortion?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

21	**Have you lost a child due to illness?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

22	**Have you lost a child due to accident?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seemed to you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

23	**Have you been caring for family member with disability?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seemed to you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

24	**Have you been disabled yourself?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seems for you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

25	**Does a close family member have HIV/AIDS?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many family members		1 one	2 More than one		
	Please rate how bad it seems to you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

26	**Do you have HIV/AIDS?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes					
	Please rate how bad it seems to you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

27	**Does a close family member have a life threatening disease (other than HIV/AIDS) such as cancer?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seems to you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

28	**Do you have a life threatening disease (other than HIV/AIDS) yourself?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad it seemed to you to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

29	**Have you experienced violent death of close family member?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the it seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

30	**Have you experienced death of close family member in an accident?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the worst incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

31	**Have you experienced death of close family member due to suicide?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the worst incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

32	**Have you experienced attempted suicide of close family member?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the worst incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

33	**Have you attempted suicide yourself?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the this seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

34	**Have you been beaten at school by authority figures such as teacher or principal?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

35	**Have you been bullied at school by learners?**			**OFFICE USE**
	1 Yes	2 No	If no please go to next question	
	If yes how many times	1 Once	2 More than once	
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all			

Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

36	**Have you experienced domestic violence?**			**OFFICE USE**
	1 Yes	2 No	If no please go to next question	
	If yes how many times	1 Once	2 More than once	
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all			

Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

37	**Have you experienced physical abuse (hit slapped pushed or shoved) as a child?**			**OFFICE USE**
	1 Yes	2 No	If no please go to next question	
	If yes how many times	1 Once	2 More than once	
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all			

Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

38	**Have you experienced physical abuse (hit slapped pushed or shoved) as an adult?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

39	**Have you witnessed physical abuse of a close family member?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

40	**Have you witnessed sexual abuse of family member?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

41	**Have you been sexually abused/molested as an adult?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

42	**Have you been sexually abused/molested as a child?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

43	**Have been verbally/emotionally abused as a child?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

44	**Have been verbally/emotionally abused as an adult?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

45	**Have you witnessed verbal/ emotional abuse of family member?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

46	**Have experienced discrimination based on race?**					**OFFICE USE**
	1 Yes		2 No	If no please go to next question		
	If yes how many times		1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

Do you consider yourself previously disadvantaged?		
1 Yes	2 No	

47	**Do you view poverty as trauma?**					**OFFICE USE**
	1 Yes	2 No				
48	**Have you experienced extreme poverty**					
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad this seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						

49	**Have you experienced disruption of relationships with ancestors?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

50	**Have you lost your home?**					**OFFICE USE**
	1 Yes	2 No	If no please go to next question			
	If yes how many times	1 Once	2 More than once			
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all					
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1		
How does this experience affect you now?						
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..						

51	**Have you lost your job/been retrenched?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the **worst** incident seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

52	**Have experienced bankruptcy?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad the situation seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

53	**Have you experienced substance abuse by close family member (drug and/or alcohol)?**				**OFFICE USE**
	1 Yes	2 No	If no please go to next question		
	If yes how many times	1 Once	2 More than once		
	Please rate how bad this situation seemed to you on a scale where 5 is devastating and 1 is not traumatic at all				
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

54	**Have you abused drugs and/or alcohol?**			**OFFICE USE**
	1 Yes	2 No	If no please go to next question	
	If yes how many times	1 Once	2 More than once	
	Please rate how bad the experience seemed to you on a scale where 5 is devastating and 1 is not traumatic at all			

Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now?					
Please complete the following sentence: When I speak to someone who has been in a similar situation I……..					

55	**Please add any other painful experience you have been through and rate the trauma as before**				**OFFICE USE**
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now? (specify which experience)					
Please complete the following sentence: When I speak to someone who has been in a similar situation (specify I……..					

56	**Please add any other painful experience you have been through and rate the trauma as before**				**OFFICE USE**
Devastating 5	Severe 4	Moderate 3	Mild 2	Not traumatic 1	
How does this experience affect you now? (specify which experience)					
Please complete the following sentence: When I speak to someone who has been in a similar situation (specify I……..					

57	**What did you do to cope with any of the painful experiences mentioned anywhere in this questionnaire?**			**OFFICE USE**
58	**Did you receive counselling from**			**OFFICE USE**
	1 Doctor		12 Teacher	
	2 Psychologist		13 University lecturer	
	3 Social worker		14 University supervisor	
	4 Religious figure		15 Hospital staff	
	5 Self help group		16 Clinic	
	6 Lay counsellor		17 Police	
	7 Traditional healer		18 Paramedic	
	9 Friend		19 Employer	
	10 Family		20 No- one	
	11 Church		20 Other (specify)	
59	**Did you receive any other help e.g. medical help**			**OFFICE USE**
	1 Yes	2 No	If yes specify below	

60	How do you see these experiences currently? (e.g. as a challenge, obstacle , growth experience) PLEASE EXPLAIN YOUR ANSWER.	OFFICE USE

61	Does it affect your work as a social worker?			OFFICE USE
	1 Yes	2 No		
	If yes, in what way?			
	Could you change that?			

APPENDIX 5

THERAPEUTIC STORY

THE SPORTS CAR AND THE ALARM

Once upon a time there was a white Porche with leather seats and a powerful engine. It was a rare and expensive car. In order to protect his car from thieves, the owner installed the best car alarm money could buy. Even though the Porche was a car, it seemed to sense it was powerful and fast. It seemed to find pride in knowing that many boys dreamed of owning a Porche when they grew up. When the Porche was parked along the street or in a parking lot, many people would walk up to the Porche, saying very complimentary things. The Porche understood that these admirers were harmless, therefore, it made sure that the car alarm never went off. The sports car liked being admired and hearing boys and girls remark, “When I grow up, I want a Porche just like that one.”

Now, every once in a while one of these people admiring the Porche would be destructive or aggressive. They would kick his tyres or scratch the paint with a key. Even the sports car understood the difference between admiration and abuse, so he would quickly sound the car alarm. The car alarm would scream, “Get away from the car, you are hurting it.” The person who had been hurting the car was quickly scared away.

The Porche could not have designed a better life for himself. Every weekend his owner would drive him to a race track where there were no speed limits. Then the Porche would drive over 100 miles per hour. He loved to drive as fast as he could. Sometimes the Porche joined parades where he was decorated and admired even more than usual.

As happens in the lives of most people and cars at one time or another, tragedy befell the Porche. It rained and rained for days. The river that ran near where the Porche was parked, rose suddenly over its banks. As the water rose higher and higher, the Porche soon disappeared under a sea of mud. Water, mud and sand settled in the engine.

When the flood was over and the water ran once again between the banks of the river, the owner of the Porche attempted to rescue his car. He washed it, dried it and polished it, but he did not understand the damage that the flood had caused to the engine. The mud and sand from the water had settled in the electrical system, causing it to run much too fast.

Believing that driving the car would work out any problems from the flood, the owner took the Porche for a drive. When he stepped on the gas, however, rather than accelerating and running smoothly as the sports car had done before the flood, it ran off the road. It made strange noises and ran very differently from the Porche the owner was used to. Sometimes the Porche would run other cars off the road believing that these cars were trying to take his space on the road or cause him to have an accident.

When the Porche was parked and admirers approached it as they had before, the car alarm would go off. Sometimes it would even go off when people were walking down the street paying no interest to the Porche at all. The car alarm would yell, “Get away from the car, get away from the car.”

The owner did not know how to fix the Porche by himself, although at first he tried to repair it. The owner took the car to several car mechanics, but the Porche seemed afraid to allow the mechanics to work on him. When his hood was opened, the alarm would go off screaming “Get away from the car, get away from the car.” Several mechanics tried to repair the Porche. One put new oil and fluids in the engine. Another changed the battery and added a water pump. Still another changed the spark plugs and adjusted the carburettor. Nothing seemed to work, and the alarm of the Porche continued to sound even when there was no danger at all.

One day the owner noticed a newspaper article about a mechanic who specialised in repairing cars that had been damaged by floods. One satisfied customer remarked that the mechanic was so good his car was running better than it had before being covered with water and mud. Wanting very much for his Porche to function as it had before the storms, the owner took his Porche to the mechanic mentioned in the news. The owner explained that the Porche had been covered with water, mud and sand. Then the owner added, “The alarm keeps going off when there is no danger.” Furthermore, my car runs other cars off the road. Sometimes it goes too fast and at other times it goes too slow. I have had my car to many mechanics, but no one seems to know how to fix it. This is an extremely valuable car and it is very important that it is repaired. I plan to keep this car forever. It is the best car I have ever had.”

At first, the Porche sounded his alarm when the new mechanic approached him. This mechanic was different from the other ones that had tried and failed

to repair the Porche. He understood how floods can change the way an engine functions and what needs to be done so the engine can began to work in a normal way again.

“I have worked on many cars that have been through floods,” the mechanic told the owner. These cars need to be repaired in a very different way than cars that break down because of normal use. The flood has caused the electrical system in the engine to go too fast. Although this may seem very strange, it can be repaired by using the headlights.

At that, the mechanic brought out a headlight adjusting mechanism and turned on the headlights of the Porche. Then he touched the car and acted like he was going to kick the tyres as he moved the beams of the headlight back and forth. Then the mechanic rubbed the mud and sand from the flood on the engine, and again he moved the headlights back and forth. “When you are reminded of the flood,” the mechanic told the Porche, “Find a way to move your headlights back and forth until it seems as if the flood happened quite a long time ago. Soon you will find yourself staying on the road, running the way you are directed to run, and only sounding your alarm when there is real danger.”

The owner watched this mechanic moving the headlights and talking to his car. He wondered if he had made a mistake by bringing his treasured car to his repair shop. The mechanic directed the owner to take his car home and allow it to return to maximum functioning without pushing it too hard. Figuring he had nothing to lose since no one else had repaired his car, the owner drove his Porche home.

Soon, to the surprise of the owner, the Porche was running much the way it used to run. When he drove the Porche on the road, his car responded exactly as it was designed to do. When parked, the alarm of the Porche only activated when someone started to kick the car, tried to steal it or hurt it in any way. The owner drove the Porche to the racetrack for its final test. The sports car drove over 100 miles per hour; it stayed on the track and the engine purred as a car does when it believes it is the best car ever made. It wasn’t long before the Porche was running better than it had before the flood, because as all car buffs know, a great car gets better with age.

In the days that followed, when the owner noticed other cars had been damaged by the flood, he made sure to tell their owner about the car mechanic who used head lights to repair the damage from the flood. (Davis 1996:27-29)